

Adventist Health Tillamook 2022 Community Health Plan



The following Implementation Strategy serves as the 2020 – 2022 Community Health Plan for Adventist Health Tillamook and is respectfully submitted to the Office of Statewide Health Planning and Development on May 19th, 2023 reporting on 2022 results.

Executive Summary

Introduction & Purpose

Adventist Health Tillamook is pleased to share its Community Health Implementation Strategy. This follows the development of its 2019 Community Health Needs Assessment (CHNA) in accordance with requirements in the Affordable Care Act and IRS 990 Schedule H requirements and approved by the Adventist Health Board of Directors on October 17, 2019.

After a thorough review of the health status in our community through the community health needs assessment (CHNA), we identified areas that we could address using our resources, expertise and community partners. Through these actions and relationships, we aim to empower our community and fulfill our mission of “Living God’s love by inspiring health, wholeness and hope.”

Adventist Health Tillamook, through a collaborative partnership with Tillamook County Community Health Centers, Rinehart Clinic & Pharmacy and Tillamook Family Counseling Center, conducted the 2019 CHNA. Adventist Health Tillamook assessed the health needs identified in the CHNA and directly aligned community programs and outcome measures with the Columbia Pacific Coordinated Care Organization’s (CCO) 2020 community health plan. This collaboration and alignment allowed for the prioritization of community health programs which best provide for our community and the vulnerable among us.

This Implementation Strategy summarizes the plans for Adventist Health Tillamook to develop and collaborate on community benefit programs that address prioritized health needs identified in its 2019 CHNA. Adventist Health Tillamook has adopted the following priority areas for our community health investments.

Prioritized Health Needs – Adventist Health Tillamook will address in our Community Health Plan

- [Health Priority #1: Housing and Homelessness](#)
- [Health Priority #2: Mental Health](#)
- [Health Priority #3: Access to Health Care](#)
- [Health Priority #4: Prevention and Management of Chronic Diseases](#)

Building a healthy community requires multiple stakeholders working together with a common purpose. We invite you to explore how we intend to address health challenges in our community and partner to achieve change. More importantly, we hope you imagine a healthier

region and work with us to find solutions across a broad range of sectors to create communities that define the well-being of people.

The purpose of the CHNA was to offer a comprehensive understanding of the health needs in Adventist Health Tillamook service area and guide the hospital's planning efforts to address those needs.

The significant health needs were identified through an analysis of primary and secondary data and community input. These health needs were prioritized according to a set of criteria that included the following twelve items: identified community need, addressing the disparities of subgroups, availability of evidence or practice-based approaches, community assets and internal resources for addressing needs, existing resources and programs, feasibility of intervention, importance to the community, magnitude, mission alignment and resources of the hospital, opportunity to intervene at population level, severity and whether the solutions could impact multiple problems.

For further information about the process to identify and prioritize significant health needs, please refer to Adventist Health Tillamook CHNA report at the following link:

<https://www.adventisthealth.org/about-us/community-benefit/>

Adventist Health Tillamook and Adventist Health

Adventist Health Tillamook is an affiliate of Adventist Health, a faith-based, nonprofit integrated health system serving more than 80 communities on the West Coast and Hawaii.

Vision

We will transform the health experience of our communities by improving health, enhancing interactions and making care more accessible.

Mission Statement

Living God's love by inspiring health, wholeness and hope.

Adventist Health Includes:

- 23 hospitals with more than 3,393 beds
- 370 clinics (hospital-based, rural health and physician clinics)
- 14 home care agencies and eight hospice agencies
- 3 retirement centers & 1 continuing care retirement community

- A workforce of 37,000 including medical staff physicians, allied health professionals and support services

We owe much of our heritage and organizational success to the Seventh-day Adventist Church, which has long been a promoter of prevention and whole person care. Inspired by our belief in the loving and healing power of Jesus Christ, we aim to bring physical, mental and spiritual health and healing to our neighbors of all faiths. Every individual, regardless of his/her personal beliefs, is welcome in our facilities. We are also eager to partner with members of all faiths to enhance the health of the communities we serve.

Our commitment to quality health care stems from our heritage, which dates to 1866 when the first Seventh-day Adventist healthcare facility opened in Battle Creek, Michigan. There, dedicated pioneers promoted the “radical” concepts of proper nutrition, exercise and sanitation. Early on, the facility was devoted to prevention as well as healing. They called it a sanitarium, a place where patients—and their families—could learn to be well.

More than a century later, the health care system sponsored by the Seventh-day Adventist Church circles the globe with more than 170 hospitals and more than 500 clinics, nursing homes and dispensaries worldwide. And the same vision to treat the whole person—mind, body and spirit—continues to provide the foundation for our progressive approach to health care.

Summary of Implementation Strategies

Implementation Strategy Design Process

Stakeholders from the 19 hospital facilities in the Adventist Health System were invited to participate in a Mission Integration Summit on September 26 and 27, 2019. During these two day-long events, participants were introduced to the 2019 Adventist Health Implementation Strategy Template. After the summit, each hospital was invited to participate in a series of technical assistance calls and consultation sessions with representatives from Adventist Health Community Integration and Conduent Health Communities Institute to further develop and refine their implementation strategy.

Adventist Health Tillamook Implementation Strategy

The implementation strategy outlined below summarizes the strategies and activities by Adventist Health Tillamook to directly address the prioritized health needs. They include:

- **Health Need 1: Housing and Homelessness**
 - Contribute staff time, direct and in-kind resources through community partnerships to increase the number of affordable and attainable dwelling units in Tillamook County.
 - Conduct closed-loop referrals to help low-income individuals access support for housing and other basic social determinants of health.
- **Health Need 2: Mental Health**
 - Provide telehealth mental health services through our medical offices.
 - Increase education on mental health services for people with substance use disorder (SUD) and / or opioid use disorder (OUD).
 - Work with community partners to further develop mental health services.
 - Develop a comprehensive medication assisted treatment (MAT) program.
- **Health Need 3: Access to Health Care**
 - Explore and create a mobile integrated healthcare team.
 - Identify and employ Health Promoters (Community Health Workers) as part of our mobile integrated healthcare team.
 - Prioritize and implement secure, closed-loop referral platform.
 - Screening and referrals for early childhood developmental needs.
- **Health Need 4: Prevention and Management of Chronic Disease**
 - Deploy mobile integrated care team to improve follow-up and health behavior maintenance among chronically ill and discharged patients.
 - Expand delivery of shared medical appointments via Lifestyle Medicine program.
 - Continue our partnership with Tillamook County Wellness programs.

The Action Plan presented below outlines in detail the individual strategies and activities Adventist Health Tillamook will implement to address the health needs identified through the CHNA process. The following components are outlined in detail in the tables below: 1) actions the hospital intends to take to address the health needs identified in the CHNA, 2) the anticipated impact of these actions as reflected in the Process and Outcomes measures for each activity, 3) the resources the hospital plans to commit to each strategy, and 4) any planned collaboration to support the work outlined.

No hospital can address all the health needs identified in its community. Adventist Health Tillamook is committed to serving the community by adhering to its mission, and using its skills, expertise and resources to provide a range of community benefit programs. When developed in 2019, this Implementation Strategy did not include specific plans to address the following significant health needs identified in the 2019 CHNA.

Significant Health Needs – Activities NOT included in the 2020 Community Health Plan

Physical Environment, Safety, Access to Parks and Recreation

- We are currently partnered with the Tillamook YMCA which provides free services to community members, including offering programming to seniors age 60 and over and people with disabilities at no charge. Examples include: Tai Chi: Moving for Better Balance, Enhance Fitness, Qigong, and a pool-based arthritis class.
- Oregon Coast Visitors Association and Tillamook Coast Visitors Association have had good results facilitating investment in outdoor recreation facilities that promote activities such as hiking, biking, kayaking, boating and camping, among others.
- AH Tillamook will continue to partner with Tillamook County Wellness to provide collaboration to increase safe access to physical built environments, including coordination and promotion of detailed, interactive recreational maps.

COVID 19 Considerations

The COVID-19 global pandemic caused extraordinary challenges for Adventist Health hospitals and health care systems across the world. Diversion of resources, workforce shortages, burnout and other mental health concerns have taken a toll. Providing care in rural communities is a challenge under typical circumstances. The recent pandemic exacerbated those challenges and has affected our ability to meaningfully support community health and well-being in the ways we planned.

Adventist Health, like other health care systems, had to pivot its focus to meet the most urgent healthcare needs of its community during the pandemic, as well as reassess the ability to continue with some community health strategies due to public health guidelines for social distancing. Adjustments have been made to continue community health improvement efforts as possible, while ensuring the health and safety of those participating. The Strategy Action Plan Grids on the following pages reflect updated activities for each strategy.

In 2021, Adventist Health as a system took the following actions in response to the needs created or exacerbated by COVID-19:

- Began offering more virtual health care visits to keep community members safe and healthy.
- Developed an online symptom tracker to help community members determine if they may have COVID-19 or some other flu type illness and what steps to take.
- Active participation in a countywide, collaborative effort to vaccinate eligible community members to help stop the spread of the virus.

Locally, Adventist Health Tillamook (AHTM) took these additional actions:

- On-going monitoring of needs and actions by the COVID-19 Incident Command Team.
- Offered walk-in COVID testing and vaccination sites.
- Market President conducted daily COVID-related status reports, including case counts, local and regional response capacity.
- Hospital leadership participated in community COVID strategic planning, response and public outreach, including weekly radio broadcasts.
- On-going collaboration among Tillamook County vaccine partners to plan, coordinate and execute vaccination distribution throughout Tillamook County.

Adventist Health Tillamook

PRIORITY HEALTH NEED: HOUSING & HOMELESSNESS

GOAL STATEMENT: PARTNER ACROSS SECTORS TO REDUCE THE IMPACT THAT HOUSING INSECURITY HAS ON HEALTH AND WELLBEING FOR ALL INDIVIDUALS IN TILLAMOOK COUNTY.

Mission Alignment: Well-being of People

Strategy 1: Partner to support community action programs, and community-based organizations that provide shelter/transitional housing supports in the region.

Programs/ Activities	Process Measures	Results: Year 1	Short Term Outcomes	Results: Year 2	Medium Term Outcomes	Results: Year 3
<i>Activity 1.1 Housing Commission Appointment</i>	Create Communication plan: # of Media touches related to housing	See narrative below	Acres of developable land	On-going, Not done	Number of available dwelling units	133 new affordable and/or workforce units started
<i>Activity 1.2 Referrals for housing assistance</i>	Closed-loop referral process in place for housing assistance (CARE, Helping Hands)	Completed	Increased # of AHTM referrals for housing using the Connect Oregon Network (Unite Us)	8 closed- loop housing/s helter referrals	# of individuals who safely transition into housing programs	Transitional housing assistance provided to 16 households, affecting 21 individuals

Source of Data:

- AHTM Electronic Medical Records for housing referrals and/or Unite Us reports for housing referrals
- CARE, Inc. and/or Helping Hands
- Tillamook County Housing Commission and Oregon Housing Alliance

Target Population(s):

- Individuals with housing insecurities and / or homelessness

Adventist Health Resources:

- Financial
- Staff
- Cash & In-Kind Donations

Collaboration Partners: (place a "*" by the lead organization if other than Adventist Health)

- *Tillamook County Housing Commission
- CARE, Inc.
- Helping Hands
- Tillamook Seventh-day Adventist Church
- AH Tillamook
- Media Partners (Headlight-Herald, Tillamook County Pioneer, KTIL Radio, etc.)

PRIORITY HEALTH NEED: HOUSING & HOMELESSNESS**CBISA Category:** (A - Community Health Improvement; E - Cash and In-Kind; F - Community Building; G - Community Benefit Operations)**Strategy Results 2022:**

All 2021 activities have continued or have been expanded.

Housing Commission: In 2022, the Housing Commission established and began distributing funds from Short Term Rental Operator fees, to help offset costs for workforce housing development. Funds were distributed to six developers to further development of a total of 87 new housing units. In addition, members of the Housing Commission presented public testimony in favor of a multi-family housing development that came under public appeal. After testimony from members of the Housing Commission, including the large employer representative from AHTM, the City Council voted in favor of the development, bringing 46 new affordable apartments to the city proper. Work continues on creating a developable lands inventory. Additionally, Brownfields grant funding was awarded in 2022, with up to 6 assessment sites, targeting housing development. Finally, the Housing Commission was instrumental in getting an ordinance passed to permit Accessory Dwelling Units (ADUs) in incorporated communities of Tillamook County. Through the Housing Commission's public outreach committee's efforts, these measures are helping expand housing stock as well as generating a sense of hope and optimism among residents, employers and policy makers regarding our housing crisis. The AHTM Well-Being Director continues to serve as an active member of the Housing Commission.

CARE, Inc.: In partnership with CARE, Inc., during 2022, 16 households were provided transitional housing assistance, affecting a total of 21 individuals. Through state funded rental assistance programs 33 households were served, totaling 88 people.

PRIORITY HEALTH NEED: MENTAL HEALTH

GOAL STATEMENT: ALLOW ACCESS TO AND CAPACITY FOR ANY INDIVIDUAL SEEKING MENTAL HEALTH SERVICES

Mission Alignment: Well-being of People

Strategy 1: Increase access to mental and behavioral health and treatment for substance use disorders through new services, education and partnerships.

Programs/ Activities	Process Measures	Results: Year 1	Short Term Outcomes	Results: Year 2	Medium Term Outcomes	Results: Year 3
<i>Activity 1.1 Increase education and trainings related to SUD and / or OUD through O.U.R. Tillamook</i>	Create messaging campaign, informational website and provider trainings	Website & training completed	Number of AH behavioral health providers who have completed training	1	10% increase in AH provider trainings (initial or continuing education)	Hazelden Betty Ford held three sessions about SUD/OD: science behind SUD, Treatments and therapies, serving pts with SUD/OD.
<i>Activity 1.2 Develop comprehensive medication assisted treatment (MAT) program</i>	Development of a comprehensive model which supports MAT programs	See narrative below	Number of AH behavioral health providers who complete training	0	10% increase in AH behavioral health provider trainings (initial or continuing education)	Dr. Williams offered technical assistance three separate times around providing MAT.

Source of Data:

- AH Tillamook
- O.U.R. Tillamook

Target Population(s):

- Anyone seeking mental health services

Adventist Health Resources:

- Financial
- Staff
- In-kind donations

Collaboration Partners: (place a "*" by the lead organization if other than Adventist Health)

- AH Tillamook
- O.U.R. Tillamook (HRSA funded grant)

CBISA Category: (A - Community Health Improvement; E - Cash and In-Kind; F - Community Building; G - Community Benefit Operations)

- A- Community Health Improvement

Strategy Results 2022:

Opioid Use Response: The O.U.R. Tillamook consortium, funded by the aforementioned RCORP-I grant, continued and expanded the work from previous years and received newly available funding from Oregon's Measure 110.

OUR Tillamook accomplishments include:

- Five O.U.R. Tillamook partners received \$2.2 Million from Measure 110 to create a Behavioral Health Resource Network (BHRN) for Tillamook County
- Distributed 16 additional naloxboxes to local businesses and organizations.
- Distributed free naloxone at the Tillamook County Fair adding 200 more kits out in the community.
- Hosted Hazelden Betty Ford Foundation to provide five SUD/OD training events. Almost 100 professionals in healthcare and supportive services attended.

PRIORITY HEALTH NEED: ACCESS TO HEALTH CARE

GOAL STATEMENT: ELIMINATE BARRIERS TO PRIMARY CARE, INCLUDING, GEOGRAPHIC AND TRANSPORTATION INCONVENIENCES, LACK OF KNOWLEDGE, AND LACK OF INSURANCE COVERAGE.

Mission Alignment: Well-being of People

Strategy 1: Increase access to primary care through programs that seek to address barriers by engaging in the community.

Programs/ Activities	Process Measures	Results: Year 1	Short Term Outcomes	Results: Year 2	Medium Term Outcomes	Results: Year 3
<i>Activity 1.1 Explore and create a mobile integrated healthcare team</i>	Develop and implement program	In process	# of people served (meals, other services...)	1,722	10% increase in the number of people served	Provided 977 documented mobile healthcare services in 2022
<i>Activity 1.2 Connect Oregon Network (UniteUs)</i>	Prioritize and implement integration of a secure community- referral platform	Comple ted in 2021	# of trained staff with program access	14	# of referrals for community-based services and programs	3 initial referrals. Pivoted to integration of Unite Us into EHR (Cerner) to facilitate workflows
<i>Activity 1.3 Screening for early childhood developmental delays</i>	All providers seeing children (especially ages 0-5) are screening for developmental delays	3 providers meeting this	# of trained staff # of screenings # of PTOT/Speech encounters	Not actively pursued due to staff capacity issues	# of closed loop referrals for developmental and pediatric behavioral health services Revenue generated from increase in encounters	Not actively pursued due to staff capacity issues

Source of Data:

- AH Tillamook
- UniteUs Reports
- Early Intervention Services/Northwest Regional Education Service District

Target Population(s):

- Individuals in need of increased access to healthcare, community programs and social services

Adventist Health Resources:

- Financial
- Staff
- Supplies

PRIORITY HEALTH NEED: ACCESS TO HEALTH CARE

- In-kind donations

Collaboration Partners: (place a “*” by the lead organization if other than Adventist Health)

- AH Tillamook
- Tillamook County Wellness
- UniteUs (funding through Columbia Pacific CCO)
- Tillamook School District 9
- Approx. 30 Community-Based Organizations (CBOs)

CBISA Category: (A - Community Health Improvement; E - Cash and In-Kind; F - Community Building; G - Community Benefit Operations)

* A- Community Health Improvement

Strategy Results 2022:

Community Based Care: Documented 977 mobile/community-based care visits in 2022 in Vernonia, Oregon clinic. Significantly more visits occurred in Tillamook Plaza clinic; however, due to staff capacity constraints these have not been documented. Mobile visits include pharmacy deliveries, home and street well-checks, senior center visits, community outreach events (e.g. Homeless Connect), adolescent sports physicals, and flu/vaccine clinics.

Connect Oregon Network (Unite Us): In early 2022, we conducted 3 successful closed-loop referrals. It was determined that making closed-loop referrals for health-related social needs would be more achievable if the Unite Us platform was integrated into our Cerner Electronic Medical Records system. Rather than moving forward with the planned implementation of Unite Us, we pivoted to working with the Adventist Health system IT division and Unite Us to integrate the platforms. This took almost one year to complete and went live in January 2023. The net effect of this work during 2022, is that care teams can now launch the community referral platform within the patient chart and have the patient’s information automatically pull into the referral platform, saving several steps and valuable time, thus making it more likely we can make referrals for social determinants of health (SDOH) in the future. This is also timely given the new Joint Commission requirement to begin screening and referring for social determinants of health.

PRIORITY HEALTH NEED: PREVENTION AND MANAGEMENT OF CHRONIC DISEASES

GOAL STATEMENT: DECREASE CHRONIC DISEASE PREVALENCE THROUGH FOCUS ON REDUCING CHRONIC DISEASE RISK FACTORS.

Mission Alignment: Well-being of People

Strategy 1: Provide follow up care to high-risk individuals and partner to increase lifestyle management programs targeted to those with chronic disease.

Programs/ Activities	Process Measures	Results: Year 1	Short Term Outcomes	Results: Year 2	Medium Term Outcomes	Results: Year 3
<i>Activity 1.1 Follow up process for critically ill and discharged patients</i>	# of patients recently discharged or at high risk receiving visits from mobile integrated healthcare team.	See narrative regarding community based care	Decrease in: emergency room visits, urgent care visits, and readmissions	68 Readmissions (66 in 2020)	Decrease in: emergency room visits, urgent care visits, and readmissions, specifically level 4 and 5	56 emergency room visits in 2022 (17.6% reduction over prior year)
<i>Activity 1.2 Screen for prediabetes</i>	Internally operationalize pre-diabetes screening: - Communication - Clinician buy-in	2 providers participating	Increased # of at-risk patients screened for prediabetes	3 referrals not operationalized	# of closed loop referrals to NDPP (National Diabetes Prevention Program)	4 closed loop referrals(see narrative)
<i>Activity 1.3 Lifestyle Medicine</i>	Number of patients enrolled in Lifestyle Medicine program	N/A	# of participants who are diagnosed with: - Diabetes - Hypertension - Obesity - Cholesterol	N/A	# of participants referred to community lifestyle programs # of continuing participants with: - Diabetes - Hypertension - Obesity - Cholesterol	N/A, program was suspended due to covid. Plans to restart in 2023.
<i>Activity 1.4 Develop comprehensive medication assisted</i>	Development of a comprehensive model which supports MAT programs	On-going	Number of AH healthcare providers who complete training	11	10% increase in AH healthcare provider trainings (initial or continuing education)	Hosted Grand Rounds, with over 100 providers over a 3-day period

PRIORITY HEALTH NEED: PREVENTION AND MANAGEMENT OF CHRONIC DISEASES

treatment (MAT) program

Source of Data:

- AH Tillamook
- County Health Rankings
- Unite Us Reports
- Community program participation data (National Diabetes Prevention Program, Walking groups, Cooking Matters, etc)

Target Population(s):

- People at risk for or with chronic diseases

Adventist Health Resources:

- Staff
- Supplies
- In-kind

Collaboration Partners: (place a "*" by the lead organization if other than Adventist Health)

- AH Tillamook
- Tillamook County Wellness
- Tillamook YMCA
- OSU Extension
- NorthWest Senior and Disability Services (NWSDS)

CBISA Category: (A - Community Health Improvement; E - Cash and In-Kind; F - Community Building; G - Community Benefit Operations)

Strategy Results 2022:

Hospital Readmissions: We reduced emergency room readmissions by 17.6%, from 68 to 56 in 2022. Through interdisciplinary team meetings and continuous improvement strategies, we continue to work on reducing readmissions.

NDPP Referrals: While many of the 2021 strategies continued during 2022, limited staff capacity and funding prevented meaningful progress toward planned goals. It was determined that making closed-loop referrals to the YMCA's National Diabetes Prevention Program (NDPP) would be more achievable if the Unite Us platform was integrated into our Cerner Electronic Medical Records system, for reasons stated above. Despite the lack of operationalized referrals, we did have four closed loop referrals for NDPP. The local YMCA continued to provide classes, which were promoted through flyers at AHTM. A total of 6 participants completed the program in 2022, with a total weight loss of 126, or an average of 21 pounds per person. Due to pandemic concerns, the program was offered virtually, which program leaders believe affected adherence. Four of the original 12 participants were referred by AHTM providers. Additionally, we were able to refer patients to community-based pain and chronic disease management education programs, also offered at the YMCA.

Lifestyle Medicine: The on-going covid-19 pandemic led to delays in restarting in-person Lifestyle Medicine classes. They are planned to resume in 2023.

MAT: Medication for Addiction Treatment (MAT) delivery continues at AHTM. We also facilitated and hosted Grand Rounds with over 100 providers in attendance over a 3-day period.

The Adventist Health + Blue Zones Solution

Our desire to improve community well-being grew out of not only our mission at Adventist Health to live God's love by inspiring health, wholeness and hope but also by the need seen across our system of 23 hospitals. Overwhelmingly, we see issues related to health risk behaviors, mental health, and chronic illnesses throughout the communities we serve. That is why we have focused our work around addressing behavior and the systems preventing our communities from achieving optimal health.

In an effort to meet these needs, our solution is to create a sustainable model of well-being that measurably impacts the well-being of people, well-being of places and equity.

In 2020, Adventist Health acquired Blue Zones as the first step toward reaching our solution. By partnering with Blue Zones, we will be able to gain ground in shifting the balance from healthcare – treating people once they are ill – to transformative well-being – changing the way communities live, work and play. In 2021, Adventist Health committed to launching six Blue Zone Projects within our community footprint, and as we enter 2022 these projects are active. Blue Zone Projects are bringing together local stakeholders and international well-being experts to introduce evidence-based programs and changes to environment, policy and social networks. Together, they measurably improve well-being in the communities we serve.