Schwabe

February 25, 2026

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VIA ELECTRONIC MAIL

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RE: Two-Year Follow-Up Review
Transaction 006: Adventist-MCMC
Public Version

Dear Sarah:

Attached please find the response of Adventist Health Columbia Gorge ("AHCG") to your supplemental information request of January 28, 2026. Documentation supporting AHCG's responses, as well as a redaction log, have also been attached.

Please let me know if you have any questions or need anything else from AHCG in order for the HCMO division to complete its two-year follow-up review.

Sincerely,

Gary Bruce

Enclosures

cc: Karine Gialella, Oregon Department of Justice (karine.gialella@doj.oregon.gov)
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ATTACHMENT A: 006 ADVENTIST MCMC TWO-YEAR FOLLOW UP REVIEW

1. Provide a description of all activities undertaken by AHCG to further integrate AHCG into Adventist since AHCG's September 11, 2024, Response to OHA's Information Request for One-Year Follow-Up Review ("September 11 Response"). At minimum, please include detailed information regarding the following:

a. Electronic Health Record (EHR) tools and systems

AHCG has begun the process of transitioning from its current, standalone EHR to Adventist's systemwide, Epic EHR in August 2026. The hospital believes this standardization and streamlining will improve interoperability between AHCG and other Adventist and non-Adventist healthcare providers, reduce redundancies and administrative burdens, improve data quality, save costs, facilitate better clinical decisionmaking, and, ultimately, increase patient safety and improve patient care.

b. Quality and safety management systems and processes

AHCG recently upgraded its quality and safety management system to the Press Ganey platform that is being used by other facilities within the Adventist system. This platform, which is referred to by Press Ganey as the "High Reliability Platform" or "HRP," contains reporting tools, quality dashboards, AI-powered analytical tools, and other features that are designed to streamline event reporting and safety detection and improvement efforts. HRP is supplemented by Press Ganey's patient rounding tracking tool, iRound. It is also supplemented by PG Connect, a solution designed to help AHCG meaningfully collaborate with other Press Ganey clients. AHCG believes that adoption of these new tools will help it improve its quality and safety programs, and better synchronize its quality and safety enhancement efforts with the efforts of other facilities within the Adventist system.

c. Billing and payment systems and processes

On January 1, 2026, AHCG completed its transition from utilizing a hospital-specific, in-house revenue cycle team to utilizing the systemwide, centralized Adventist revenue cycle team. While this transition was taking place, AHCG outsourced a number of revenue cycle-related responsibilities to third parties. These third parties provided valuable support but, ultimately, were unable to meet all of the hospital's revenue cycle needs. The shift to the systemwide, shared service model has already started to pay dividends in the form of reduced third-party vendor costs, enhanced communication between operational service line leaders and revenue cycle subject matter experts, and improved revenue cycle metrics. For example, since January 1, 2026, the average number of days elapsing between the date when a patient is discharged, and the date the patient's items and services are properly coded for billing purposes, has fallen from 13 to 3.

d. Clinical standards and protocols

AHCG has continued progressively to adopt the policies, procedures, protocols, and clinical standards of the Adventist system. Part of this transition has involved implementing the system's Lucidoc policy management platform and the corresponding, structured approach for reviewing and approving policies and related documents. The integration of

AHCG's and the Adventist system's policies and policy management approaches is helping ensure that AHCG benefits from the expertise and experience of other Adventist healthcare facilities and providers, and is implementing clinical standards and protocols that reflect evidence-based, best practices.

e. Clinical staff employment and compensation terms

AHCG has adopted Adventist's systemwide philosophy for compensating clinical staff members who are not subject to a collective bargaining agreement ("CBA"). This philosophy is founded on the premise that clinical staff members should receive competitive, market-based compensation that rewards their hard work and dedication to providing excellent patient care. The compensation philosophy and terms for clinical staff members who are subject to a CBA are dictated by the terms of the CBA. AHCG has benefitted from the robust clinical staff recruitment support it receives from Adventist's Oregon service team. It has also benefitted from high clinical staff retention rates.

f. Sourcing of supplies and services

AHCG has taken advantage of Adventist's supply and service contracts to strengthen its buying power and secure more competitive pricing. The hospital has also reinforced purchasing compliance to ensure that supplies and services are ordered through approved, system-level contracts, whenever feasible. These efforts are supporting better financial stewardship, contract integrity, and supply consistency across the organization.

2. Describe in detail any material changes to contracts with commercial or Medicare Advantage payors for services at AHCG since the September 11 Response. At minimum, please describe in detail any changes to:

a. Insurance plans accepted by AHCG

Since submitting its earlier response, AHCG has entered into new payor contracts with Aetna and Devoted. AHCG had not previously been in network with either of these payors. Adventist's contracting team is currently working to negotiate a replacement of the payor contract between AHCG and Pacific Source CCO that existed before the merger, and to enter into new contracts with payors that serve residents of Wasco and the surrounding counties.

b. AHCG's contracted rates

AHCG's contracted rates with commercial insurers that pay on a percentage-of-charges basis have remained fairly constant over the past few years. However, new payor contracts have been supplemented with provisions that contemplate AHCG's proposed change to critical access hospital status, and the payment modifications that will accompany that change. Also, AHCG is working directly with the CCO to anticipate and account for changes to contracted rates that may stem from impending Medicaid cuts.

c. AHCG's services and locations included in contracts

AHCG has worked to negotiate and enter into payor contracts that apply to all of its services and facilities. Therefore, there are no changes to report with respect to this subsection.

d. AHCG's network status with any plans

Since submitting its earlier response, AHCG has made no changes to its network status with any plans.

3. Please provide a detailed update on AHCG's efforts since the September 11 Response to recruit and retain clinical staff at AHCG. At minimum, please provide detailed responses the following:

a. Please clarify whether AHCG has completed the process of formulating its "recruitment and retention plan" as noted in the September 11 Response. If no, please describe in detail the current status of this plan and expected timeline for completion. If yes, please provide a fully unredacted copy of the plan. If this plan is not yet finalized, please provide a copy of the current draft of this plan.

AHCG has not implemented a "recruitment and retention plan," per se. Instead, the hospital has focused on complying with Adventist's systemwide, "Recruitment and Hiring Process Policy," a copy of which is attached as **Exhibit 3.a.** This policy allows AHCG to take advantage of Adventist's standardized and proven methodologies for posting, interviewing, screening candidates, and, ultimately, hiring for new positions.

b. Please clarify whether AHCG has completed the process of formulating a "post-hire check-in and support program" as noted in the September 11 Response. If no, please describe in detail the current status of this program and expected timeline for completion. If yes, please provide a fully unredacted copy of all program documentation. If such documentation is not yet finalized, please provide a copy of all current drafts of this program documentation.

AHCG has not yet completed the process of formulating a "post-hire check-in and support program." But hospital leaders continue to work with system-level leaders in Human Resources and other departments to develop a program that can implemented across Adventist's Oregon facilities. The project is currently in the scoping and research phase, and is expected to be completed by January 2027.

4. Provide a detailed update on AHCG's operation of Celilo Cancer Center ("CCC"). In doing so, please provide the following:

a. Average number of days per week of provider coverage for each quarter in calendar year 2024.

Each quarter in calendar year 2024, CCC had medical oncology coverage an average of 4 days per week, and radiation oncology coverage an average of 5 days per week.

b. Number of unique patients and number of visits for Radiation Oncology in calendar year 2024.

In calendar year 2024, CCC's radiation oncology service had 467 unique patients in 467, and 1,013 provider-only visits.

c. Number of unique patients and number of visits for Medical Oncology in calendar year 2024.

In calendar year 2024, CCC's medical oncology service had 515 unique patients in 467, and 1,779 provider-only visits.

d. Provider Full-Time Equivalent ("FTE") in calendar year 2024. Please list Radiation Oncology and Medical Oncology separately.

For its radiation oncology service, CCC had 1.0 provider FTE (a radiation oncologist) for the entirely of calendar year 2024. For its medical oncology service, CCC had 0.8 provider FTE (medical oncologists/hematologists employed by OHSU) for the period of January to March 2024; 0.4 provider FTE for period of April to August 2024; and 1.0 provider FTE for the period of September to December 2024. These OHSU physicians were supplemented by locum tenens providers, as necessary and appropriate, to ensure that CCC maintained medical oncology provider coverage an average of 4 days per week.

e. Support staff FTE in calendar year 2024. Please list Radiation Oncology and Medical Oncology separately.

In calendar year 2024, CCC had 8.0 support staff FTE in radiation oncology, and 13.3 support staff FTE in medical oncology. The radiation oncology support staff included one patient care coordinator, one medical assistant, one dosimetrist, one physicist, and three radiation therapy technicians. The medical oncology support staff included two patient care coordinators, three medical assistants, one laboratory technician, two pharmacists, and 5.3 registered nurses.

f. Detailed information on efforts to recruit a permanent physician for Medical Oncology.

AHCG has taken several steps to recruit a permanent physician for medical oncology. First, it enlisted the support of OHSU providers to review and make appropriate revisions to its medical oncologist job description. Second, it tasked its internal recruiting team with updating the compensation amount (i.e., salary plus RVU-based compensation) to be offered to an incoming medical oncologist. Third, it engaged both internal and external recruiting resources to try to identify, attract, and, ultimately, hire a qualified candidate. These resources, which included Cancer CarePoint staffing company from October 2024 to October 2025, and Pacific Companies from October 2025 to the present, have posted online advertisements, conducted database searches, sent out direct mailers, represented AHCG at job fairs, made cold calls, and made other targeted attempts to recruit a medical oncologist who will thrive in a permanent position at CCC.

g. Detailed information on clinical FTEs provided by Knight Cancer Institute employed providers.

The Knight Cancer Institute has provided varying levels of clinical FTE support to CCC over the past few years. From June 2023 to March 2024, it sent its employed medical oncologists to CCC to cover the equivalent of 0.4 FTE. From April to August 2024, it reduced this coverage to an as needed or PRN level. From September to November 2024, it ramped up to a 0.3 FTE coverage level before dropping back down to PRN coverage for

the period of December 2024 to August 2025. Since September 2025, the Knight Cancer Institute has provided no provider support to CCC.

h. Describe any impacts of the OHSU agreement on CCC, as announced by AHCG in February 2025. In doing so, specifically address any impacts on:

i. Clinical staffing levels

The OHSU/CCC agreement has not yet affected clinical staffing levels at CCC. However, the parties continue to work together to find ways of leverage their respective strengths. For example, AHCG and OHSU share recruitment opportunities across their respective markets in order to cast as broad a net as possible. Also, AHCG's and OHSU's social workers regularly communicate and collaborate with one another to identify the best resources to assist their respective patients.

ii. Range or volume of services offered

The OHSU/CCC agreement has not affected the range or volume of services offered at CCC.

iii. Patient care

The OHSU/CCC agreement has not materially affected the patient care offerings, protocols, or practices of CCC, except to the extent that OHSU providers have brought with them their unique experiences and expertise when covering shifts at CCC. However, CCC and its patients have benefitted from the educational support that has been provided by OHSU under the agreement. For example, if CCC providers and staff have questions about the best ways of treating a given patient, they can call OHSU for advice and recommendations.

5. Provide a detailed description of AHCG's current arrangements for hospital transfers. At minimum, specifically address the following:

ACHG's current arrangements for hospital transfers are outlined in the "Wasco County Ambulance Service Plan," attached as **Exhibit 5**. While this plan remains under negotiation and has not yet been finalized, it provides the most comprehensive and up-to-date guidance on how transfers will be managed and carried out in the Wasco Ambulance Service Area. Key stakeholders, such as ACHG, Mid-Columbia Fire & Rescue ("MCFR"), Metro West Ambulance, Life Flight Network, and OHSU's Pediatric and Neonatal Doernbecher Transport Team ("PANDA"), have therefore followed the draft plan in good faith pending its completion and signature.

It is important to point out that ACHG has neither the authority nor the responsibility to finalize the Wasco County Ambulance Service Plan. Under applicable laws and regulations, that authority and responsibility lies with the Wasco County Commissioners. But AHCG has remained an active participant in efforts to finalize the plan, doing everything it can to ensure that the final product secures safe, efficient, and responsive transportation options for the hospital's patients.

a. Please provide a copy of the guidance and plan between AHCG and Mid-Columbia Fire & Rescue, as implemented on October 27, 2025, regarding inter-facility transfers.
A copy of the guidance and plan is attached as **Exhibit 5.a.**

b. Please provide a written description of this plan and describe how (if at all) this plan differs from AHCG's previous arrangement with Mid-Columbia Fire & Rescue.
Under the new plan, MCFR continues to provide interfacility transfers for AHCG. However, MCFR no longer provides transportation services for patients who have been intubated or put on BiPAP/CPAP machines. Also, MCFR no longer provides transportation services outside of the hours of 8:00 a.m. to 8:00 p.m. Transfers falling outside of these parameters are now handled by other ambulance service providers, such as Metro West Ambulance, Life Flight Network, or PANDA, either independently or in conjunction with MCFR.

c. Please provide an update on the status of the three-month trial period, including the date(s) of upcoming target review(s).
The three-month trial was initially scheduled to run from October 27, 2025, to January 27, 2026. The results of this trial are summarized in the document titled, "AHCG/MCFR Trial Transfer Data," which is attached as **Exhibit 5.c.** Essentially, the purpose of the trial was (and is) to determine the types and numbers of transfers that can be safely and effectively carried out by MCFR. Data compiled by MCFR, and presented to AHCG in January 2026, shows that MCFR overtook Life Flight Network as the hospital's most-used transfer provider during the period of the trial. ACHG and MCFR are scheduled to revisit this data when they meet for a targeted review on February 27, 2026.

6. For the Community Board, please provide the following information:

a. Copies of minutes for all meetings held between March 1, 2024, and January 26, 2026.
The minutes are attached as **Exhibit 6.a.**

b. A copy of the current Community Board membership roster. For each member, please include the name of the member, their role on Board, and the membership category the member represents (e.g., initial MCMC trustee, Adventist representative, medical staff physician, community member).
The Community Board membership roster is attached as **Exhibit 6.b.**

c. Describe any changes since the roster supplied with the September 11 Response.
Three members—Dr. Paul Cardosi, Victor Mondragon, and Robb Van Cleave—have rotated off of the Community Board since AHCG submitted its September 11 response. Meanwhile five new members have joined the Community Board. They include Dr. Keith Stelzer, Dr. Patrick Grimsley, Dr. John Rogers (retired), Jack Henderson, Cynthia Kortge, and Eric Davis. For 2026, Kerry Heinrich, the President and CEO of Adventist, has stepped into the board chair role formerly held by Kyle King.

7. Please provide copies of all AHCG Quality & Safety Dashboard reports from February 2024 through the date of this correspondence.
Copies of the reports are attached as **Exhibit 7.**

8. Question 18 of AHCG's February 6, 2025, Response to OHA's Information states that "AHCG has not yet adopted Adventist's policy on termination of pregnancy." Please provide an update on the status of AHCG's adoption of this "Termination of Pregnancy, Induced" policy and, if applicable, a copy of the adopted policy. If a final version is not yet available, please provide a copy of any drafts of this adopted policy.
AHCG adopted the termination of pregnancy policy of Adventist Health System/West on or about January 24, 2025. This policy mirrors the hospital's prior policy in several respects, including: (1) it acknowledges that a decision to terminate a pregnancy is a deeply personal decision that is best made by patients and their providers; (2) it allows for terminations of pregnancies to occur in the hospital in emergency situations; (3) it gives providers discretion to refer their patients to outside clinics and agencies that routinely perform pregnancy terminations and provide other reproductive health services; and (4) it leaves providers free to prescribe whatever medications or other therapies they deem most appropriate for their patients.

Importantly, the new policy, which is attached as **Exhibit 8**, does nothing to limit or otherwise affect the hospital's pre-merger levels of "reproductive health care services, including but not limited to induced abortion, birth control methods (including emergency contraception), sterilization, fertility services, and testing for pregnancy and sexually transmitted infections. . . ," within the meaning of subsection of 2.e.i. of the final order approving the Transaction.

9. Analysis of data provided by AHCG as part of its submission to OHA's Hospital Reporting Program shows that admissions to AHCG from the Emergency Department (ED) increased significantly from 2023 to 2024 as a percentage of total inpatient discharges. Please describe in detail the potential reason(s) for this change, including whether the increase was related to the Transaction.
It is true that a substantially higher percentage of AHCG's admissions came from the ED in 2024 than in 2023. However, this shift is due primarily to an increase in ED visits and a drop off in non-ED admissions during this period. The actual percentage of ED patients who are admitted to the hospital has actually remained remarkably consistent over the years, with an average of 8.84% of such patients being admitted in the period of 2020-2024, and 8.88% of such patients being admitted in 2024. AHCG has no reason to believe that the increase in ED patient admissions was related to the Transaction. Likewise, AHCG can think of no changes to ED protocols or practices that might have contributed to the increase.

10. Analysis of data provided by AHCG as part of its submission to OHA's Hospital Reporting Program shows that the percentage of commercial inpatient discharges fell significantly in 2024 compared to 2023, whereas the percentage of Medicare inpatient discharges increased. Please describe in detail the potential reason(s) for this change, including whether the increase was related to the Transaction.

AHCG believes that this change is primarily the result of different reporting approaches. Whereas Mid-Columbia Medical Center ("MCMC") treated payments from MedAdvantage and non-traditional Medicare as commercial payments, Adventist includes such payments the category of Medicare payments. AHCG has not made any operational or service changes that seem likely to have contributed to this shift. Thus, the apparent increase in Medicare inpatient discharges is related to the Transaction, but only inasmuch as it stems from reporting changes.

11. Analysis of payroll data provided by AHCG as part of its submission to OHA's Hospital Reporting Program shows that non-physician payroll hours at AHCG decreased by more than one third between July 2023 and July 2024. Please describe in detail the potential reason(s) for this change.

AHCG suspects that the primary reason for the apparent decrease in non-physician payroll hours is its shift from a pre-merger, hospital-specific accounting model to a post-merger, shared services accounting model. Specifically, non-physician payroll hours used to be tracked and reported by AHCG at the hospital level as "Salaries and Wages," since the employees who worked those hours served only AHCG. But 74 employees were transitioned after the merger to "shared services" roles that potentially serve multiple facilities within the Adventist system. This change resulted in the employees' hours being tracked and reported at the system level as "purchased service fees" or costs that are allocated to AHCG (and to other facilities and services within the health system) based on an established, percentage-of-use methodology.

It is important to reiterate that the employees whose hours are included in the non-physician payroll hours metric were not eliminated or subject to reductions in FTE status; they were instead transitioned into shared services roles that fall under a system-level cost center. Most of the affected employees work in Materials Management, Finance, Accounting, Revenue Cycle, HIM, IT, Human Resources, and similar support departments. The practice of centralizing support functions is not unique to Adventist and is intended to reduce costs, improve efficiencies, enhance collaboration, and standardize processes for all facilities in the health system.

12. Analysis of community benefit data submitted by AHCG as part of its ordinary reporting to OHA shows a significant increase in Medicaid net cost as a percentage of community benefit spending in 2023 compared to 2022. Please describe in detail the potential reason(s) for this increase, including whether the increase was related to the Transaction.

Because of a lack of documented evidence or historical knowledge of how MCMC reported Medicaid net costs as a percentage of community benefit spending, AHCG can only speculate as to why the hospital's pre-merger percentages appear in the community benefit data to be higher than the post-merger percentages. The most plausible explanation is that MCMC's methodology for capturing Medicaid net costs is different from the standardized methodology used by Adventist.

If and to the extent this theory is correct, AHCG acknowledges that the increase was related to the Transaction.

Exhibit 3.a.

Recruitment and Hiring Process Policy

Recruitment and Hiring Process Policy

Disclaimer

Approvals

- Signature: Cheri McCall, Director, Human Resources signed on 5/7/2025, 12:18:11 PM

Revision Insight

Document ID:	12132
Revision Number:	1
Owner:	Cheri McCall, Sr. Human Resources Business Partner
Revision Official Date:	5/7/2025

Revision Note:
this is an AH standard policy and follows practice. 1/13/25 cmc

Adventist Health
Columbia Gorge

☒ Systemwide Standard Policy
☐ Systemwide Model Policy

Standard Policy No. 12132
Approval Pathway: Nonclinical
Department: Human Resources

STANDARD POLICY: RECRUITMENT AND HIRING PROCESS POLICY

Adventist Health Columbia Gorge adopts the following systemwide Adventist Health Standard Policy.

POLICY SUMMARY/INTENT:

Adventist Health (AH) will recruit and hire qualified candidates for available positions. AH is committed to providing an inclusive and welcoming environment for all members of our communities and to ensuring that employment decisions are based on individuals' abilities and qualifications.

DEFINITIONS:

1. Not Applicable

AFFECTED DEPARTMENTS/SERVICES:

A. All departments and services

POLICY: COMPLIANCE – KEY ELEMENTS

A. Employee Recruitment/Selection

1. When a position within a department becomes available, the department director/manager will complete an on-line requisition through the Applicant Tracking System.

2. All new and replacement positions must be approved through the local market's management process with consideration of department productivity, number of FTEs, budget constraints, etc. Approved positions will be posted on the AH website, internally for a minimum of three (3) days and externally as appropriate.

3. Advertising and utilization of third-party recruitment agencies for open positions is coordinated through, and at the discretion of, Talent Acquisition leadership.

4. The Talent Acquisition team reviews applications of candidates based on job description requirements and qualications. Candidate's residence location (state) is also reviewed to ensure compliance with Remote-Hybrid Work Policy. New hire for out-of-state remote position is only allowed for Adventist Health System/West (Roseville-based employees).Talent Acquisition may conduct screening interviews. Any required testing of candidates must pertain to the skills required for the position and will be completed before any interviews with the Hiring Manager are scheduled

5. The Talent Acquisition team then refers the most qualified candidates to the Hiring Manager for interview and final selection. Talent Acquisition will assist with orchestrating interview details including candidate scheduling,

travel and work with the Hiring Manager regarding panel member selection.

6. Hiring Managers should prepare in advance and utilize standard interview questions for all applicants, for the same position, using the job description to verify applicant's/transfer's qualifications and ability to perform the essential functions of the position. Standard interview questions are encouraged to prevent inadvertent discrimination.

    a. In addition, federal, state and local laws prohibit prospective employers from making medically-related inquiries during the pre-offer stage. Similarly, other laws also prohibit an employer from inquiring about criminal history or past / current salary history.

7. The interview feedback form must be submitted to Talent Acquisition by the Hiring Manager following each interview. The Hiring Manager must indicate hiring selection via the Interview Feedback Form.

8. When a final decision to employ an individual has been made, Talent Acquisition will create an offer letter with the appropriate wage for their job category and experience. Talent Acquisition will make a verbal job offer. If the candidate verbally accepts the job offer, Talent Acquisition will send an email notification with a link to review and sign policies, employee handbook, alternate work schedule if applicable, arbitration letter if applicable, and the offer letter. All offers are contingent upon successfully clearing a background check, employment verification and employee physical examination, as appropriate.

B. Background Checks and Verifications

1. Inquiries into the background of employees, volunteers and prospective employees are intended to comply with federal and state laws and are required as per the AH corporate compliance plan. Applicants who have received and accepted a job offer must successfully pass all items outlined in section B and C of this policy before completing the hiring process and beginning employment.

2. The Talent Acquisition team facilitates the following for all new hires at the post-offer stage:

    a. Check criminal background/sex-offender records/and DMV Check. Evidence of a conviction does not automatically disqualify an applicant. However, if an individual has a criminal history, the organization will consider the following factors before the hiring process may continue: the nature and gravity of the offense(s); the time since the conviction/completion of the sentence; the nature of the job held or sought and the relatedness of the conviction(s) to the duties and responsibilities of the position. Upon consideration of these issues, AH may rescind the offer. A credit history may be conducted where the applicant would be, if hired, able to affect the organization financially (i.e., working in the Accounting Department, handling cash, holding an AH credit card, or ability to commit AH to debits, obligations or reimbursement for goods and services.)

    b. The new hire's name will be checked against the Federal Government List of Excluded Individuals/Entities via the background vendor's exclusions check.

    c. The need for a background check for a global transfer will be assessed on a case-by-case basis, according to job requirements and pre-existing background check on file. A background check of a global transfer will only be performed if it is job-related and consistent with business necessity.

C. New Hire Processing

1. After the applicant has satisfactorily completed the pre-employment health screening, (as appropriate), the Talent Acquisition team will send an email containing a link to fill out new hire paperwork. The employee will be required to complete all new hire documentation. A new employee may not begin work with Adventist Health or attend New Employee Orientation until they have completed the hiring process.

2. Primary Source Verification of required licenses and/or job related educational requirements will be completed prior to the new hire's first day of work by Talent Acquisition, as applicable. Copies of required licenses and/or certifications will be requested and collected on the new hire's first day of work. Meeting all state and federal licenses renewal requirements are the responsibility of the employee. Any ongoing license/certification renewals will be verified and tracked by the Human Resources Department.

3. All new employees must provide proof of eligibility to work, complete appropriate tax forms and present valid I-9 documentation. Documentation will be verified.

4. Once the new employee has completed the hiring process, the Talent Acquisition team will schedule their first day along with the organization's new hire orientation. These sessions are designed to welcome the new

employee, share AH's mission and culture and help the employee become familiar with the policies and procedures of the market.

5. The new employee must also complete their department specific orientation and satisfactorily pass competencies required for their position.

6. Employees who are rehired within ninety (90) days of separation can be reinstated as if there were no break in service, and are given their former accrual rate and do not need to complete a physical, orientation or any new hire paperwork. However, if the re-hire has been separated for ninety-one (91) days or more, they may be given their former accrual rate, but will require an updated physical. New employee orientation and new hire paperwork will be required if the break in service is twelve (12) months.

ATTACHMENTS: (REFERENCED BY THIS DOCUMENT)	
OTHER DOCUMENTS: (WHICH REFERENCE THIS DOCUMENT)	
FEDERAL REGULATIONS:	
ACCREDITATION:	
CALIFORNIA:	**Not applicable**
HAWAII:	**Not applicable**
OREGON:	**Not applicable**
WASHINGTON:	**Not applicable**

REFERENCES:

ADVENTIST HEALTH SYSTEM/WEST POLICY OWNER:	**Administrative Director, Employee Relations & Compliance**
ENTITY POLICY OWNER:	**Director, Human Resources**

APPROVED BY:

ADVENTIST HEALTH SYSTEM/WEST:	**(08/14/2024) Nonclinical Policy Review Team - Human Resources Leadership Team, (08/19/2024) System Policy Leadership (SPL)**
ADVENTIST HEALTH SYSTEM/WEST INDIVIDUAL:	
ENTITY:	
ENTITY INDIVIDUAL:	**(05/07/2025 12:18PM PST) Cheri McCall, Director, Human Resources**
REVIEW DATE:	**11/03/2020**
REVISION DATE:	**01/10/2018, 01/06/2023, 01/03/2024, 08/28/2024**
NEXT REVIEW DATE:	**05/06/2028**
APPROVAL PATHWAY:	**Nonclinical**

Exhibit 5

Wasco County Ambulance Service Plan (Draft)

WASCO COUNTY

AMBULANCE SERVICE PLAN

ADOPTED_____, 2025

Wasco County Ambulance Service Plan

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#6 Wasco County Ambulance Service Ordinance 2025
#7 Wasco County Mass Casualty Incident Plan

1. CERTIFICATION BY WASCO COUNTY OF COUNTY AMBULANCE SERVICE PLAN

The undersigned certify pursuant to Oregon Administrative Rule 333-260-0030 (2)(a)(b) and (c) that:

1. Each subject or item contained in the plan was addressed and considered in the adoption of the plan;

2. In the governing body's judgment, the ASAs established in the plan provides for the efficient and effective provision of ambulance services; and

3. To the extent they are applicable, the county has complied with ORS 682.205(2)(3) and 682.335, which have been renumbered ORS 682.062 and ORS 682.063, respectively, and existing local ordinances and rules.

Dated this_____day of_____, 2025.

_____
Scott C. Hege, Commissioner, Position 1

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Steve Kramer, Commissioner, Position 2

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Phil Brady, Commissioner, Position 3

2. OVERVIEW OF WASCO COUNTY (DEMOGRAPHIC AND GEOGRAPHIC DESCRIPTION)

Wasco County is located in the north central part of Oregon. The US Census Bureau population estimate as of July 1, 2022, was 26,561. The City of the Dalles is the Wasco County seat and has a population as of the 2022 census of 15,932, with the remaining population scattered throughout the county in rural areas or the remaining six small, rural communities. Wasco County spans approximately 2,396 square miles on the south shore of the Columbia River in the north central part of Oregon.

The Mid-Columbia region begins just east of the Cascade mountain range and extends into the high plateaus of Oregon and Washington's Columbia Basin. In general, this region's geographical position results in a climate characterized by relatively mild temperatures, seasonal precipitation, mild winters, and dry summers. The Cascades serve as an effective moisture barrier for the majority of the Columbia River Gorge, causing storms to concentrate much of their moisture west of the peaks and leaving areas to the east in a "rain shadow."

Wasco County is bordered by the Columbia River to the north, the high desert of Central Oregon to the south, the Cascade Mountains to the west, Sherman County, PR to the east, and the Columbia River Gorge to the north west. The Columbia River is the only fresh-water corridor for ocean-going commerce on the entire West Coast of North America, and the only water-grade route through the Cascade Range between Canada and California.

Along the Columbia River are low-lying bottomlands, from which a series of alluvial plains and terraces extend southward. Land elevations rise from less than 100 feet on the Columbia River and floodplains to over 4,000 feet above mean sea level. The western half of Wasco County lies at the eastern end of the Columbia River Gorge; once away from the Gorge, the County is comprised of a series of rolling hills and valleys that extend south into central Oregon. The major driving route is Interstate 84, which leads west to the metropolitan areas of Portland, Oregon. Interstate 84 and State Highways 97 and 197 provide access to the county’s major population centers and recreational opportunities.

According to US Census Bureau estimates for 2017-2021, approximately 15.4% of Wasco County’s population over the age of five speaks a language other than English at home. An inability to speak or read English may present a challenge to emergency managers since instructions for self-protective action and general disaster information are usually provided only in English. In certain areas of Wasco County, it may be advisable for emergency managers and emergency response agencies to arrange for translation of the instructions and for providing information in different languages. The North Central Public Health District (NCPHD) translates their messaging to Spanish for distribution to all media sources. Upon request, NCPHD will, as able, translate emergency manager’s messages to Spanish.

3. DEFINITIONS

(a) "ALS" stands for Advanced Life Support and defines the maximum functions that may be assigned to an EMT, EMT-Intermediate or Paramedic, as defined in OAR 333-265-0000, in accordance with OAR 847-035-0030 and OAR 333-255-0070.

(b) "Ambulance" or "ambulance vehicle" means a privately or publicly owned motor vehicle, aircraft, or watercraft that is regularly provided or offered to be provided for the emergency transportation of persons who are ill or injured or who have disabilities. ORS 682.025(1).

(c) "Ambulance Service" means a person, governmental unit or other entity that operates ambulances and that holds itself out as providing prehospital care or medical transportation to persons who are ill or injured or who have disabilities. ORS 682.025(2).

(d) "Ambulance Service Area ("ASA")" means a geographic area which is served by one Ambulance Service Provider and may include all or a portion of a county, or all or portions of two or more contiguous counties. OAR 333-260-0010(3).

(e) "Ambulance Service Plan ("ASP")" means a written document, which outlines a process for establishing a county emergency medical services system. A plan addresses the need for and coordination of ambulance services by establishing ambulance service areas for the entire county and by meeting the other requirements of these rules. Approval of a plan shall not depend upon whether it maintains an existing system of Providers or changes the system. For example, a plan may substitute franchising for an open-market system. OAR 333-260-0010(4).

(f) "Ambulance Service Provider" means a licensed ambulance service that responds to 9-1-1 dispatched calls or provides pre-arranged non-emergency transfers or emergency or non-emergency inter-facility transfers. OAR 333-260-0010(5)

(g) "ASA Advisory Committee" is defined in the Wasco County Ambulance Service Area Ordinance, Appendix 6, and the members are appointed by the Wasco County Board of Commissioners.

(h) "BLS" stands for Basic Life Support and defines the maximum functions that may be assigned to an Emergency Medical Responder or EMT in accordance with OAR 847-035-0030 and OAR 333-255-0070.

(i) "Board" means the Wasco County Board of Commissioners.

(j) "County Government or County Governing Body ("County")" means a Board of County Commissioners or a County Court. OAR 333-260-0010(6).

(k) "Communication System" means two-way radio communications between ambulances, dispatchers, hospitals, and other agencies as needed. A two-channel multi-frequency capacity is minimally required.

(l) "Division" means the Public Health Division, Oregon Health Authority. OAR 333-260-0010(7).

(m) "Emergency Medical Responder" means a person who is licensed by the Authority as an Emergency Medical Responder. OAR 333-265-0000(16).

(n) "Emergency Medical Service ("EMS")" means those prehospital functions and services whose purpose is to prepare for and respond to medical traumatic emergencies, including rescue and ambulance services, patient care, communications, and evaluation. OAR 333-260-0010(8).

(o) "License" means the document issued by the Oregon Health Authority to the owner of an ambulance for ambulance vehicle licensing when the vehicle is found to be in compliance with ORS 682.017 to 682.991 and Administrative Rules 333-255-0000 through 333-255-0073.

(p) "Notification Time" means the length of time between the initial receipt of the request for emergency medical service by either a Provider or an emergency dispatch center (9-1-1), and the notification of all responding emergency medical service personnel. OAR 333-260-0010(9).

(q) "Patient" means a person who is ill or injured, or who has a disability and who receives emergency or nonemergency care from an emergency medical services provider. ORS 682.025(10).

(r) "Provider" means the Ambulance Service Provider that has been assigned to the ASA.

(s) "Provider selection process" means the process established by the county for selecting an Ambulance Service Provider or Providers.

(t) "Public Safety Answering Point ("PSAP")" means a communications facility established as an answering location for emergency calls originating within 9-1-1 service areas. An example of a PSAP is a 9-1-1 Center. ORS 403.105(21).

(u) "Response time" means the length of time between the notification of each Provider and the arrival of each Provider's emergency medical service unit(s) at the incident scene. OAR 333-260-0010(11).

(v) "Subareas" are the current ASAs designated as ASA Areas 1-8.

(w) ”Subcontractor” means the Ambulance Service Provider under an agreement with the Provider to serve Subareas 1 and 3-8.

(x) “Supervising physician” means a physician licensed under ORS 677.100 to 677.228, actively registered and in good standing with the Oregon Medical Board, who provides direction of emergency or nonemergency care provided by emergency medical services Providers. ORS 682.025(14).

4. BOUNDARIES

(a) ASA MAP(s) WITH RESPONSE TIME ZONES (See Appendix #1 and #2)

Currently there are eight (8) ASA service areas, described below. This ASP is designed to have one county-wide ASA Provider responsible for emergent, non-emergent, and inter-facility transports; provided, however, if the current ASA Providers in Subareas 1, and 3-8 elect to continue providing ambulance services, they may continue to provide ambulance services under a Subcontractor agreement with the Provider. The Provider is expected to provide ambulance services in Subarea 2, maintain the current number of ambulances in Subarea 2 and maintain the current response times in Subarea 2. If the current Provider in a Subarea does not agree to become a Subcontractor, the Provider will be required to provide the service directly or through intergovernmental agreements or subcontracts.

The purpose of this structure is to preserve existing rural providers, preserve their revenue sources, build depth in the system, and take advantage of economies of scale. Rural providers may, in effect, share the revenue from Subarea 2, and will add to the depth and quality of ambulance services throughout the county. This structure will result in cost savings through efficiency and avoidance of overlapping fees, e.g., one physician supervisor for the county. Other examples of in-kind contributions could include ambulance loan programs, non-durable medical equipment resupply program, continuous quality improvement programs, co-staffing of transportation units in rural areas, such as one agency providing a paramedic or EMT with another providing a driver and facility, protocol development, records management systems or billing services, and continuous training for continued education and relicensing. It is expected that the Provider will expend some of its resources to bring ambulances into compliance with minimum equipment requirements, to enhance services and training, and to reinforce the ability of ambulance providers to timely respond with appropriate assets and expertise. The Provider of ambulance services in Subarea 2 will be required to provide ambulance services to Mid-Columbia Medical Center. Services will continue to be provided without reduction in response times or service levels. Non-emergent ambulance and inter-facility transports will be provided to area hospitals and care facilities. Lastly, the County is a party to an Intergovernmental Agreement with Mid-Columbia Fire and Rescue whereby Mid-Columbia is qualified to support, manage, and oversee County employee EMS provider recertification. The Provider will provide the training documentation and periodic practical skills audit to County employees as required.

(b) ASA NARRATIVE DESCRIPTION(Subareas)

Subarea **#1 (Mosier)**. Mosier is an incorporated community with a population of 451 (approximately 2,000 within a 30-mile radius of the community's center). Mosier does not have its own ambulance at present but is staffed with volunteer First Responders. Mosier is closer to Hood River Fire & EMS, which is 7 road miles closer than Mid-Columbia Fire & Rescue. Mid-Columbia Fire & Rescue is at present a mutual aid partner with Hood River Fire & EMS.

Hood River Fire & EMS at 9 miles from Mosier I-84 Freeway Interchange, has a response time of 8 minutes 90 percent of the time. Inclement weather, such as ice, or freeway closure due to traffic accidents, could alter this response time as the freeway is the only road between Hood River Fire & EMS and Mosier. Most roads in ASA 1 are either paved or graveled and are generally well maintained throughout. This would place Area #1 generally within the Trauma System Minimum Standards designation, as defined in Section 5(c), as Rural with a response time of 45 minutes to the southern tip 90 percent of the time. However, the extreme southeast tip of ASA 1 must be considered as frontier depending on the exact location with response times to 4 ½ hours 90 percent of the time. There are some areas where only all-terrain vehicles or helicopters would be able to access the incident area.

The response times, labeled as travel times, are in Appendix 2, and designate Urban, 6 minutes, Suburban, 13 minutes, Rural, 43 minutes, and Frontier, 4 hours 28 minutes. Run and response times will be provided quarterly to the ASA Advisory Committee. The Wasco County ASA Advisory Committee shall then review these run-times and proposed changes may then be submitted to the Board for approval when appropriate.

Boundaries:

- **West Boundary:** Where the I-84 Interstate Freeway on the south shore of the Columbia River intersects the west line of Section 34, T-3N, R-12E; thence going south to the S.W. corner of Section 10, T-2N, R-12E; thence west to the S.W. corner of Section 9, T-2N, R-12E; thence south to the S.E. corner of Section 20, T-2N, R-12E; thence west to the S.W. corner of Section 22, T-2N, R-11E. Said point being on the County line.
- **North Boundary:** I-84 Interstate Freeway from the Hood River County line to the Mosier exit interchange, then south to Old Highway 30 and east along Old Highway 30 to the west line of section 34, T-3N, R-12E. The community of Rowena Dell shall also be included in this area.
- **East and South Boundaries:** Beginning at the intersection of Old Highway 30 and the west line of Section 34, T-3N, R-12E; thence south to the S.W. corner of Section 10, T-2N, R-12E; thence west to the S.W. corner of Section 9, T-2N, R-12E; Thence west to the S.W. corner of Section 9, T-2N, R-12E; thence south to the S.E. corner of Section 32, T-

2N, R-12E; thence west to the S.E. corner of government lot 4 of Section 31, T-2N, R-12E; thence in a southwesterly direction to the S.W. corner of Section 13, T-1N, R-11E; thence west to the N.W. corner of the NE 1/4 of Section 23, T-1N, R-11E; thence southwesterly to the S.W. corner of Section 26, T-1N, R-11E; thence southwesterly to the N.W. corner of the SW 1/4 of the SW 1/4 of Section 34, T-1N, R-11E; thence south to the S.W. corner of said Section 34.

Subarea #2 (The Dalles). The Dalles Area is classified as "Rural" according to the Trauma System Minimum Standards. The City of The Dalles Area has a population of 15,932 and a population density of 2,295 per square mile according to 2022 census data. The Minimum Trauma Standard of 15 minutes shall apply within the city limits 90 percent of the time.

The remaining part of ASA 2 is classified as Rural or Frontier depending on the location.

The "Rural" classification shall be maintained along all major paved roads. The response shall be maintained within 45 minutes 90 percent of the time.

The southeast section of ASA 2 becomes a "Frontier" area depending on the exact location with response times of 2 hours. Search and rescue areas are the areas of the state that are primarily forest, recreational, or wilderness lands that are not accessible by paved roads or not inhabited by six or more persons on a year-round basis and have no established prehospital response time. These are areas where only all-terrain vehicles or helicopters would be able to access the incident area.

The response times, labeled as travel times, are in Appendix 2, and designate Urban, 6 minutes, Suburban, 13 minutes, Rural, 43 minutes, and Frontier, 4 hours 28 minutes. Run and response times will be provided quarterly to the ASA Advisory Committee. The Wasco County ASA Advisory Committee shall then review these run-times and proposed changes may then be submitted to the Board for approval when appropriate

Boundaries:

- **West Boundary:** West along I-84 Interstate Freeway from The Dalles to the Mosier interchange exit; then south beginning at the intersection of Old Highway 30 and the west line of Section 34, T-3N, R-12E; thence south to the S.W. corner of Section 10, T-2N, R-12E; thence west to the S.W. corner of Section 9, T-2N, R-12E; thence west to the S.W. corner of Section 9, T-2N, R-12E; thence south to the S.E. corner of Section 32, T-2N, R-12E; thence west to the S.E. corner of government Lot 4 of Section 31, T-2N, R-12E;. thence in a southwesterly direction to the S.W. corner of Section 13, T-1N, R-11E; thence west to the N.W. corner of the NE 1/4 of Section 23, T-1N, R-11E; thence southwesterly to the S.W. corner of Section 26, T-1N, R-11E; thence southwesterly to the N.W. corner of the S.W. 1/4 of Section 34, T-1N, R-11E; thence south to the S.W. corner of said Section 34.

- **North Boundary:** Following the south shore of the Columbia River from the Mosier interchange exit at milepost 70 east to the mouth of the Deschutes River.
- **East Boundary:** From the south shore of the Columbia River south along the west bank of the Deschutes River to the Willamette Base line.
- **South Boundary:** Starting at the point where Willamette Base line intersects with the Deschutes River and continuing in the west direction to the Emerson Roberts Market Road in the north direction to the junction with Fifteen Mile Boule Market Road; thence continuing in a westerly direction on the Emerson Roberts Market Road to the junction with the Wrentham Cut-off Road; thence proceeding southwesterly on the Wrentham Cut-off Road to Wrentham. Continuing west from Wrentham along the Emerson Loop Road to the junction of Eight Mile Creek Road. Continuing in a S.W. direction on the Eight Mile Creek Road to the junction with Highway 197; thence crossing Highway 197 and continuing in a general S.W. direction along the summit of Pleasant Ridge between Upper Five Mile Road and the Hollow/Pleasant Ridge Road continuing to the east boundary of the Mount Hood National Forest.

Subarea #3. (Dufur) Dufur is an incorporated community with a population of 638 as of 2017. The Trauma System Minimum Standards places Dufur and the surrounding area of ASA 3 in the "Rural" classification of 45 minutes, with some mutual aid areas in the western section for the Mount Hood National Forest as "Frontier," with the maximum time of 4 ½ hours, both with a 90 percent time response. Some of the western areas in the Mount Hood National Forest are accessible only with four-wheel drives, all-terrain vehicles, or helicopter during good weather. With inclement weather, the response will be narrowed down to four-wheeled vehicles in some areas close to roadways, with snowmobiles or helicopters in others. Response will be entirely dependent on the weather conditions, possible avalanche, and the discretion of the Incident Command on Rescue Units.

The response times, labeled as travel times, are in Appendix 2, and designate Rural, 43 minutes, and Frontier, 4 hours 28 minutes. Run and response times will be provided quarterly to the ASA Advisory Committee. The Wasco County ASA Advisory Committee shall then review these run-times and proposed changes may then be submitted to the Board for approval when appropriate

Boundaries:

- **North Boundary:** Starting at the point where Willamette Base line intersects with the Deschutes River and continuing in the west direction to the Emerson Roberts Market Road in the north direction to the junction with Fifteen Mile Boule Market Road, then continuing in a westerly direction on the Emerson Roberts Market Road to the junction with the Wrentham Cut-off Road; proceeding S.W. on the Wrentham Cut-off Road to Wrentham; continuing west from Wrentham along the Emerson Loop Road to the junction of Eight Mile Creek Road; continuing in a S.W. direction on the Eight Mile Creek Road to the junction with Highway 197; crossing Highway 197 and continuing in a general S.W.

direction along the summit of Pleasant Ridge between Upper Five Mile Road and the Japanese Hollow/Pleasant Ridge Road continuing to the east boundary of the Mount Hood National Forest.

- **East Boundary:** South along the west bank of the Deschutes River from the Willamette Base Line to S.W. corner of Section 23, T-3S, R-14E.

- **South Boundary:** From the west bank of the Deschutes River at S.W. corner of Section 23, T-3S, R-14E west to the S.W. corner Section 19, T-35, R-14E; thence north to the S.W. corner of Section 18, T-3S, R-13; thence west to the S.W. corner of Section 14, T-3S, R-12E; thence north to the S.W. corner of Section 11, T-3S, R-12E; thence west to the S.W. corner of Section 10, T-3S, R-12E intersection Mount Hood Forest north/south boundary.

  West Boundary: At the intersection with Mount Hood Forest Boundary at the S.W. corner of Section 10, T-3S, R-12E; thence north to the S.W. corner of Section 3, T-3S, R-12E; thence west to S.W. corner of Section 4, T-3S, R-12E; thence north to the S.W. corner of Section 33, T-3S, R-12E; thence west to the S.W. corner of Section 31, T-2S, R-12E and Mount Hood Forest Boundary; thence north along Mount Hood Forest Boundary to the S.W. corner of Section 6, T-2S, R-12E and Eight Mile Creek Road.

Subarea #4 (Maupin). Maupin is an incorporated community with a population of 437 as of 2017. This would place ASA 4 in a "Frontier" classification under the Trauma System Minimum Standards with a 90 percent response within the maximum time of 4 ½ hours to the outer limits of the ASA. This shall apply outside the City of Maupin. The time will vary according to location and weather conditions. The response within the City of Maupin shall be a maximum of 45 minutes 90 percent of the time. This area of Wasco County is sparsely populated and would be better served in some areas by helicopter or possibly by private transport meeting the ambulance under certain physician-controlled conditions operating under direct radio communications. During inclement weather, some areas would become impossible to reach except by helicopter, four-wheel drive, snowmobile, or ski-sled. This type of response would be used in the mutual aid agreement with Mount Hood National Forest in the western section of Wasco County.

The response times, labeled as travel times, are in Appendix 2, and designate Rural, 43 minutes, and Frontier, 4 hours 28 minutes. Run and response times will be provided quarterly to the ASA Advisory Committee. The Wasco County ASA Advisory Committee shall then review these run-times and proposed changes may then be submitted to the Board for approval when appropriate

Boundaries:

- **North Boundary:** From the west bank of the Deschutes River at the S.W. corner of Section 23, T-3S, R-14E west; thence to the S.W. Corner of Section 19, T-35, R-14E; thence north to the S.W. corner of Section 18, T-3S, R-13; thence west to the S.W. corner of Section 14, T-3S; R-12E; thence north to the S.W. corner of Section 11, T-3S, R-12E; thence west to

the S.W. corner of Section 10, T-3S, R-12E, with intersection of Mount Hood Forest north/south boundary.

- **East Boundary:** South from the west bank of the Deschutes River at S.W. corner 23, T-38, R-14E to the junction of the Deschutes River and Buck Hollow Creek at Section 35, T-3S, R-14E; then continue south on the west bank of Buck Hollow Creek turning S.E. at N.E. Corner Section 23, T-4S, R-14E; continue west on the bank of Buck Hollow Creek to S.E. corner Section 31, T-6S, R-17E; thence east along the south bank of Buck Hollow Creek at N.W. corner Section 5, T-6S, R-17E, to N.E. corner Section 2, T-6S, R-18E; thence south to S.E. corner of Section 15, T-75, R-18E.

- **South Boundary:** Beginning at the N.E. corner of Section 22, T-7S, R-18E; thence going westerly to the N.W. corner of Section 19, T-7S, R-17E; thence south one mile (more or less) to the S.W. corner of said Section 19; thence westerly to the N.W. corner of Section 26, T-7S, R-15E; thence south one mile to the S.W. corner of said Section 26; thence going westerly to the point where the south line of Section 29, T-7S, R-14E intersects the Deschutes River.

- **West Boundary:** Beginning at the point where the Deschutes River intersects the South line of Section 29, T-7S, R-14E; thence following said Deschutes River in a northerly direction 8 miles, more or less, to the intersection of the McQuinn line which marks the northerly boundary of the Warm Springs Indian Reservation (restored area); thence following said McQuinn line to the S.W. corner of Section 29, T-5S, R-11e; turning in a northerly direction where the east Mount Hood National Forest boundary intersects the McQuinn line and following the east Mount Hood National Forest boundary in a northerly direction, 1 mile (more or less) to the N.W. corner of said Section 29; thence east on Forest boundary to the S.W. corner of Section 21, T-5S, R-11E; thence north continuing to follow the east boundary four miles (more or less) to N.W. corner of Section 4, T-5S, R-11E; thence east 4 miles (more or less) to S.E. corner of Section 36, T-4S, R-11E; thence north 5 miles (more or less) to N.W. corner of Section 7, T 4S, R-12E; thence continuing to follow Forest boundary east 2 miles (more or less) to S.E. corner of Section 33, T-3S, R-12E; thence north along Forest boundary 4 miles (more or less) to N.E. corner of Section 15, T-3S, R-12E, intersecting with the north boundary of this ASA and the east Mount Hood National Forest Boundary.

Subarea #5 (South County). This ASA is very sparsely populated and Madras is the nearest medical facility. Most of the area would be better served by helicopter or private transport under physician radio-control. This would be classified under the Trauma System Minimum Standards as a "Frontier" area and under normal conditions be responded to with the maximum standard of 4 ½ hours 30 percent of the time. Even during inclement weather, this minimum standard shall be adhered to through the use of helicopter, four-wheel drive, or snowmobile.

The response times, labeled as travel times, are in Appendix 2, and designate Rural, 43 minutes, and Frontier, 4 hours 28 minutes. Run and response times will be provided quarterly to the ASA Advisory Committee. The Wasco County ASA Advisory Committee shall then review these run-times and proposed changes may then be submitted to the Board for approval when appropriate

Boundaries:

- **North Boundary:** Beginning at a point where the John Day River intersects the north line of Section 16, T-8S, R-19E; thence going westerly to the northwest of Section 16, T-8S, R-18E; thence going north five miles (more or less) to the N.E. corner of said Section 20, T-7S, R-18E; thence westerly to the N.W. corner of Section 26, T-7S, R-15E; thence south one mile to the S.W. corner of said Section 26; thence going westerly to the point where the south line of Section 29, T-7S, R-14E intersects the Deschutes River.
- **East Boundary:** Beginning at a point where the John Day River intersects the north line of Section 19, T-7S, R-19E; thence following the west bank of the John Day River in a southerly direction to the intersection with the Jefferson County line.
- **South Boundary:** Starting from the intersection point of the Jefferson County line and the John Day River, proceeding in a westerly direction along the Jefferson County line to the east bank intersection point of the Deschutes River with the Jefferson County Line.
- **West Boundary:** From the point of intersection of the east bank of the- Deschutes River and the Jefferson County line north along the east bank of the Deschutes River to the intersection of the north boundary at the south line in the center of Section 29, T-7S, R-14E.

Subarea #6 (Southeast County). This small area is located below the Antelope Grade and along the John Day River Recreation Community area in the southeast section of South Wasco County, north and south of Highway 218 along the west side of the John Day River.

The response times, labeled as travel times, are in Appendix 2, and designate Rural, 43 minutes, and Frontier, 4 hours 28 minutes. Run and response times will be provided quarterly to the ASA Advisory Committee. The Wasco County ASA Advisory Committee shall then review these run-times and proposed changes may then be submitted to the Board for approval when appropriate

Boundaries:

- **North Boundary:** Beginning at the west bank of the John Day River at the N.E. corner of Section 1, T-6S, R-18E, thence in a westerly direction to the N.W. corner of Section 2, T-6S, R-18E.

- **East Boundary:** Beginning at the N.E. corner Section 1, T-6S, R-18E and the West bank of the John Day River and continuing south along the west bank of the John Day River to the S.E. corner of Section 9, T-8S, R-19E.
- **South Boundary:** Beginning at the junction of the S.E. corner of Section 9, T-8S, R-19E and the west bank of the John Day River thence in an easterly direction to the S.W. corner of Section 9, T-8S, R-18E.
- **West Boundary:** Beginning at the N.W. corner of Section 2, T-6S, R-18E in a southerly direction to the S.E. corner of Section 15, T-75, R-18E; thence in a westerly direction to the N.E. corner of Section 21, T-75, R-18E; thence in a southerly direction to the S.W. corner of Section 9, T-8S, R-18E.

Subarea #7 (Extreme West Wasco County). This is a small section of Wasco County that is isolated by the Warm Springs Indian Reservation on the east and Clackamas County on the north, west, and south. It is a sparsely populated area with minimal access. Area #7 has been served by South Wasco County Ambulance Service and aided by Mutual Aid with American Medical Response ("AMR") units.

The response times, labeled as travel times, are in Appendix 2, and designate Rural, 43 minutes, and Frontier, 4 hours 28 minutes. Run and response times will be provided quarterly to the ASA Advisory Committee. The Wasco County ASA Advisory Committee shall then review these run-times and proposed changes may then be submitted to the Board for approval when appropriate

Boundaries:

- **North/West/South Boundary:** This area has a common boundary with Clackamas County.
- **East Boundary:** Common boundary with the east boundary of the Warm Springs Indian Reservation.

Subarea #8 (Wamic). This is a small section of Wasco County that includes the community of Wamic. This area is considered to be a "Frontier" area as outlined by the Trauma System Minimum Standards with a 4 ½ hour or less response time required 90 percent of the time.
An estimated response time schedule based on 90 percent of the time to major intersections shall be attached to this ASP when the ASA is awarded and reviewed periodically by the Wasco County ASA Review Committee with adjustments made in requirements as indicated.

The response times, labeled as travel times, are in Appendix 2, and designate Rural, 43 minutes, and Frontier, 4 hours 28 minutes. Run and response times will be provided quarterly to the ASA Advisory Committee. The Wasco County ASA Advisory Committee shall then review these run-times and proposed changes may then be submitted to the Board for approval when appropriate

Boundaries:

From the Western right-of-way of the intersection of Hwy 35 and USFS 48 (not including Hwy 35) south to the intersection of USFS 48 and USFS 43, then west to the western bank of the White River, following along its western and southern bank to the intersection with the section line 4S 13E 9 and 10, then north to the top edge of the cliff (1520' contour), then NE and NW along the cliff rim to the bottom of the grade of the southern edge-of-pavement of Wamic Market Rd (excluding the last house (82623 address)) in Tygh Valley, then to the northern edge of pavement of Wamic Market Rd, then West along the northern edge of pavement to the intersection of the 1520' contour (top of the cliff), then NW along the top of the cliff (1520' and 1640') to the intersection with the 4S 12E 1 / 4S 13E 6 section line, then north along that line to the NE corner of SE ¼ of SE ¼ of Section 36, 3S 12E, then northwest to SW corner of NW ¼ of NW ¼ of Section 36, 3S 12E, then north along that line (3S 12E 35/36) (excluding the gravel pit and USFS building) to NW corner Section 24 3S 12E, then NW along the bluff edge to the SE ¼ of SW ¼ of Section 4, 3S 12E, then west along that line to the SW corner of Section 4, 3S 12E, then north along that line to the southern right-of-way of Friend Rd, then west along the southern Friend Rd ROW to the intersection of the 2S 12E / 3S 13E line (No Friend Rd addresses are in ASA-8), then west along the township line to the NW corner of Section 3, 3S 11E, then south to the NW corner of Section 15, 3S then west along that section line to the intersection with the Wasco County line, then south and west along the County line to the Eastern ROW of USFS 48, then north along the ROW to the intersection with Hwy 35, across to the Western ROW of USFS 48, and the point of beginning.

(c) Maps Depicting 9-1-1, Incorporated Cities, and Fire Districts (See Appendix #3, #4, and #5, respectively)

(d) Alternatives Considered to Reduce Response Times

The alternatives to reduce response times to the primitive wilderness areas during good weather will be through the use of mutual aid, four-wheel drive vehicles, all-terrain vehicles, and helicopters from air-ambulance services available to Wasco County, depending on time factor, weather, and access to the incident area. During inclement weather, four-wheel vehicles will be used where possible, with snowmobiles and helicopters as the necessary alternative to unplowed roads and wilderness areas.

Air Ambulance services are provided by:

Lifeflight - (800) 232-0911

Airlink – (541) 706-6305

All-terrain vehicles support is provided by:

Wasco County Search and Rescue – (541) 296-5454

In addition to mutual aid, the county uses the nearest available Emergency Medical Responder to provide care while the ambulance is in-route to the scene. A list of County resources to include specialized rescue can be found in Sections 6(d) and 6(e).

Wasco County has many natural response barriers, including rivers and large roadless areas, which were considered when designating the ASA Response Subareas.

A barrier to response time throughout Wasco County is the fact that some EMS personnel are volunteers, and as such are subject to other employment obligations and non-EMS activities. Consequently, response times can be delayed through the process of locating available personnel.

A second barrier is the limited number of ambulances in the county. If existing ambulances in the county are already responding to an incident, response times to subsequent incidents may be delayed while mutual aid is requested and other units respond from a more distant location.

In instances in which a response may be delayed, there are several options which may be considered and employed based on the circumstances:

- Multiple ambulances may be dispatched from different locations within the ASA and/or outside of the ASA utilizing mutual aid agreements;
- An air ambulance may be requested;
- Additional personnel may be requested; and
- Other agencies, such as a fire district, may be contacted for assistance.

5. SYSTEM ELEMENTS

(a) 9-1-1 Dispatched Calls:

There are three 9-1-1 Communications Centers serving Wasco County. The Wasco County Sheriff operates a 9-1-1 Communications Center, the Warm Springs Tribal Police operates dispatch for Fire/EMS and LE for Warm Springs only, and the third 9-1-1 communications center is operated by Frontier Regional 9-1-1 for EMS dispatch only for Wasco County ASA 5 and 6 . The Communications Centers are known as PSAPs (Public Safety Answering Points) and receive all 9-1-1 calls from within Wasco County. The Communications Centers also receives business calls for several emergency response agencies after normal business hours. The Wasco County Sheriff Communications Center is located in the City of The Dalles. The 9-1-1 Dispatch Center Non-Emergency Reporting number is 541-298-5507. The Warm Springs Tribal Police is located at 2144 Kota St., Warm Springs, OR 97761. The non-emergency number is 541.553.3272. The Frontier Regional 9-1-1Communications Center is located at 135 S Main Street, PO Box 297, Condon, OR 97823. The Non-Emergency number is 541.384.2080.

(b) Pre-arranged Non-emergency Transfers and Inter-facility Transfers:

The Provider will Subcontract with one emergency Ambulance Service Provider for ASA Subareas 1 and 3-8. The Board may designate one or more non-emergency ambulance Provider for each ASA Subarea. OAR 333-260-0070(3).

The designated emergency ambulance Provider and Subcontractors are also authorized to provide non-emergency ambulance service within its assigned ASA or ASA Subarea.

If a non-emergency Ambulance Service Provider is not assigned to an ASA Subarea, the emergency Ambulance Service Provider shall have the right of first refusal for non-emergency and inter-facility transfers; provided, however, it does not negatively impact its ability to meet the requirements of this Agreement or ability to respond to other 9-1-1 emergencies. It is the responsibility of the hospital or facility requesting non-emergency and inter-facility transfers to locate an alternate Ambulance Service Provider if the assigned Ambulance Service Provider is unable to fill the transport request. Alternative inter-facility transfer capable services can be found in Sections 6(d) and 6(e).

Critical Care transport, Specialty Care transport and State Contracted inter-facility transfers should be scheduled directly with those Ambulance Service Providers capable of providing the relevant specialized services outside of the scope of the Ambulance Service Provider.

If an issue with non-emergency and inter-facility transfer arises, the hospital or the Ambulance Service Provider has the right to request an emergency meeting of the ASA Advisory Committee. The ASA Advisory Committee will consider recommended proposals from the hospital and /or Ambulance Service Providers for changing the language of the non-emergency and inter-facility transfer section to address the issue. Upon agreement, the ASA Advisory Committee will follow the appropriate process of sending the proposed amendments to the Board of County Commissioners and to the Oregon Health Authority for approval. The hospital and ASA Provider will meet and agree on the update prior to presenting the potential changes to the ASA Review Committee.

(c) Notification and Response Times:

When an emergency call is received by the Wasco County 911 Dispatch Center, the Ambulance Service Provider or Subcontractor will be immediately dispatched to handle the call.

Response times for each ASA shall meet the Trauma System Minimum Standards as outlined in OAR 333-200-0080(2) and are defined in the description of each ASA in Section 4 of this ASP. Additional information on response times is provided in Appendix #2 of this ASP.

“Trauma patient” means a person who at any time meets field triage criteria for inclusion in the Oregon Trauma System, as described in OAR 333-200-0010(26) and Exhibit A to those rules.

Trauma system patients shall receive prehospital emergency medical care within the following prehospital response time parameter 90 percent of the time:

- Urban area, an incorporated community of 50,000 or more population – 8 minutes;
- Suburban area, an area which is not urban, and which is contiguous to an urban community. It includes the area within a 10-mile radius of that community's center. It also includes areas beyond the 10-mile radius which are contiguous to the urban community and have a population density of 1,000 or more per square mile – 15 minutes;
- Rural area, a geographic area 10 or more miles from a population center of 50,000 or more, with a population density of greater than six persons per square mile – 45 minutes:
- Frontier area, the areas of the state with a population density of six or fewer persons per square mile and are accessible by paved roads – 2 hours; and
- Search and rescue area, the areas of the state that are primarily forest, recreational or wilderness lands that are not accessible by paved roads or not inhabited by six or more persons on a year-round basis. No established prehospital response time. OAR 333-200-0080(2)(b).

In reviewing proposed changes to the response time maps, the County may consider the above guidelines. The response time maps utilize the above designations and outline the current established response times for each ASA.

The Emergency Management Services Manager or designee may recommend changes to the ASA Advisory Committee, and the Advisory Committee may recommend modification of the response times to the Board. Since the standard for trauma patients is a high standard that may not be necessary or difficult to meet for general EMS responses, the Emergency Management Services Manager or designee shall consider developing response times for standard or non-trauma patients.

(d) Level of Care:

All ambulances and ambulance services in Wasco County must maintain a current license with the Oregon Health Authority, Public Health Division. Equipment and supplies for vehicles must meet or exceed standards as outlined in OAR and this ASP. See Section 3, Definitions, for BLS, ALS, and Licensing requirements.

A Provider or Subcontractor may utilize a mutual aid subcontractor or automatic aid agreements within its Subarea ASA to provide any part of its response commitments. Such agreements are subject to the approval of the County's Emergency Management Services Manager, or designee, and signed copies of the agreements will be held in the office of the County's Emergency Management Services Manager.

The delivery of Advanced Life Support assessment and treatment is the preferred level of care for Wasco County. Providers that cannot provide continuous coverage at the ALS level shall, if

possible, maintain written agreements for an automatic response with other Providers capable of ALS service delivery during those times that they cannot provide ALS service levels. Automatic aid requires the parties to work with the PSAP to establish and agree on dispatch procedures to effect this coverage.

All Providers assigned a Subarea ASA which includes an incorporated city with a total population in excess of 9,000 and in any ASA Subarea with a population density of 2,000 or more people per square mile shall provide service at the Advanced Life Support level and provide adequate staffing to maintain the ALS service level. In accordance with applicable Oregon Health Authority Rules. It will be the goal of the Ambulance Service Provider to provide Advanced Life Support staffing on a 24-hour basis.

This provision does not preclude an Ambulance Service Provider from providing an initially staffed BLS Ambulance when:

- A call for service is triaged by the dispatch center as a BLS response.
- ALS level of care is triaged by the dispatch center and the Ambulance Service Provider is responding in another unit to provide treatment and transport.
- In time of high volume only a BLS staffed ambulance is available.

(e) Personnel:

All Ambulance Service Providers or Subcontractors shall maintain minimum staffing and training levels for their designated BLS or ALS/BLS ambulance units in accordance with OAR 333-255-0070 and provide ambulances properly equipped to provide responses in their ASAs.

When an ASA or ASA Subarea is awarded to a Provider or Subcontractor, the ASA Application Form shall show the number of personnel in-house at the station (if applicable), call-ins, or volunteers that are available on a regularly scheduled basis.

The accepted ASA Application Form when submitted shall show the schedule of full-time paid, paid-per-call, or volunteer personnel.

(f) Medical Supervision:

All Providers and Subcontractors require the services of a Supervising physician under OAR Chapter 847, Division 035. The Provider shall provide the Supervising physician for itself and all Subcontractors. The Supervising physician shall conform to the following minimum level of medical services:

(A) Comply with the requirements listed in OAR 847-35-025;

(B) Hold a quarterly meeting with the EMS staff affiliated with the respective ambulance services Subcontractors;

(C) Designate an EMS coordinator who shall conduct case reviews in the physician's absence and send summaries of the review, problems identified, and proposed problem resolution to the physician; and

(D) Provide or authorize at least one case review meeting for all EMTs/Paramedics quarterly.

(g) Patient Care Equipment:

Patient care equipment must meet or exceed the requirements specified in OAR 333-255-0072. The Ambulance Service Provider or Subcontractor shall maintain a list of equipment for their ambulances, which shall be furnished to the County's Emergency Management Services Manager, which shall maintain a fully executed copy.

(h) Vehicles:

All Ambulance Service Providers and Subcontractors shall maintain vehicles as to age, type, and capacity as required by the Oregon Health Authority, Public Health Division licensing program for both BLS and ALS vehicles. Each Ambulance Service Provider shall provide the Board the necessary documentation for each vehicle operating under their control. The initial information shall be completed on the ASA Application Form which shall become an attachment to this ASP when a Provider is granted an ASA or ASA Subarea. The ASA Application Form and the financial statement shall be required at the annual license renewal.required by the Oregon Health Authority

An ambulance shall not be operated unless the ambulance meets the requirements of OAR 333-255-0060 Ground Ambulance Vehicle Construction Criteria.

All Ambulance Service Providers and Subcontractors shall provide maintenance records of vehicles to verify the safe and sound operation of their equipment. All ambulances shall be maintained in conformity with vehicular manufacturer's recommendations and the ambulance conversion manufacturer.

All Ambulance Service Providers and Subcontractors must have an on-going safety program for setting and administering safety practices. Ambulances shall be operated in accordance with applicable motor vehicle codes, rules, and statutes, and in a safe manner with due regard for lights, traffic, road, and weather conditions.

Ambulance staffing shall meet the requirements established in OAR 333-255-0070.

(i) Training:

The Ambulance Service Provider for Wasco County shall have an initial and continued training program for their ambulance personnel and Subcontractors which meets at the minimum, but not limited to, Oregon Administrative Rules 333 Division 265 and ORS Ch. 682. All ASA Emergency Medical Service Providers providing emergency medical response service in Wasco County shall maintain continuing medical education and meet licensing standards as identified by the Oregon Health Authority, Public Health Division.

(j) Quality Improvement:

(A) Structure.

In order to ensure the delivery of efficient and effective prehospital emergency medical care, an ASA Advisory Committee is hereby established.

The ASA Advisory Committee shall serve at the pleasure of the Board of Wasco County without compensation. The ASA Advisory Committee shall be chaired by the County's Emergency Management Services Manager, and meet at such times as called by the Chair. The Chair or any two members of the ASA Advisory Committee may call a special meeting with five days' notice to other members of the committee; provided, however, that members may waive such notice. The ASA Advisory Committee may establish subcommittees to consider and advise it on specific issues. The ASA Advisory Committee shall consist of the following voting members, appointed from the following:

(1) The Provider's Supervising physician or designee ;

(2) A representative from the Provider and one representative selected by the Subcontractors;

(3) The Director of Nursing Service or designee appointed by Adventist Health, Columbia Gorge, aka Mid-Columbia Medical Center;

(4) The Director or designee of the North Central Public Health District;

(5) One at large member appointed by the Board who shall serve a two-year term;

(6) One representative selected by the non-transporting fire departments.

(7) One 9-1-1 systems representative appointed by Wasco County's PSAP;

(8) A mental health representative from Mid-Columbia Center for Living;

(9) The County's Emergency Management Services Manager.

The Chair of the Board, or the Chair's designee, shall be a non-voting member of the ASA Advisory Committee, with authority to vote only to break a tie vote. The Wasco County Emergency Manager shall provide staff and facilities to facilitate the meetings of the ASA Advisory Committee.

Any member of the Board of Commissioners may attend regular meetings of the ASA Advisory Committee to learn the State and Federal regulations, local policies, and the general operation of an ambulance service. Information will be presented to the Board at appropriate meetings to determine the effectiveness and efficiency of existing ambulance services and potential applicant services.

(B) QA Program Process.

(1) The ASA Advisory Committee shall have the following powers, duties, and responsibilities:

(a) Advise the Board on all matters relating to prehospital emergency medical care.

(b) The Quality Improvement Program shall include regular monitoring of prehospital provider notification times, response times, and patient care standards to ensure compliance with applicable statutes, ordinances, and rules. The ASA Advisory Committee shall evaluate quarterly:

- **Dispatch Data**: Review call receipt-to-dispatch intervals to ensure timely notification of prehospital providers.
- **Ambulance Response Data**: Analyze response times to confirm adherence to established time standards for urban, suburban, ~~and~~ rural areas, and frontier areas.
- **Patient Care Records**: Assess patient care reports for compliance with clinical protocols and quality of care metrics. Evaluations will occur quarterly, with findings documented in a report submitted to the ASA Advisory Committee. The committee will review trends, identify areas for improvement, and implement corrective actions as needed. Annual summaries of these

evaluations will be compiled to track long-term performance and compliance.

(c) Plan, assist and coordinate programs for the improvement of the EMS system in Wasco County.

(d) Advise the Board as to the standards for information required of applicants for an Ambulance Service Provider.

(e) Provide an open forum for members of the public to comment on or discuss EMS systems issues.

(f) Foster cooperation among the prehospital care providers and medical community.

. (g) Develop and maintain an effective quality assessment and performance improvement system that is approved by the EMS medical director, which will include specific monitoring and tracking systems elements, such as those outlined in OAR 333-250-0320, in order to identify, investigate, and propose remedies for the correction of substandard ambulance services provided in Wasco County.

(h) Report directly to the Board on all matters coming before the ASA Advisory Committee.

(i) Adopt rules of procedure, subject to approval by the Board.

(j) All investigations shall, to the greatest extent allowed by law, be conducted pursuant to ORS 41.675 and ORS 41.685, and medical information shall be further protected under the Health Insurance Portability and Accountability Act regulations and Oregon Public Records laws. Subject to approval by the County Commissioners, the ASA Advisory Committee shall develop and propose approval of procedures to ensure confidentiality under the above provisions.

(2) The ASA Advisory Committee shall conduct meetings in accordance with the Oregon Public Meetings laws and comply with the Oregon public records law, ORS Chapter 192. Executive sessions closed to the public may be held when authorized by Oregon law. Both the records and minutes of executive sessions shall be handled to ensure patient confidentiality in compliance with state and federal laws. The ASA

Advisory Committee chairperson shall have the following duties, powers, and responsibilities:

(i) Maintain a filing system for the records of the ASA Advisory Committee.

(ii) Provide for the administration of appeals and hearings to the appropriate government bodies.

(iii) Administer the ASA Plan and ASA Ordinance when appropriate.

(iv) Review all applications for an ASA and make documented findings and recommendations to the Board on Provider selection.

(C) Sanctions for Non-Compliant Personnel, Provider, or Subcontractor.

Sanctions for non-compliance of the Provider or Subcontractors with this Ambulance Service Plan are addressed in the Wasco County Ambulance Service Ordinance. (See Appendix #6)

Quality Improvement Problem Resolution.

(1) In the event that the ASA Advisory Committee identifies an issue with the Provider's or Subcontractor's compliance with this Ambulance Service Plan, the ASA Advisory Committee:

(a) may request additional information necessary to evaluate the compliance concern;

(b) contact the Provider in writing and identify the specific facts, laws, rules, or protocols of concern; or

(c) request that within thirty (30) days the Provider or Subcontractor submit a written response and a plan to correct any deficiencies.

(2) Upon receipt of the written response, the ASA Advisory Committee shall:

(a) Review the response to ensure that it responds to all questions;

(b) Review the written plan for resolution of any deficiency;

(c) Upon findings of compliance, continue to monitor the plan for solution of the deficiencies;

(d) Upon findings of continued non-compliance, serve written notice to comply with ASA Plan or protocol;

(e) If compliance is not evident with ten (10) days of receipt of the notice, schedule a meeting within the next ten (10) days and attempt to gain compliance; and

(f) Attempt to obtain voluntary correction or compliance, but if compliance is not obtained, request a hearing on the matter before the Board.

(3) In the event the ASA Advisory Committee is unable to obtain compliance or correction of a deficiency under the above procedures, the matter may be referred to the Board for its determination on proceeding with a hearing or taking other actions.

(4) If the Provider or any Subcontractor is dissatisfied with the results of a meeting with the ASA Advisory Committee, the Provider or Subcontractor may request a hearing before the Board by filing a request, setting forth the reasons for the hearing and the issues to be heard. The Board may prescribe forms for the filing of a request for hearing.

(5) A hearing under this section shall be conducted by the Board chairperson or vice-chairperson in accordance with the Attorney General's Model Rules of Procedures.

(6) In the event that the Board is unable to obtain compliance or correction as a result of a hearing, the Board may sanction the Provider if appropriate, or terminate the Provider's ASA territory.

(7) The ASA Advisory Committee will periodically review the Mass Casualty Incident Management Plan ("MCI") and suggest revisions to the Board. Subject to approval by the Board, the Emergency Management Services Manager may amend the Medical component of the County Emergency Management Plan.

6. COORDINATION

(a) The Entity That Shall Administer and Revise the ASA Plan:

The County Board of Commissioners shall administer the ASA Plan with the assistance of the ASA Advisory Committee as noted above. Revisions to the ASA Plan can only be made by the County Board of Commissioners.

(b) Process for Review of Input from Prehospital Care Consumers, Providers, Subcontractors, the Medical Community, and the Public:

(A) **Input Submission**: Complaints, concerns, or suggestions may be submitted via:

- A dedicated online portal on the county's EMS website: https://www.co.wasco.or.us/departments/emergency_management/ambulance_service_area_plan.php.
- Email to the ASA Advisory Committee at WascoASAC@co.wasco.or.us.
- Written correspondence mailed to Emergency Management Services Manager, 511 Washington St. Suite 102, The Dalles, OR 97058.
- In-person or virtual public forums held biannually by the ASA Advisory Committee.

Processing Input: All submissions will be logged and reviewed by the ASA Advisory Committee within 30 days of receipt. The committee will categorize input as complaints, concerns, or suggestions and assign follow-up actions, which may include consultation with prehospital providers, medical directors, or other stakeholders.

Feedback and Resolution: Submitters will receive acknowledgment of their input within 5 business days and a resolution or status update within 45 days. Summaries of input and actions taken will be included in the committee's quarterly reports, with anonymized data shared publicly to ensure transparency. The county will promote these channels through community outreach, including EMS provider networks, local healthcare facilities, and public announcements

(B) If any Provider, Subcontractor, individual or organization is dissatisfied with the results of a meeting with the ASA Advisory Committee, a request for hearing before the Board may be made by filing a request, setting forth the reasons for the hearing and the issues to be heard. The Board may prescribe forms for the filing of a request for hearing. Subject to approval by the Board, the ASA Advisory Committee may select a hearings officer to make recommendations of findings, penalties, fees,

County charges, resolution, or other information in the enforcement of provisions of this ASP or the approving Ordinance.

(C) A hearing under this section shall be conducted by the Board chairperson or vice-chairperson in accordance with the Attorney General's Model Rules of Procedures.

(D) In the event that the Board is unable to obtain compliance or correction as a result of a hearing, the Board may sanction the Provider or Subcontractor if appropriate, or terminate the Providers ASA Territory or Subcontractors ASA Subarea.

(c) Mutual Aid Agreements:

(A) The Ambulance Service Provider shall sign a mutual aid agreement with other providers adjacent to the County and respond with needed personnel and equipment in accordance with the agreement. Mutual aid agreements will be subject to prior approval by the Board. Signed copies of mutual aid agreements will be maintained by, and copies can be obtained from, Wasco County's Emergency Management Services Manager. The Provider will include mutual aid agreements with all Subcontractors.

(B) All requests for mutual aid shall be made through the appropriate PSAP.

(C) All mutual aid agreements will be reviewed annually and modified as needed by mutual consent of all parties.

(D) Mutual Aid Advance Life Support (ALS) assists shall be automatically dispatched in accordance with the Emergency Medical Dispatch Protocols established by the ASA Advisory Committee.

(d) Disaster Response:

(A) County resources other than ambulances.

(1) When resources other than ambulances are required for the provision of emergency medical services during a disaster, a request for additional resources shall be made through the appropriate PSAP to the County Emergency Management Office.

(2) The Emergency Management Services Manager shall be responsible for locating and coordinating all county EMS resources any time that the MCI Plan, as defined below in Section 6 (d)(C)(2) is implemented.

(3) The Emergency Management Services Manager shall work directly with local agencies, departments, and governments to coordinate necessary resources during any implementation of the MCI Plan.

(B) Outside county resources.

(1) When resources from outside Wasco County are required for the provision of emergency medical services during a disaster, a request for those resources shall be made through the appropriate PSAP to the County Emergency Management Office.

(2) The Emergency Management Services Manager shall be responsible for requesting and coordination all out of county resources any time the MCI Plan is implemented.

(3) Additional Ambulances

(i) Rotary-wing ambulances

(ii) Life Flight (Pendleton, OR)
1-800-452-7434

(iii) AirLink of Oregon (Bend, OR)
1-800-621-5433

(4) Fixed-wing ambulances

(i) AirLink of Oregon (Bend, OR)
1-800-621-5433

(ii) Life Flight (Pendleton, OR)
1-800-452-7434

(5) Ground ambulances

(i) Umatilla County Fire District #1 1-541-567-8822

(ii) American Medical Response Northwest, Inc., Operations Manager, Clackamas County, OR 503-659-8892

(iii) Pendleton Ambulance 1-541-267-1442

(iv) The City of Fossil Volunteer Ambulance 541-763-2698 or 9-1-1

(v) Condon Ambulance 676-5317 or 9-1-1

(vi) Arlington Ambulance 676-5317 or 9-1-1

(vii) Sherman County Ambulance 541-565-3100 or 9-1-1

(viii) Klickitat County EMS District #1 509-773-1026 or 9-1-1

(C) Mass Casualty Incident Management Plan ("MCI Plan").

(1) Purpose. The purpose of the disaster response plan is to provide guidance to EMS response personnel in the coordination of response activities relating to mass casualty incidents in Wasco County.

(2) Implementation: This plan shall be implemented whenever the Ambulance Service Provider resources are unable to handle the incident or at the request of the Wasco County Emergency Management Services Manager. All Ambulance Service Providers will utilize the ATAB 6 MCI. A copy of the MCI Plan is attached Appendix #7.

(D) Response to Terrorism.

Wasco County does not have adequate resources to sustain a reinforced response to a major terrorist incident. As a result, it is necessary for the Providers and Subcontractors to establish mutual aid agreements with all surrounding jurisdictions. The Provider and Subcontractors must be prepared to recall to duty employees, and to develop volunteers to supply additional assistance. The Provider and Subcontractors shall establish recall lists of phone numbers, pages, or other contact information, and keep them current, and establish and maintain a current list of volunteers. The Provider and Subcontractors shall authorize first responders to self-dispatch to local or nearby events. The Provider and Subcontractors shall establish access to individual personal protection equipment for employees and volunteers and define a reporting location or process for receiving directions and coordination of response from command. Provider and Subcontractor employees and volunteers should be advised not to respond to incidents outside of their jurisdiction without deployment instructions from the Provider's acting command. If the size, scope, or complexity of an incident is beyond a Provider's or Subcontractor's resources, they should request mutual aid and contact the county emergency incident command team, the Fire Board Acting Chief,

and the State Fire Marshall for implementation of the State Fire Service Mobilization Plan. Protocols should be established for all employees and volunteers to be aware of and comply with these requirements.

(e) Personnel and Equipment Resources:

(A) Non-transporting EMS providers.

Mosier Fire Department 9-1-1 or 541-478-3333 Secondary number when not staffed 541-578-9071

Dufur Fire Department 9-1-1 or 541-467-2349

Juniper Flat Rural Fire Protection Department 9-1-1 or 541-328-6388

(B) Hazardous Materials.

The response for the On-Scene Incident Command is outlined in the Wasco County Emergency Operations Plan, Emergency Support Function 10 – Oil and Hazardous Materials and responding agency response plans and procedures. Response to Hazardous Materials is augmented by the Oregon State Fire Marshal through the Oregon Emergency Response System ("O.E.R.S.") and the On-Scene Incident Commander. Specialized Resources for HAZMAT Response can be found in Appendix H.

Additional resources are as follows:

(1) O.E.R.S. --- (provides notification and activation of state agencies) --- 1-800-452-0311 or 503-378-6377

(2) CHEMTREC--- 1-800-424-9300

(3) Umatilla County Fire District #1 (Hazmat Decon for Eastern Oregon) 1-541-567-8822

(C) Search and Rescue.

(1) Wasco County Sheriff's Office -- 9-1-1 or 541-506-2580

(2) Oregon Civil Air Patrol -- 1-800-452-0311 or 503-378-6377

(3) U.S. Coast Guard, (since the Columbia River falls under the jurisdiction of the U.S. Coast Guard, they will provide specialized

aircraft and watercraft for rescue operations. These units will respond from either Astoria, OR 1-503-861-2242 or 1-503-861-6248; or Walla Walla, WA.

(D) Specialized Rescue.

(1) Wasco County Sheriff's Office -- 9-1-1 or 541-506-2580

(2) U.S. Navy Bombing Range --541-481-2565

(E) Extrication.

(1) Fire and Rescue Jaws and Rescue Equip -- 9-1-1

(2) Wasco County Road Dept - heavy equipment – 541-506-2640 during business hours; 541-296-5454 after hours.

(f) Emergency Communication and System Access:

(A) Telephone access.

Wasco County is served by a county-wide EMS dispatch and PSAP. It is located at the Wasco County Sheriff's Office in The Dalles. Overflow calls to Wasco County Communications Center are automatically routed to Hood River County Dispatch Center. Wasco County and the Providers are activated by the 9-1-1 prefix system into the Wasco County Communications Center.

(B) Dispatch Procedures.

To establish a minimum standard of medical dispatching within Wasco County, all First Response Agencies, Ambulance Service Providers, PSAP's and Dispatch points shall:

(1) Follow the established standards of emergency medical dispatching and follow the procedures and protocols as approved by the Committee, ATAB Rules and OAR 333-260-0050 (1) & (2).

(2) Conform to a call received to notification of Initial Responders and Ambulance Service Providers of < 2 minutes 90% of the time (see Section 5.3.1 of this ASP).

(3) Notify Initial Responders and Ambulance Service Providers by the use of radio communications including pagers and tone activated devices.

(4) Include in every dispatch the following:

- Pre-announcement identifying agency(ies) to respond, nature of the problem and a general location;
- Announcement identifying agency(ies) to respond, nature of the problem identified through the use of dispatch priority protocols and the exact location of the patient; and
- Any specific instructions or information pertinent to the emergency.

(5) Repeat the announcement to each agency first response unit(s) when they respond to include any additional information obtained about the patient's situation, history, or problem.

(6) Dispatch Advanced Life Support (ALS) Assist according to the Providers protocols which are identified as ALS in nature.

(7) While primary communication is through central dispatch, once the ambulance has been dispatched, ambulance personnel may be in contact with the area hospitals on the Med-Net / HEAR radio link system, or by direct phone call with the Emergency Room Staff.

The Wasco County Communications Center is a priority one for re-establishing phone lines. It has its own emergency power unit and is equipped with three consoles and carries frequencies in fire, police, sheriff, public works, and emergency service.

(C) Radio System.

Radios are used for communication between the ambulance crews and their departments. The radio is also used for communication between the ambulance crews and the dispatch centers. All radios will have access to fire channels within their ASA Subareas and be able to talk to the local PSAP and hospital. The Incident Commander shall, during large events, use the Fire Districts channels appropriate to the Fire District the event is located in for communication.

(D) Emergency Medical Services Dispatcher Training.

(1) All EMS dispatchers shall successfully complete an Emergency Medical Dispatch (EMD) training course as approved by the Oregon

Emergency Management Division and the Board on Public Safety Standards and Training.

(2). Dispatchers are encouraged to attend any class, course or program which will enhance their dispatching abilities and skills.

7. PROVIDER SELECTION

(a) Initial Assignment:

The Wasco County Board of Commissioners recognizes the value of maintaining and enhancing contributions towards ambulance services from rural ambulance services, such as volunteer fire departments and non-profit organizations. Retaining those services and providers, and integrating the services with the Provider, enhances the all-hazard response to the community through integration, cross trained EMS providers, and reinvestment of funds to improve the system.

If a current Provider remains in good standing as of the effective date of this Ambulance Service Plan, the Board may approve the current Provider as a Subcontractor for that ASA Subarea without requiring the submission of a full application.as specified below. The Board may rely on County staff for recommendations and may request limited information in its discretion.

Selection of the Provider will be through a Request for Proposal ("RFP") process. As part of that RFP process current Providers will be asked to confirm whether they elect to continue providing ambulance services and to identify their needs. The RFP Applicants will then be given an opportunity to address those needs with the current Provider and in its RFP submission. Memorandum of understanding between the RFP Applicant and the current Provider will be accepted.

County staff may communicate with the applicants and advisors to discuss service options. Upon being fully advised, the Board will appoint the initial Provider under this Ambulance Service Plan and Subcontractors for Subareas.

(b) Term:

If a Provider or Subcontractor remains in good standing, the assignment or subcontract will be effective for five (5) years, or until a successor is assigned to the ASA Service Area. However, the County may approve an agreement with a rolling two (2) year extension following the first five (5) years conditioned on compliance with new terms or conditions that may be required by the Oregon Health Authority during its required five (5) year review and approval.

During any extended period, the Board may open the appointment for the next five (5) years in its discretion. The Provider and Subcontractors may reapply for extended terms of five (5) years

(c) Application for the ASA:

The Wasco County ASA Plan establishes standards to evaluate the efficiency and effectiveness of existing service Providers and Subcontractors as well as establishing guidelines for potential applicants for a service area.

Ambulance Service Providers are required to comply with all state, local and federal laws, and ordinances applicable to the work performed as a Provider or Subcontractors. Providers and Subcontractors are required to cooperate with other emergency Providers and to conduct themselves in a professional manner. Failure to comply may be a basis for sanctions, including financial sanctions or other remedies as may be proposed by the ASA Advisory Committee, up to and including termination of an ASA.

The Provider and Subcontractor shall not respond to a medical emergency outside its assigned ASA Subarea except:

- When a Provider is unavailable to respond, and mutual aid is exercised.
- When dispatched by Wasco County 9-1-1 Communications to fill an extreme emergency need.

The Provider understands and agrees that the assigned ASA Area shall not be arbitrarily transferred to another Provider. The Provider may subcontract ambulance transport subject to approval by the Board. Assignment of an ASA Area by the Wasco County Board of Commissioners is through a non-negotiable contract between the Provider and Wasco County Board of Commissioners and shall be terminated only in accordance with the elements of this ASA Plan and the Wasco County ASA Ordinance.

Should a vacancy occur in a Subarea, fire districts or other Ambulance Service Providers within the Subarea will be given thirty (30) days to submit an application with the Provider. If there is no request during that time period, or partial request, or the applicant refuses to enter into a subcontractor agreement with the Provider, the Provider may provide the service directly or seek another Ambulance Service Provider for a Subcontractor relationship.

Should a vacancy occur in the ASA, the County will advertise the vacancy by public notice. This notice will be published in all Wasco County communities, surrounding areas, the medical community, and with the Oregon Health Authority, if appropriate.

The Board will review all applications received requesting assignment of the ambulance service area in Wasco County. The Board may seek information and input from the ASA Advisory Committee when evaluating applications. Each Ambulance Service Provider applicant will be required to:

(A) show the level of service that will be provided for prehospital emergency medical care;

(B) show that the call volume and financial ability of the Provider will be sufficient to provide financial soundness for operation;

(C) show its service will provide quality care to all persons residing in or passing through the service area;

(D) follow all regulations pertaining to ambulance service as set forth by the Oregon Health Authority, Oregon Board of Medical Examiners and Oregon Department of Motor Vehicles;

(E) provide the following information in the proposal: number and type(s) of ambulances, including medical equipment; vehicle storage arrangements; communication capabilities; dispatching capabilities; and number of personnel, qualifications, and their method of providing prehospital emergency medical continuing education training; and

(F) adhere to all policy, procedures and guidelines set forth in the Wasco County ASA Plan.

(d) Notification of Vacating an ASA or Subarea:

(A) The assigned Ambulance Service Provider and Subcontractors agree to provide to Wasco County Emergency Management Services Manager not less than a ninety (90) day written notice of a decision to vacate an ASA.

(B) The notice to vacate must be approved by the Provider's Board of Directors.

(C) The following procedure will be implemented until such time that a new Provider can be awarded the affected area.

(1) The Board will request the remaining Subcontractors to adjust their service area boundaries to ensure adequate coverage of the vacated area. Assistance may also be requested from the closest Provider outside the County through a mutual aid agreement.

(2) If possible, an award of the ASA or Subarea will be made to a new Provider or Subcontractor within the ninety (90) days after the notice to vacate.

(3) In the event a new Provider or Subcontractor cannot be identified before the expiration of the notice period, the Board may ask the ASA Advisory Committee to recommend a solution.

(4) In the event a satisfactory solution to all parties involved cannot be reached within a reasonable amount of time, the ASA Advisory Committee will appoint a task force comprised of representative from each ambulance service, the Board, the medical community, and a citizen of each community involved (not affiliated with the health care industry), to reach a reasonable and workable solution.

(5) The Ambulance Service Provider vacating its area will advise their ASP employees that the replacement service Provider is required, during the six-month period immediately following the date of replacement, to give preference to qualified employees of the previous ambulance service at comparable levels of licensure. ORS 682.089(1)(b). Transferring employees and employers are also subject to the provisions of ORS 236.605 et. seq.

(e) Maintenance of Level of Service:

A Provider or Subcontractor that no longer provides ambulance services will cooperate with the Board to ensure a smooth transition of services to a new replacement Provider.

8. COUNTY ORDINANCES AND RULES
See Attached Appendices

APPENDICES:

#1 ASA and Subareas Map
#2 Response Time Zones
#3 9-1-1 Map
#4 Incorporated City Maps
#5 Fire District Boundaries Maps
#6 Wasco County Ambulance Service Ordinance 2025
#7 Wasco County Mass Casualty Incident Plan

Exhibit 5.a.

AHCG and Mid-Columbia Fire & Rescue Plan

AHCG TRANSFER TRIAGE CATEGORIES

	1	2	3	4
Transfer Priority	**Immediate-** Requires continued resuscitation and/or life sustaining measures during transport, or has high likelihood of loss of life or limb without immediate transfer	**Critical-** Requires acute interventions for treatment or stabilization	**Urgent-** Requires minimal to moderate acute treatment. Need for tertiary care. 0800-2000	**Scheduled-** Requires little or no medical evaluation or treatment but cannot travel POV. 0800-2000
Level	ALS options: 1st= Air if available within 1 hr. 15 min 2nd= Ground w/LF Crew 3rd=Ground w/ 3rd provider if required *Coordinate with MCFR on Inclement Weather transfers when the helicopter and or crew are not available. *		ALS/BLS options: Dependent on treatment required enroute. Ground -Intermediate crew Ground- Advanced crew	BLS Options: Ground -Basic BLS crew
Patient Status	Critical ACLS Life or Limb	Emergent ACLS	Urgent ACLS/ AMLS	Non-Emergent
Examples	Resuscitation STEMI Stroke Trauma System Entry	Spinal fractures with neurological deficits. CVA,who received thrombolytics NSTEMI-UNSTABLE	Complex hip fracture Stable trauma Need for definitive care from tertiary center. ERPC NSTEMI – STABLE VS	Transfer back to residence Transfer to Hood River (viewed as local transfer)

LEVELS OF EMS CREWS: (Oregon Secretary of State Administrative Rules**)**

- **BASIC (BLS)**
- **ADVANCED (ACLS)**
- **INTERMEDIATE (ACLS)**
- **PARAMEDIC**

Pediatric Level 1 & 2 ALS Transfers

- **Transfer Priority**
  - Life Flight
  - PANDA
  - MCFR Ground w/ LF Crew
  - MCFR Ground w/Extra Provider

Please note when determining BLS vs ALS vs Critical Care:

• **BASIC** (BLS) can transport a patient with a saline locked IV in place but cannot give or monitor IV fluids or medications. Can give aspirin, albuterol, Narcan, oral dextrose, IM epinephrine for anaphylaxis, and oxygen.

• **ADVANCED** (ALS) can start IV's and IV fluids. And meds stated above for BASIC (BLS).

• **INTERMEDIATE** (ALS) can give select cardiac meds, Zofran, IV pain meds or additional treatments ordered on transfer form at the discretion of the physician and EMS provider with training.

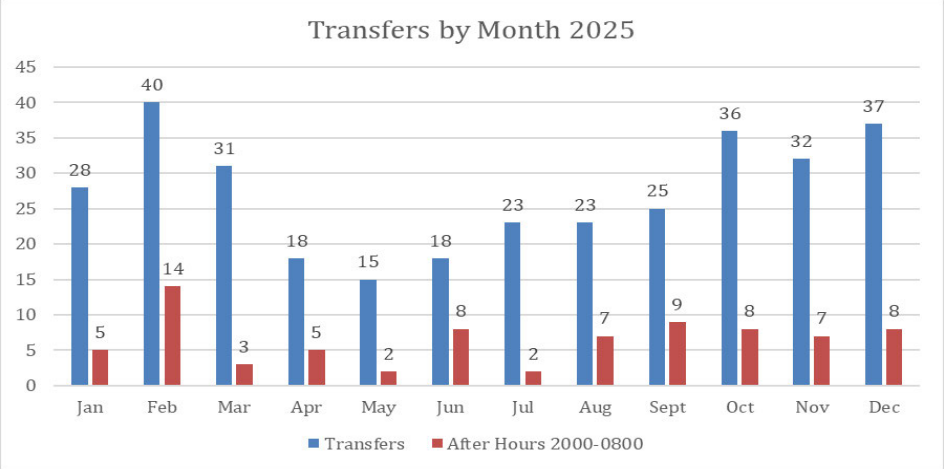
- It is **vital** that the Duty Captain receives via fax: EMTALA Physician Certification form, EMTALA Order form, and Patient Demographic to determine the correct level of EMS crew for the impending transfer. The crew will not depart the station until it's received and reviewed.
- Unstable patients should be transferred by LifeFlight, if possible. LifeFlight should be able to provide a crew to transfer patients via ground ambulance if unable to fly.
- MCF&R cannot do CPAP >30% FIO2 or BI-PAP transfers – Air transportation will need to be arranged. Nor can MCF&R take intubated patients.
- If there are more than 1 pending transfer out, the Nursing House Supervisor will prioritize which patient to transfer 1st.
- Priority 3 & 4 transfers will be conducted between 0800 – 2000 hrs.
- Transfer Initiation Timeframes
    - 1. Timeframe A facilities- 1-1 ¾ hour drive time (typically Portland area)
    - 2. Timeframe B facilities- 1 ¾ -2 ¾ hour drive time hospitals- (typically Central Oregon, Salem, Tri-Cities, and Yakima): **With the exception of a critical care transfer with a Lifeflight crew, transfers to Timeframe B facilities will not depart The Dalles between the hour's of 2000 hours and 0800 hours.

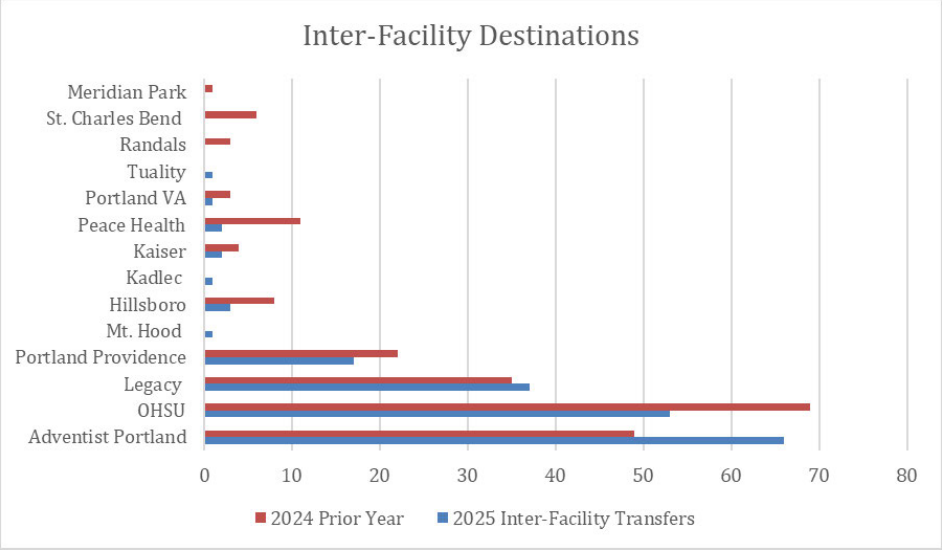
Exhibit 5.c.

Summary of Transfer Trial Results

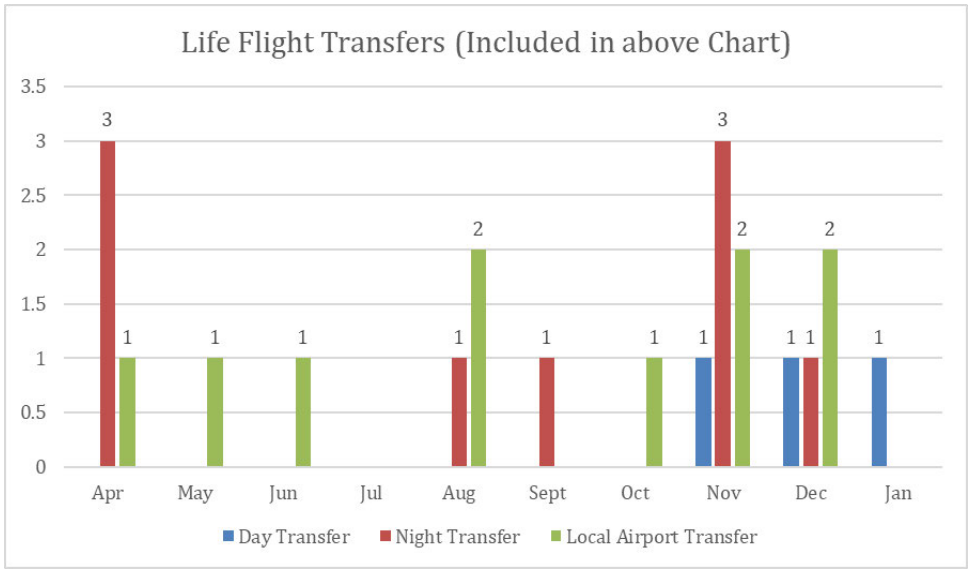
AHCG/ MCFR Trial Transfer Data

1) Initial 3-month trial: October 27th - January 27th
   a) Met with MCFR Operational Chief, Josh Beckner on October 14th to discuss triage categories.
   b) Follow up meeting on December 1st to discuss adding stable NSTEMI transfers to category 3 transfers including patients that transfer with cardiac medications.
      i) Amendable to inclusion of stable NSTEMI transfers (Level III).
2) Meeting review of transfer trial period on January 21st at MCFR
   a) Request to share transfer data by both MCFR and AHCG for 2025 total transfers.
   b) Data transfer received on January 22nd from MCFR
      i) MCFR 2025 Transfer Data:

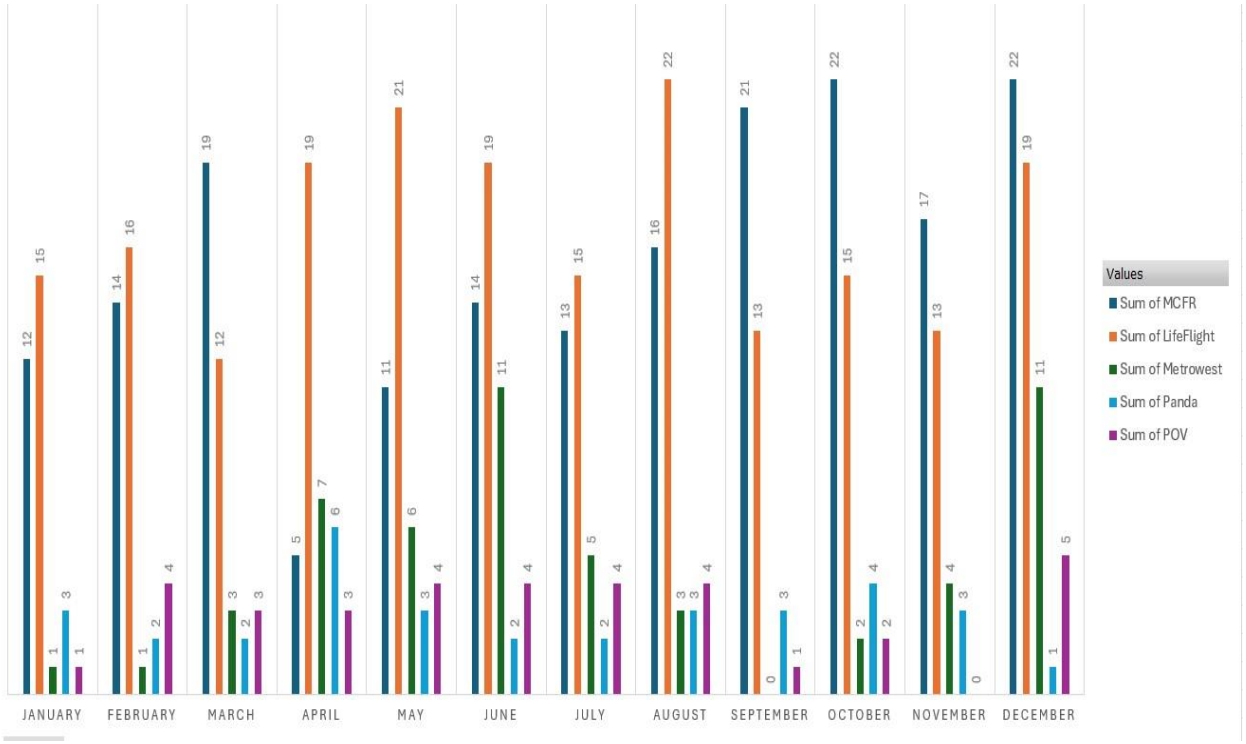




AHCG/ MCFR Trial Transfer Data



ii) AHCG 2025 Transfer Data:



AHCG/ MCFR Trial Transfer Data

Row Labels	Sum of MCFR	Sum of LifeFlight	Sum of Metrowest	Sum of Panda	Sum of POV	
January	12	15	1	3	1	
February	14	16	1	2	4	
March	19	12	3	2	3	
April	5	19	7	6	3	
May	11	21	6	3	4	
June	14	19	11	2	4	
July	13	15	5	2	4	
August	16	22	3	3	4	
September	21	13	0	3	1	
October	22	15	2	4	2	
November	17	13	4	3	0	
December	22	19	11	1	5	
Grand Total	**186**	**199**	**54**	**34**	**35**	**508**

Next meeting:

Targeted review scheduled for February 16th and February 27th

Exhibit 6.a.

Community Board Meeting Minutes

BOARD OF TRUSTEES
Minutes of Meeting
Wednesday, May 22, 2024
In Person/ TEAMS Meeting

Board Members Present: Joyce Newmyer, Board Vice-Chair; Board Vice- Chair; Paul Cardosi, MD; Janet Hamada, Kyle King, incoming Board Vice- Chair.
TEAMS Board Member Attendees: Bill Ketchum; Sue Knapp; Nolan Young; Michele Spatz, Victor Mondragon; Dr. Frank Toda.
Board Members Not in Attendance via ZOOM/ In person: Rob Van Cleave,
Also Present: Camie Overton, COO; Jayant Eldurkar, MD; Wendy Apland, CFO; Jayme Mason, CNO, Analene Pentopoulos, MD, Past Medical Staff President, Lisa Grant, MD.

I. **Call to Order:** Joyce Newmyer called the meeting to order at: 5:17 pm
Joyce called the meeting to order and thanked everyone for attending today. She then introduced Terry Johnson.

II. **Prayer and Planetree Moments:** *Terry shared a story about his journey to Adventist Health and a power point about the Mission Foundation. He then led the Board in a prayer.*

[redacted]

[redacted]

III. Consent Agenda: Joyce Newmyer, Board Vice-Chair

A. **Minutes Approval:**
A MOTION *was made by Michele Spatz to accept the February 28, 2024, Board Meeting and May 1, 2024, Board/ELT Meeting minutes as presented. Frank Toda seconded the motion. Motion was carried out and approved by the Board.*

IV. New Business

A. **Office of Mission Presentation: Terry Johnsson –** *Shared a power point of the Mission Foundation at the beginning of the meeting. (See above)*

B. **System Updates: Joyce Newmyer – Joyce** *shared information about the new Central Coast acquisition. This was a 30-day transaction and there are still items being worked on. Currently working with the California Nursing Association (CNA). We already have a tentative agreement with them, they were surprised at how easy AH were to work with. AH sold 1.2M in Bonds to purchase the two new hospitals. Overall, this was the right thing to do. We have a triple B+ rating with a stable outlook. We are very happy with how it turned out.*
At AHCG, we have had some painful structural changes and there is still a lot of streamlining being done to make sure we are on the right track. There is safety in the system.

C. **Administrator Report: Camie Overton –** *The overall tone of the organization is "we're going to make it." We had an amazing amount of new information to learn in the onboarding process and in the last few months. We now have access to data and Dashboards of which we could only dream. We are making progress on our budget. Our volumes look to be increasing in both the hospital and clinics. We have thirteen initiatives that we are working on. One important thing coming up is the Foundation golf tournament. It is coming up on Tuesday, June 11th. We hope that you can come out and support the Foundation. Dr Eldurkar and Wendy will provide the update on the provider contract negotiations since they have been working closely together on that.*

Joyce asked Kyle and Camie to give an update on the meetings that are being held to discuss how we can improve efficiency within the Oregon Network.

Kyle reported that they have already had 3 or 4 meetings and have produced 18 initiatives that can be worked on together and share services wherever possible. We have four sub workgroups and are in the process of prioritizing the 18 initiatives and working on improving services, i.e., Epic training, Infection Prevention, and LIS coordinator. (these are examples of where we can share the work). Cheri McCall was helpful in advising the Central Coast hospitals regarding nursing negotiations. Kyle also said that he had a great conversation with Patrick McCormick from OHSU regarding the relaunch of Celilo Cancer Center. He was feeling very optimistic about the future of CCC.

D. **MO Report: Jayant Eldurkar, M.D. –** *Reported that only five out of 80 Dr's have not decided on signing new contracts. There have been a few Dr's that have left but there has been a great team effort in retention. There are 3.5 ER Dr's coming in early fall. We signed an agreement with OBHG, a third-party vendor, that he hopes will start in October covering 15 days per month in OB. He has been meeting with the Oregon Service Group and the three area Medical Officers have discussed the need to recruit an Endocrinologist. Audra Schmidt has done a yeoman's job of bringing people in. She just returned from New York and has seventy-five names of providers that are interested in Oregon. A lot of work is being done and a lot still to go, but we are getting there. Michelle asked who the providers are that are leaving?* [redacted]

E. **Medical Staff Update: Lisa Grant, M.D.** – *Peer reviews are being worked on by streamlining and improving the process. Updated a few things that are listed in the packet. There was a Med-Staff meeting last month. Contracts are the big issue. There is still some angst about the timeline constraints of the July 1 deadline.*

F. **Board of Directors Resolution- Wendy Apland –** *There were four annual filings that needed to be filed with OHA by July 1st, and those were sent off as well as the confirmation that Celilo would*

remain open as well. Copies of all of these along with a copy of the resolution is in the Board effect portal.
Bill asked about when the Capitol Committee would be formed.
Joyce noted that they could create the Capital Committee tonight. Addition general discussion was had regarding the Capital Committee. The Board did not want to create the committee tonight.

***A MOTION** was made by Michelle Spatz to accept the Resolution as presented. Dr Cardosi seconded the motion. The Motion was carried forward and approved by the board.*

Further discussion after the motion: Nolan would like additional information about the Capital Committee structure and information about the capital requests. Wendy agreed to add the capital list to the board portal and report on it in the future quarterly Financial Report.
Joyce mentioned that the Capital focus has been on items that were patient safety and areas that were noted in the last Joint Commission survey.
Camie gave a brief update on the Fluoroscopy unit, a C-arm, the washers for the OR., the Obix System, striker beds, and fire doors. There are several other items on the list. Wendy will share this list quarterly going forward.
Joyce stated that a Capital Committee would be set up and include a report in the financial reports. Michelle mentioned that it is important for the public to also know what AH has purchased in the past year. Joyce agreed and Dr Cardosi mentioned that Marketing was working on a public statement to release soon.

V. Old Business

VI. Committee Reports and Recommendations

A. **Clinical Committee of Community Board: Paul Cardosi, M.D. and Jayant Eldurkar, M.D.**
Dr Cardosi discussed the report included in the board packet and highlighted a few pages and reports that were included. He described the information collected from various locations, 10 – 15 committees that report to Quality Resources. This information will be added to the Board Effect for easy access. He shared committee structure and hierarchy that reports to Quality and where the data will be coming from. Also included will be a Dashboard report that includes incidents and root cause analysis. They will also be reviewing all policies and procedures in the new Lucidoc Policy manager system.

***A MOTION** was made by Janet Hamada to accept the Clinical Committee Reports as presented and reviewed by the board on **, Dr. Toda seconded the motion. The motion was carried out and approved by the board.*

B. **Finance Update**: **Wendy Apland –** *Wendy shared her Financial Report power point that was included in the board packet. The April report was good. She went through the highlights in her power point and discussed where the gains and losses were in April. All in all, it was a strong month. Ebita was + 139k. YTD net revenue 1% higher than budget. Still some work to do on the ytd Ebita numbers.*

Joyce Congratulated everyone on all the hard work that has been done and was encouraged by the progress that has been made.

A MOTION *was made by Dr. Cardosi to accept the Finance Update as presented. Michelle Spatz seconded the motion. The motion was carried out and approved by the board.*

Additional Items:
Jayme mentioned the notice from our local Mid-Columbia Fire and Rescue about the changes coming. She was notified at the end of April that they will no longer provide interfacility transfers for AHCG by the end of the year. That means all mid-level 2, 3 & 4 transfers going to higher levels of care to Portland will no longer be supported by our local Fire and Ambulance. They will continue to provide level 1 transportation to Portland with Lifeflight crew and be able to get patients home from the hospital and hospice. She has reached out to Metro West and Klickitat (who is not interested). We will be going to the MCFR board meeting in June. Physician leaders will speak to the board and discuss the impact on our community.

Michelle asked what the rationale of the decision was. Jamie said, "They wanted to keep their resources local." They are not able to keep the resources on staff. The MCFR Board meeting is on the 3rd Monday in June at 5:30 pm at the fire hall. Jayme will send out the information.
Nolan would like to see the information that will be shared at the board meeting.

Terry mentioned that he has been sending Senior Chaplains to AHCG and they just love coming here. Out of the four he has sent; they love the staff and culture here.

Joyce thanked the board for the experience and will always be close and keep her eye on AHCG.

VII. Meeting adjourned: Joyce Newmyer adjourned the meeting at 7:26 pm.

Respectfully Submitted by
Mechelle Gibson, Executive Assistant

_____
Wendy Apland, Secretary

BOARD OF TRUSTEES
Minutes of Meeting
Wednesday, August 28th, 2024
In Person/ TEAMS Meeting

Board Members Present: Kyle King, Board Vice-Chair; Robb Van Cleave, Board Vice- Chair; Paul Cardosi, MD; Victor Mondragon; Michele Spatz
TEAMS Board Member Attendees: Sue Knapp; Frank Toda; Nolan Young
Board Members Not in Attendance via TEAMS/ In person: Bill Ketchum
Also Present: Camie Overton, COO; Jayant Eldurkar, MD, CMO; Wendy Apland, CFO; Jayme Mason, CNO; Terry Johnsson; Wes Welch
TEAMS Attendees: Lisa Grant, MD, Medical Staff President
Not in Attendance via ZOOM/ In Person: Sonia Shishido, MD, Medical Staff Vice- President; Marc McAllister, MD, Medical Staff Secretary; Analene Pentopoulos, MD, Past Medical Staff President

I. Call to Order: Kyle King called the meeting to order at 5:15pm

II. Prayer and Planetree Moments:

- Terry Johnnson shared a reminder of what spiritual care looks like. Terry explained how the Spiritual Care department work. When a Chaplin is called to see a patient the first thing we do is ask is spiritual care important to you? If the patient says yes- we ask what community of faith they are a part of, and if it is important to have someone of that spiritual background to talk with you. Then we go to work getting someone of their faith there to visit with them.
- Wes talked about his passion for becoming a part of this community. He shared an experience with a Celilo patient that he had established a relationship with. Last week Wes received a call from the ED that there was an anxious patient, so he went over to see the patient. Upon arrival the staff said that this patient had declined spiritual care, however this patient caught sight of Wes and invited him in. It was the patient from Medical Oncology. They had a great conversation and Wes was able to help deescalate the situation. The following week Wed ran into the patient's wife, and she shared how appreciative she was with the time that Wes had spent with her husband.
- Wes ended his sharing time with a prayer.
- We will be working on a Ministry Appreciation luncheon in October.

III. Consent Agenda: Kyle King, Board Vice-Chair

A. Minutes Approval:
Community Board Meeting Minutes May 22, 2024
A MOTION was made by Paul Cardosi, M.D. to accept the May 22, 2024 minutes as presented. Michele Spatz seconded the motion. Motion was carried out and approved by the Board.

IV. **New Business**:

A. System Updates: Kyle King

- System every year makes a calendar for the quarterly Board Meeting. Katie will send these out for the year.
    - Discussion regarding frequency of meeting as a Board: discussed meeting quarterly and having monthly communication/updates. Would like to try this for the first quarter and then reassess.
- Camie Overton will be retiring at the end of October. Thank you for all of your dedication. Her willingness to stay and help us is a gift that we can not measure. Much appreciation for her kindness and her commitment to people here.
- We have the position posted and are working with our Executive Recruitment team. We will be screening all internal and external candidates and hope to stream it down to 3 to interview.
    - Ideal candidate will want to be here for 5 years or longer.
    - Ideal candidate would live here in the community.
    - Would love to have an offer out in the month of September.
- CMS rule making process: CMS is interested in how much your Board is in the Quality drivers of the hospital for 2025. They are putting in a bunch of criteria, one being 20% of the total time the Board spends in meeting or is sub-committee has to be documented that it is spent on Quality. Every safety event will have to come to the Board to review and approve. We will be getting help from our System to help navigate this.

B. **Administrator Report:** Camie Overton
- Thank you to the Governance Committee and creating an initial slate on people to potentially join the Board.
- Foundation is doing amazing things. The Tournament of Tradition brought in $6K. December 6th is Festival of Trees: proceeds will go to Celilo Cancer Center Patient Assistance Fund and Ultrasound Probe Disinfectors.
- Rural Health Clinic surveyor arrived (after an 18 month wait)
    - No condition level findings.
    - All four had 2 standard findings: aesthetics, requirement that everyone in clinic have there emergency training. We have 60 days to report back.
    - Sleep DME Program had a survey: we had a few small finding that we have reported back on.
- Strategic Plan should be ready to present at the next Board Meeting.
- Continuing to work on our Back to Budget plan.
- Working on getting a monthly newsletter out to the Board.

C. MO Report: Jayant Eldurkar, M.D.
- 4 contracts outstanding out of 80+
- Recruitment:
    - Emergency Department has 4 hires: 2 started in august, 1 starting next week, and 1 starting in November.

- OB/Gyn: Dr. Saito is starting next week. We are still working closely with OBHG. They will provide 3 physician that will come every month (clinic, surgery, call). Robb: are we still discussing broadening the horizon on who can deliver babies? Dr. Eldurkar: this is still something that is possible, however would still require an OB for back-up. Will have continued discussions with our new provider(s) and OBHG.
- Continuing to recruit for pathology.
- Pediatrics: we have 2 candidates in the pipeline.
- Internal Medicine we have 1 applicant.
- General surgery: continuing to recruit. Dr. Mathisen is still our trauma medical director.
- Urology: we are recruiting for an APP.
- Medical Oncology: Continuing to recruit for a full-time physician and an APP. We have a locums APP starting full time next week.

- Flu Vaccine Campaign will be starting soon. Employee Health will be available to give the Board Flu shots.
- Culture Survey will be distributed October 10th.
- MCFFR Update: Jayme Mason
  - Met with County Commissioner.
  - Continuing to have conversations with Metro West.
  - Reached out to Klickitat, Bend AMR and they were not interested.
  - Tessie Adams out of Corbett area. She was interested in however would require a large amount to
  - Met with Chief Palmer and Chief Jensen today. Will meet again in September to discuss what the next steps are.
  - County Commissioner are working to get language into the ASA to have it be an entire package- all 9-1-1 calls and interfacility transfers.
    The ASA update is in Legal Review.
- MCCFL Update: Jayme Mason.
  - MCCFL provided notice that they will not be providing crisis support.
  - We are going to meet with the CCO as they provide funding to MCCFL to provide crisis support.
  - We are talking with a company that provides telepsych.

D. Medical Staff Update: Lisa Grant, M.D.

- Learning to work on the policies.
- Had attorney here last week to help us with processes.

V. Old Business

VI. Committee Reports and Recommendations

A. Clinical Committee of Community Board: Paul Cardosi, M.D. and Jayant Eldurkar, M.D.

- Dr. Cardosi shared a presentation that reviewed regulatory dates, reporting schedule, Press Ganey patient experience, dashboard of KPI, approved policies and procedures, recognizing exceptional improvements, and clinical committee minutes.
  Discussion ensued regarding the KPI dashboard.

A MOTION *was made by Robb VanCleave to accept the Clinical Committee of Community Board information as presented. Victor Mondragon seconded the motion. Motion was carried and approved by the board.*

B. Governance Committee: Camie Overton

- Shared document that discussed that the Board needs to add 4 new Board members.
- The Governance Committee Identified: [redacted]

C. Finance Update: **Wendy Apland**

- Volumes have been trending up, clinic provider visits have gone up, surgeries have been mixed, length of stay is trending down, case mixes remain decent.
- There is a lot of noise in the numbers. We converted to the new oracle tool. The numbers are still being refined.
- Our net revenue was at budget, however expenses were high for the month.
- Year to date EBITDA -$5.4M
  Michele: When can we expect to see some positive with the back to budget initiatives?
  Wendy: We are already starting to see that. We are working on consolidating clinics, managing our labor daily.
- Weather Forecast: Field of wildflowers with one daisy, we need to be the one daisy.

VII. Meeting adjourned: Kyle King adjourned the meeting at 7:25pm.

Respectfully Submitted by
Katie Cummings, Executive Assistant

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Wendy Apland, Secretary

BOARD OF TRUSTEES
Minutes of Meeting
Wednesday, November 20th, 2024
In Person/ TEAMS Meeting

Board Members Present: Kyle King, Board Vice-Chair; Robb Van Cleave, Board Vice- Chair; Bill Ketchum
TEAMS Board Member Attendees: Sue Knapp; Frank Toda; Michele Spatz; Victor Mondragon
Board Members Not in Attendance via TEAMS/ In person: Paul Cardosi, MD, Nolan Young
Also Present: Jayant Eldurkar, MD, CMO; Wendy Apland, CFO; Jayme Mason, CNO; Terry Johnnson;
TEAMS Attendees:
Not in Attendance via ZOOM/ In Person: Sonia Shishido, MD, Medical Staff Vice- President; Marc McAllister, MD, Medical Staff Secretary; Analene Pentopoulos, MD, Past Medical Staff President, Lisa Grant, MD, Medical Staff President

I. Call to Order: Kyle King called the meeting to order at 5:18pm

II. Prayer and Planetree Moments:

- Terry Johnson shared a Foundation booklet with the group that discusses the similarities of all people of faith. He will distribute a copy to everyone to review and will give them out during new hire as well.
- Planetree moment – Terry shared that we hosted our first ministerial on campus, thank you to Wes Welch for putting this together. Wes recently joined that association and will be having Jayme present for their next meeting in December.
- Terry shared that he recently had lunch with Father Renee from St. Peters and is working towards building up our relations with the Catholic faith.
- Wes is working towards getting two volunteers in spiritual care.
- Luke Sherly from the Lutheran church has volunteered as chaplain for the next few months.

III. Consent Agenda: Kyle King, Board Vice-Chair

A. Minutes Approval:
Community Board Meeting Minutes May 22, 2024
A MOTION was made by Robb Van Cleave, to accept the August 28th, 2024 minutes as presented. Bill Ketchum seconded the motion. Motion was carried out and approved by the Board.

IV. **New Business**:

A. System Updates: Kyle King

- Kyle started out with some bright news regarding replacing Camie's position. Reviewed 25 applicants, completed a large number of screenings and narrowed down the list to two applicants. Completed several full days of interviews with the interview panels including 35-36 people. After an extensive due diligence, we have selected Jayme Mason as our new

Operations Executive! Jayme was the highest score of any executive within Adventist Health with a score of 4.85 out 5. Kyle rounded with every physician on the interview panel, and the results show a unanimous vote with feedback reflecting Jayme as someone with a ton of trust, respect, great leadership and is great at building programs.

- Mechelle stated that she is thrilled and is looking forward to Jayme's leadership.
- We are now starting the process for replacing Jayme's CNO role.

- Kyle shared that Joyce Newmeyer who has worked for Adventist Health for 41 years is stepping away from her role. Joyce and Kyle are working together on the next steps regarding Joyce's desire for staying involved in the Oregon Network part time.
    - Joyce has an amazing skill in mentoring leaders, and there is great potential between Joyce and Jayme.
    - Hopefully by next Board Meeting there should have a scope of work within the Oregon Network.
- Yesterday the Executives met with all providers that are not hospital based (excluding the Hospitalist, ED and Pathologist groups). We are working on building volume within our Healthcare ecosystem overall. There is a large difference in net revenue from then until now largely due to the pandemic effect as our community is slower to come out of this compared to others.
    - How do we rebuild? We as a team have recruited and stabilized Primary Care, which is the cornerstone in this project. We now have same day access in almost all Primary Care practices. We have the opportunity for our panels to grow, and our goal together is to ask for partnership and written plans for everyone to be at median or average volumes. Adventist Health uses three MGMA benchmarks.
    - The Executive team met with the sub-specialist group and displayed that Primary Care is at 6,000+ more visits this year compared to last year at this time, will need to work on getting the sub-specialty groups to that number as well.
    - The physicians are more settled now then they once were.
    - Our math reflects with cancer services all up and running and providers at the median we will be a sustainable organization.
- Michele Spatz asked about the MGMA company that determines productivity levels and if it considers all measures?
    - Kyle stated yes, MGMA takes all clinicians by sub-specialty and graphs out productivity, compensation, as well as being able to look at geographic information and rural information. MGMA is directional information.
- Our goal is to drive all clinicians to the 50th, subspecialities will be a stretch for those that are over hired to cover call.
- Wendy pointed out an Emphasis on coding!
    - Wendy shared that we now use an outsourced company in Portland. There was a coding training that took place with good attendance and great feedback. A PowerPoint was provided as a reference tool, and there will be a once-a-month

open Teams meeting for coding office hours specifically for providers. Our first open office hours had 13 providers who attended and 11 of them asked questions.

- Robb Van Cleave discussed an Immediate Care incident regarding communication from staff about "hitting our quota" and potentially turning patients away.
    - This will be looked into more closely, a lengthy discussion ensued.

B. **Administrator Report: Jayme Mason**

- Jayme Mason provided a brief update on interfacility transfers. We had a good meeting with Metro West and Mid – Columbia Fire and Rescue. Metro west will now be available for calls from us and will be stationed at Mid-Columbia Fire and Rescue. This a win-win! Most likely if all falls into place, the beginning of next year we will post unified messaging on our plans for working together and make this clear to our to community.
    - ASA by the county is still under legal review. Pushing review out and will not be completed until beginning of next year.
- We are close to completing negotiations with our ONA Nursing. This has been very collaborative and we are receiving good outcomes. This new contract will be for 3 years.

C. MO Report: Jayant Eldurkar, M.D.

- We achieved 100% for flu vaccines / declination within the system deadline, this is great news!
- Happy NP Week!
- Audra Schmidt is currently in New York at a recruitment fair. Audra, along with Nicole Cumming who is an Adventist Health Tillamook Provider Recruiter. Together they are recruiting for 17 positions across the Oregon Service Area.
- Our ER is fully staffed as of this week. [redacted]
- Dr. Robertson is our new Medical Oncologist and is well loved by all staff. She has a meeting with ELT in a week or two to see where she wants to land.

D. Medical Staff Update: Lisa Grant, M.D.

- There were no new updates, there have been a large amount policies that have been reviewed within the last several months.

E. Mission and Spiritual Care Update: Terry Johnson

- Terry requested if anyone knows of any community faith leaders, to please let him know.
    - Rob Van Cleave recommends Pointman Ministries.

F. Strategic Plan Update: Jayme Mason

- Jayme shared the Strategic Plan document.

    - Michele Spatz stated that she thought it was great and very well done, good job!

    - It was asked where are we in process to adopt this strategic plan? Jayme stated that she thinks we are ready to move forward in January 2025. This is a site-specific local document and it does not take system approval to approve it. Questions posed included: How are our managers and employees connected to the strategic plan? How do we make this real? Kyle King stated that there is no one right way, but we will work through the process.

V. Old Business

VI. Committee Reports and Recommendations

A. Clinical Committee of Community Board: Jayant Eldurkar, M.D.

- Dr. Eldurkar shared a presentation that reviewed survey updates, reporting schedule for the clinical committee, Medical Staff education plan, engagement and satisfaction patient experience, the dashboard of KPIs and approved policies and procedures.
- Robb shared an experience while getting lab work done and seeing immune comprised patients waiting for labs in the hallways of the Emergency Room. Discussed the design issues with this, as sick patients and well patients are sharing the same area.
  - Jayme reported that Wendy, Angela Gehers (Director of Lab), Stacy Marsh (Director of PVS) and herself are having a meeting to discuss this issue and to look into opening lab express back up. Current hold up is staffing.
  - Stacy Marsh just hired someone for nightshift and can come back to her normal shift schedule. We can now continue to move forward with doing a salary review of the area. This is a difficult puzzle, as it is a combination of HR reviewing salary and a reviewing a bigger incentive that we can put in place to hopefully solve staffing issues.

A MOTION *was made by Robb Van Cleave to accept the Clinical Committee of Community Board information as presented. Mechelle Spatz seconded the motion. Motion was carried and approved by the board.*

B. Governance Committee: Robb Van Cleave

- Robb Van Cleave shared the new Board Members: [redacted] Our plan is to expand on the physician side for the Board.
  - [redacted] Michele relayed that she has great respect for Dr. Stelzer and stated he would be a big asset to the Board.
  - [redacted] Dr. Rogers has expressed his interest and has a strong belief in full scope Primary Care involvement. He is willing to serve on at least 1 if not 2 committees.
  - The candidates will go through the System Board to get voted through and if approved would be official Board members for the February Board Meeting.
  - The group took a vote on the three candidates. Robb Van Cleave motioned for the three to be approved, Bill Ketchum seconds.
  - [redacted]

C. Finance Update: **Wendy Apland**

- Wendy gave the financial update. For the month, our volumes were mixed. Admissions were higher by 11 percent, patient days by 2 percent, with Emergency visits slightly down. Surgeries were substantially down by 22 percent. On the Ambulatory side, we were slightly below budget by 8 percent, though we are higher this quarter compared to last year at this time, which is a sign of growth! The volumes translate to 27.4 million for gross charges, just 3 percent lower than budget. Deductions will continue to be a moving target. We currently have a negative EBIDA of 7 million, year to date our EBIDA is negative 13.6 million. We did have an expense issue for the month due to several

factors including purchased services. We have an active back to budget under way to work out the variance.
    - Big items to move through: change of status to be more of critical access hospital, Celilo Cancer Center and a collaboration with Knight Cancer Center, OB initiative and labor reductions.
- Hoping our forecast would be blue skies and wildflowers, but we are not quiet there yet.
- Wendy shared PNN Capital Available Balance and Status with the group.
    - Will get capital meetings on the schedule to plan for, through end of year.
    - Sue thanks Wendy for her work.
- Wendy shared that our hospital was voted best hospital in the Gorge! There will be social media posts about this in print.

Kyle wanted to give a huge thank you to Robb for all the years he has spent on the Board and relayed this will be Robb's last official board meeting. Kyle to propose a get together in January with food to usher Robb out appropriately.

- Robb stated it has been a great journey, from being a patient to being on the Board, he has seen both side of things. This is an amazing place that is worth fighting for!

VII. Meeting adjourned: Kyle King adjourned the meeting at 7:07pm.

Respectfully Submitted by
Amanda Cimmiyotti, Executive Assistant

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Wendy Apland, Secretary

AHCG Community Board

Meeting Minutes
Date: 2.19.2025

Board Members Present:

	Kerry Heinrich Community Board Chair	X	**Sue Knapp** Board Member	V	**Victor Mondragon** Board Member
X	**Kyle King** Vice-Chair	V	**Michele Spatz** Board Member	X	**Patrick Grimsley**
X	**Jayme Thompson**	X	**Paul Cardosi**, MD Board Member	V	**Eric Davis** Vice-Chair, SDS
V	**Frank Toda**		**Bill Ketchum**	X	**Keith Stelzer**
X	**Nolan Young**	X	**John Rogers**		

X Present, V: Virtually Present

Additional Attendees

X	*Jayant Eldurkar, MD*	X	*Nick Dills*	X	*Amy Schanno-Sugg*
X	*Cheri McCall*		*Lisa Grant, MD*		*Marc McAllister, MD*
	Micah Smith	X	*Analene Pentpoulos, MD*		*Caitlin McCarthy, MD*
X	*Katie Cummings*	X	*Terry Johnsson*	X	*Wes Welch*
V	*Chris Ley*				

Agenda Topic	Committee Discussion	Recommendation/ Conclusions/ Actions
Call to Order	The meeting was called to order at 5:19pm, once quorum was met.	
AH Mission Board Education: Terry Johnsson	Terry Johnsson took a moment to highlight Wes Welch, our AHCG Chaplin. Wes has really taken the time to integrate into the community and recently bought a house. Wes will be graduating in May with his CPE- Clinical Pastoral Education. We are so happy for him and blessed to have him her at AHCG. Wes thanked everyone for the warm welcome and the support he has received being a part of this community. Terry shared a PPT sharing what the 2025 Mission theme is for this quarter: Trustworthy, Leading with Integrity. Choosing the right path when it is difficult. Every time we get the chance let us work together for the benefit of all, our calling is to love everyone that comes through our doors. Terry shared a story of when he was put into a challenging position and had to chose the right thing. Terry shared that it is easy to love people that love like us, but at Adventist Health we are called to love all that walk through our doors. Our goal is to create a culture of love. Wes closed out the Mission time with prayer.	
Consent Agenda: Kyle King	Sue Knapp motioned to approve November 20,2024 meeting minutes as presented. Dr. Frank Toda seconded the motion. Motion carried without dissent.	Minutes approved
System News: Kyle King	Kyle shared that there is a lot of change at the Federal level. One of the biggest changes is the proposed changes to Medicaid. Instead of funding as a whole it would be funded as a block and states would determine how the funding is used. Oregon has 1.3 Medicaid enrollees, the newest rules would unfund roughly 400K because of status problems. This is a system focus and making sure that our voice is heard. Kyle shared that Housebill 3320 went into effect in July, this is a charity care bill. The rural health clinics are exempt with this bill. Housebill 3320 moved to	

Agenda Topic	Committee Discussion	Recommendation/ Conclusions/ Actions
	prescreen of all patients, not an application process. We are required to prescreen all of our patients and are not allowed to ask the patient. For example, in 2023 AHPL we had $9m charity care, currently the run rate for 2025 is $56M. We are working on policies that meet the intent of the law and working on doing the right thing for our patients. MCMC (now AHCG) has been a 49-bed hospital and has struggled financially for many years. Over the last 20 years healthcare has changed and many things that used to qualify for hospital admissions do not qualify now. In 2024 we had an average of 17 patients in house. That being said we are currently looking into becoming a Critical Access Hospital. Hood River, Skyline, and White Salmon are Critical access hospitals. We reached out to ODOT to be designated as Mountainous Terrain and it was approved. With that approval we can now file with CMS to become a Critical Access Hospital. To be a critical access hospital we have to be 25 acute beds. We will have to rebuild our EPIC. We will make sure that we are working with consultants on how to set this upon the back end. With our application we will try to keep all 49 beds live and active, which would give us the ability to flex up in crisis. Jayme- This will give us the opportunity to explore swing bed program and inpatient rehab which is not factored into the 25 bed. We are very excited about the future and providing stability for this community. Critical Access status is built to help high Medicaid / Medicare patient. In uncertain times this helps to build plans. Kyle- Huge thank you to Wendy for all of her work on this project! Huge thank you to Jayme and team, the Medical Staff…to everyone who has put in the work to get us to this point.	
Administrator Report: Jayme Thompson	Roundtable of introductions, welcome to our new Board Members: John Rogers, Patrick Grimsley, and Keith Stelzer. Also a warm welcome to Amy Schanno-Sugg as our new Associate PCE, and Micah Smith as our new Finance Officer. Wendy has been working with Grant team to apply for Congressional Directed Spending. They requested a $3M grant to help support our OB service line. We got word last week that we have been selected and we will now begin the official process to request the grant. Our next step is to request letters of support from local city, county, and state leadership as well as our community partners. Celilo/KCI partnership is moving forward. We have our first team meeting next week. Sleep Solutions has closed and Occ Health will be closing at the end of February. We need to focus on what our core responsibilities are for this community. We have no updates from MCFR. The did finish negotiations. Next step would be for MCFR to reach out to MetroWest to nail down a contract and then meet with us. Our Executive Team is continuing to work on Community outreach. Meeting with Providence, Skyline, One Community Health and Klickitat Valley Health this month. Our goal is to build a collaborative healthcare for this region. [redacted] Kyle: Thank you Nick for all of your hard work on this initiative.	
Medical Officer Report: Jayant Eldurkar M.D.	We had 2 hospitalist interviews-both were very strong candidates. We had a really great Orthopedic interview, and if all pans out this provider will be here in 2026. We had a Medical Oncologist interview and OB interview- both candidates were not a fit. Even though we desperately need these positions filled we are committed to filling these with the right fit for our culture, Keith- How will recruiting for Medical Oncology go with the partnership with Knight Cancer if we are not liking or feeling like a potential candidate is a good fit? Kyle- OHSU has taken a good road and have made it clear that if we at AHCG determine the candidate is not a good fit they will support the decision.	

Agenda Topic	Committee Discussion	Recommendation/ Conclusions/ Actions
Clinical Committee of Community Board: Paul Cardosi, M.D.	Dr. Cardosi reviewed document that is placed in Board Effect highlighting what the Clinical Committee has been working on. Dr. Cardosi highlighted the QAPI plan which is posted in Board Effect as well for review. He also shared that we have put a large focus on how to increase our CMS star ratings from 2 to 3. Dr. Cardosi reviewed our dashboard of KPI's and spent time discussing an RCA that took place. Dr. Rogers: Do we know what the response rate is for the surveys that are sent out? Amy: It is low. However, we are working on ways to increase our response rate to the surveys that are sent out- email, text. We are working hard to round on all of our patients. Jayme: We have an IRound tool that we can use on patients that are in-house. Dr. Rogers: Are patients going told that they are going to get a survey when they leave? Amy: No, we are not supposed to coach however we are asking the questions to ensure patient satisfaction. Jayme: Regarding RCA HLD- we are working on what the next step will be. We are always putting checks and balances in place for all vendors that come that they are following manufacturer recommendations. Kyle: Thank you Dr. Cardosi, and our Clinical Committee. This is important work! Dr. John Rogers motioned to approve the Clinical Committee Report meeting as presented. Dr. Frank Toda seconded the motion. Motion carried without dissent.	Clinical Committee Report Approved
Governance Committee		
Community Well-Being Committee		
Finance Update: Chris Ley	Chris Ley shared a PPT that is loaded into Board Effect. In December we had our lowest contract labor, great work. Our salaries, benefits, and wages came in under what we had budgeted for. Our volumes were greater than our budget. Our average length of stay ended at a 3.57, our goal was 3.91. Our case mix index was greater than. ED admits were buy for the year. We just received the 2025 Budget in the new system. Reviewing the January financials, we were only off $19K. We have some for improvement in our salaries and contract labor. Dr. Stelzer: We currently do not have inpatient rehab, what happens if we bring that back? Do we segregate out the length of stay? Kyle: The length of stay slides would have to be separated. You would look at your acute length of stay.	
Payer Strategy Education: Kyle King	Kyle shared an overview of the slide deck "Securing Our Financial Future" that is in Board Effect. Dr. Toda: Enjoy the fact that we are doing internal benchmarking	
Meeting Concluded:	Kyle King brought the meeting to a close at 7:17pm	

Minutes created by: Katie Cummings, Executive Assistant

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Signed by: Jayme Thompson Date:

AHCG Community Board

Meeting Minutes

Date: 5.28.2025

Board Members Present:

x	**Kyle King** Chair	x	**Sue Knapp** Board Member		**Victor Mondragon** Board Member
x	**Jayme Thompson** Board Member	x	**Michele Spatz** Board Member	x	**Patrick Grimsley** Board Member
v	**Eric Davis** Vice-Chair, SDS	x	**Paul Cardosi**, MD Board Member	x	**Keith Stelzer** Board Member
	Frank Toda Board Member	x	**Bill Ketchum** Board Member	x	**John Rogers** Board Member
	Nolan Young Board Member				

X Present, V: Virtually Present

Additional Attendees

x	*Jayant Eldurkar, MD*	x	*Nick Dills*	x	*Amy Schanno-Sugg*
x	*Cheri McCall*	x	*Lisa Grant, MD*		*Marc McAllister, MD*
x	*Micah Smith*		*Analene Pentpoulos, MD*		*Caitlin McCarthy, MD*
x	*Katie Cummings*	x	*Terry Johnsson*		

Agenda Topic	Committee Discussion	Recommendation/ Conclusions/ Actions
Call to Order	The meeting was called to order at 5:18pm, once quorum was met.	
AH Mission Board Education: Terry Johnsson	Terry Johnsson shared a PowerPoint Presentation "Adventist Health Chaplaincy". Terry shared about a patient that he was called to be with, she had tears, however, was not speaking. Terry sat with her and asked where are the tears coming from? She finally spoke and shared that she felt like she was dying and didn't want to die without speaking to her daughter whom she had not spoke to in years. The daughter was called and there was nothing more beautiful then to see the two reunite. In addition to this story the PowerPoint shared what chaplains are, and when to call a chaplain. This PowerPoint is loaded into Board Effect. Terry opened the meeting with prayer.	
Consent Agenda: Kyle King	Dr. Paul Cardosi motioned to approve February 19,2025 meeting minutes as presented. Michele Spatz seconded the motion. Motion carried without dissent.	Minutes approved
System News: Kyle King	EPIC: Adventist Health has made the decision to buy the foundation model of EPIC which will keep us current with technology, and include full AI model. Go - live is scheduled for September 2026. Revenue Cycle: Adventist Health has had multiple revenue cycle avenues which have not worked well. Currently working on bringing this back in house. Federal Government- Medicaid Cuts and Budget Balance: Diligently watching the house/ senate and are concerned on what this does to Medicaid. Feds are contemplating implementing work and eligibility requirements for those on Medicaid. We are doing our best to learn and understand what this means. We are hoping to have a better idea by October or November on what the Medicaid budget will look like for us. We are working hard to be operationally good. We continue to work on managing our supplies, find ways to drive out waste, and working hard on volumes. We are company built on taking great care of people, however, are continuing to see the payor mix shifts towards Medicaid. If continue to see these shifts, we will have to take a deep look on how to manage that. Michele: What is happening with OHSU/ Legacy agreement?	

Agenda Topic	Committee Discussion	Recommendation/ Conclusions/ Actions
	Kyle: They are 2 years into this agreement and have decided mutually to break this agreement up. Michele: Where is the list of hospitals that are vulnerable? Kyle: Providence has made some drastic moves to get their house in order. McMinville, Coos Bay, Springfield, Asanti, Samaritan Health, Legacy have all been in the news. Out of 61 hospitals, 20 are vulnerable. Adventist Health appointed eric stevens as our Chief Operating Officer. He is largely focused on our communities, driving forward, and how to grow things that are important to our communities. Doing amazing things in the communities that we live in.	
Administrator Report: Jayme Thompson	Administration has moved over to the Main Campus, and Human Resources has moved into the old Administration space. Critical Access application has been approved for the office of rural health and is moving on the step 2 to move to the OHA. Celilo and KCI collaborative agreement is going fantastic. We have a nurse practitioner that is interesting in coming back, and a physician that is interesting in part time permanent position. We made the decision to drop to a trauma level 4 as of June 1st. Strategy behind that is to reduce our Orthopedic Locums. We have a created a streamlined structure with AHPL for a transfer process. Our current Orthopedic doctors are picking up additional call for the ED. OB Service Line: we made the decision to not move forward with OBHG. We are actively recruiting and working to reduce our Locums expense. Clinic Moves: Our Pediatric Clinic will be moving into Family Medicine this summer. The goal of this move is to get out of the Columbia Crest lease space. Home Health will be moving out of Columbia Crest and back into their old space as well. We are also working with Nichols Landing and getting out of that lease space. MCFR is waiting for the ASA to open. We have had robust conversations with our County Commissioners and feel positive that they will support moving forward with someone that will provide inter-facility transfers. Currently they are providing inter-facility transfers, however we are leaning on life flight pretty heavily. MCCFL is currently not helping with crisis support however we are working hard on an internal process. We are looking at various tele-psych programs. Nursing Awards: Awarded 9 amazing nurses at the beginning of May, with a focus on our “Be” statements. Celebrated Healthcare week with various activities and celebrations. We have been attending many local events- resilience Rally, Cherry Festival, Middle school Carnival. Our Tournament of Tradition Golf Tournament will be taking place June 10th. Jayme shared in depth the Executive Summary regarding Critical Access which is also available on Board Effect. This document addressed 17 questions which are listed below: 1. Survival - Is the CAH conversion being considered because the hospital will fail without it? Could the health care facility survive as it currently exists? What happens if you do nothing? This step ensures the survival of the facility. There are additional steps that have been taken and more will need to be taken to ensure our ability to continue to provide care in the Columbia Gorge community. 2. Community Needs - Will the CAH conversion meet the needs of the community? Yes, we will continue to meet the needs of the community as we have for the last 120+ years. This change helps to ensure that to be the case. 3. Mission - Will the CAH conversion enhance the mission of the health care facility? Will the mission need to change as a result of the change in sponsorship? Who will decide what the mission will be? There is no need to change our Mission. The Mission of Adventist Health will carry on just as it does in all the other communities served.	

Agenda Topic	Committee Discussion	Recommendation/ Conclusions/ Actions
	4. Goals - Will the CAH conversion foster goals within the current strategic plan? Change them? This aligns with our strategic plan. There will be no need that plan as a result of this change. 5. Market share - Will the CAH conversion protect or improve market share? Will it prevent migration of rural residents to other outside services? We believe this will protect and enhance the market share currently experienced. With the affiliation of Adventist Health, we now have a stronger organizational partner that also will enhance the healthcare market within the Columbia Gorge. 6. Financial losses - Will the CAH conversion lessen financial losses? Absolutely – this is one of the primary reasons to make this change. Additionally, Adventist Health currently operates 5 CAH and understands the nuances how to support those facilities and services. 7. New technologies - Will the CAH conversion develop new services or make new technologies available (i.e., EMS, telehealth)? Do the new services match the local scope of service/needs? We will be adopting new technologies provided by our Adventist Health System. One upcoming change will be the EMR to the Adventist Health Epic system. These types of technologies will provide and enhance the local scope and services needs in the Columbia Gorge. 8. Revenue sources - Will the CAH conversion expand or diversify revenue sources? Will new services provide a profit? Will it change access to tax dollars or grant dollars? The organization will determine any diversification of revenue 4 sources as those become available or known. This will not change access to tax or grant dollars. 9. Further action - Will the CAH conversion foster a closer relationship within the rural health network for possible further action? Is this option moving closer to the goals in the long-range plan? Yes, this change will allow further relationship development within the other CAH's that support patients living in the Columbia Gorge. 10. Reputation - Will the CAH conversion enhance the reputation of the organization? What is the reputation of the network partner(s)? The hospital has a long history and reputation of providing care to the citizens that living within Columbia Gorge. For example, full cancer care is offered at our facility which enables patients who need this care to get it locally and not have to travel 90 minutes or further to get the full services that may be needed. 11. Skills and ideas - Will the CAH conversion bring new management skills, techniques, services or ideas to the current organization? There are differences within various hospital facilities structures and statuses. As Adventist Health currently operates other CAH's we will be well positioned to train our staff to any new services or techniques needed. 12. Political acceptability - Will the public accept the option? Will the community resist it? The public will accept this option as it maintains services that are needed within the community. As little will change with the delivery of services, there will be no need to resist this change. 13. Stability - Will the CAH conversion so dramatically change the hospital that it could falter? No, on the contrary. This change enhances the financial stability that is needed to provide these services to the community. 14. Existing personnel - How will the CAH conversion affect existing personnel? Will they stay? What will be the process for releasing them? How will current employees be handled? This desired change has been discussed with the hospital personnel including all employed providers. The staff is supportive of this change. This will not change how employees are handled. 15. Costs - Does the CAH conversion involve an expenditure or debt? Is it a debt you are willing to accept? What investment is required in terms of money, time or resources? There will be no debt needed as a result of this change. There are no known expenditures needed. Once the site survey assessing our ability to meet the conditions of participation, if something is needed or determined, that will be reviewed. 16. Organizational behavior - Will the CAH conversion substantially change the style, culture or values of the health care facility? We anticipate no known cultural change or no change in how patients are cared for. 17. Quality of care – Will the CAH conversion affect the quality of care the hospital has determined is necessary? How does your medical staff and other community providers think it will affect their clinical practice? Are you prepared to participate in the Medicare Beneficiary Quality Improvement Program (MBQIP)? We are prepared to participate in MBQIP as we currently participate in other improvement programs within our CCO and ACO. This has been discussed with 5 providers and there are no anticipated changes to care that will result from this	

Agenda Topic	Committee Discussion	Recommendation/ Conclusions/ Actions
	change in hospital status. A discussion ensued regarding the Executive Summary. Michele Spatz made a motion to accept the Executive Summary regarding Critical Access as presented. Dr. John Rogers seconded the motion. Motion carried without dissent.	Executive Summary Approved
Medical Officer Report: Jayant Eldurkar M.D.	[redacted] Recruitment: We have 3 new clinicians joining us in the next several months. We will have 1 urology, and 2 hospitalists. We signed a letter of intent with a total joint surgeon that will start in July 2026. We have several other LOI's in process. Attended Oregon Service Area retreat in Sunriver at the beginning of May which included teams from Portland, Tillamook, and Columbia Gorge. Medical Staff Business Meeting: Dr. Kerry Proctor was recognized as Inpatient Clinician of the year, and Dr. Caitlin McCarthy was recognized as Outpatient Clinician of the Year.	
Medical Staff Update: Lisa Grant, M.D.	Dr. Grant shared that the Oregon Service Network retreat was great. We are continuing to increase our volumes and working on remembering our well-being. Dr. Kerry Proctor is focusing on Well-Being for the clinicians. Dr. Corboy has encouraged more rounding. We are also hoping to have some informal gatherings outside of work hours for team bonding.	
Clinical Committee of Community Board: Paul Cardosi, M.D.	Dr. Cardosi reviewed document that is placed in Board Effect highlighting what the Clinical Committee has been working on. This report highlighted the quarterly reporting schedule, Quality and Safety, Survey Readiness, Culture Survey, Dashboard of KPI's, Press Ganey Patient Experience, Policies and Procedures that have been approved, and past meeting minutes. Dr. John Rogers made a motion to accept the Clinical Committee Report as presented and posted in Board Effect. Micah Smith seconded the motion. Motion carried without dissent.	Clinical Committee Report Approved
CSSM Education and SSE Report: Paul Cardosi, M.D.	Dr. Cardosi reviewed document that is placed in Board Effect highlighting CSSM Education and SSE Report. This report highlighted PSSM Summary and requirements Related to 'The Board", What "The Board' means at Adventist Health, The Five PSSM Domains, and Specific Board Report Requirements. Kyle: regarding a serious safety event and Board involvement, will follow-up with Patty Atkins to weigh in the requirements on alerting the Board. Will likely have to have an off-cycle meeting to discuss. HLD Scope Cleaning Update: Dr. Jayant Eldurkar By the time we were prepared to get letters sent out we were at the 6-month mark and decide to not send the letters out. No negative outcomes identified, and process has been changed.	CSSM Education and SSE Report Presented
Governance Committee		
Community Well-Being Committee		
Finance Update: Micah Smith	Micah shared a PPT that is loaded into Board Effect. This PPT highlighted our current financials. This PPT covered Oregon Statewide Healthcare, AH Oregon Finances, 2025 Budget, and Revised 2025 Financial Target.	
Board Membership Change	Pursuant to Article 3.2(a) of the Corporation's Community Board Bylaws, Kerry Heinrich has designated Kyle King as Chair of the Community Board and Mr. Heinrich will no longer be a Community Board member, effective May 1, 2025. The role of designated Vice Chair and ex officio Vice Chair have been removed. Eric Davis is now the Vice Chair of the Community Board, effective May 16, 2025.	
Meeting Concluded:	Kyle King brought the meeting to a close at 7:29pm	

Minutes created by: Katie Cummings, Executive Assistant

Signed by: Jayme Thompson Date:

Exhibit 6.b.

Community Board Roster

CONFIDENTIAL

Adventist Health Columbia Gorge
2026 Community Board

Name	Work Address/Phone	Home Address/Phone	e-mail / Cell	Term Expires
Kerry Heinrich **Chair**	President/ CEO Adventist Health	[redacted]		bylaws
Kyle King Secretary 6/27	Oregon Network President			bylaws
Frank Toda Member, AHCG Board 4/5	Retired			12/31/26
Michele Spatz Member, AHCG Board 4/28	Community Engagement Coordinator National Network of Libraries of Medicine			12/31/26
Bill Ketchum Member, AHCG Board 7/23	[redacted]			12/31/27
Victor Mondragon Member, AHCG Board 6/14				12/31/27
Sue Knapp Member, AHCG Board 9/14				12/31/26
Nolan Young Member, AHCG Board 1/25	Retired			12/31/27
Keith Stelzer , MD Member, AHCG Board 9/14	Semi-retired			12/31/26
Patrick Grimsley, DO Member, AHCG Board 12/27				12/31/26
John Rogers, MD Member, AHCG Board 8/18	Retired			12/31/26
Eric Davis, **Vice Chair**	Adventist- Oregon Conference Rep.			bylaws
Jack Henderson Member, AHCG Board	Retired			12/31/2027
Cynthia Kortge Member, ACHG Board	The Dalles Chamber			12/31/2027

updated 2/2/2026

Exhibit 7

AHCG Quality & Safety Dashboard Reports

Infection Control 1st Quarter 2024

Class I Surgical Site Infections

	Qtr 1	YTD	YTD Rate
Total Class I			
Public Reporting			
KPRO			
HPRO			

1.

Class II Surgical Site Infection

Total Class II			
Public Reporting			
COLO			
HYST (Abd)			

1.

II. Ventilator Associated Ever

		SIR	
Ventilator		nc	(ICU,tele)
Ventilator-Associated Events			
VAP			

III. Central Line Associated Bl

		SIR
ICU		nc
Tele Line Days		nc
Acute Care Line Days		nc

IV. Catheter Associated Urina

		SIR
ICU		nc
Tele		nc
Acute Care Cath Days		nc
FI Cath Days		nc

V. C Dificile

Lab ID CDI Facility wide			

VI. MDRO

	Qtr 1	YTD	SIR

[ADVENTISTHEALTH:INTERNAL]

Lab ID MRSA Bacteremia	[redacted]	nc
VRE/CRE/Other		
ESBL (inpt)		

VII. HAP

VIII. Sharps/Exposures

Exposures reported (total)	[redacted]
Surgery/cleanup	
Double/Mishandling	
Injection related	
Trash	
Splash blood/body fluids	

Previous annual totals

2022	[redacted]
2021	
2020	
2019	

IX. Environmental Services IP Room Cleaning Audit

11 rooms audited, 89.8%

X. Infection Control Projects/Information

1. Biohazard spill kits distributed
2. Risk assessment, program plan and goals
3. SPD audit
4. NHSN Annual survey
5. Clinic/HLD rounding
6. MDRO staff ed

XI. Inpatient Communicable Disease Reporting

Hep C, chlamydia, gonorrhea, 1 COVID outbreak

XII. Hand Hygiene Qtr 1 (goal 85%)

	Wash-In	Wash-Out
Critical Care	[redacted]	
Acute Care		
FI		
ED		
OR/SDS		

COLO=colon surgeries
HYST=abdominal hysterectomies
VAP=ventilator-associated pneumonia
KPRO=knee prosthesis surgeries
HPRO=hip prosthesis surgeries
Lab Id=laboratory identified
NHSN=National Healthcare Safety Network (CDC)
RA=risk assessment
HAP=hospital-associated pneumonia
SIR=Standardized Infection Ratio
SUR=Standardized Utilization Ratio
PATOS=Present at time of surgery
CDI CO=Community Onset
CDI HO=Hospital Onset
CDI CO-HCFA=Comm. Onset, Healthcare facility associated

Data For Action:

The TAP Report Dashboard

Facility CAD by HAI Type

CLABSI Data for Acute Care Hospitals
FACWIDEIN MRSA Data for Acute Care Hospitals
FACWIDEIN CDI Data for Acute Care Hospitals

Show All HAI Types

View Last 5 Quarters.

Print Graph

Infection Control 2nd Quarter 2024

Class I Surgical Site Infections

1. Mastectomy- DIP

Now reporting IUSS cycles, beginning Q2:
9 IUSS loads, cycle 1, 505 surgical cases.
rate of 1.8

	Qtr 2	YTD	YTD Rate
Total Class I	[redacted]		
Public Reporting			
KPRO			
HPRO			

Class II Surgical Site Infections

Total Class II			
Public Reporting			
COLO			
HYST (Abd)			

II. Ventilator Associated Event

			SIR	
Ventilator			not calc	all ICU days
Ventilator-Associated Events				
VAP				

III. Central Line Associated Blo

			SIR
ICU			**not calc**
Tele Line Days			not calc
Acute Care Line Days			not calc

IV. Catheter Associated Urina

			SIR
ICU			**not calc**
Tele Cath Days			not calc
Acute Care Cath Days			not calc
FI Cath Days			not calc

V. C Dificile

Lab ID CDI Facility wide			

VI. MDRO

	Qtr 2	YTD	SIR

Lab ID MRSA Bacteremia	[redacted]	not calc
VRE/CRE/Other		
ESBL		

VII. HAP

	Qtr 2	YTD

VIII. Exposures

	Qtr 2	YTD
Exposures reported (total)	[redacted]	
Surgery/cleanup		
Double/Mishandling		
Injection related		
Trash		
Splash blood/body fluids		

Previous annual totals

2023 [redacted]
2022
2021
2020

IX. Environmental Services IP Room Cleaning Audit

89.8% - black light audits of patient rooms (after patient discharge cleaning, 11 rooms audited)

X. Infection Control Projects/Information

1. Laundry audit - Two Rivers Correctional Institution
2. Norovirus outbreak
3. Lucidoc
4. SPD audit
5. IP Committee

XI. Inpatient Communicable Disease Reporting

norovirus outbreak

XII. Hand Hygiene Qtr 2

(goal > 85%)

	Wash-In	Wash-Out
Critical care	[redacted]	
Acute care		
FI		
ED		
OR/SDS		

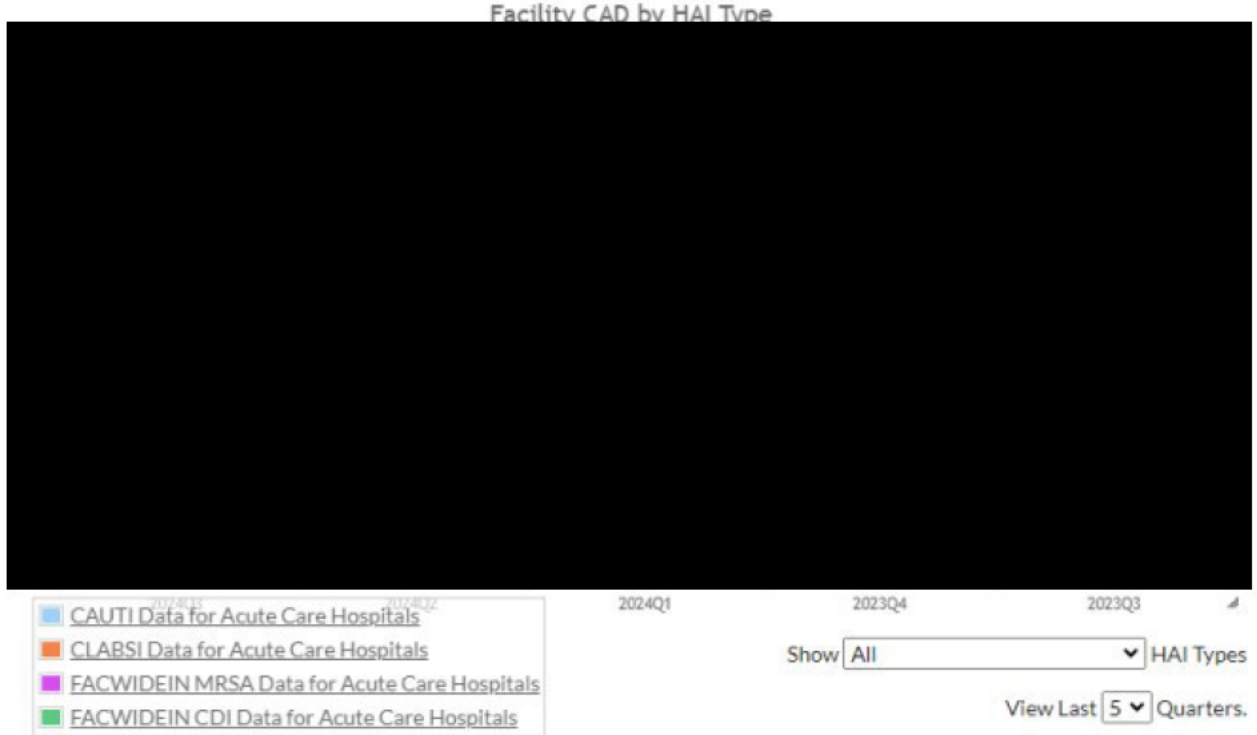
COLO=colon surgeries
HYST=abdominal hysterectomies
VAP=ventilator-associated pneumonia
KPRO=knee prosthesis surgeries
HPRO=hip prosthesis surgeries
Lab Id=laboratory identified
NHSN=National Healthcare Safety Network (CDC)
RA=risk assessment
HAP=hospital-associated pneumonia
SIR=Standardized Infection Ratio
SUR=Standardized Utilization Ratio
PATOS=Present at time of surgery
CDI CO=Community Onset
CDI HO=Hospital Onset
CDI CO-HCFA=Comm. Onset, Healthcare facility associated

TAP Strategy Dashboard

Graph reads right to left

2015 Baseline

Facility CAD by HAI Type



Reportable HAI - trending

Quarter	CDIFF HO infections	CLABSI	CAUTI	MRSA Bacteremia HO	KPRO SSI	HPRO SSI	total
2021Q1							
2021Q2							
2021Q3							
2021Q4							
2022Q1							
2022Q2							
2022Q3							
2022Q4							
2023Q1							
2023Q2							
2023Q3							
2023Q4							
2024Q1							
2024Q2							
2024Q3							
2024Q4							
2025Q1							
2025Q2							

AHCG - Immediate Use Steam Sterilization

Infection Control 2nd Quarter 2025

Class I Surgical Site Infections

	Qtr 2	YTD	YTD Rate
Total Class I	[redacted]		
Public Reporting			
KPRO			
HPRO			

1. Hip pinning

Class II Surgical Site Infections

Total Class II			
Public Reporting			
COLO			
HYST (Abd)			

orted

arget = 0.796

II. Ventilator Associated Event

Ventilator			
Ventilator-Associated Events			
VAP			

III. Central Line Associated Blo

ICU			
Tele Line Days			
Acute Care Line Days			
System Target SIR = 0.636. Events last 1			

IV. Catheter Associated Urinar

ICU			
Tele Cath Days			
Acute Care Cath Days			
FI Cath Days			
System Target SIR = 0.514. Events last 1			

V. C Difficile

Lab ID CDI Facility wide			
System Target SIR = [redacted]			

VI. MDRO

	Qtr 2	YTD	SIR
Lab ID MRSA Bacteremia			nc
VRE/CRE/Other			
ESBL			

System Target SIR = 0.669. Events last 1

VII. IUSS

VIII. Exposures

Exposures reported (total)	
Surgery/cleanup	
Double/Mishandling	
Injection related	
Trash	
Splash blood/body fluids	

Previous annual totals
2024
2023
2022
2021
2020

IX. Environmental Services IP R

5 inpatient rooms audited using blacklig orrectly disinfected.

X. Infection Control Projects/I

SPD audit
Rounding: Immediate care and internal gsy
APIC conference skforce

XI. Inpatient Communicable Di

Chlamydia, Rubella

XII. Hand Hygiene Qtr 2

Critical care	
Acute care	
FI	
ED	
OR/SDS	

By role:
Doctors:
Nurses:

COLO=colon surgeries
HYST=abdominal hysterectomies
VAP=ventilator-associated pneumonia
KPRO=knee prosthesis surgeries
HPRO=hip prosthesis surgeries
Lab Id=laboratory identified
NHSN=National Healthcare Safety Network (CDC)
RA=risk assessment

HAP=hospital-associated pneumonia
SIR=Standardized Infection Ratio
SUR=Standardized Utilization Ratio
PATOS=Present at time of surgery
CDI CO=Community Onset
CDI HO=Hospital Onset
CDI CO-HCFA=Comm. Onset, Healthcare facility associated

Infection Control 3rd Quarter 2025

Class I Surgical Site Infections

	Qtr 3	YTD	YTD Rate
Total Class I			
Public Reporting			
KPRO			
HPRO			

none reported

Class II Surgical Site Infections

Total Class II			
Public Reporting			
COLO			
HYST (Abd)			

1. COLC (deep) class IV
2. COLO (sup)
3. Ovarian cystectomy (deep)

II. Ventilator Associated Even

			SIR
Ventilator			
Ventilator-Associated Events			nc
VAP			nc

III. Central Line Associated Bl

			SIR
ICU			nc
Tele Line Days			nc
Acute Care Line Days			nc
System Target SIR = 0.636. Events last			

IV. Catheter Associated Urina

			SIR
ICU			
Tele Cath Days			
Acute Care Cath Days			
FI Cath Days			
System Target SIR =			

V. C Difficile

	Qtr 3	YTD	SIR
Lab ID CDI Facility wide			
System Target SIR =			

VI. MDRO

	Qtr 3	YTD	SIR
Lab ID MRSA Bacteremia			nc
VRE/CRE/Other			
ESBL			

System Target SIR = 0.669. Events las

VII. IUSS

VIII. Exposures

Exposures reported (total)	
Surgery/cleanup	
Double/Mishandling	
Injection related	
Trash	
Splash blood/body fluids	

Previous annual totals

2024	
2023	
2022	
2021	
2020	

IX. Environmental Services I

no data

X. Infection Control Project

NHSN annual training	E	ily med
Theradoc implementation	E	D Urology
Update to TEE HLD	S	
Lab/public health reporting	S	

XI. Inpatient Communicable

Chlamydia, campylobacteriosis, CRA by the state to not be CRAB)

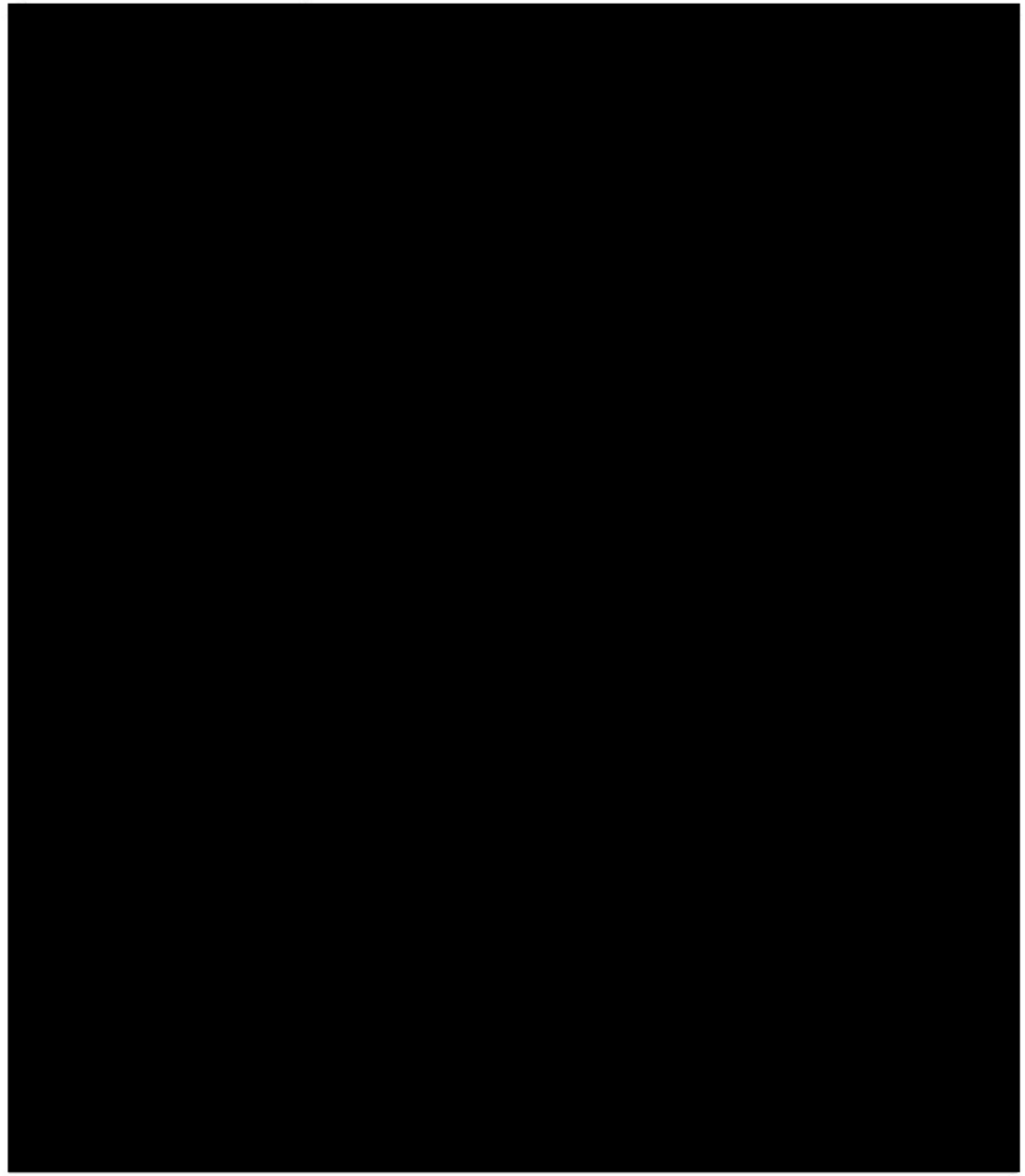
XII. Hand Hygiene Qtr 3

Critical care	
Acute care	
FI	
ED	
OR/SDS	

COLO=colon surgeries
HYST=abdominal hysterectomies
VAP=ventilator-associated pneumonia
KPRO=knee prosthesis surgeries
HPRO=hip prosthesis surgeries
Lab Id=laboratory identified
NHSN=National Healthcare Safety Network (CDC)
RA=risk assessment
HAP=hospital-associated pneumonia
SIR=Standardized Infection Ratio
SUR=Standardized Utilization Ratio
PATOS=Present at time of surgery
CDI CO=Community Onset
CDI HO=Hospital Onset
CDI CO-HCFA=Comm. Onset, Healthcare facility associated

Trending data 2025Q3

CLABSI events and utilization



First number per quarter represents “washing in”, second is “washing out”.

Blue = washing either with soap/water or foam

Orange = missed hand hygiene opportunity

MCMC Risk Management Indicators
Q4 2024- Report out 3/2025

Key: Fully meets expectations Does not meet expectations

Indicator	Goal/target	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024
Patient						
Patient SSE 1-4 / RCA Events	Zero	[redacted]				
SSE events reported to patient or family	100%					
Patient Serious Safety Event Rate (SSER) (Rolling 12-mo average of serious safety events per 10,000 adjusted patient days) *SSE 1-4*	12 month rolling average Less than or equal to 1.00					
Patient Safety Events (Non-RCA Events) *SSE 5 + PSE 1-4*	TBD					
Near Miss Events (NME 1-3)	Future goal: increase near miss events, decrease errors that reach pt.					
Safety Metric NME: SSE+PSE	≤ 1:7					
Fall Events (all patient (in/out) and visitor falls)	< 3.5 per 1000 adjusted patient days					
Pt (inpt and outpt) Falls with injury (SSE 1-5)	Zero					
Medication Errors (voluntary reporting)	No permanent harm or death *SSE 1-3*					
Total HAPI Rate (Stage 1-4, unstageable, DTIs)	Reduction: 20% CMS HIIN Goal < 0.79 10% CMS HIIN Goal < 0.89					
Hospital Acquired Pressure Injuries (HAPI) *Stage 3, 4, and DTI*	No stage 3, 4 or deep tissue injuries					
Pa						
• # of complaints	TBD					
• # of grievances	<6 per month					
• Lost/damaged patient belongings	Zero					
Cases in Litigation (professional liability only)	None					
Claims Opened (not in litigation)	TBD					

AHCG Risk Management Indicators
Q1 2025- Report out 9/2025

Key: Fully meets expectations Does not meet expectations

Indicator	Goal/target	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Patient						
Patient SSE 1-4 / RCA Events	Zero	[redacted]				
SSE events reported to patient or family	100%					
Patient Serious Safety Event Rate (SSER) (Rolling 12-mo average of serious safety events per 10,000 adjusted patient days) *SSE 1-4*	12 month rolling average Less than or equal to 1.00					
Patient Safety Events (Non-RCA Events) *SSE 5 + PSE 1-4*	TBD					
Near Miss Events (NME 1-3)	Future goal: increase near miss events, decrease errors that reach pt.					
Safety Metric NME: SSE+PSE	≤ 1:7					
Fall Events (all patient (in/out) and visitor falls)	< 3.5 per 1000 adjusted patient days					
Pt (inpt and outpt) Falls with injury (SSE 1-5)	Zero					
Medication Errors (voluntary reporting)	No permanent harm or death *SSE 1-3*					
Total HAPI Rate (Stage 1-4, unstageable, DTIs)	Reduction: 20% CMS HIIN Goal < 0.79 10% CMS HIIN Goal < 0.89					
Hospital Acquired Pressure Injuries (HAPI) *Stage 3, 4, and DTI*	No stage 3, 4 or deep tissue injuries					
Pa						
• # of complaints	TBD					
• # of grievances	<6 per month					
• Lost/damaged patient belongings	Zero					
Cases in Litigation (professional liability only)	None					
Claims Opened (not in litigation)	TBD					

AHCG Risk Management Indicators
Q3 2025- Report out 12/2025

Key: Fully meets expectations Does not meet expectations

Indicator	Goal/target	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Patient						
Patient SSE 1-4 / RCA Events	Zero	[redacted]				
SSE events reported to patient or family	100%					
Patient Serious Safety Event Rate (SSER) (Rolling 12-mo average of serious safety events per 10,000 adjusted patient days) *SSE 1-4*	12 month rolling average Less than or equal to 1.00					
Patient Safety Events (Non-RCA Events) *SSE 5 + PSE 1-4*	TBD					
Near Miss Events (NME 1-3)	Future goal: increase near miss events, decrease errors that reach pt.					
Safety Metric NME: SSE+PSE	≤ 1:7					
Fall Events (all patient (in/out) and visitor falls)	< 3.5 per 1000 adjusted patient days					
Pt (inpt and outpt) Falls with injury (SSE 1-5)	Zero					
Medication Errors (voluntary reporting)	No permanent harm or death *SSE 1-3*					
Total HAPI Rate (Stage 1-4, unstageable, DTIs)	Reduction: 20% CMS HIIN Goal < 0.79 10% CMS HIIN Goal < 0.89					
Hospital Acquired Pressure Injuries (HAPI) *Stage 3, 4, and DTI*	No stage 3, 4 or deep tissue injuries					
Pa						
• # of complaints	TBD					
• # of grievances	<6 per month					
• Lost/damaged patient belongings	Zero					
Cases in Litigation (professional liability only)	None					
Claims Opened (not in litigation)	TBD					

Annual Staffing Report to Board Quality & Safety Committee
Date: 2/2024_____

Key: Fully meets expectations Partially meets expectations Does not meet expectations

Measure	Goal/ target	Q1	Q2	Q3	Q4	Comments/ Follow up
# RCAs with staffing concerns/issues	0	[redacted]				
# Medication Error trending reports from departments/units with staffing issues/concerns	0					
# Falls with staffing concerns/issues	0					
# HAPIs with staffing concerns/issues	0					
# SRDF with staffing concerns/issues identified by managers/directors	0					See below
Days hospital in "cirisis care"						

Summary of actions taken to resolve issues identified:

Q4- discussed at staffing committee meeting and changes were made to the staffing plan on the unit

Annual Staffing Report to Board Quality & Safety Committee
Date: __5/2024

Key: Fully meets expectations Partially meets expectations Does not meet expectations

Measure	Goal/ target	Q1	Q2	Q3	Q4	Comments/ Follow up
# RCAs with staffing concerns/issues	0	[redacted]				
# Medication Error trending reports from departments/units with staffing issues/concerns	0					
# Falls with staffing concerns/issues	0					
# HAPIs with staffing concerns/issues	0					
# SRDF with staffing concerns/issues identified by managers/directors	0					
Days hospital in "cirisis care"						

Summary of actions taken to resolve issues identified: _____

_____

_____

Annual Staffing Report to Board Quality & Safety Committee
Date: 12/2024

Key: Fully meets expectations Partially meets expectations Does not meet expectations

Measure	Goal/ target	Q1	Q2	Q3	Q4	Comments/ Follow up
# RCAs with staffing concerns/issues	0	[redacted]				
# Medication Error trending reports from departments/units with staffing issues/concerns	0					
# Falls with staffing concerns/issues	0					
# HAPIs with staffing concerns/issues	0					
# SRDF with staffing concerns/issues identified by managers/directors	0					
Days hospital in "cirisis care"						

Summary of actions taken to resolve issues identified: _____

_____

_____

Annual Staffing Report to Board Quality & Safety Committee
Date: 8/2025

Key: Fully meets expectations Partially meets expectations Does not meet expectations

Measure	Goal/ target	Q1	Q2	Q3	Q4	Comments/ Follow up
# RCAs with staffing concerns/issues	0	[redacted]				
# Medication Error trending reports from departments/units with staffing issues/concerns	0					
# Falls with staffing concerns/issues	0					
# HAPIs with staffing concerns/issues	0					
# SRDF with staffing concerns/issues identified by managers/directors	0					
Days hospital in "cirisis care"	0					

Summary of actions taken to resolve issues identified:

[redacted]

Q2 2025- 1 in May- First Impressions

Annual Staffing Report to Board Quality & Safety Committee
Date: 1/2026

Key: Fully meets expectations Partially meets expectations Does not meet expectations

Measure	Goal/ target	Q1	Q2	Q3	Q4	Comments/ Follow up
# RCAs with staffing concerns/issues	0	[redacted]				
# Medication Error trending reports from departments/units with staffing issues/concerns	0					
# Falls with staffing concerns/issues	0					
# HAPIs with staffing concerns/issues	0					
# SRDF with staffing concerns/issues identified by managers/directors	0					
Days hospital in "crisis care"	0					

Summary of actions taken to resolve issues identified:

[redacted]

Q2 2025- 1 in May- First Impressions

Adventist Health Columbia Gorge

Dashboard of KPIs

Rolling 12 Month Report

HC = Health Care
CLBSI = Central Line Blood Stream Infection
SSI = Surgical Site Infection
WC = Workers Comp
HAI: Includes CAUTI, CLABSI, CDI, SSI

CAUTI = Catheter Associated Urinary Tract Infection
CDI = Clostridium Difficile Infection
OSHA = Occupational Safety and Health Administration
VAC = Ventilator Associated Condition
HAP = Hospital Acquired Pneumonia

Red: Not meeting goal by >20%
Yellow: Not meeting goal by 20% or less
Green: Meeting Goal

INDICATOR	Feb '24	Mar '24	April '24	May '24	June '24	July '24	Aug '24	Sept '24	Oct '24	Nov '24	Dec '24	Jan '25	YTD
Risk Management													
Number of lawsuits filed *Goal: 0*	[redacted]												
Number of Root Cause Analysis (SSE 1-4) events *Goal: 0*													
Number of days between RCA events *(reported when an event occurs)*													
Inpatient Falls w/ Injury/1,000 pt days *Goal: Less than MCMC 2020 Ave. Rate of 1.07*													
# Hospital (inpatients) Acquired Pressure Injury stage 3, 4, unstageable, or deep tissue injury *Goal: 0*													
Patient Satisfaction													
Number of Civil Rights Complaints *Goal: 0*													
Number of Patient Grievances *Goal: less than 6/month*													
Infection Prevention													
Influenza Vaccination Coverage HC personnel *Goal: 90%*													
COVID Positivity Detection rate *Goal: Less than 10%*													
# of Reportable Hospital Acquired Infections Reportable per NHSN Guidelines *Goal: 0*													
Employee Safety													
Time Loss associated with worker injury *Benchmark: 2 per month*													

INDICATOR	Feb '24	Mar '24	April '24	May '24	June '24	July '24	Aug '24	Sept '24	Oct '24	Nov '24	Dec '24	Jan '25	YTD
Healthcare Assaults *(per OSHA reporting – physical only)* *Goal: < 3/month*	0 GREEN	0 GREEN	0 GREEN	0 GREEN	0 GREEN	0 GREEN	0 GREEN	0 GREEN	0 GREEN	0 GREEN	0 GREEN	0 GREEN	0 Avg. GREEN

Adventist Health
Columbia Gorge

Dashboard of KPIs

Rolling 12 Month Report

DEFINITIONS:

SSE = Serious Safety Event
HC = Health Care
CLBSI = Central Line Blood Stream Infection
SSI = Surgical Site Infection
WC = Workers Comp
HAI: Includes CAUTI, CLABSI, CDI, SSI
NDNQI = National Database of Nursing Quality Indicators
CAUTI = Catheter Associated Urinary Tract Infection
CDI = Clostridium Difficile Infection
OSHA = Occupational Safety and Health Administration
VAC = Ventilator Associated Condition
HAP = Hospital Acquired Pneumonia

Red: Not meeting goal by >20%
Yellow: Not meeting goal by 20% or less
Green: Meeting Goal

INDICATOR	Mar `24	April `24	May `24	June `24	July `24	Aug `24	Sept `24	Oct `24	Nov `24	Dec `24	Jan `25	Feb `25	YTD
Risk Management													
Number of lawsuits filed *Goal: 0*	[redacted]												
Number of Root Cause Analysis (SSE 1-4) events *Goal: 0*													
Number of days between RCA events *(reported when an event occurs)*													
Inpatient Falls w/ Injury/1,000 pt days *Goal: Less than MCMC 2020 Ave. Rate of 1.07*													
# Hospital (inpatients) Acquired Pressure Injury stage 3, 4, unstageable, or deep tissue injury *Goal: 0*													
Patient Satisfaction													
Number of Civil Rights Complaints *Goal: 0*													
Number of Patient Grievances *Goal: less than 6/month*													
Infection Prevention													
Influenza Vaccination Coverage HC personnel *Goal: 90%*													
COVID Positivity Detection rate *Goal: Less than 10%*													
# of Reportable Hospital Acquired Infections Reportable per NHSN Guidelines *Goal: 0*													
Employee Safety													
Time Loss associated with worker injury *Benchmark: 2 per month*													
Healthcare Assaults *(per OSHA reporting – physical only)* *Goal: < 3/month*													

[ADVENTISTHEALTH:INTERNA

AdventistHealth Columbia Gorge

Dashboard of KPIs

Rolling 12 Month Report

DEFINITIONS:

SSE = Serious Safety Event
HC = Health Care
CLBSI = Central Line Blood Stream Infection
SSI = Surgical Site Infection
WC = Workers Comp
HAI: Includes CAUTI, CLABSI, CDI, SSI
NDNQI = National Database of Nursing Quality Indicators
CAUTI = Catheter Associated Urinary Tract Infection
CDI = Clostridium Difficile Infection
OSHA = Occupational Safety and Health Administration
VAC = Ventilator Associated Condition
HAP = Hospital Acquired Pneumonia

Red: Not meeting goal by >20%
Yellow: Not meeting goal by 20% or less
Green: Meeting Goal

INDICATOR	May `24	June `24	July `24	Aug `24	Sept `24	Oct `24	Nov `24	Dec `24	Jan `25	Feb `25	Mar `25	April `25	YTD
Risk Management													
Number of lawsuits filed *Goal: 0*	[redacted]												
Number of Root Cause Analysis (SSE 1-4) events *Goal: 0*													
Number of days between RCA events *(reported when an event occurs)*													
Inpatient Falls w/ Injury/1,000 pt days *Goal: Less than MCMC 2020 Ave. Rate of 1.07*													
# Hospital (inpatients) Acquired Pressure Injury stage 3, 4, unstageable, or deep tissue injury *Goal: 0*													
Patient Satisfaction													
Number of Civil Rights Complaints *Goal: 0*													
Number of Patient Grievances *Goal: less than 6/month*													
Infection Prevention													
Influenza Vaccination Coverage HC personnel *Goal: 90%*													
COVID Positivity Detection rate *Goal: Less than 10%*													
# of Reportable Hospital Acquired Infections Reportable per NHSN Guidelines *Goal: 0*													
Employee Safety													
Time Loss associated with worker injury *Benchmark: 2 per month*													
Healthcare Assaults *(per OSHA reporting – physical only)* *Goal: < 3/month*													

Adventist Health
Columbia Gorge

Dashboard of KPIs

Rolling 12 Month Report

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INDICATOR	July `24	Aug `24	Sept `24	Oct `24	Nov `24	Dec `24	Jan `25	Feb `25	Mar `25	April `25	May `25	June` 25	YTD
Risk Management													
`25Number of lawsuits filed *Goal: 0*	[redacted]												
Number of Root Cause Analysis (SSE 1-4) events *Goal: 0*													
Number of days between RCA events *(reported when an event occurs)*													
Inpatient Falls w/ Injury/1,000 pt days *Goal: Less than MCMC 2020 Ave. Rate of 1.07*													
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Protected as peer review data under ORS 41.675; not to be disclosed voluntarily or involuntarily.

Adventist Health Columbia Gorge

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INDICATOR	Aug `24	Sep `24	Oct `24	Nov `24	Dec `24	Jan `25	Feb `25	Mar `25	Apri `25	May `25	June` 25	July `25	YTD
Risk Management													
`25Number of lawsuits filed *Goal: 0*	[redacted]												
Number of Root Cause Analysis (SSE 1-4) events *Goal: 0*													
Number of days between RCA events *(reported when an event occurs)*													
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INDICATOR	Sep '24	Oct '24	Nov '24	Dec '24	Jan '25	Feb '25	Mar '25	April '25	May '25	June 25	July '25	Aug '25	YTD
Risk Management													
'25Number of lawsuits filed *Goal: 0*	[redacted]												
Number of Root Cause Analysis (SSE 1-4) events *Goal: 0*													
Number of days between RCA events *(reported when an event occurs)*													
Inpatient Falls w/ Injury/1,000 pt days *Goal: Less than MCMC 2020 Ave. Rate of 1.07*													
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INDICATOR	Dec `24	Jan `25	Feb `25	Mar `25	April `25	May `25	June `25	July `25	Aug `25	Sep `25	Oct `25	Nov `25	YTD
Risk Management													
`25Number of lawsuits filed *Goal: 0*													
Number of Root Cause Analysis (SSE 1-4) events *Goal: 0*													
Number of days between RCA events *(reported when an event occurs)*													
Inpatient Falls w/ Injury/1,000 pt days *Goal: Less than MCMC 2020 Ave. Rate of 1.07*													
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INDICATOR	Jan '25	Feb '25	Mar '25	April '25	May '25	June '25	July '25	Aug '25	Sep '25	Oct '25	Nov '25	Dec '25	YTD
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'25Number of lawsuits filed *Goal: 0*	[redacted]												
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Healthcare Assaults *(per OSHA reporting – physical only)* *Goal: < 3/month*													

2024 Environment of Care Monitors

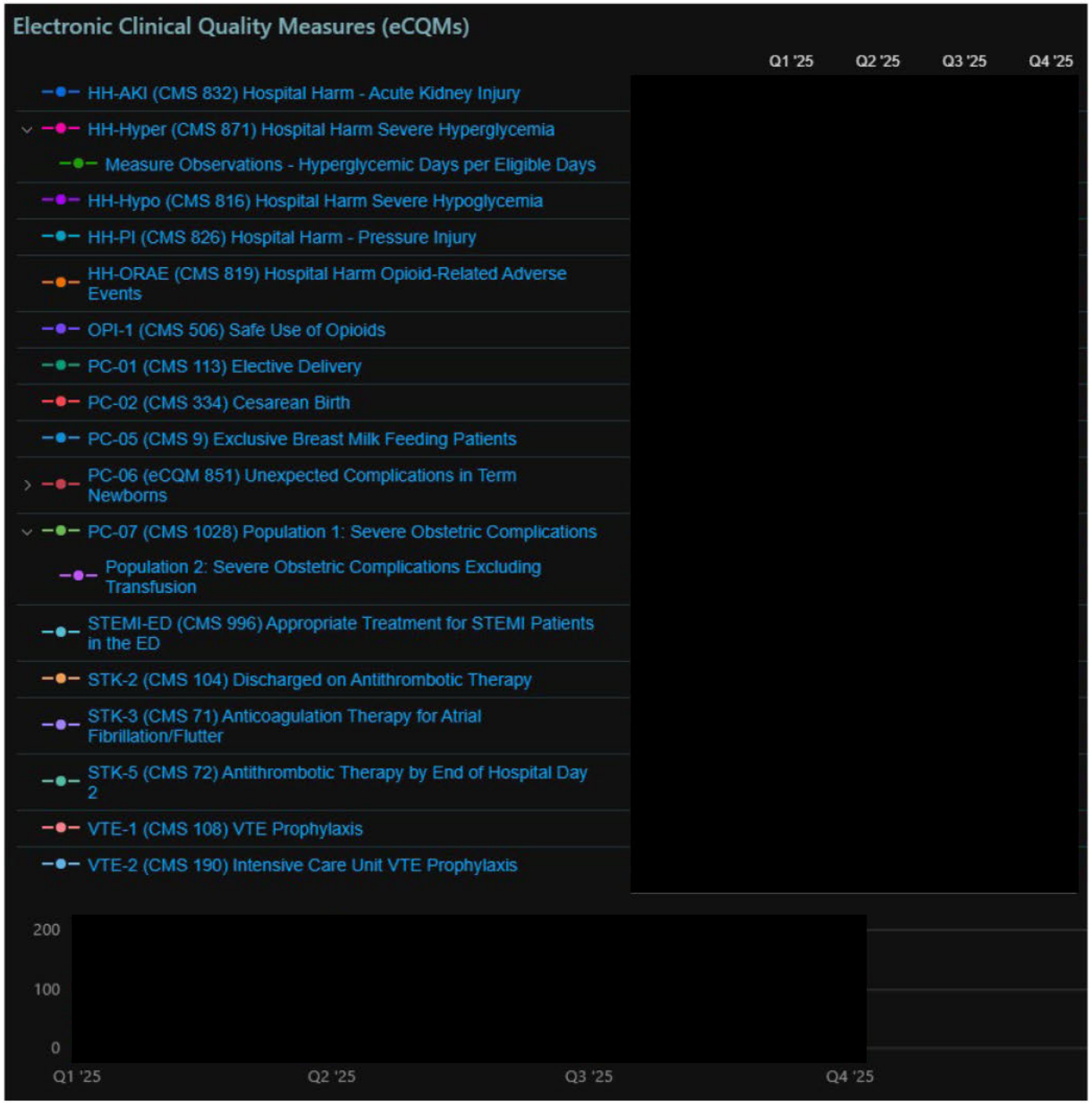
	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sept	Q3	Oct	Nov	Dec	Q4	Fiscal Total
Safety Management - Joe Abbas																	
EC related Patient Injuries EC.04.01.01 EP1 Chris B.																	
Occupational illnesses & EC Related Staff injuries EC.04.01.01 EP1 Sheila O.																	
Incidents of damage to MCMC property & others EC.04.01.01 EP1																	
Medical Equipment Management - Adam Ondrus																	
Medical/Lab equip mngmt problems, failures & use errors < 30 days EC.04.01.01 EP1																	
Safe Medical Devices Act (SMDA) death or serious injury caused by medical equipment																	
Life Safety Management - Stacy Alleman																	
FS Management problems, deficiencies & failures EC.04.01.01 EP1																	
Conditions Requiring ILSM and/or Fire Protection Impairments																	
2024 Monitor: Staff errors during fire drills																	
Security Management - Dawn OpBroek																	
Security incidents involving patients, staff, or others EC.04.01.01 EP1																	
Patient Unanticipated Elopements - does not include AMA situations																	
2024 Monitor: Perform at least 1 code grey drill per quarter																	
Hazardous Materials & Waste Management - Ra																	
Hazardous materials & waste spills & exposures EC.04.01.01 EP1																	
2024 Monitor: Survey at least 2 off campus departments monthly to confirm/update SDS																	
Utilities Management - Sam Evans																	
Utility System mangmnt problems, failures or user errors EC.04.01.01 EP1																	
Improper temperature & humidity levels EC.04.01.01 EP1																	
% Utility PMs Completed																	
2024 Monitor: Equip failure / month & downtime average (Days)																	
Emergency Preparedness Management - Stefanie																	
Events and Drills per Month related to Emergency Prep																	
2024 Monitor: 2 Events a year. 1 may be an actual event.																	

	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sept	Q3
Safety Management - Tiffany Norton												
EC related Patient Injuries EC.04.01.01 EP1 Chris B.												
Occupational illnesses & EC Related Staff injuries EC.04.01.01 EP1 Bri S.												
Incidents of damage to MCMC property & others EC.04.01.01 EP1												
Medical Equipment Management - Adam Ondrusek												
Medical/Lab equip mngmt problems, failures & use errors < 30 days EC.04.01.01 EP1												
Safe Medical Devices Act (SMDA) death or serious injury caused by medical equipment												
Life Safety Management - Stacy Alleman												
FS Management problems, deficiencies & failures EC.04.01.01 EP1												
Conditions Requiring ILSM and/or Fire Protection Impairments												
Security Management - Dawn OpBroek												
Security incidents involving patients, staff, or others EC.04.01.01 EP1												
Patient Unanticipated Elopements - does not include AMA situations												
Hazardous Materials & Waste Management - Maxx Ruvalcaba												
Hazardous materials & waste spills & exposures EC.04.01.01 EP1												
Utilities Management - Sam Evans												
Utility System mangmnt problems, failures or user errors EC.04.01.01 EP1												
Improper temperature & humidity levels EC.04.01.01 EP1												
% Utility PMs Completed												
Emergency Preparedness Management - Stefanie Boen												
Events and Drills per Month related to Emergency Prep												

2025 CMS Hospital Quality Star Rating Performance

Facility	Jul-23	Jul-24	Apr-25	Change from July 2024
AHBD	★★★★☆	★★☆☆☆	★☆☆☆☆	-1
AHCL	★★★★☆	★★★☆☆	★☆☆☆☆	-2
AHCS	★★★★★	★★★★★	★★★★★	
AHGL	★★★★★	★★★★★	★★★★☆	-1
AHHF	★☆☆☆☆	★☆☆☆☆	★★☆☆☆	1
AHHM	★★★★☆	★★★★★	★★★★★	
AHLM	★★★★☆	★★★☆☆	★★★☆☆	
AHPL	★★★☆☆	★★☆☆☆	★★★★☆	2
AHRO	★★☆☆☆	★★☆☆☆	★★☆☆☆	
AHSH	★★★★★	★★★★★	★★★★☆	-1
AHSR	★★★★☆	★★☆☆☆	★★★☆☆	1
AHSV	★★★☆☆	★★☆☆☆	★★☆☆☆	
AHTM	★★★☆☆	★★★☆☆	★★★★☆	1
AHUV	★★★☆☆	★★★★★	★★★★☆	-1
AHWM	★★☆☆☆	★★★☆☆	★★★☆☆	
AHMC	★★☆☆☆	N/A	★☆☆☆☆	N/A
New Markets				
AHCG	★★☆☆☆	★★☆☆☆	★★★☆☆	1
AHSL	★★☆☆☆	★★★☆☆	★★★☆☆	0
AHTC	★★☆☆☆	★★☆☆☆	★★☆☆☆	0

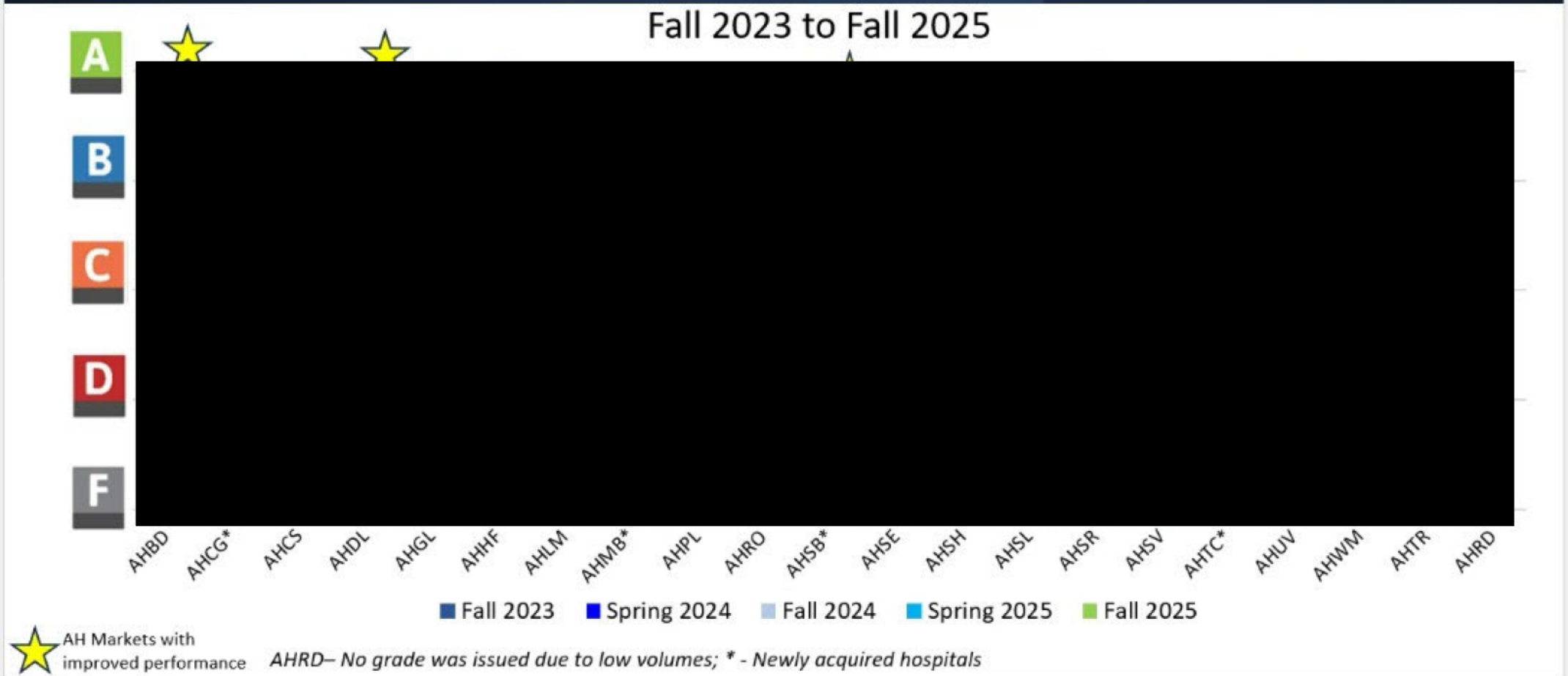
NA (low volume) for AHDL, AHRD, AHTR, AHTV



eCQMs	Q1 25	Q2 25	Q3 25	Q4 25
HH-PI (CMS 826) – Pressure Injury ↓				
STK-2 (CMS 104) – Discharged on Antithrombotic Therapy ↑				
STK-5 (CMS 72) – Antithrombotic Therapy by End of Hospital Day 2 ↑				
OPI-1 (CMS 506) – Safe Use of Opioids ↓				
PC-02 (CMS 334) – Cesarean Birth ↓				
PC-07 (CMS 1028) – Severe Obstetric Complications ↓				
STEMI-ED (CMS 996) Appropriate Treatment for STEMI Patients in the ED ↑				

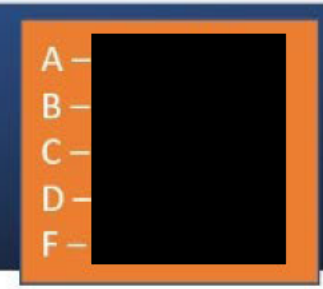
Leapfrog Safety Scores

Fall 2023 to Fall 2025

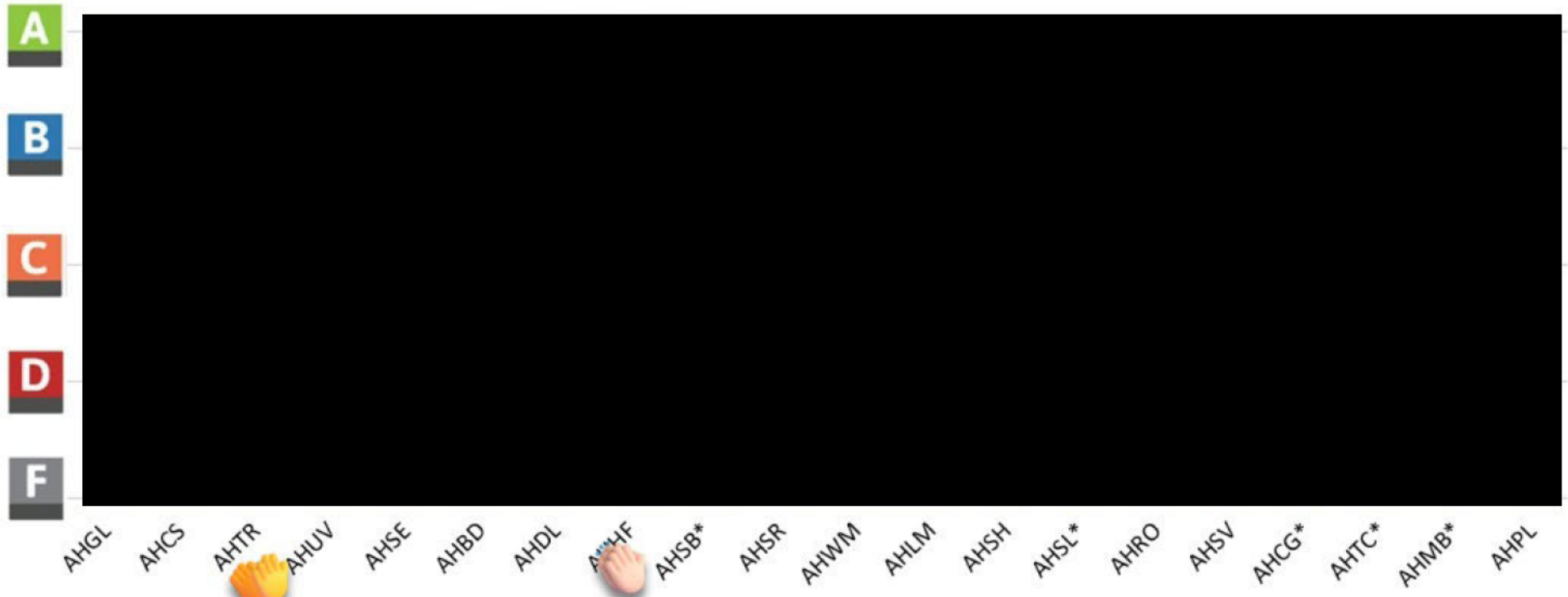


Leapfrog Safety Scores

Release Date: November 2025



2025 Fall Results



*AHRD– No grade was issued due to low volumes, * - Newly acquired hospitals*

to add notes

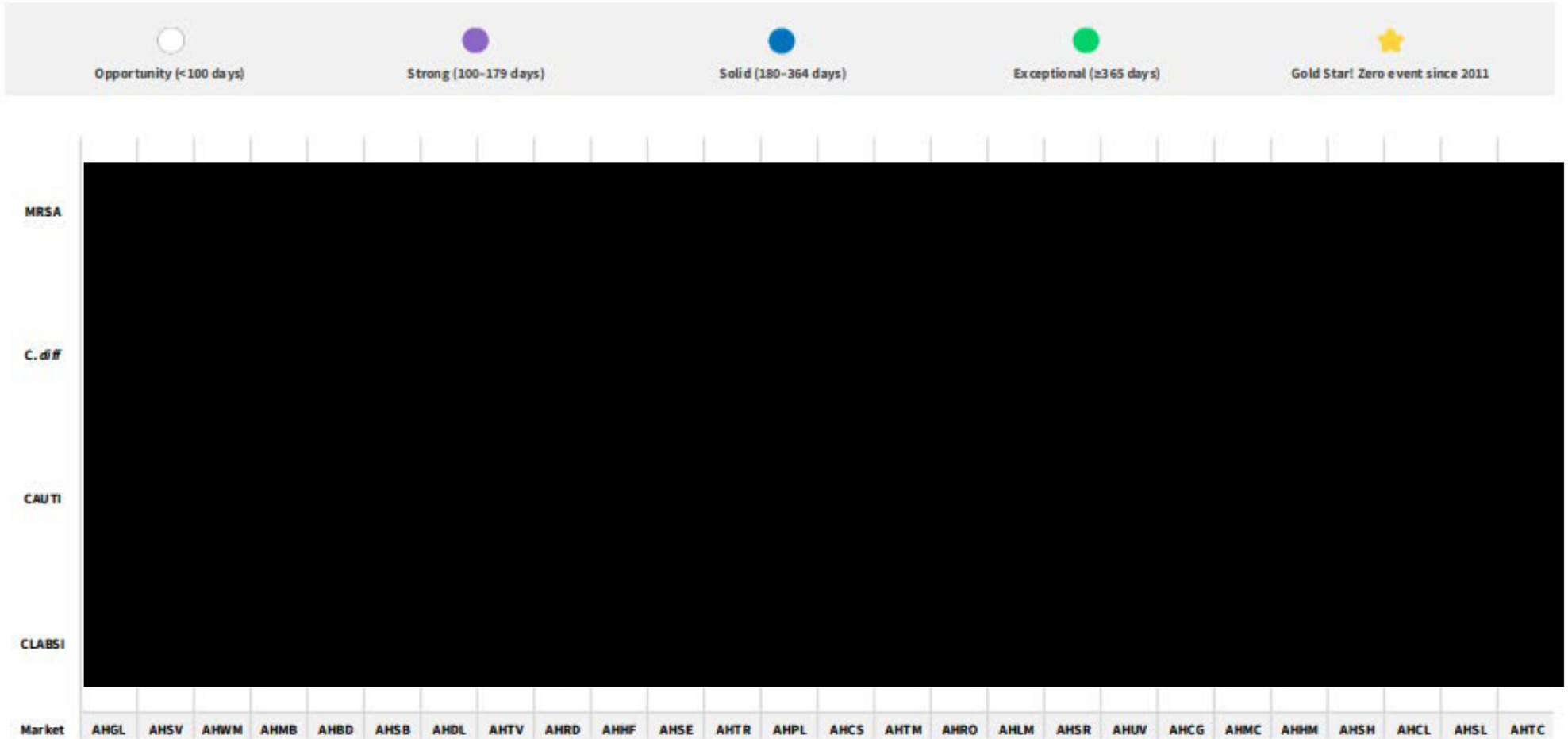
Leapfrog Letter Grade Distribution – Fall 2025

Grade	Safety Grade Criteria *(at or above cut point)*	Percentage of Hospitals				
		Fall 2025	Spring 2025	Fall 2024	Spring 2024	Falls 2023
A	≥ 3.202	32%	32%	32%	29%	30%
B	≥ 2.991	26%	24%	24%	26%	24%
C	≥ 2.401	33%	35%	36%	37%	39%
D	≥ 1.837	8%	7%	7%	7%	7%
F	< 1.837	1%	<1%	<1%	<1%	<1%

[redacted]

AHRD - No grade was issued due to low volumes;

Celebrating HAI Free Streak: Days Since Last HAI



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Celebrating HAI Free Streak:
Days Since Last HAI

⭐ = Gold Star! Zero event since 2011
🔷 = Exceptional (≥365 days)
🔵 = Solid (180–364 days)
🟩 = Strong (100–179 days)
🟣 = Opportunity (<100 days)

Market	CLABSI	CAUTI	C. *diff*	MRSA
AHGL				
AHSV				
AHWM				
AHMB				
AHBD				
AHSB				
AHDL				
AHTV				
AHRD				
AHHF				
AHSE				
AHTR				
AHPL				
AHCS				
AHTM				
AHRO				
AHLM				
AHSR				
AHUV				
AHCG				
AHMC				
AHHM				
AHSH				
AHCL				
AHSL				
AHTC				

Safety Composite

	CAUTI				CLABSI				CDI				MRSA				COLO SSI				
MARKET	Infections	SIR*	2026 TARGET	Met/ Not Met	Infections	SIR*	2026 TARGET	Met/ Not Met	Infections	SIR	2026 TARGET	Met/ Not Met	Infections	SIR	2026 TARGET	Met/ Not Met	Infections	SIR	2026 TARGET	Met/ Not Met	TOTAL
AHTV	[redacted]																				
AHGL																					
AHWM																					
AHUV																					
AHTR																					
AHSR																					
AHDL																					
AHHM																					
AHBD																					
AHSV																					
AHMB																					
AHSB																					
AHTC																					
AHSL																					
AHLM																					
AHRO																					
AHCL																					
AHSH																					
AHMC																					
AHHF																					
AHTM																					
AHPL																					
AHCG																					
AHRD																					
AHCS																					
AHSE																					
System																					

** Baseline period: July 2024 - June 2025*

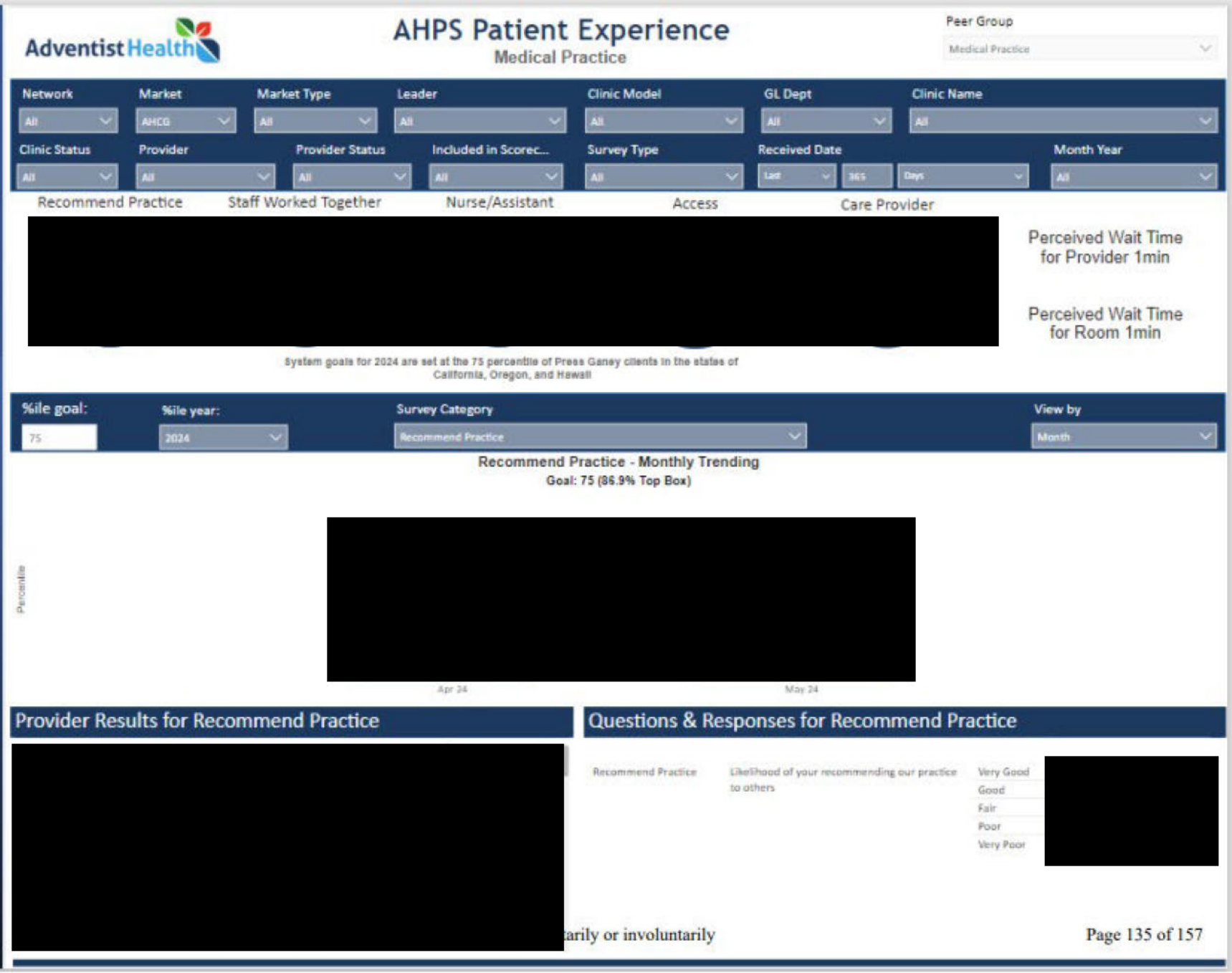
CDI: Clostridioides Difficile Infection
CLABSI: Central Line-Associated Bloodstream Infection
CAUTI: Catheter-Associated Urinary Tract Infection

MRSA BSI: Methicillin-Resistant Staphylococcus Aureus Bloodstream Infection
SSI: Surgical Site Infection Colon Surgeries

AdventistHealth

Press Ganey Patient Experience

PowerBI - AHPS Clinics



Press Ganey Patient Experience

Q1 2024 Data

2024 OASCAHPS/Satisfaction Surveys Stop Light
Ambulatory Surgery

FILTER BY All sections selected

● High Point ● Low Point

Survey Items	SECTION/DOMAIN	Survey Type	n	Top Box Score: Current (Q1 2024)	Top Box Score: Previous (Q4 2023)	Goal	Change	Percentile Rank	Score Trendline
Facility rating 0-10	GLOBAL ITEMS	CAHPS	[redacted]						
Recommend the facility	GLOBAL ITEMS	CAHPS							
Domain: Communication	COMMUNICATION	CAHPS							
Domain: Facility/Personal Trtment	FACILITY/PERSONAL TRTMENT	CAHPS							
Domain: Discharge	DISCHARGE	CAHPS							
PG Overall	PG OVERALL	PG							
Section: Nurses	NURSES	PG							
Section: Care Provider	CARE PROVIDER	PG							
Section: Overall Assessment	OVERALL ASSESSMENT	PG							

† Custom Question ^ Focus Question

Q4 2022 Q1 2023 Q2 2023 Q3 2023 Q4 2023 Q1 2024

At or Above Goal <5 Points Below Goal >5 Points Below Goal No Goal

Benchmark Goal: All Press Ganey Database

n = Number of patients to answer the question | Data by Service/Visit Date

Press Ganey Patient Experience

Q1 2024 Data

2024 CAHPS/Satisfaction Surveys Stop Light
Emergency Department

FILTER BY All sections selected

● High Point ● Low Point

Survey Items	Survey Type	n	Top Box Score: Current (Q1 2024)	Top Box Score: Previous (Q4 2023)	Goal	Change	Percentile Rank	Score Trendline
PG OVERALL: PG Overall	PG							
ARRIVAL: Section: Arrival	PG							
NURSES: Section: Nurses	PG							
DOCTORS: Section: Doctors	PG							
OVERALL ASSESSMENT: Section: Overall Assessment	PG							
OVERALL ASSESSMENT: Overall rating of care	PG							
OVERALL ASSESSMENT: Likelihood of recommending	PG							

Q4 2022 Q1 2023 Q2 2023 Q3 2023 Q4 2023 Q1 2024

† Custom Question ^ Focus Question

At or Above Goal <5 Points Below Goal >5 Points Below Goal No Goal

Benchmark Goal: All Press Ganey Database

n = Number of patients to answer the question | Data by Visit/Service Date

Press Ganey Patient Experience

Q1 2024 Data

2024 HCAHPS/Satisfaction Surveys Stop Light
Inpatient Units (AC, L&D, ICU, Tele)

FILTER BY All sections selected

● High Point ● Low Point

Survey Items	Survey Type	n	Top Box Score: Current (Q1 2024)	Top Box Score: Previous (Q4 2023)	Goal	Change	Percentile Rank	Score Trendline
GLOBAL ITEMS Rate hospital 0-10	CAHPS							
GLOBAL ITEMS Recommend the hospital	CAHPS							
COMM W/ NURSES Domain: Comm w/ Nurses	CAHPS							
RESPONSE OF HOSP STAFF Domain: Response of Hosp Staff	CAHPS							
COMM W/ DOCTORS Domain: Comm w/ Doctors	CAHPS							
HOSPITAL ENVIRONMENT Cleanliness of hospital environment	CAHPS							
HOSPITAL ENVIRONMENT Quietness of hospital environment	CAHPS							
COMM ABOUT MEDICINES Domain: Comm About Medicines	CAHPS							
DISCHARGE INFORMATION Domain: Discharge Information	CAHPS							
CARE TRANSITIONS Domain: Care Transitions	CAHPS							

† Custom Question ^ Focus Question

Q4 2022 Q1 2023 Q2 2023 Q3 2023 Q4 2023 Q1 2024

At or Above Goal <5 Points Below Goal >5 Points Below Goal No Goal

Benchmark Goal: All Press Ganey Database

n = Number of patients to answer the question | Data by Discharge Date

Press Ganey Patient Experience

Q1 2024 Data

2024 Medical Practice Clinics CAHPS/Satisfaction Surveys Stop Light

FILTER BY All sections selected

High Point Low Point

Top Box Score

Survey Items	Survey Type	n	Current (Q1 2024)	Previous (Q4 2023)	Goal	Change	Percentile Rank	Score Trendline
Recommend this provider office	CAHPS							
Rate provider 0-10	CAHPS							
Domain: Physician Comm Quality	CAHPS							
Domain: Office Staff Quality	CAHPS							
Domain: Access to Care 3 month	CAHPS							
Domain: Care Coordination	CAHPS							
Section: Access	PG							
Section: Moving Through Your Visit	PG							
Section: Nurse/Assistant	PG							
Section: Care Provider	PG							
Section: Personal Issues	PG							
Section: Overall Assessment	PG							
Likelihood of recommending	PG							

[redacted]

Q4 2022 Q1 2023 Q2 2023 Q3 2023 Q4 2023 Q1 2024

† Custom Question ^ Focus Question

At or Above Goal <5 Points Below Goal >5 Points Below Goal No Goal

The n number includes the following departments: Cardiology Clinic, Columbia River Women's Clinic, ENT Clinic, Family Medicine, Internal Medicine, Pediatric Clinic, Neurology Clinic, Occupational Health, Orthopedic Clinic, Sleep Medicine Clinic, Surgical Clinic, and Urology Clinic

Benchmark Goal: National Facilities

n = Number of patients to answer the question | Data by Received Date

Press Ganey Patient Experience

Q1 2024 Data

2024 Outpatient Satisfaction Surveys Stop Light

FILTER BY All sections selected

● High Point ● Low Point

Survey Items	Survey Type	n	Top Box Score: Current (Q1 2024)	Top Box Score: Previous (Q4 2023)	Goal	Change	Percentile Rank	Score Trendline
PG OVERALL: PG Overall	PG							
REGISTRATION: Section: Registration	PG							
YOUR CARE: Section: Your Care	PG							
OVERALL ASSESSMENT: Section: Overall Assessment	PG							
OVERALL ASSESSMENT: Likelihood of recommending	PG							

† Custom Question ^ Focus Question

Q4 2022 Q1 2023 Q2 2023 Q3 2023 Q4 2023 Q1 2024

At or Above Goal <5 Points Below Goal >5 Points Below Goal No Goal

The n number includes the following departments: Anticoagulation Clinic at Celilo, Anticoagulation at Columbia Crest Clinic, Bone Density at MCMC Hospital, Cardiac Rehabilitation at Water's Edge, Cardiology at Water's Edge, Cardiopulmonary Services at MCMC Hospital, Celilo Cancer Center, Celilo Cancer Center - Lab, Celilo Cancer Center - Massage & Acupuncture, Celilo Cancer Center - Medical Oncology, Celilo Cancer Center - Radiation, Celilo Cancer Center - Radiation Oncology, Diabetes Education at Water's Edge, Diagnostic Imaging at MCMC Hospital, Endoscopy Department at MCMC Hospital, Laboratory at Columbia Crest, Laboratory at MCMC Family Medicine, Laboratory at Medical Office Building, Laboratory at Mid-Columbia Medical Center, Laboratory at Water's Edge, Mammography at MCMC Hospital, Maternity Services at MCMC Hospital, Mid-Columbia Physical Therapy at Nichols Landing, Mid-Columbia Speech Therapy at Nichols Landing, Nuclear Medicine at MCMC Hospital, Nutrition at Water's Edge, Outpatient Therapy at Water's Edge, PET CT at Patient Access Center, Post-Partum Care Clinic at MCMC Hospital, Pulmonary Rehabilitation at Water's Edge, Same Day Procedures at MCMC Hospital, Same Day Surgery at MCMC Hospital, Telemetry at MCMC Hospital, Ultrasound at MCMC Hospital, Water's Edge Immediate Care Clinic, Water's Edge Sports Medicine & Orthopedic Surgery

Benchmark Goal: All Press Ganey Database

n = Number of patients to answer the question | Data by Visit/Service Date

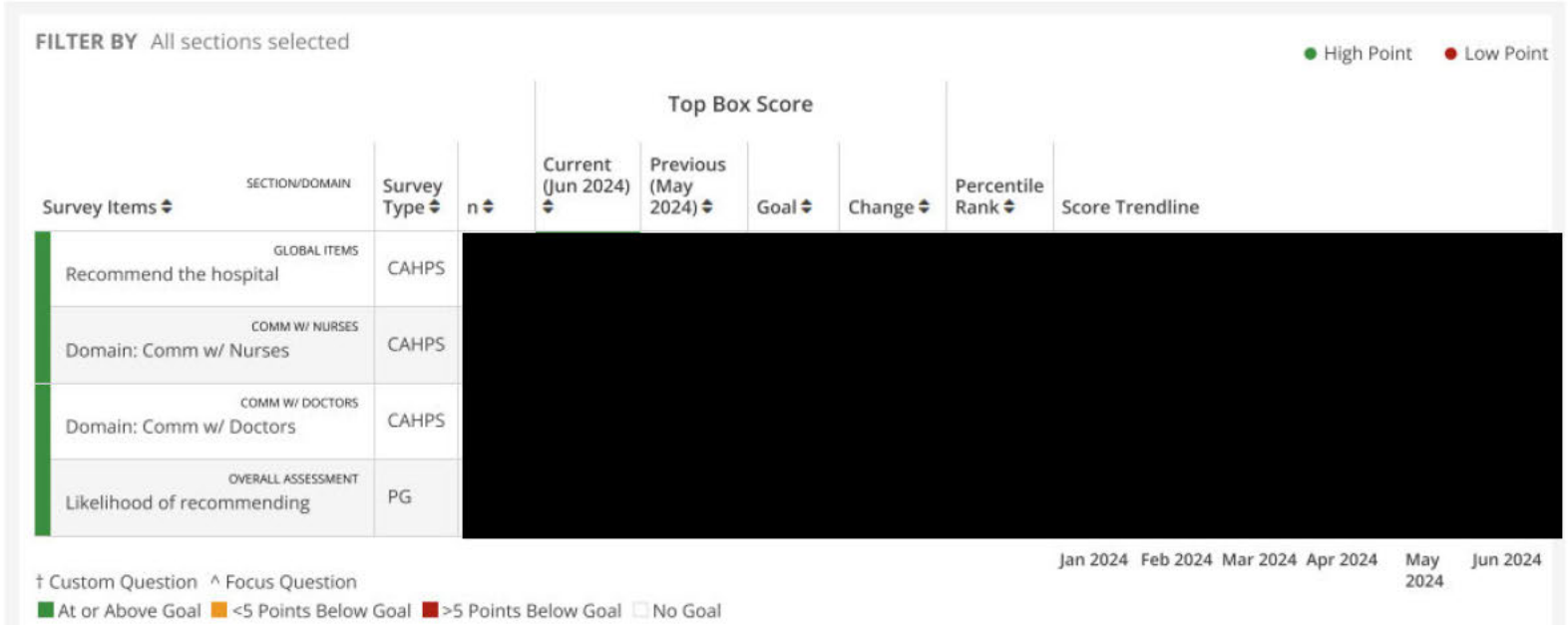
Patient Experience

AH System Measures

June data not complete

<u>AH Initiatives:</u>
Weekly Patient Experience System Call
Nurse Leader Rounding - Inpatient

<u>AHCG additional actions:</u>
All Clinical Leader Rounding
Inpatient & ED Rounding
Weekly PCE Data Review

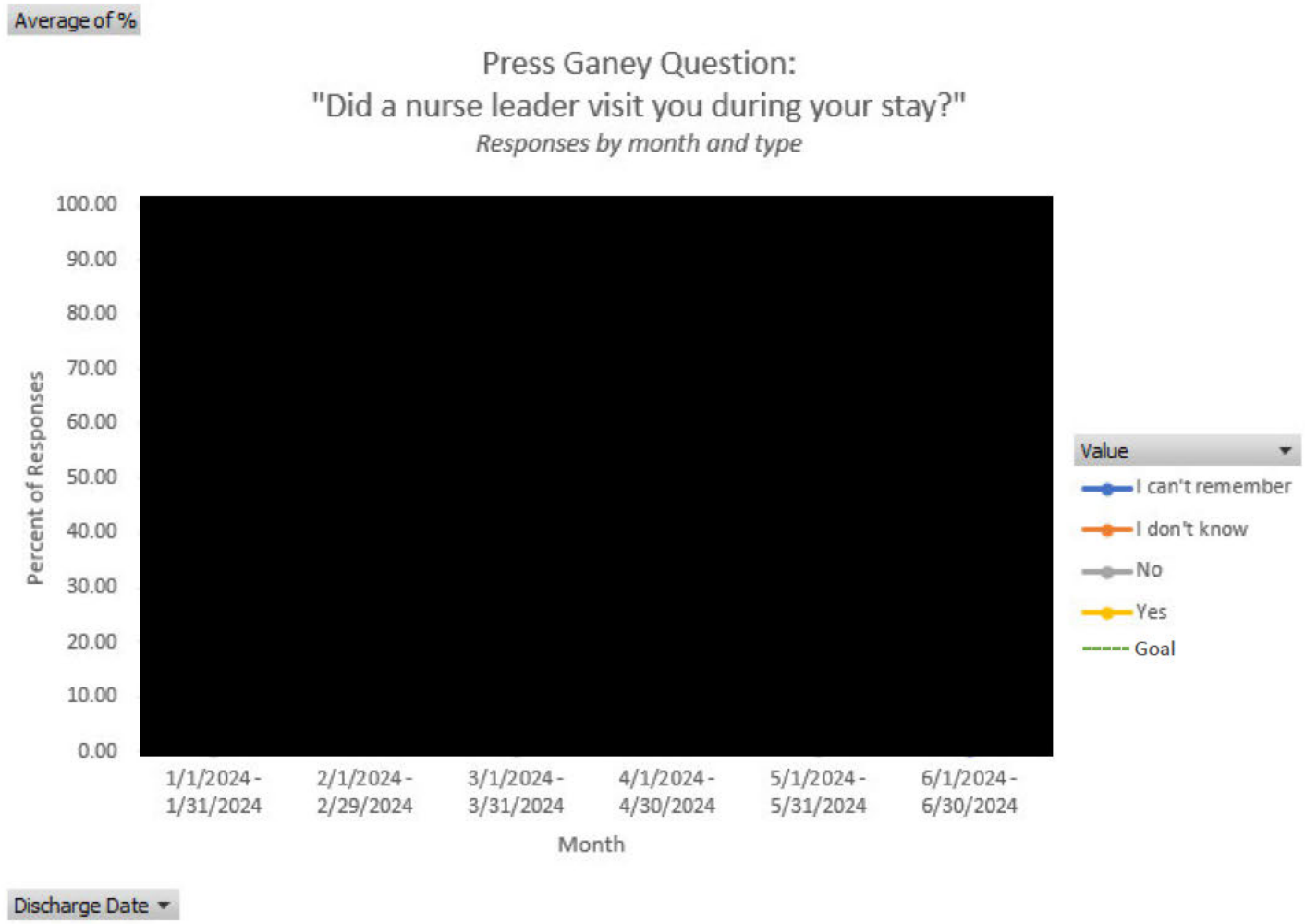


Patient Experience

Nurse Leader Rounding Compliance

June data not complete

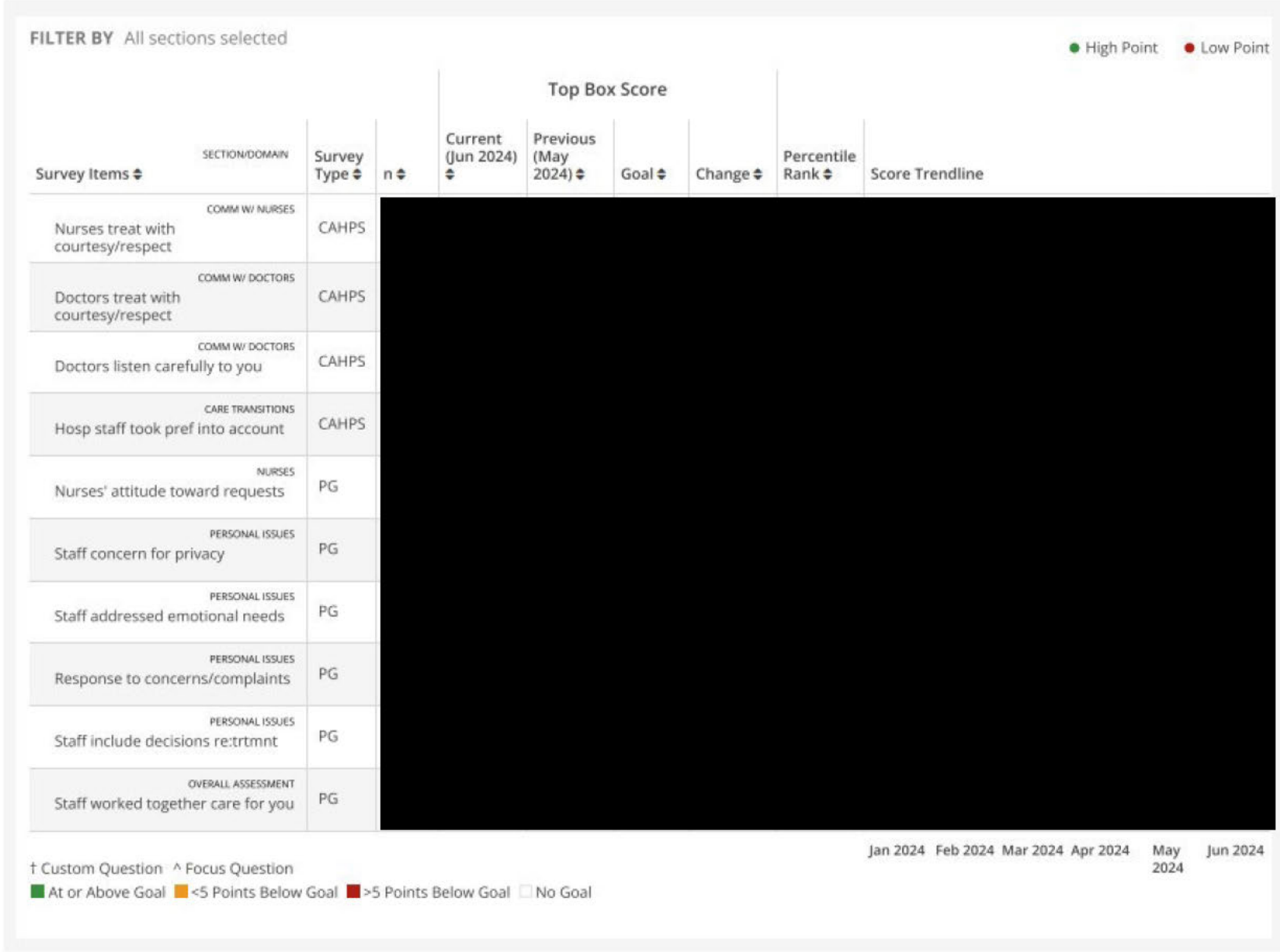
AH System Goal: 65% of patients respond, 'Yes', to the question *"Did a nurse leader visit you during your stay?"*



Patient Experience

Key Drivers:

Likelihood to Recommend



Patient Experience

AH System Measures

Q2 data complete

<u>AH Initiatives:</u>

Weekly Patient Experience System Call

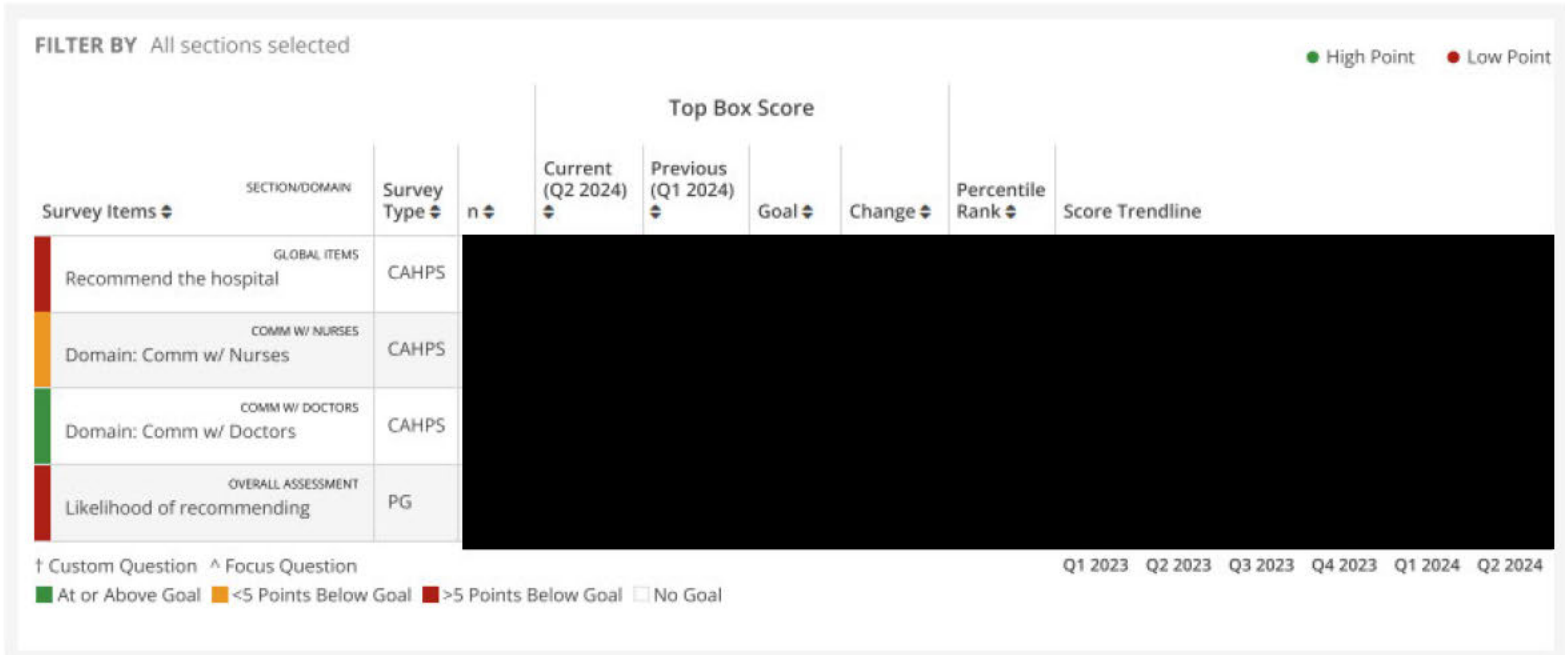
Nurse Leader Rounding - Inpatient

<u>AHCG additional actions:</u>

All Clinical Leader Rounding

Inpatient & ED Rounding

Weekly PCE Data Review



Patient Experience

Nurse Leader Rounding Compliance

July data not complete

AH System Goal: 80% of patients respond, 'Yes', to the question *"Did a nurse leader visit you during your stay?"*

Patient Experience

Top 10 Key Drivers: 'Likelihood to Recommend' current performance, Top 3 graphed

FILTER BY All sections selected

● High Point ● Low Point

SECTION/DOMAIN / Survey Items	Survey Type	n	Top Box Score: Current (Q2 2024)	Previous (Q1 2024)	Goal	Change	Percentile Rank	Score Trendline
COMM W/ NURSES — Nurses treat with courtesy/respect	CAHPS							
COMM W/ DOCTORS — Doctors treat with courtesy/respect	CAHPS							
COMM W/ DOCTORS — Doctors listen carefully to you	CAHPS							
CARE TRANSITIONS — Hosp staff took pref into account	CAHPS							
NURSES — Nurses' attitude toward requests	PG							
PERSONAL ISSUES — Staff concern for privacy	PG							
PERSONAL ISSUES — Staff addressed emotional needs	PG							
PERSONAL ISSUES — Response to concerns/complaints	PG							
PERSONAL ISSUES — Staff include decisions re:trtmnt	PG							
OVERALL ASSESSMENT — Staff worked together care for you	PG							

[redacted]

Q1 2023 Q2 2023 Q3 2023 Q4 2023 Q1 2024 Q2 2024

† Custom Question ^ Focus Question

At or Above Goal <5 Points Below Goal >5 Points Below Goal No Goal

TRENDLINE COMPARISON

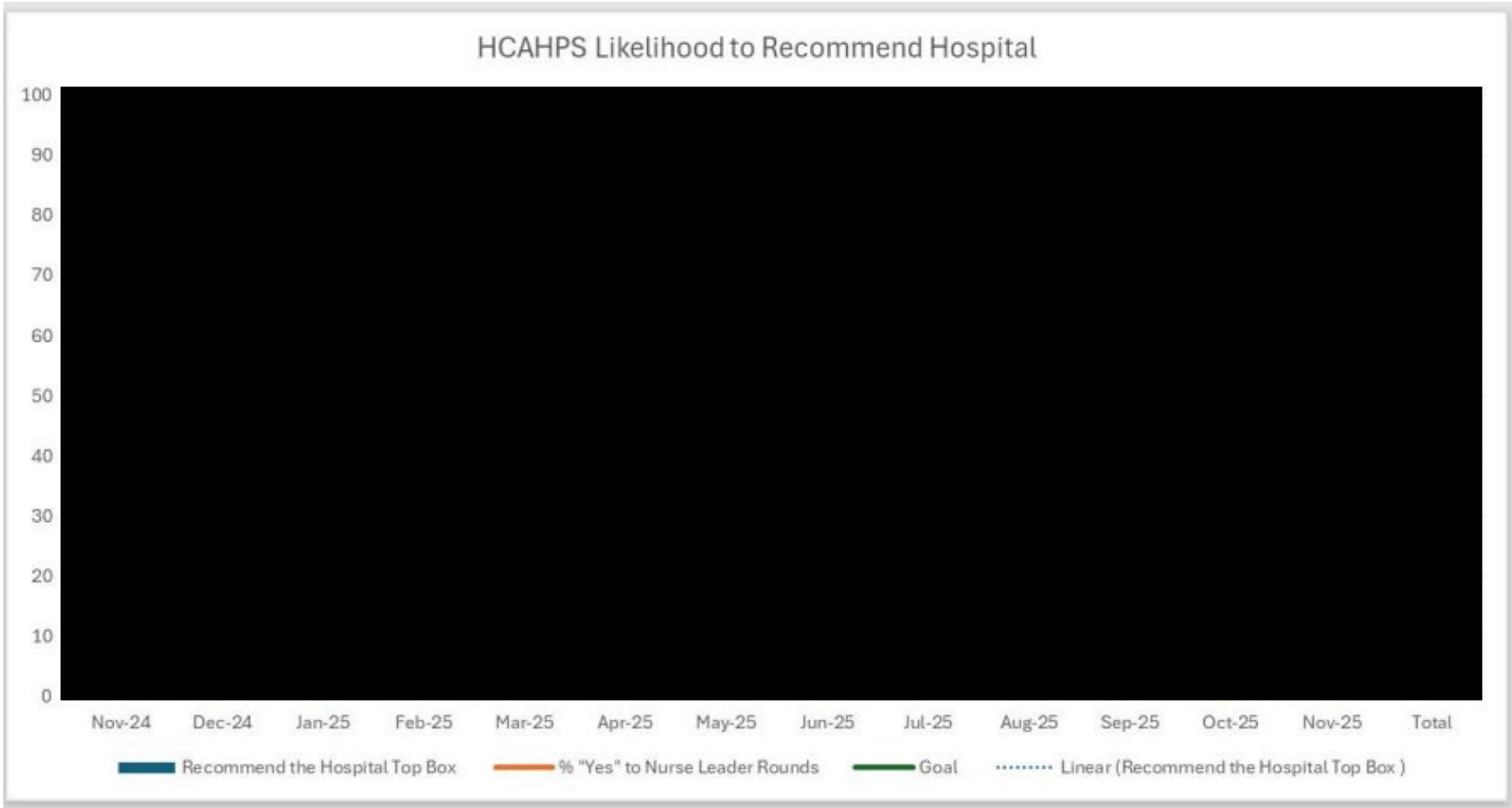
Select up to 5

1. Nurses treat with courtesy/respect
2. Response to concerns/complaints
3. Doctors treat with courtesy/respect

[redacted]

94.48%
82.92%
71.37%
59.81%
48.25%

Q1 2023 Q2 2023 Q3 2023 Q4 2023 Q1 2024 Q2 2024



PATIENT EXPERIENCE – HCAHPS

Adventist Health's 2026 Target Walk (Patient Experience)

HCAHPS Likely to Recommend						
AH Market	Base (Jan - Sep 2025)	N	PR	Min*	2026 Target (TOP)	2026 Stretch (TDP)
AH and Rideout	[redacted]					
AH Bakersfield						
AH Castle						
AH Clear Lake						
AH Delano						
AH Glendale						
AH Hanford						
AH Howard Memorial						
AH Lodi Memorial						
AH Mendocino Coast						
AH Portland						
AH Reedley						
AH Selma						
AH Simi Valley						
AH Sonora						
AH St. Helena						
AH Tehachapi Valley						
AH Tillamook						
AH Tulare						
AH Ukiah Valley						
AH White Memorial						
AH Montebello						
AH Specialty Bakersfield						
AH Columbia Gorge						
AH Sierra Vista						
AH Twin Cities						
AH System						

HCAHPS Nurse Communication						
AH Market	Base (Jan - Sep 2025)	N	PR	Min	2026 Target (TOP)	2026 Stretch (TDP)
[redacted]						

HCAHPS Physician Communication						
AH Market	Base (Jan - Sep 2025)	N	PR	Min	2026 Target (TOP)	2026 Stretch (TDP)
[redacted]						

Mn target = 65th percentile | AHSL/AHTC are excluded from the System rollup

[ADVENTISTHEALTH:INTERNAL]

PATIENT EXPERIENCE – CLINICS, ED, AMBULATORY SURGERY

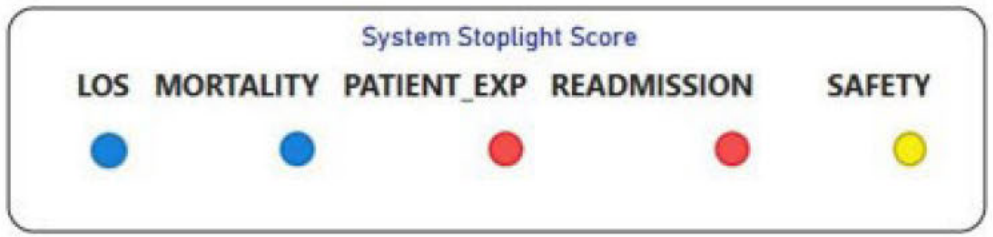
Adventist Health's 2026 Target Walk (Patient Experience)

Clinics Likely to Recommend							ER Likely to Recommend							Ambulatory Surgery Recommend the Facility						
AH Market	Base (Oct 24 - Sep 25)	N	PR	Min	2026 Target (TQP)	2026 Stretch (TDP)	AH Market	Base (Oct 24 - Sep 25)	N	PR	Min	2026 Target (TQP)	2026 Stretch (TDP)	AH Market	Base (Oct 24 - Sep 25)	N	PR	Min	2026 Target (TQP)	2026 Stretch (TDP)
AH and Rideout																				
AH Bakersfield																				
AH Castle																				
AH Clear Lake																				
AH Delano																				
AH Glendale																				
AH Hanford																				
AH Howard Memorial																				
AH Lodi Memorial																				
AH Mendocino Coast																				
AH Portland																				
AH Reedley																				
AH Selma																				
AH Simi Valley																				
AH Sonora																				
AH St. Helena																				
AH Tehachapi Valley																				
AH Tillamook																				
AH Tulare																				
AH Ukiah Valley																				
AH White Memorial																				
AH Montebello																				
AH Specialty Bakersfield																				
AH Columbia Gorge																				
AH Sierra Vista																				
AH Twin Cities																				
AH System																				

Min target = 65th percentile | AHSL/AHTC are excluded from the System rollup

[ADVENTISTHEALTH:INTERNAL]

Adventist Health System Clinical Metrics



Metrics	Timeframes
Mortality **LOS** **Patient Experience**	January - September 2025
Safety	October 2024 – September 2025
Readmissions	December 2024 – August 2025

Market Stoplight Score

EntityName	LOS	MORTALITY	PATIENT_EXP	READMISSION	SAFETY
AH Bakersfield					
AH Castle					
AH Clear Lake					
AH Columbia Gorge					
AH Delano					
AH Glendale					
AH Hanford					
AH Howard Memorial					
AH Lodi Memorial					
AH Mendocino Coast					
AH Portland					
AH Reedley					
AH Rideout					
AH Selma					
AH Simi Valley					
AH Sonora					
AH Specialty Bakersfield					
AH St. Helena					
AH Tehachapi Valley					
AH Tillamook					
AH Tulare					
AH Ukiah Valley					
AH White Memorial					
AH White Memorial Montebello					

Mortality Index

Mid-year Target Revision:

Impact

Adventist Health			PREVIOUSLY APPROVED					MID-YEAR REVISION					Current Performance Jan - May 2025	
Vizient Risk Model	Vizient Cohorts	AH Markets	Baseline (Sep 23 - Aug 24)	Min	2025 Target	Stretch	Vizient 25th (TQP)	Baseline (Sep 23 - Aug 24)	Min	2025 Target	Stretch	Revised Vizient 25th (TQP)	Current Methodology	Mid-Year Revised Methodology
AMC	LSMC	AH Bakersfield	[redacted]											
		AH Glendale												
Community	Complex Care	AH Castle												
		AH Portland												
		AH Rideout												
		AH Simi Valley												
		AH St Helena												
		AH White Memorial												
	Community Community	AH Hanford												
		AH Lodi Memorial												
		AH Montebello												
		AH Sonora												
	Small Community	AH Columbia Gorge												
		AH Delano												
		AH Reedley												
		AH Selma												
		AH Specialty Bakersfield												
		AH Tulare												
		AH Ukiah												
	Critical Access and Small Hospitals	AH Clearlake												
		AH Howard Memorial												
		AH Mendocino												
		AH Tehachapi												
		AH Tillamook												
		SYSTEM *Weighted Averages based on volumes*												

Readmissions Index

Mid-year Adjustments:

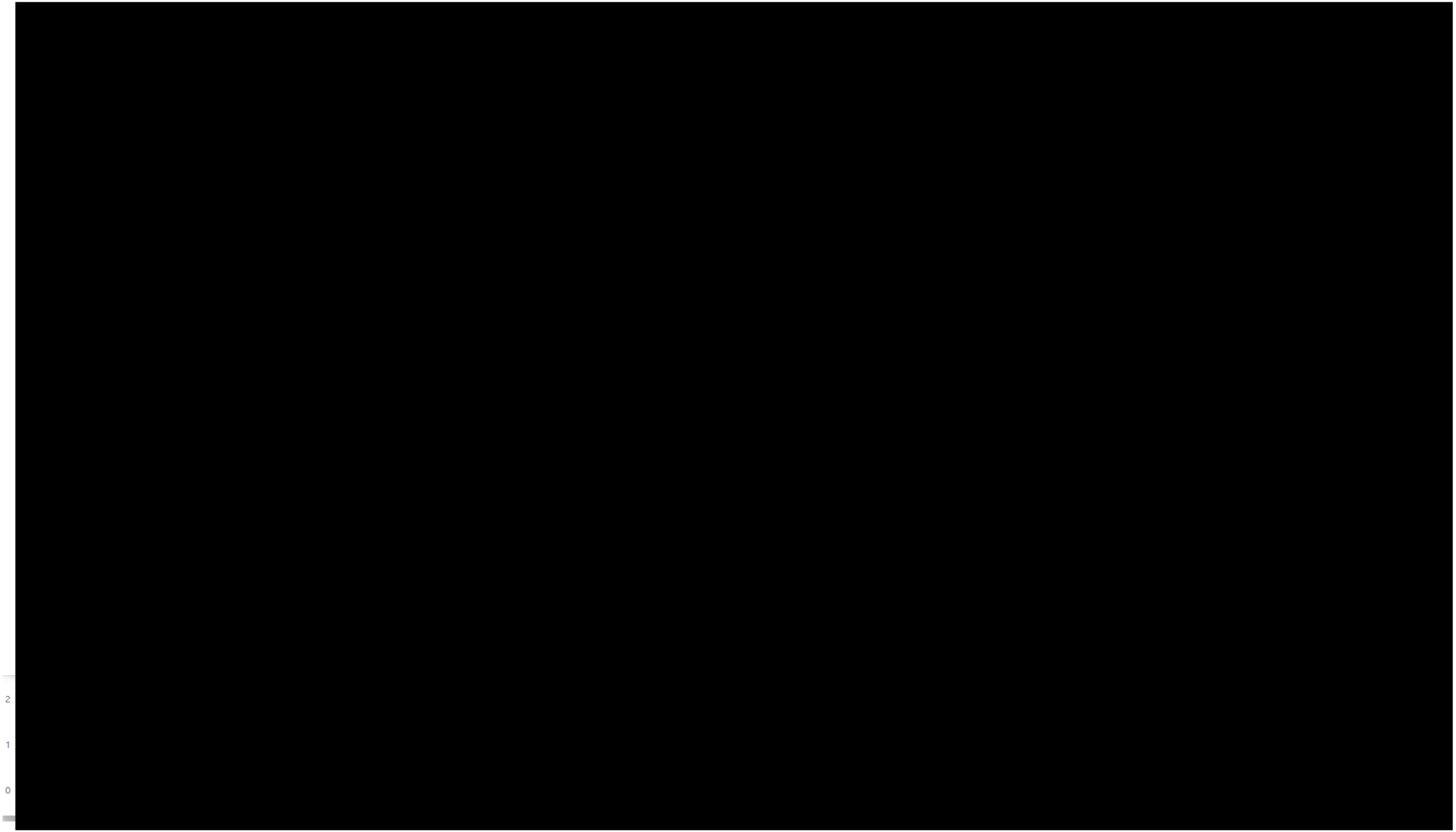
Impact:

Vizient Risk Model	Vizient Cohorts	AH Markets	PREVIOUSLY APPROVED: Baseline (Aug 23 - Jul 24)	PREVIOUSLY APPROVED: Min	PREVIOUSLY APPROVED: 2025 Target	PREVIOUSLY APPROVED: Stretch	PREVIOUSLY APPROVED: Vizient 25th (TQP)	MID-YEAR REVISION: Baseline (Aug 23 - Jul 24)	MID-YEAR REVISION: Min	MID-YEAR REVISION: 2025 Target	MID-YEAR REVISION: Stretch	MID-YEAR REVISION: Revised Vizient 25th (TQP)	Current Performance Dec'24- Apr'25: Current Methodology	Current Performance Dec'24- Apr'25: Mid-Year Revised Methodology
AMC	LSMC	AH Bakersfield												
		AH Glendale												
Community	Complex Care	AH Castle												
		AH Portland												
		AH Rideout												
		AH Simi Valley												
		AH St Helena												
		AH White Memorial												
	Community	AH Hanford												
		AH Lodi Memorial												
		AH Montebello												
		AH Sonora												
	Small Community	AH Columbia Gorge												
		AH Delano												
		AH Reedley												
		AH Selma												
		AH Specialty Bakersfield												
		AH Tulare												
		AH Ukiah												
	Critical Access and Small Hospitals	AH Clearlake												
		AH Howard Memorial												
		AH Mendocino												
		AH Tehachapi												
		AH Tillamook												
		SYSTEM *Weighted Averages based on volumes*												

2025 Adventist Health Clinical Targets

AdventistHealth

Vizient Risk Model	Vizient Cohorts	AH Markets	MORTALITY INDEX					30-DAYS READMISSIONS INDEX					LOS INDEX						SAFETY COMPOSITE			
			Baseline (Sep 23 - Aug 24)	Min	2025 Target	Stretch	Vizient 25th (TQP)	Baseline (Aug 23 - Jul 24)	Min	2025 Target	Stretch	Vizient 25th (TQP)	LOS Mean Observed (days)	Baseline (Sep 23 - Aug 24)	Min	2025 Target	Stretch	Vizient 25th (TQP)	Baseline (Oct 23 - Sep 24)	Min	2025 Target	Stretch
AMC	LSMC	AH Bakersfield	[redacted]																			
		AH Glendale																				
Community	Complex Care	AH Castle																				
		AH Portland																				
		AH Rideout																				
		AH Simi Valley																				
		AH St Helena																				
		AH White Memorial																				
	Community – Community	AH Hanford																				
		AH Lodi Memorial																				
		AH Montebello*																				
		AH Sonora																				
	Community – Small Community	AH Columbia Gorge																				
		AH Delano																				
		AH Reedley																				
		AH Selma																				
		AH Specialty Bakersfield																				
		AH Tulare																				
		AH Ukiah																				
	Critical Access and Small Hospitals	AH Clearlake																				
		AH Howard Memorial																				
		AH Mendocino																				
		AH Tehachapi																				
		AH Tillamook																				
		SYSTEM *Weighted Averages based on volumes*																				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Hospital Compare Preview Report

MID-COLUMBIA MEDICAL CENTER
1700 E 19TH STREET
THE DALLES, OR, 97058

CCN-380001
(541) 296-1111

Facility Type: Short-term
Ownership Type: Voluntary non-profit - Other
Emergency Service: Yes

Star Rating Preview

3 Stars

Summary Score: 0.01

	Standardized Group Score	Weight	Scored Measures	# Measures Better	# Measures Same	# Measures Worse
Timely and Effective Care	[redacted]					
Safety of Care						
Mortality						
Readmission						
Patient Experience						

Mortality

Service Line Performance

Hospital	Cardiology		CT Surgery		Gastroenterology		Medicine General		Neurology		Neurosurgery		Oncology		Ortho/Spine		Pulmonary/Critical Care		Surgery General		Trauma		Vascular Surgery	
	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score
ADVENTIST_BAKERSFIELD																								
ADVENTIST_GLENDALE																								
ADVENTIST_CASTLE																								
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ADVENTIST_SIMIVALLEY																								
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ADVENTIST_HANFORD																								
ADVENTIST_LODI																								
ADVENTIST_MONTEBELLO																								
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ADVENTIST_BAKERSFIELDS																								
ADVENTIST_COLUMBIAGO																								
ADVENTIST_DELANO																								
ADVENTIST_SELMA																								
ADVENTIST_TULARE																								

LOS

Service Line Performance

	Cardiology		CT Surgery		Gastroenterology		Medicine General		Neurology		Neurosurgery		Oncology		Ortho/Spine		Pulmonary/Critical Care		Surgery General		Trauma		Urology		Vascular Surgery	
	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score
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ADVENTIST_BAKERSFIE																										
ADVENTIST_COLUMBIA																										
ADVENTIST_DELANO																										
ADVENTIST_SELMA																										
ADVENTIST_TULARE																										

Readmission

Service Line Performance

Hospital	Cardiology		CT Surgery		Gastroenterology		Medicine General		Neurology		Neurosurgery		Oncology		Ortho/Spine		Pulmonary/Critical Care		Surgery General		Trauma		Vascular Surgery	
	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score
ADVENTIST_BAKERSFIELD	[redacted]																							
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ADVENTIST_BAKERSFIELDS																								
ADVENTIST_COLUMBIAGO																								
ADVENTIST_DELANO																								
ADVENTIST_SELMA																								
ADVENTIST_TULARE																								

Excess Days

Service Line Performance

Hospital	Cardiology		CT		Gastroenterology		Medicine General		Neurology		Neurosurgery		Oncology		Ortho/Spine		Pulmonary/Critical Care		Surgery General		Trauma		Vascular Surgery	
	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score
ADVENTIST_BAKERSFIELD	[redacted]																							
ADVENTIST_GLENDALE																								
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ADVENTIST_COLUMBIAGO																								
ADVENTIST_DELANO																								
ADVENTIST_SELMA																								
ADVENTIST_TULARE																								

Effectiveness

	Lactate level for sepsis patients within 12hrs of admit labs		Transfusion for hemoglobin ≥ 9 prior to first RBC transfusion		Outpatient Procedure Revisits - Colonoscopy		Outpatient Procedure Revisits - Biliary		Outpatient Procedure Revisits - Urological		Outpatient Procedure Revisits – Arthroscopy	
	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score
ADVENTIST_BAKERSFIELD	[redacted]											
ADVENTIST_GLENDALE												
ADVENTIST_CASTLE												
ADVENTIST_PORTLAND												
ADVENTIST_RIDEOUT												
ADVENTIST_SIMIVALLEY												
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ADVENTIST_SONORA												
ADVENTIST_BAKERSFIELDS												
ADVENTIST_COLUMBIAGO												
ADVENTIST_DELANO												
ADVENTIST_SELMA												
ADVENTIST_TULARE												

Safety

Hospital	PSI-03 Pressure Ulcer		PSI-06 Iatrogenic Pneumothorax		PSI-09 Postoperative Hemorrhage or Hematoma		PSI-11 Postoperative Respiratory Failure		PSI-13 Postoperative Sepsis		NHSN-CAUTI SIR		NHSN-CLABSI SIR		HSN-SSI-COLO S		NHSN-CDI SIR		Hypoglycemia and insulin use		Warfarin-elevated INR		THK Complication	
	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score
ADVENTIST_BAKERSFIELD	[redacted]																							
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ADVENTIST_COLUMBIAGO																								
ADVENTIST_DELANO																								
ADVENTIST_SELMA																								
ADVENTIST_TULARE																								

Patient Centeredness																
Hospital	Cleanliness/quietness		Discharge		Doctor		Medications		Nurse		Overall		Responsiveness		Transition of Care	
	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score
ADVENTIST_BAKERSFIELD	[redacted]															
ADVENTIST_GLENDALE																
ADVENTIST_CASTLE																
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ADVENTIST_SIMIVALLEY																
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ADVENTIST_BAKERSFIELDS																
ADVENTIST_COLUMBIAGO																
ADVENTIST_DELANO																
ADVENTIST_SELMA																
ADVENTIST_TULARE																

Direct cost																												
Service Line Performance																												
Hospital	Cardiology		CT Surgery		Gastroenterology		Medicine General		Neurology		Neurosurgery		Oncology		Ortho/Spine		Pulmonary/Critical Care		Surgery General		Trauma		Urology		Vascular Surgery	
	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score	Metric Value	Z-Score
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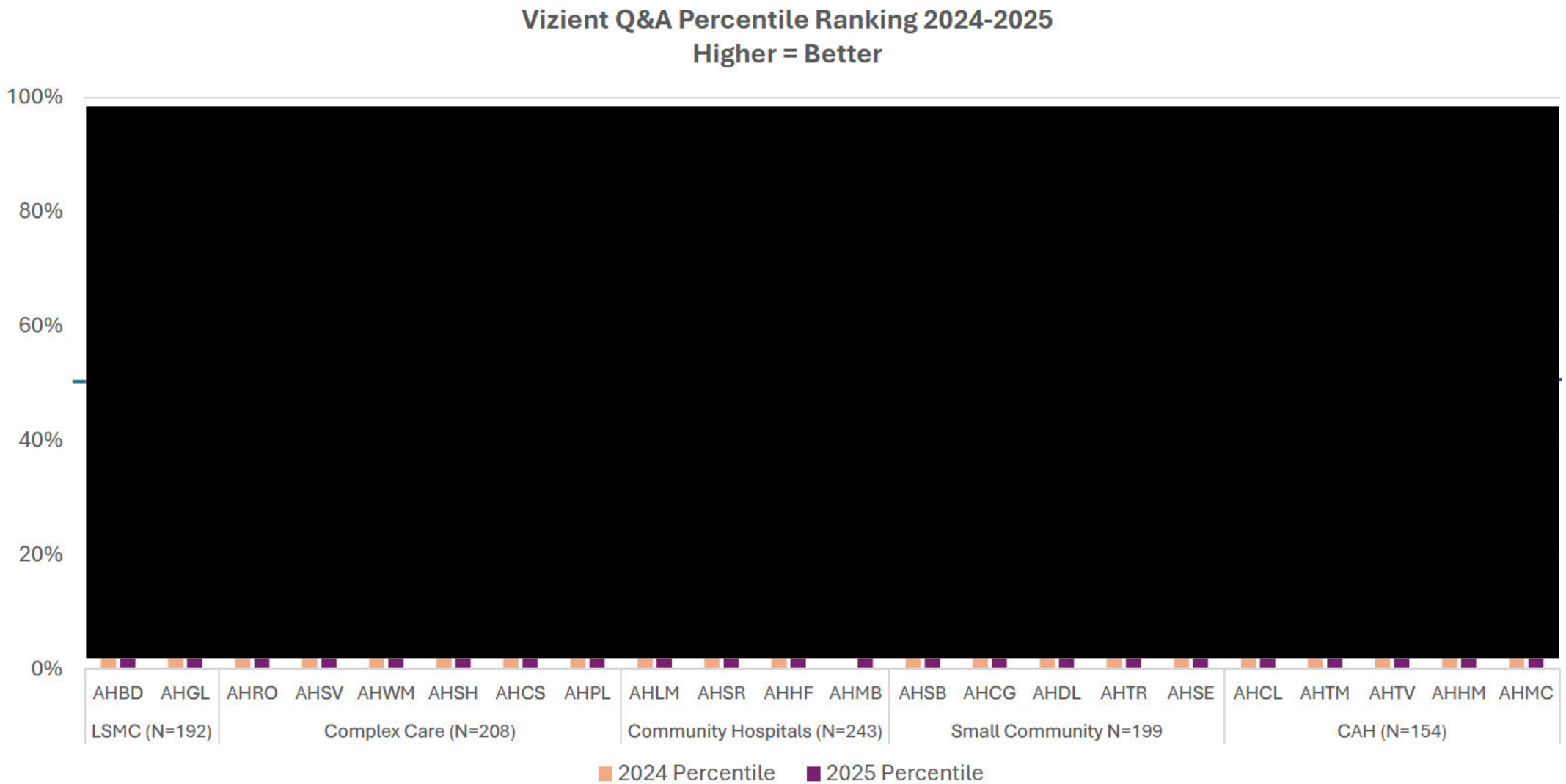
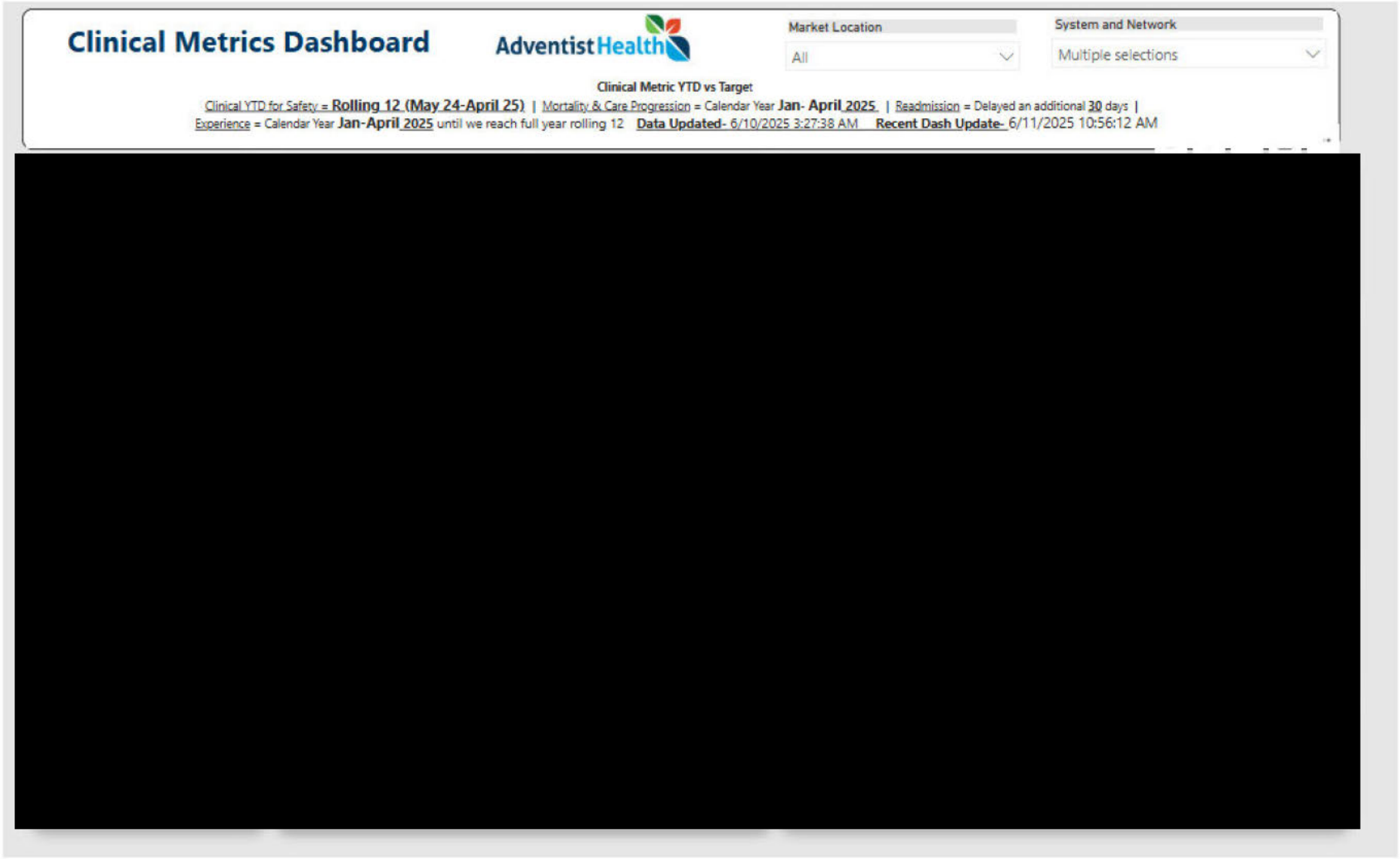
ADVENTIST_COLUMBIAGO																										
ADVENTIST_DELANO																										
ADVENTIST_SELMA																										
ADVENTIST_TULARE																										

Q&A Domain Percentile Rank Performance by hospital					
Hospital	Mortality	Efficiency	Safety	Effectiveness	Patient Centeredness
ADVENTIST_BAKERSFIELD					
ADVENTIST_GLENDALE					
ADVENTIST_CASTLE					
ADVENTIST_PORTLAND					
ADVENTIST_RIDEOUT					
ADVENTIST_SIMIVALLEY					
ADVENTIST_STHELENA					
ADVENTIST_WHITEMEMORIAL					
ADVENTIST_HANFORD					
ADVENTIST_LODI					
ADVENTIST_MONTEBELLO					
ADVENTIST_SONORA					
ADVENTIST_BAKERSFIELDSPECIALTY					
ADVENTIST_COLUMBIAGORGE					
ADVENTIST_DELANO					
ADVENTIST_SELMA					
ADVENTIST_TULARE					

Higher = Better

Vizient Quality and Accountability (Q&A) Annual Report





Clinical Metrics Dashboard

AdventistHealth

Market Location: AH Columbia Gorge

System and Network: Multiple selections

Clinical Metric YTD vs Target

Clinical YTD for Safety = **Rolling 12 (Sept. 24-Aug 25)** | Mortality & Care Progression = Calendar Year **Jan- Aug. 2025** | Readmission = Delayed an additional 30 days **Dec- July 2025** |
Experience = Calendar Year **Jan-Aug 2025** until we reach full year rolling 12 **Data Updated-** 10/9/2025 12:15:57 PM **Recent Dash Update-** 10/9/2025 2:46:01 PM

Clinical Metrics Dashboard

AdventistHealth

Market Location: AH Columbia Gorge

System and Network: Multiple selections

Clinical Metric YTD vs Target

Clinical YTD for Safety = **Rolling 12 (Sept. 24-Oct. 25)** | Mortality & Care Progression = Calendar Year **Jan - Oct. 2025** | Readmission = Delayed an additional **30** days **Dec- Sept 2025** |
Experience = Calendar Year **Jan - Oct 2025** until we reach full year rolling 12 **Data Updated-** 12/4/2025 10:49:06 AM **Recent Dash Update-** 12/11/2025 10:17:03 AM

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Clinical Metrics Dashboard

AdventistHealth

Market Location: AH Columbia Gorge

System and Network: Multiple selections

Clinical Metric YTD vs Target

Clinical YTD for Safety = **Rolling 12 (Dec. 24 - Nov. 25)** | Mortality & Care Progression = Calendar Year **Jan - Nov. 2025** | Readmission = Delayed an additional **30** days **Dec. 24 - Oct 2025** |
Experience = Calendar Year **Jan - Nov. 2025** until we reach full year rolling 12 **Data Updated-** 1/7/2026 4:11:24 AM **Recent Dash Update-** 1/16/2026 10:54:25 AM

Stoplight Dash for Clinical Metrics- Clinical YTD

- Meeting Max Target
- Meeting Target
- Meeting Min Target
- Not Meeting Target

System Stoplight Score

LOS	MORTALITY	PATIENT_EXP	READMISSION	SAFETY
●	●	●	●	●

Market Stoplight Score

EntityName	LOS	MORTALITY	PATIENT_EXP	READMISSION	SAFETY
AH Bakersfield	[redacted]				
AH Castle					
AH Clear Lake					
AH Columbia Gorge					
AH Delano					
AH Glendale					
AH Hanford					
AH Howard Memorial					
AH Lodi Memorial					
AH Mendocino Coast					
AH Portland					
AH Reedley					
AH Rideout					
AH Selma					
AH Simi Valley					
AH Sonora					
AH Specialty Bakersfield					
AH St. Helena					
AH Tehachapi Valley					
AH Tillamook					
AH Tulare					
AH Ukiah Valley					
AH White Memorial					
AH White Memorial Montebello					

Hospital Readmission Reduction Program (HRRP)

Systemwide Impact

[redacted]

Market	2025 HRRP Penalty	2026 HRRP Penalty
Performance Period	July 20 - June 23	July 21 - June 24
[redacted]		

Market	AMI	COPD	HF	PNA	TKA/THA	CABG
National Rates	13.3%	18.3%	19.6%	16.0%	4.9%	10.5%
AHBD	[redacted]					
AHCG						
AHCS						
AHDL						
AHGL						
AHHF						
AHLM						
AHPL						
AHRO						
AHSH						
AHSL						
AHSR						
AHSV						
AHTC						
AHTR						
AHUV						
AHWM						

CMS Penalty Indicator

Exhibit 8

New Termination of Pregnancy Policy

Termination of Pregnancy

Disclaimer

Approvals

- Committee Approval: Medical Staff Executive Committee (MEC) approved on 12/18/2024
- Committee Approval: Community Board Clinical Committee (CBCC) approved on 1/23/2025
- Committee Approval: Perinatal Committee approved on 11/20/2024

Revision Insight

Document ID:	12408
Revision Number:	0
Owner:	Shayla A Stankwitz, Manager, RN
Revision Official Date:	1/24/2025

Revision Note:
No revision note

Adventist Health
Columbia Gorge

☒ Systemwide Standard Policy
☐ Systemwide Model Policy

Standard Policy No. 12408
Approval Pathway: Clinical
Department: Nursing

STANDARD POLICY: TERMINATION OF PREGNANCY

Adventist Health Columbia Gorge 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.

Adventist Health believes a person's ability to make decisions about their health and well-being should not be limited by resources, bias, prejudice, or absence of care. Adventist Health honors the sanctity of the patient-physician relationship, and respects each patient's decision-making about their healthcare needs, including patients seeking reproductive care and services. Adventist Health does not direct healthcare providers regarding contraception and pregnancy-ending medications. This policy regarding termination of pregnancy is not subject to ethical and religious directives from any church or other religious organization. Adventist Health affirms the special trust-based relationship that exists, and the decisions made between patients and their physicians about their healthcare needs, including reproductive care.

Adventist Health adheres to all applicable Federal and/or State laws, including reporting requirements.

DEFINITIONS:

1. **Facility:** In this policy, "Facility" refers to all Adventist Health clinical sites.

AFFECTED DEPARTMENTS/SERVICES:

All Clinical Departments

POLICY: COMPLIANCE – KEY ELEMENTS:

A. **Termination of Pregnancy:**

1. All human life deserves respect. Every reasonable effort must be made to nourish, support, and value life.
2. Facility does not permit surgical termination of pregnancy for reasons of birth control, gender selection or convenience.
3. No member of the medical staff nor associate of the Facility is required to participate in any termination of pregnancy.[1]
4. Adventist Health does not direct physicians/providers at the Facility on referrals, contraception, or hormonal therapies.

ATTACHMENTS:
(REFERENCED BY THIS DOCUMENT)

OTHER DOCUMENTS: (WHICH REFERENCE THIS DOCUMENT)	
FEDERAL REGULATIONS:	
ACCREDITATION:	
CALIFORNIA:	**Not applicable**
HAWAII:	**Not applicable**
OREGON:	**Not applicable**
WASHINGTON:	**Not applicable**
REFERENCES:	**(1) CA Health and Safety Code 123420 (a)**
ADVENTIST HEALTH SYSTEM/WEST POLICY OWNER:	**General Counsel**
ENTITY POLICY OWNER:	**Director, RN**
APPROVED BY:	
ADVENTIST HEALTH SYSTEM/WEST:	**(10/10/2022) Clinical Cabinet (CC), (10/20/2022) AH System Board**
ADVENTIST HEALTH SYSTEM/WEST INDIVIDUAL:	
ENTITY:	**(11/20/2024) Perinatal Committee, (12/18/2024) Medical Staff Executive Committee (MEC), (01/23/2025) Community Board Clinical Committee (CBCC)**
ENTITY INDIVIDUAL:	
REVIEW DATE:	
REVISION DATE:	**08/07/2019, 04/08/2020, 01/13/2022, 10/24/2022**
NEXT REVIEW DATE:	**01/24/2028**
APPROVAL PATHWAY:	**Clinical**

REDACTION LOG
Transaction 006: Adventist-MCMC
Response to OHA Information Request
For Two-Year Follow-Up Review
February 25, 2026

Page/Reference	Information Redacted	Statutory Basis
Exhibit 6.a., Community Board Minutes, May 22, 2024, p. 1.	Personal information about hospital board members	ORS Sec. 415.501(13)(c); 192.355(3)
Exhibit 6.a., Community Board Minutes, May 22, 2024, p. 2.	Personal information about hospital providers	ORS Sec. 415.501(13)(c)
Exhibit 6.a., Community Board Minutes, Aug. 28, 2024, p. 4.	Personal information about potential hospital board members	ORS Sec. 415.501(13)(c); 192.355(3)
Exhibit 6.a., Community Board Minutes, Nov. 20, 2024, p. 3.	Personal information about a candidate for a physician job role	ORS Sec. 415.501(13)(c)
Exhibit 6.a., Community Board Minutes, Nov. 20, 2024, p. 4.	Personal information about currently-serving and potential hospital board members	ORS Sec. 415.501(13)(c); 192.355(3)
Exhibit 6.a., Community Board Minutes, Feb. 19, 2025, p. 2.	Competitively sensitive information about the hospital's physician management outcomes	ORS Secs. 415.501(13)(c); 192.345(2)
Exhibit 6.a., Community Board Minutes, May 28, 2025, p. 4.	Personal information about a hospital provider	ORS Sec. 415.501(13)(c); 192.345(12)
Exhibit 6.b., Community Board Roster	Home addresses and other contact information of hospital board members	ORS Sec. 415.501(13)(c)
Exhibit 7, AHCG Quality & Safety Dashboards	Confidential, privileged, and competitively-sensitive information about AHCG's (and other Adventist hospitals' and facilities') quality, safety, patient satisfaction, risk, and legal outcomes and opportunities.	ORS Secs. 415.501(13)(c); 192.345(2); 41.675