



# Samaritan Health Services Community Benefit Plan

2011



*Building healthier communities together*



Community benefit is not a new concept for Samaritan Health Services. Developing and implementing a system-wide community benefit plan, however, is a new process for our organization. The SHS Community Benefit Plan is a result of identified community health needs, goals and priorities in our tri-county region. The plan is designed to guide our efforts as we work to build healthier communities together.

The Community Benefit Plan is reviewed and approved by a Community Benefit Advisory Committee that is made up of hospital staff, board representatives and community members. The committee will review and monitor the progress of the plan each year.

As our communities grow, and as the health care profession continues to undergo transformation, our Community Benefit efforts will become increasingly important. This plan reflects a significant step towards positioning SHS to successfully address the needs of our region moving forward.

Larry Mullins, DHA  
President/CEO  
Samaritan Health Services

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Samaritan Health Services Inc., (SHS) is the not-for-profit parent organization for a network of Oregon hospitals, physicians, senior care services and health plans serving the 250,000 residents of Benton, Lincoln and Linn counties.

## **Mission**

SHS was formed in the late 1990s with the mission of improving the health and well-being of the community by providing high quality, caring services, regardless of any individual's ability to pay. The current mission of SHS states: "we enhance community health and achieve high value through quality services across a continuum of care."

## **Vision**

The collective vision of the SHS system is to be a "values-driven organization governed by community members, physicians and other health care providers. We seek to be the first choice of consumers in the region and to lead collaborative efforts among those who share similar goals."

## **Values**

The community-based hospitals and physicians that form Samaritan Health Services believe it is possible to create a successful regional health system based on collective organizational values. Decisions continue to be made by local community members, physicians and hospital leaders within the following values framework.

- Excellence: Striving to achieve the highest standards of care within our varied health professions
- Respect: For ourselves, our co-workers and those we serve
- Service: Recognizing the value of exemplary service in creating a positive experience for patients, visitors and co-workers
- Integrity: Aligning our words with our deeds
- Stewardship: Ensuring that we act responsibly with the resources that have been entrusted to our care
- Compassion: Demonstrating on a daily basis the healing power of the human touch
- Leadership: Modeling and sharing best practices in the midst of tremendous change in the way health care is delivered and paid for



SHS is comprised of five hospitals: Good Samaritan Regional Medical Center, Samaritan Albany General Hospital, Samaritan Lebanon Community Hospital, Samaritan North Lincoln Hospital and Samaritan Pacific Communities Hospital. SHS also encompasses 70 primary care and specialty physician clinics, senior care facilities, four insurance plans and the administrative headquarters located in Corvallis.

**Good Samaritan Hospital, dba Good Samaritan Regional Medical Center (GSRMC)**, the largest of the five hospitals, is a 188-bed Level 2 trauma center established in 1913. GSRMC serves all of Benton, Linn and Lincoln counties with regional programs including cancer, cardiac surgery, cardiology, vascular surgery and orthopedics, with several programs receiving a “five-star” quality rating. The cancer program also received the highest possible rating from the Commission on Cancer during its most recent on-site survey. GSRMC has been recognized by *Oregon Business* magazine as one of the top 100 companies to work for in Oregon.

**Samaritan Albany General Hospital (SAGH)** is a 76-bed acute care facility established in 1924. SAGH serves the greater Albany area. In 2006, the hospital received recognition from Care Science as a “Select Practice National Quality Leader in the Category of Pneumonia.” Also in 2006, the *Salem Statesman Journal* ranked SAGH fifth in the state for both heart attack treatment and congestive heart failure treatment. The hospital’s free weekly service for low-income patients, the InReach Clinic, received the 2010 Oregon Governor’s Outstanding Volunteer Program.

**Mid-Valley Healthcare, Inc. (MVH)** is a member of SHS that includes Samaritan Lebanon Community Hospital (SLCH), a 25-bed Critical Access Hospital established in 1956. SLCH serves the east Linn County area. Internationally recognized for the healing environment it provides, the hospital’s Japanese-style Healing Garden has won numerous awards and was featured in the *Journal of Japanese Gardening*. Services include emergency care, obstetrics, infusion therapy, critical care, diabetes education, health and medical/surgical services.

**Samaritan North Lincoln Hospital (SNLH)** is a 25-bed Critical Access hospital established in 1967. SNLH serves north Lincoln and south Tillamook Counties and is a part of the North Lincoln Health District. The hospital’s licensed professional staff includes more than 20 local physicians, physician assistants, nurse practitioners and a nurse-midwife. Services include obstetrics, critical care, diabetes education, health and medical/surgical services.

**Samaritan Pacific Communities Hospital (SPCH)** is a 25-bed Critical Access hospital established in 1952. SPCH serves all of south Lincoln County and is part of the Pacific Communities Health District. The hospital recently opened the first dialysis center in the Newport area. Other services include emergency care, obstetrics, critical care, diabetes education, health and medical/surgical services.



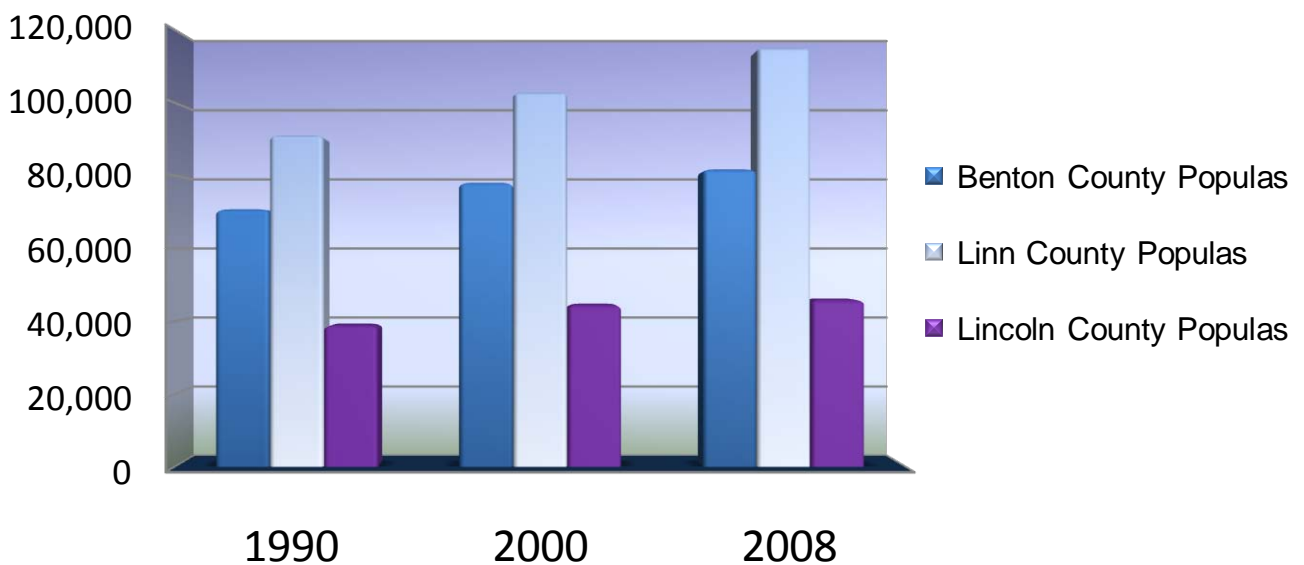
Stretching from the Oregon coast to the foothills of the Cascade Mountain range, the SHS service area includes Benton, Lincoln and Linn counties. Each county is unique in its populations, geography and community needs.

**Benton County**

Benton County was established by the Provisional Legislature in 1847. Benton County occupies 679 square miles of the central Willamette Valley. Benton County is bordered on the east by the Willamette River and Linn County, with Lincoln County on the west, Polk County on the north, and by Lane County on the south. The city of Corvallis is the county seat for Benton County and is home to Oregon State University.

According to the 2008 Population Estimates from the US Census Bureau, approximately 81,859 people reside in Benton County which is a growth of nearly 16% since 1990. Although the majority of residents live in Corvallis or other incorporated cities in the county, a large portion of residents live in rural Benton County. These rural communities include Alsea, Kings Valley, Wren, Blodgett, Summit and Bellfountain.

Benton County has ranked first or second in the state for employment rates and economic standards over the past decade. Benton County continues to receive high state rankings for K-12 education, higher education and college graduation rates, including ranking 22<sup>nd</sup> in the United States for the percentage of adults with a bachelor’s degree or higher in a community. The County Health Rankings for Oregon 2010 by the University of Wisconsin and the Robert Wood Johnson Foundation identified Benton County as the number one county in the state for positive Health Outcomes and Health Factors in a community.



## Lincoln County

Lincoln County was created by the Legislative Assembly on February 20, 1893, from the western portions of Benton County and Polk County. The county is bordered by Tillamook County on the north, Polk and Benton Counties on the east, Lane County on the south, and the Pacific Ocean on the west. It covers an area of 992 square miles. Newport is the county seat for Lincoln County and continues to be a major tourist attraction on the Oregon coast.

The northern part of Lincoln County includes the Siletz Indian Reservation, which was created by treaty in 1855. The Siletz's tribal status was terminated by the federal government in 1954. The tribe was the first tribe in Oregon to have its tribal status reinstated by the federal government in 1977. The current reservation totals 3,666 acres and includes a gaming casino and resort.

Lincoln County is considered a rural community with a population of 45,946 and experienced an 18 percent population growth over the last decade. With the largest population concentrated in Newport or Lincoln City, many residents live in unincorporated areas of the county such as Depoe Bay, Otis, Gleneden Beach, Eddyville, Seal Rock and Agate Beach.

Lincoln County has experienced some positive trends based on the Oregon Progress Board 2007 County Data Snapshot. Similar to other coastal communities, Lincoln County has a high retirement age population and ranked sixth in the state for independent seniors. Other rankings such as high school graduates, college graduates and employment rates find Lincoln County ranking 12<sup>th</sup> or 13<sup>th</sup> in the state. The County Health Rankings for Oregon lists Lincoln County 28<sup>th</sup> in the state for Health Outcomes and 25<sup>th</sup> for Health Factors of the 36 counties.

## Linn County

Linn County was created in 1847 from the southern portion of what is known today as Marion County. Linn County consists of 2,297 square miles with boundaries of Marion, Deschutes, Jefferson, Lane and Benton Counties. With the county seat of Albany, Linn County is the most populous county in the Benton, Lincoln, Linn tri-county region.

With the wide range of climate changes throughout the year, Linn County is considered a much diversified agriculture area in the state with strawberries as a major crop in June to cabbage in November. Linn County leads the United States in producing perennial ryegrass.

The 2008 Population Estimates from the US Census Bureau lists Linn County's population at 115,348. Although the majority of residents live in Albany, Linn County geographically reaches from the I-5 corridor to the Cascade mountain range. Rural areas include Gates, Millersburg, Halsey, Tangent, Scio, Shedd and Crabtree.

Linn County has seen some improvements in its child health indicators based on the Status of Oregon Children 2008. Reading and math proficiency for children in the third grade have increased by 2 percent and juvenile arrests rates are down by 14 percent.



The major cities in Benton, Lincoln and Linn counties are outlined below.

<b>Community</b>	<b>Population</b>	<b>County</b>
Adair Village	536	Benton
Corvallis	49,322	Benton
Monroe	607	Benton
Philomath	3,838	Benton
Lincoln City	7,437	Lincoln
Newport	9,532	Lincoln
Toledo	3,472	Lincoln
Waldport	2,050	Lincoln
Albany	40,852	Linn
Brownsville	1,449	Linn
Lebanon	12,950	Linn
Sweet Home	8,016	Linn

*Source: US Census Bureau, Census 2000*

Benton, Lincoln and Linn County racial and ethnic distribution reflect similar populations in counties across the state of Oregon.

<b>Race/Ethnicity</b>	<b>Benton</b>	<b>Lincoln</b>	<b>Linn</b>
White/Caucasian	84.1%	85.3%	88.9%
Black/African American	1.1%	0.6%	.6%
American Indian/Alaska Native	1.0%	3.4%	1.4%
Asian	5.4%	1.1%	1.0%
Pacific Islander	0.3%	0.2%	0.2%
Latino	6.1%	7.6%	6.3%
Reporting two or more races	2.5%	2.8%	2.1%

*Source: US Census Bureau, 2008 Population Estimates*

Health and social indicators are used to generalize the conditions of the tri-county region.

<b>Health and Social Indicators</b>	<b>Benton</b>	<b>Lincoln</b>	<b>Linn</b>
Median Income	\$45,574	\$36,671	\$44,397
Unemployment	8.5%	11.4%	14.8%
Poverty	19.3%	17.6%	14.0%
Homelessness	268*	1,658*	329*
Early Prenatal Care	85.7%	74.2%	73.7%
Immunizations	64.7%	76.0%	64.7%
Uninsured Children	15.7%	15.1%	15.7%
Child Care Slots	23/100	17/100	14/100
Child Abuse	4.5/1000	9.3/1000	15.3/1000
Early Childhood Obesity	18.6%	44%	24.7%
Children on Free and Reduced Lunch	35.5%	58.3%	41.3%
Children Enrolled with a Dental Care Organization	89.5%	74.1%	92.5%
Homeless Students	325	484	922
Teen Pregnancy	3.2/1000	9.6/1000	11.2/1000
High School Drop Out	2.9%	6%	4.4%
Juvenile Arrests	13.5%	17.9%	12.9%
8 <sup>th</sup> Grade Alcohol Use	25.8%	**	31.9%
8 <sup>th</sup> Grade Drug Use	10.9%	**	14.3%

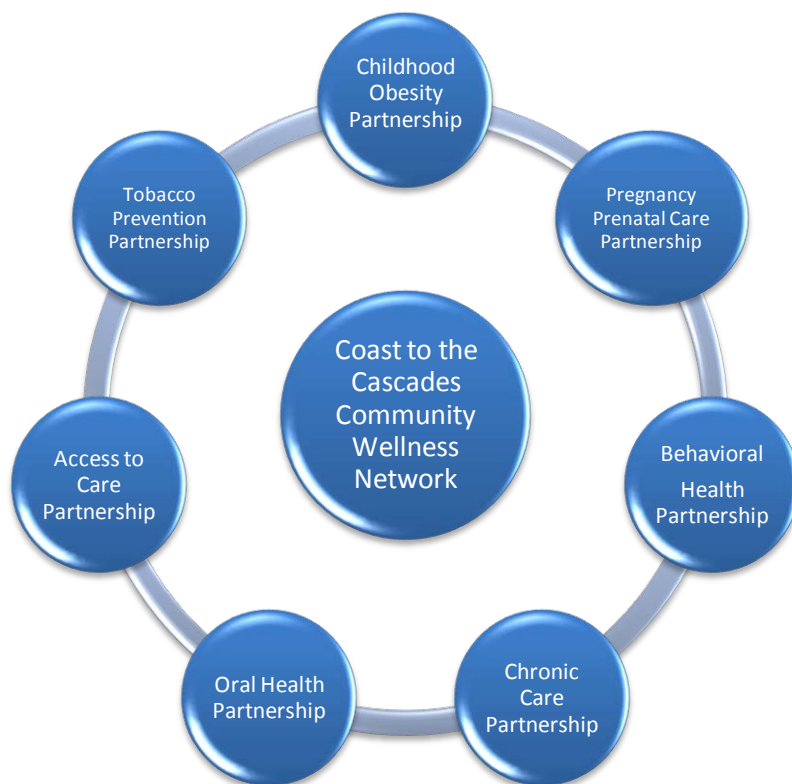
*\*There is no accurate way to count the number of homeless people in a county. Homeless data is based on local agencies serving the homeless population. \*\*Data unavailable*



In conjunction with local United Way agencies and other partners, a community needs assessment is conducted every few years in each county. These needs assessments are done in partnership with SHS, city and county government, local health departments, Oregon State University, Linn-Benton Community College, faith organizations and local school districts. Primary data is collected locally through focus groups, surveys and key informant interviews. Secondary data is gathered from state and local agencies. The Oregon Pacific Area Health and Education Center and the local Commission on Children and Families also conduct needs assessments in Benton, Lincoln and Linn counties every two years.

SHS hospitals and clinical staff in the tri-county region collaborate with local partners to examine regionally based needs that cross county lines. During the past few years, Benton, Lincoln and Linn counties have each identified common focus areas to improve health outcomes for the community. As a result of the tri-county efforts, a Coast to Cascades Community Wellness Network has been formed to develop and support collaborative partnerships to enhance the health of communities.


### Coast to Cascades Community Wellness Network



Additional regional initiatives include Ten Year Plans to Address Homelessness, Early Childhood Care and Education services and Childhood Obesity prevention.


The most recent needs assessments for Benton, Lincoln and Linn Counties identified the following most pressing needs and assets in the tri-county region.

# NEEDS




***Linn/Benton/Lincoln County***

- Reduce Child Maltreatment
- Reduce Childhood Obesity
- Improve and Increase the Quality and Availability of Child Care and Early Childhood Education



***Linn/Benton County***

- Medical Detox Facility
- Transitional Housing for the Mentally Ill
- Access and Awareness of Prenatal Programs for Teens and Reduce High Risk Sexual Behaviors Among Youth
- Increase Access for Dental Care for Families




***Benton/Lincoln County***

- Wraparound Services for Homeless Including Youth




***Linn/Lincoln County***

- Employment Opportunities



***Lincoln County***

- Reduce Tobacco Use Among Youth and Adults
- Mental Health Services for Children and Youth
- Alcohol and Drug Prevention and Treatment Services
- Workforce Housing
- Free or Low Cost Medical and Dental Health Care



***Linn County***

- Develop, Foster and Grow Health Care Practices
- Parenting Education to include Healthy Start/Relief Nursery and LBCC Parent Education

## ASSETS

- Commission on Children and Families
- Community Outreach, Inc.
- Community Services Consortium
- Federally Qualified Health Centers
- Food Banks
- Foster Grandparents Program
- Free/Reduced Lunch Programs
- Head Start/Early Head Start
- Health Departments
- Healthy Start
- Living Well with Chronic Conditions
- Meals on Wheels
- Oral Health Council
- Parks and Recreation Departments
- Safe Routes to School
- Senior Companion Program
- Service Organizations
- Strong Faith Community

### *Linn/Benton/Lincoln County*



- Lincoln County Child Advocacy Center
- Oregon Coast Community College
- Samaritan North Lincoln Hospital
- Samaritan Pacific Communities Hospital

### *Lincoln County*



- Boys and Girls Club of Albany and Lebanon
- Family Tree Relief Nursery
- FISH
- Linn-Benton Community College
- Samaritan Albany General Hospital
- Samaritan Lebanon Community Hospital

### *Linn County*



- Benton/Corvallis Public Library
- Boys and Girls Club of Corvallis
- Center Against Rape and Domestic Violence
- Dial-a-Bus
- Good Samaritan Regional Medical Center
- Jackson Street Youth Shelter
- Linn-Benton Community College
- Oregon State University
- New Beginnings
- Rally Around Families Together Relief Nursery
- Work Unlimited

### *Benton County*





In collaboration with community partners, organizations and local agencies, several recommendations to improve community health have been identified. The recommendations are not all-inclusive of what was identified in the reports and assessments used to compile the list. The list is not in priority order.

- Improve the continuum of services available to support individuals at risk for developing chronic diseases.
- Cultivate strategic partnerships between behavioral health specialists, public health practitioners and primary care physician to improve access to care.
- Develop and support policies and programs to improve physical activity and dietary behaviors at the individual and community level.
- Support nutritional programs and services that target children and low-income populations.
- Mobilize community partnerships to create a collaborative epidemiologic data base that provides health data to interested parties.
- Promote, coordinate and develop community-based youth, family and elderly mental health services.
- Create or support programs and policies that assist in promoting awareness of assistance programs that serve to decrease abusive relationships and substance abuse.
- Promote programs and policies that support prenatal and oral health care.
- Create a regional action plan to guide future planning and program development.
- Ensure those in need are referred to the most appropriate services and supports.
- Create an education and awareness program about existing veterans' services.



Community benefits are programs or activities that provide treatment and/or promote health and healing as a response to identified community needs. They are not provided for marketing purposes.

A community benefit must meet at least one of the following criteria:

- Generates a low or negative margin
- Responds to needs of special populations, such as minorities, older persons, and persons with disabilities who are living in poverty, persons with chronic mental illness and other disenfranchised persons
- Supplies services or programs that would likely be discontinued – or would need to be provided by another not-for-profit or government provider – if the decision was made on a purely financial basis
- Responds to public health needs
- Involves education or research that improves overall community health

Community benefits programs must also meet at least one of these objectives:

- Improves access to health care services:
  - Available to the public
  - Participants include vulnerable or underserved populations
  - Reduce or eliminate access barriers
  - The community would lose access to a needed service
- Enhances health of the community:
  - Designed around public health goals
  - Measurable improvements in health status
  - Community health status would decline
  - A public health agency provides comparable services
  - Operates in collaboration with public health partners
- Advances medical or health care knowledge:
  - Train health professionals/students
  - Does not require trainee to join the staff
  - Open to other professionals in the community
  - Involves research with findings available to the community
- Relieves or reduces the burden of government or other community efforts:
  - Relieves a government financial or programmatic burden
  - Government provides the same or similar services
  - Government provides support of the activity
  - If the program closed would increase government costs
  - Supported through community volunteers



### **Overview**

The SHS Board of Directors and senior leadership are accountable for demonstrating commitment to improving community health status and addressing the societal issues that contribute to poor health, as well as personally working for the betterment of the community-at-large. In addition, the SHS Board of Directors and senior leadership work to ensure that adequate resources are allocated to assess, develop and implement community benefit initiatives that respond to the unmet health priorities selected in collaboration with community partners.

### **Community Benefit Advisory Committee**

The Community Benefit Advisory Committee (CBAC) was formed in 2009 consisting of the President/CEO of SHS and representatives from SHS departments including: Physician Services, Social/Pastoral Services, Finance, Quality/Compliance, Operations and Public Relations/Marketing. The committee also includes three SHS board representatives and representatives from other affiliated hospital boards. In conjunction with the Community Benefit staff, the CBAC facilitates the process of establishing program priorities based on community needs and assets, developing the system's community benefit plan and monitoring progress toward identified goals. Committee members will inform the SHS board on activities and developments and will also ensure that the committee has information from the board and management needed to make informed decisions.

### **SHS Hospitals**

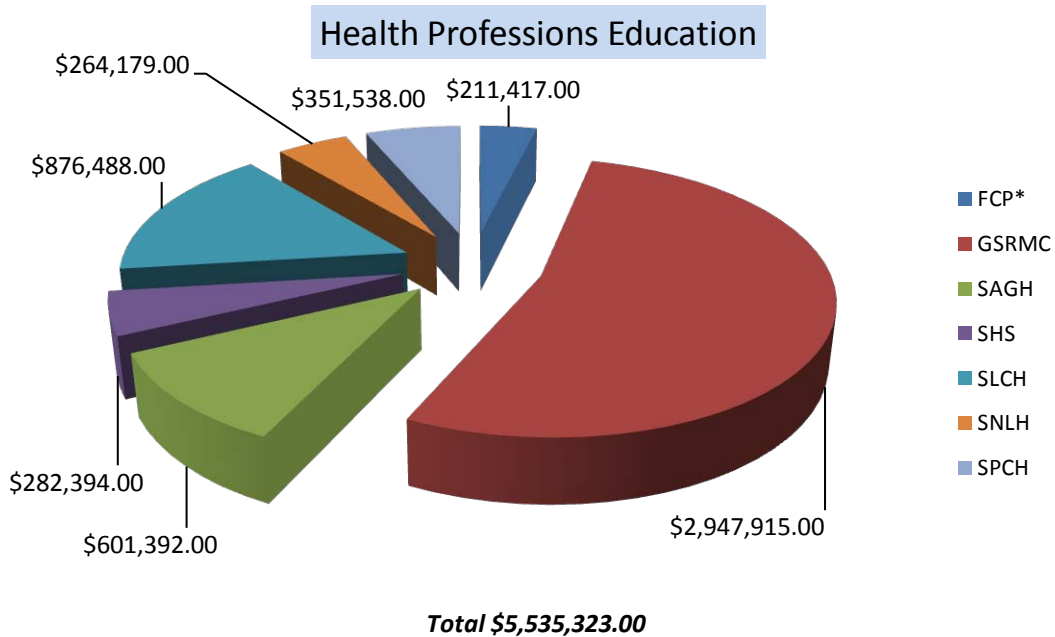
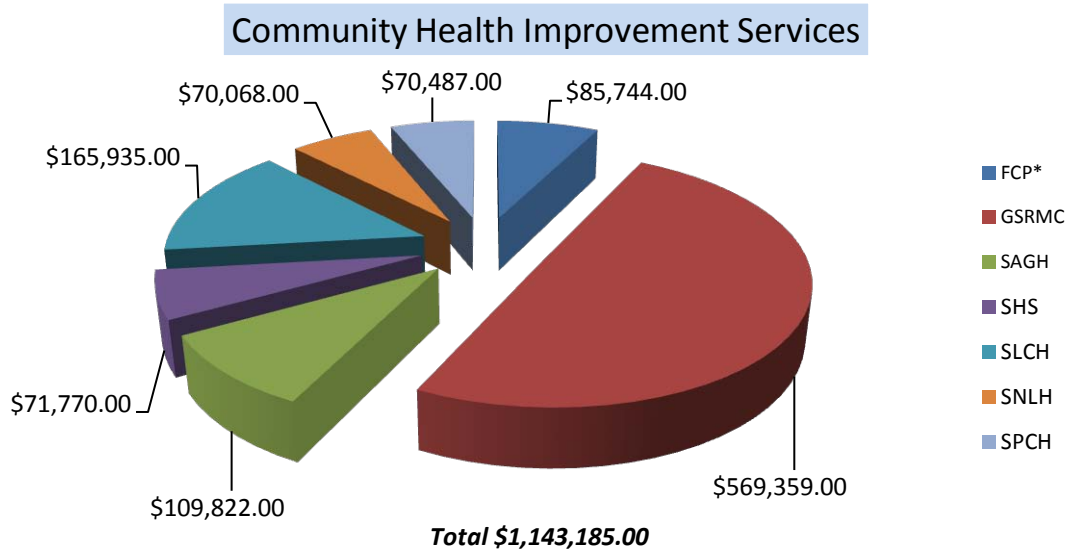
The SHS hospital boards and leadership are responsible for ensuring site-based implementation of the community benefit plan to promote the broader health of the community. This is accomplished through the work of the site-based Social Accountability Committees.

The Social Accountability Committees (SAC) are part of each SHS hospital with the responsibility of recommending funding to local non-profit organizations and community groups that support the mission, vision and values of SHS and address the needs of the Community Benefit plan. SAC membership includes the hospital Chief Executive Officer, representation of the hospital board of directors, social/pastoral services, finance, physician services and marketing/public relations. Each of the five committees is facilitated by SHS Community Benefit staff.

### **SHS Community Benefit Staff**

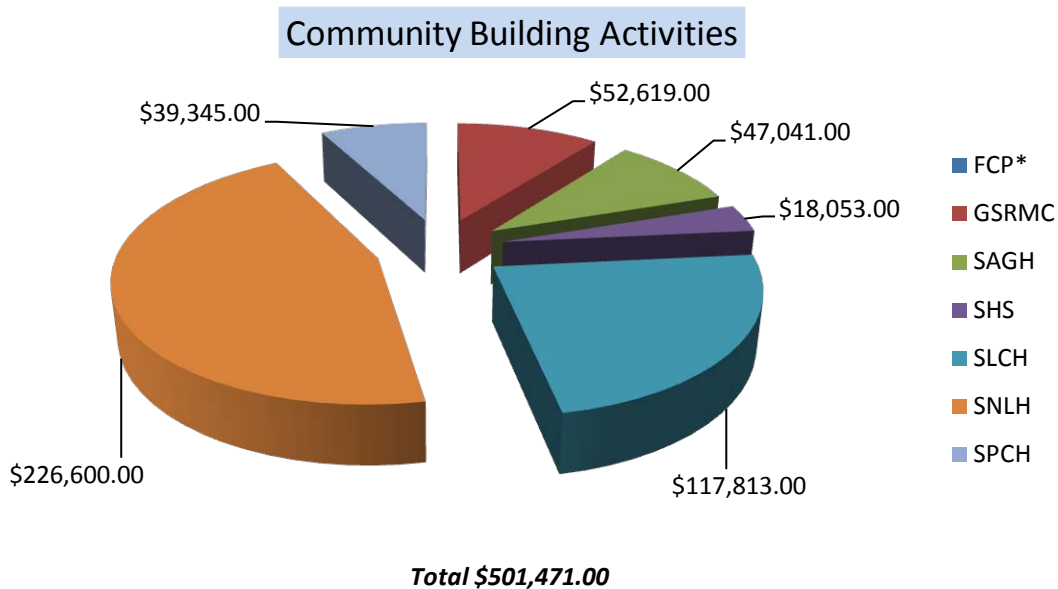
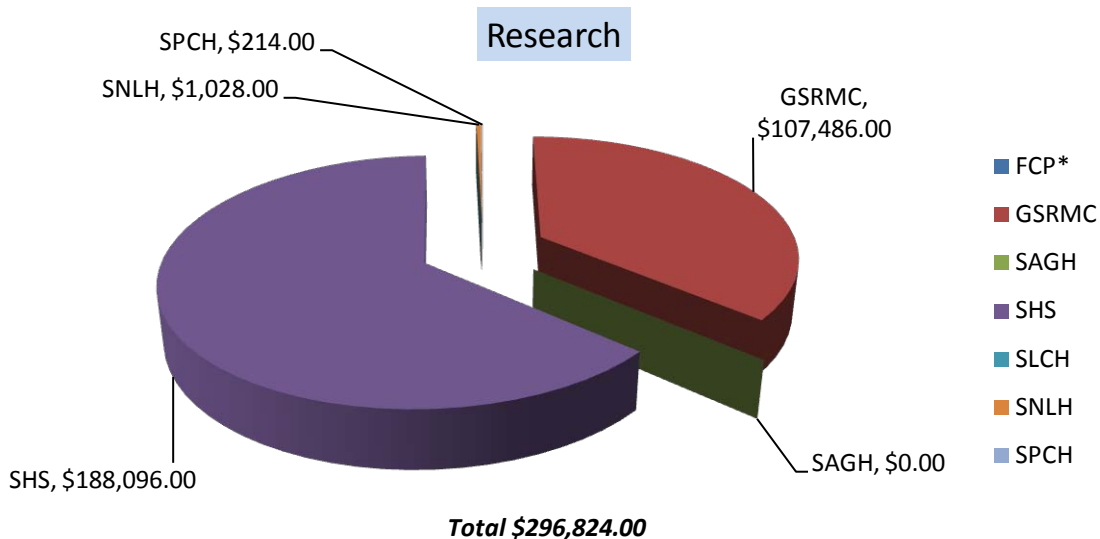
The Community Benefit Department is part of the Development and Marketing/Public Relations Department. The SHS Community Benefit staff is responsible for facilitating the development and implementation of the community benefit plan in collaboration with system leaders and community stakeholders. The Community Benefit staff shall participate in local planning efforts in the tri-county region in order to identify needs, assets and community health priorities. The Community Benefit staff work with each SAC and the CBAC to assist in prioritizing community needs, assets and services necessary to support community health.





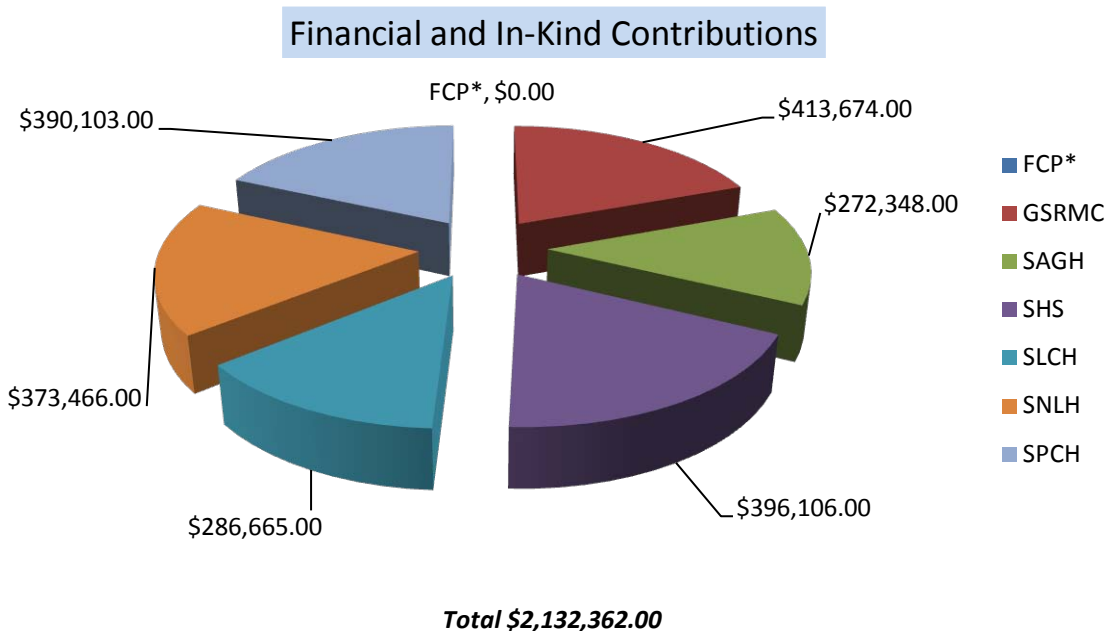
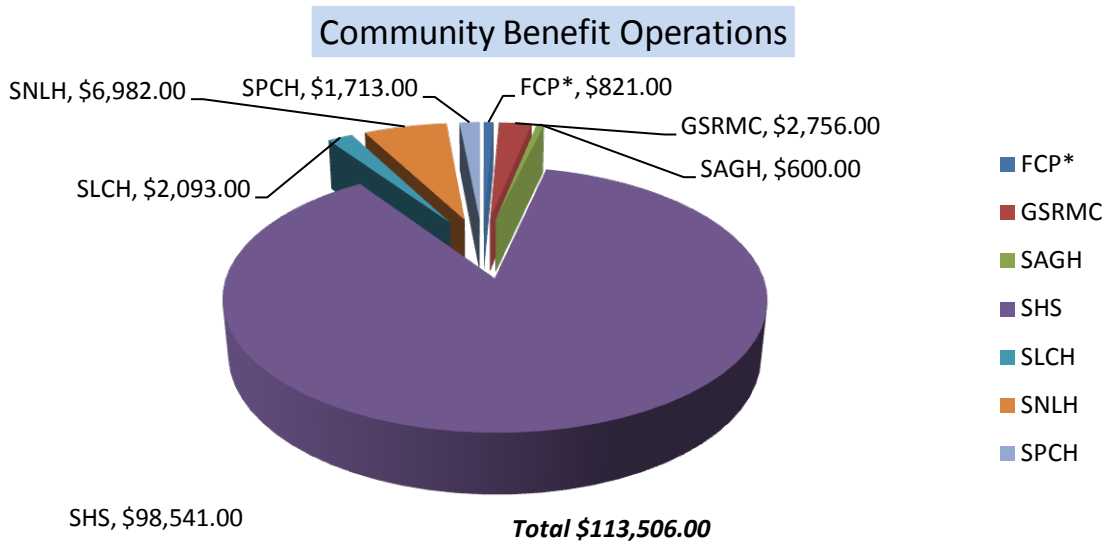
\*First Care Physician (FCP) provides professional medical services principally through direct physician services and ancillary health providers.

Community Benefit Summary 2009 (continued)



\*First Care Physician (FCP) provides professional medical services principally through direct physician services and ancillary health providers.

Community Benefit Summary 2009 (continued)



\*First Care Physician (FCP) provides professional medical services principally through direct physician services and ancillary health providers.

**Hospital Site Key:**  
**FCP**=First Care Physicians, **GSRMC**=Good Samaritan Regional Medical Center,  
**SAGH**=Samaritan Albany General Hospital, **SHS**=Samaritan Health Services,  
**SLCH**=Samaritan Lebanon Community Hospital, **SNLH**=Samaritan North Lincoln Hospital,  
**SPCH**=Samaritan Pacific Communities Hospital



SHS is committed to providing quality care for its patients and offering support that extends beyond medical treatment. Each SHS hospital has classes, group sessions, workshops, and activities that occur simultaneously in each community. For example, each hospital offers Diabetes Management and Education classes, Better Breathers workshops and Childbirth Preparation/Lamaze classes. Below is a sample of services available to the community.

**Samaritan Early Learning Center (SELC)** provides a non-competitive atmosphere where individual children are able to develop at their own rate intellectually, emotionally, socially, and physically. It is the goal of SELC that children who participate in its program will be ready and able to progress successfully in the elementary school program. SELC hopes to awaken in each child the realization that learning is fun, exciting and lifelong. SELC provides the only subsidized, extended-hour childcare services for low-income families and children six weeks through seven years of age in Lincoln County. The SELC provides daily service to 76 children each day.

**Living Well with Chronic Conditions** is a researched-based program developed by Stanford University. The program is offered free to the public in Benton, Lincoln and Linn Counties and runs for six weeks. The goal of Living Well is to teach participants ways of dealing with pain and fatigue. It also gives the participants the skills to improve or maintain nutrition, communication and pain management. Over 600 people participated in Living Well workshops in Benton, Lincoln, and Linn counties during 2009. Living Well is now available online for people unable to attend a workshop in person.

**Foster Grandparent Program** has been a part of the SHS family since 2008. The Foster Grandparent Program is a mentoring program that connects local seniors with elementary school, middle school and high school students. Foster Grandparent volunteers are trained seniors who encourage children with one-on-one support. Volunteer assignments may include listening to a child read, having lunch with a child or listening to a child talk about a new concept or idea. Income-eligible volunteers receive a \$2.65 per hour tax-free stipend, mileage reimbursement, training and the lasting reward of respect and affection from the children they work with. There are currently 54 trained Foster Grandparents serving over 200 children in Benton, Lincoln and Linn Counties.

**Senior Companion Program** volunteers touch the lives of frail older or disabled adults who need a little extra help in order to live independently in their own homes or communities for as long as safely possible. They assist their adult clients in basic but essential ways such as friendly visits to isolated and frail adults; simple chores and household organization; transportation; and respite for primary caregivers. SHS gained sponsorship of the Senior Companion Program in 2002. Today, 50 trained Senior Companion Program volunteers are serving 207 homebound adults in Linn, Benton and Lincoln Counties. The Senior Companion Program is funded in part

by the Corporation for National and Community Service and numerous local partner agencies and counties as well as SAGH and SPCH Foundations.

**Albany InReach Clinic** is safety-net clinic that serves adults and children who do not have health insurance. Medical care is provided weekly at the Linn County Public Health Building in Albany. The InReach Clinic provides services to patients who have non-urgent injuries, strains and sprains, asthma, bronchitis, high blood pressure, diabetes and other non-urgent conditions. In partnership with the City of Albany, Greater Albany Public Schools, United Way of Linn County and Linn County Health Department, InReach Clinic is a SHS service committed to ensuring all residents have access to health care. InReach Clinic served over 1500 residents in 2009.

**Community Health Improvement Project – Planting Seeds of Change** school teaching gardens continue to make great strides in building community partnerships. There are two gardens in Lebanon with plans for a third garden in the fall of 2010 which will include a 100-tree orchard. School gardens in Albany, Brownsville and Sweet Home are also scheduled to open in the fall of 2010. Over 280 students had access to the Seven Oak Middle School teaching garden during the last nine week term of the 2009/2010 school year and 250 students participated in the garden program throughout the 2009/2010 school year.

Master Gardener volunteers work in the garden on a regular basis each week and assist in the techniques of planting, watering and harvesting. The garden produce is incorporated into the school lunch program. It is offered to students and volunteers as well as the local food bank. More than 500 pounds of produce was donated to local charities and over 1,600 volunteer hours were donated in 2009.



**A commitment to community**

Justin Richards graduated from Seven Oak Middle School and credits his involvement in the school garden for the turnaround in his grades. "I would not be going to high school if it wasn't for this garden," he said.

**From a potential dropout to a star student – all because of a garden.**

Three years ago, Justin Richards of Lebanon was beginning to wonder if the word "dropout" was in his future. His grades were plummeting and his interest in school was going the same direction.

A short while later teacher Rick George invited Justin to join the garden project at Seven Oak Middle School. The garden is part of the Planting Seeds of Change Program, and allows local students to work together to create vegetable and fruit gardens at their schools.

"At first I thought it was going to be really boring," Justin admits, "but I gave it a try and I got really hooked. It's pretty much been my life for the last three years."

Justin says that the garden gave him a focus that spread to other parts of his life, including his school work. His grades and his test scores increased dramatically. He even received an award from Seven Oak for his improvement.

Justin is one of more than 400 students who have helped create school gardens throughout east Linn County. The concept is now spreading to Albany as well.

Samaritan Health Services is proud to provide administrative support, meeting space and materials to Planting Seeds of Change and other programs that strengthen the health of our communities. To learn more, visit [www.samhealth.org/communitybenefit](http://www.samhealth.org/communitybenefit).





## Community Benefit Services Inventory 2009

Facility: Samaritan Health Services		Activities: Support groups and trainings			
Category: A1 – Community Health Education		Strategy: Conduct education, support groups and trainings			
Goal: Promote Healthy Behaviors					
Objective: Provide education, support groups and training to patients, family members and caregivers.					
Baseline/Target Population: Number of participants attended support groups in 2009: 37,828					
Inputs	Activities	Outputs	Short Term Indicators	Interim Indicators	Long Term Indicators
Staff Facilitator	Organize and advertise group meetings	Conduct the following support groups: *Better Breathers Support Group	Increase in the % of patients and caregivers participating in support groups and trainings	% of support group participants and caregivers reporting their ability to manage their illness or disease.	Reduced incidence of patients reporting significant health issues  Improved Access to Care
Meeting Space	Identify meeting locations Facilitate groups	*Cardiac Support *Caregivers Support			
Materials	Conduct education services	*Childbirth Education *Community Health Fairs			
Supplies		*Community Education and lectures			
Food		*Diabetes Education and Support Groups *Grief Education and Support Groups			
		*Living Well with Chronic Conditions *Nutrition Education *Parish Nurses and Pastoral Support *Powerful Tools for Caregivers *Tobacco Cessation			

Community Benefit Services Inventory 2009

Facility: Samaritan Health Services		Activities: Health Clinics and Screenings			
Category: A2 – Community Based Clinical Services		Strategy: Conduct health clinics and screenings services			
Goal: Promote Healthy Behaviors					
Objective: Provide screenings and clinical services to patients, family members and caregivers with chronic illnesses and diseases.					
Baseline/Target Population: Number of participants attended screenings and clinics in 2009: 3,406					
Inputs	Activities	Outputs	Short Term Indicators	Interim Indicators	Long Term Indicators
Medical Staff Materials Supplies Food	Organize and advertise health screenings Arrange health screenings Conduct health screenings	Conduct the following health screenings: *Asthma Clinic *Blood Pressure Clinic *Cardiac Rehab 1 <sup>st</sup> Visit *Cardiac Screening *Heart Health Screenings *Homeless Shelter Community Service *InReach Clinics *Legs for Life *Mammograms & *Manicures *Skin Cancer Screening *Sports Medicine Clinic	Increase in the % of patients diagnosed with a chronic illness or disease participating in health screenings and clinics	% of patients reporting their ability to manage their chronic illness or disease	Reduced incidence of patients reporting significant health issues.  Increase access to health care

Community Benefit Services Inventory 2009

Facility: Samaritan Health Service		Activities: Coordination of Health Care Services			
Category: A3 – Health Care Support Services		Strategy: Provide access and quality of care of health services.			
Goal: Promote Healthy Behaviors					
Objective: Provide access to health care services and support.					
Baseline/Target Population: Number of participants in 2009: 1,986					
Inputs	Activities	Outputs	Short Term Indicators	Interim Indicators	Long Term Indicators
Medical Staff  Materials  Supplies	Organize and advertise health care services  Arrange health care services  Provide health care services	Conduct the following health care services:  *Healthy Start Services  *Maternity Care Coordination  *Palliative Care  *Patient Navigator Services  *Pregnancy Testing	Increase in the % of patients receiving health care services	% of patients reporting their ability to access health care services	Increased access to health care services

Community Benefit Services Inventory 2009

Facility: Samaritan Health Services		Activities: Health Profession Education, Externships, Internships and Scholarships			
Category: B – Health Professions Education		Strategy: Provide education and training to current and future health professionals			
Goal: Improve Systems for Public Health					
Objective: Provide education and training to current and future healthcare professionals.					
Baseline/Target Population: Number of participants in 2009: 13,659					
Inputs	Activities	Outputs	Short Term Indicators	Interim Indicators	Long Term Indicators
Medical Staff  Materials  Supplies	Organize and advertise health education classes  Advertise and promote health related education internships and scholarships  Arrange continuing medical education opportunities, internships and scholarships	Conduct the following health education opportunities:  *Medical Clerkships  *Medical Internships  *Medical Student Training  *Nursing Education  *Pharmacy Student Externships/Internships  *Scholarships  *Student Training	Increase in the % of medical staff, employees and students enrolling in health education programs	% of medical staff, employees and students completing health education programs	Increase in the number of health professionals

Community Benefit Services Inventory 2009

Facility: Samaritan Health Services		Activities: In-Kind Donations			
Category: E – Financial and In-Kind Donations		Strategy: Provide support to local agencies to promote health			
Goal: Promote Safe and Healthy Communities					
Objective: Provide support to agencies and organizations that promote health in the community.					
Baseline/Target Population: Number of participants in 2009: 41,238					
Inputs	Activities	Outputs	Short Term Indicators	Interim Indicators	Long Term Indicators
Staff Meeting Space Supplies Materials Food	Identify community service projects and programs	Participate in the following projects and programs: *Arts in Healthcare *Book Sales *Community Meetings *Day of Caring *Food Donations *Foster Grandparents *Foundation Support *Flu Immunizations *Fundraising *Gift Donations *Linen Donations *Mammography Vouchers *Pastega House *Prescription Assistance	Increase in the % of support services in the community that address gaps, needs and priorities	% of local agencies and organizations that address community gaps, needs and priorities	Reduction in gaps of services and needs in the community

Community Benefit Services Inventory 2009

Facility: Samaritan Health Services		Activities: Community Building and Supports			
Category: F – Community Building & Support		Strategy: Provide services that support the community			
Goal: Promote Safe and Healthy Communities					
Objective: Provide services that promote health in the community.					
Baseline/Target Population: Number of participants in 2009: 101,037					
Inputs	Activities	Outputs	Short Term Indicators	Interim Indicators	Long Term Indicators
Staff Facilities Materials Supplies	Identify services, projects and programs  Organize services	Participate in the following projects and programs:  *Community Coalitions  *Disaster Preparedness  *Foundation Event  *Lunch Buddy Programs  *Samaritan Early Learning Center  *School Literacy Programs	Increase in the % of support services to the community that address gaps, needs and priorities	% of services that address community gaps, needs and priorities	Reduction in gaps of services and needs in the community



**Samaritan Health Services Community Benefit Plan Fiscal Year 2010-2011**

**Goal: Promote Healthy Behaviors**

**Objective #1:** Increase physical activity, fitness and access to healthy, nutritious foods for children, youth and families.

**Community Need:**

- Percentage of children on Free and Reduced Lunch – 35.5% Benton, 58.3% Lincoln, 41.3 % Linn
- Percentage of children who are overweight/obese – 18.6% Benton, 44% Lincoln, 24.7% Linn
- Percentage of families receiving food stamps – 11% Benton, 20% Lincoln, 21% Linn

**Target Population:** Low-income, uninsured, and underinsured families

**Focus Issue:** Access\_\_\_\_\_ Community Health Improvement\_\_\_\_x\_\_

**Community Benefit Reporting Category:** Financial and In-Kind Contributions

Agency/Area	Activity	Outputs	Indicators
Backpack Food Program Lincoln County – SNLH	Students at Oceanlake and Taft	Provide food packs for 160 students.	% of students report having a healthy meal during the weekend.
Lincoln City Food Bank Lincoln County – SNLH	Distribute Food Boxes	Provide food boxes for 970 families.	% of families report receiving healthy food boxes.
Boys & Girls Club of Greater Santiam Linn County – SLCH	Summer Education and Nutrition	Provide healthy snacks to 3,000 youth.	% of youth receiving a healthy snack.
Sweet Home Emergency Ministries Linn County – SLCH	Food Boxes	Provide Food boxes for 1,050 families.	% of families report receiving healthy food boxes.
St. Vincent de Paul – Lebanon Linn County – SLCH	Food Boxes	Provide Food boxes for 12,500 families.	% of families report receiving healthy food boxes.
Sweet Home School District Linn County – SLCH	Planting Seeds of Change	Install 5 organic teaching gardens.	% of students installing teaching gardens
Lebanon Community School District Linn County – SLCH	Planting Seeds of Change	Construct a hoop house.	Completion of hoop house.
Lebanon Soup Kitchen Linn County – SLCH	New Stove/Oven	Purchase of a stove.	Stove purchased.

**Objective #2:** Increase access to medical, dental and mental health support and services in the community.

**Community Need:**

- Percentage of children who are uninsured – 15.7% (Benton, Lincoln, Linn)
- Percentage of residents living in poverty – 19.3% Benton, 17.6% Lincoln, 14% Linn

**Target Population:** Low-income, uninsured, and underinsured families

**Focus Issue:** Access \_\_x\_\_ Community Health Improvement \_\_\_\_\_

**Community Benefit Reporting Category:** Financial and In-Kind Contributions

Agency/Area	Activity	Outputs	Indicators
Centro de Ayuda Lincoln County – SPCH	Education & Interpreters	Provide translations services to 500 families.	% of families reporting accurate translation services
Lincoln County Transit Lincoln County – SNLH/SPCH	Medical Access Partnership	Provide bus passes to low-income families.	% of families that received bus passes.
The Trueman Recovery Center Lincoln County – SPCH	Medical/ Dental Services	Provide emergency health & dental care to 25 clients.	% of clients who received emergency health and dental care.
Altrusa International Lincoln County – SPCH	Dental Services	Provide dental care for 2,600 families.	% of families receiving dental care.
FISH of Lebanon Linn County – SLCH	Medical/ Prescription Costs	Provide Prescription Assistance to 75 adults.	% of adults receiving prescription assistance.
Trauma Intervention Program Linn County – SLCH	Training and Education for Volunteers	Provide training supplies.	Training supplies purchased.
Willamette Valley Rehab Center Linn County – SLCH	Automated External Defibrillator	Provide Automated External Defibrillator.	Automated External Defibrillator purchased
Mighty Oaks Children Center Linn County – SLCH	Speech Therapy	Provide Speech Therapy for 340 children.	% of children who receive Speech Therapy.
Fish of Albany Linn County – SAGH	Prescription Assistance	Provide Prescription Assistance.	% of families receiving Prescription Assistance
Rotary Club of Albany Linn County – SAGH	Dentist Fees	Provide dental services for low-income children & adults.	% of children & adults receiving dental services.
Lebanon Community School District Linn County – SLCH	Thermometers and Oscopes	Purchase Thermometers & Oscopes.	Thermometers & Oscopes purchased.
Pregnancy Alternatives Center Linn County – SLCH	Vitamin Packs	Provide prenatal vitamins to 140 pregnant women.	% of pregnant women receiving prenatal vitamins.
Lincoln Co. Health Lincoln County – SPCH	Oregon’s Mother’s Care	Provide consultation services to 140 pregnant women.	% of pregnant women receiving consultation.
Bright Horizons Lincoln County – SNLH	Therapy Services	Provide a Lift Chair.	Purchase Lift Chair.

**Objective #3:** Reduce the number of children who are abused and/or neglected.

**Community Need:** Percentage of children who are victims of abuse and/or neglect – 4.5% Benton, 9.3% Lincoln, 15.3% Linn (per 1000 children)

**Target Population:** Children

**Focus Issue:** Access \_\_\_\_\_ Community Health Improvement   x  

**Community Benefit Reporting Category:** Financial and In-Kind Contribution

Agency/Area	Activity	Outputs	Indicators
Lincoln County Children’s Advocacy Lincoln County – SNLH	Assessments of suspected child abuse victims	Provide evaluation and treatment for 150 children.	% of children who receive evaluations and treatment.
ABC House Linn County – SLCH	Computer Equipment	Provide computer equipment.	Computer equipment purchased.
Old Mill Center Benton County – GSRMC	Healthy Start Services	Provide home visits to new parents.	% of new parents who receive a home visit.
Old Mill Center Benton County – GSRMC	Crisis Relief Nursery	Provide mental health services to families.	% of families who receive mental health services.

**Objective #4:** Increase social supports for children and families.

**Community Need:** Percentage of residents living in poverty – 19.3% Benton, 17.6% Lincoln, 14% Linn

**Target Population:** Low-income families

**Focus Issue:** Access   x   Community Health Improvement \_\_\_\_\_

**Community Benefit Reporting Category:** Financial and In-Kind Contribution

Agency/Area	Activity	Outputs	Indicators
My Sister’s Place Lincoln County – SPCH	Shelter Services	Provide shelter and support services to 4,500 persons.	% of persons receiving shelter and support services.
Angels Anonymous Lincoln County – SNLH	Emergency Grants to Families	Provide assistance to families to meet basic needs.	% of families who receive basic needs assistance.
Community Outreach Benton County – GSRMC	Outreach Services	Provide support services to homeless, low-income, uninsured and under-insured families and adults.	% of families and adults receiving support services.

**Objective #5:** Increase social supports for seniors residing in the community.

**Community Need:** Percentage of residents age 65 and older living in poverty – 12% Benton, 10% Lincoln, 9% Linn

**Target Population:** Seniors

**Focus Issue:** Access \_\_\_\_\_ Community Health Improvement

**Community Benefit Reporting Category:** Financial and In-Kind Contributions

Agency/Area	Activity	Outputs	Indicators
Retired Senior Volunteer Program Lincoln County – SNLH/SPCH	Basic Health Care	Provide health care services for 300 Seniors.	% of Seniors receiving health care services.
Senior Meals on Wheels Lincoln County – SNLH	Food Assistance	Serve 100 Senior meals.	% of Seniors report receiving a healthy meal.

**Objective #6:** Increase services and supports for high-risk teens.

**Community Need:** Percentage of teen pregnancies – 8.7% Benton, 23.6% Lincoln, 24.2% Linn (per 1000 females ages 15-17)

**Target Population:** Low-income, uninsured, underinsured teens

**Focus Issue:** Access  Community Health Improvement \_\_\_\_\_

**Community Benefit Reporting Category:** Financial and In-Kind Contributions

Agency/Area	Activity	Outputs	Indicators
Lincoln Co. Health & Human Services Lincoln County – SPCH	SBHC Teen Reproductive Health Care	Provide parenting education to teens.	% of teens who receive parent education.
FISH of Albany Guest House Linn County – SAGH	Homeless Parenting and Pregnant Teens	Provide housing for 20 pregnant and parenting teens.	% of pregnant and parenting teens who receive housing.



Samaritan Health Services (SHS) has been supporting the communities of Benton, Lincoln and Linn counties for several years. As a regional health care system, SHS implements community benefit services and activities through a strategic comprehensive approach. Support groups, community education and support services are available to residents throughout the five hospitals. Each hospital also provides financial support through grants and donations to local non-profit agencies in each community. SHS is a key partner in many local coalitions and a strong collaborator in initiatives that address the mission, vision and values of the organization. Partnering with local government agencies and non-profit organizations, SHS participates in conducting a needs assessment in each county to determine health priorities. SHS also relies on community involvement to identify priorities and to help direct the type of services to be offered in each service area. During 2009 SHS provided nearly \$10 million in community benefit services and almost \$73 million in charity care and other services. In light of the current economic climate, SHS estimates an increase in community benefit services and support during 2010.





# Appendices





From: Community Benefit Department  
Subject: Community Benefit  
Adopted: October 7, 2009  
Effective: October 7, 2009  
Replaces: Social Accountability Budget: April 25, 2006

## **I. BACKGROUND**

A commitment to enhancing community health has been central to the mission of Samaritan Health Services (SHS) since its inception. This commitment includes assessing community needs and investing in best practice initiatives that address those needs in partnership with other local organizations. These investments include direct and in-kind support, dedicated to:

- Delivering compassionate, high-quality and affordable health services;
- Serving and advocating for underserved populations; and
- Partnering with others in the community to improve the quality of life.

## **II. POLICY**

Samaritan Health Services integrates community benefit into ongoing processes of planning, budgeting and reporting. At both system-wide and local levels, SHS explicitly uses its resources to benefit those in need and to promote health and healing in the community. The community benefit program at SHS addresses:

- A. Organizational Infrastructure
- B. Community-based Partnerships
- C. Community Health Assessments
- D. Resource Allocation
- E. Program Development
- F. Performance Measurement
- G. Uniform Reporting
- H. Dissemination of Community Benefit Reporting

## **III. DEFINITIONS**

A **community benefit** is a clinical or non-clinical program or activity that provides treatment and/or promotes health and healing that is:

- Responsive to identified health priorities determined in collaboration with community stakeholders;
- Focused on persons who are impoverished, disenfranchised or located in an area with disproportionate unmet health-related needs;

- Integrated into the facility's strategic planning and budgeting process; and
- Planned and implemented with program objectives and measurable outcomes that are beneficial to community stakeholders.

Community benefits also includes charity care and the unreimbursed costs of government-funded insurance programs, as well as health professions education, research, efforts to build upon the community's capacity and the costs associated with community benefit operations. In addition to its immediate geographical areas, a hospital's definition of **community** includes neighboring areas and populations with disproportionate unmet health-related needs.

**Health** is defined as a state of physical, mental and social well-being, not merely the absence of disease or infirmity.

## IV. PROCEDURE

### A. Organizational Infrastructure

- a) **System:** The SHS Board of Directors and senior leadership are accountable for a demonstrated commitment to improving community health status and addressing the societal issues that contribute to poor health, as well as personally working for the betterment of the community-at-large. In addition, the SHS Board of Directors and senior leadership will ensure that adequate resources are allocated to assess, develop and implement community benefit initiatives that respond to the unmet health priorities selected in collaboration with their community partners.

To facilitate this process, a **Community Benefit Advisory Committee (CBAC)** will be formed consisting of representatives from SHS departments including: Physician Services, Social/Pastoral Services, Finance, Quality/Compliance, Operations, and Public Relations/Marketing. The committee also includes three SHS board representatives or representatives from other affiliated boards. In conjunction with the Community Benefit staff, the **CBAC** facilitates the process of establishing program priorities based on community needs and assets, developing the system's community benefit plan and monitoring progress toward identified goals. Committee members will inform the SHS board on activities and developments and will also ensure that the committee has information from the board and management needed to make informed decisions.

- b) **Hospitals:** The hospital boards and leadership are responsible for ensuring site-based implementation of the community benefit plan to promote the broader health of the community.
- c) **Staff:** The SHS Community Benefit staff is responsible for facilitating the development and implementation of the community benefit plan in collaboration with system leaders and community stakeholders. The person accountable for community benefit shall report to the Vice President of Development and Marketing/Public Relations.

## **B. Community-based Partnerships**

From planning the community health assessment to establishing priorities, implementing, monitoring and evaluating programs, SHS works with other private and public organizations in their communities. Collaborators include, but are not limited to, the public health departments, school districts, faith-based organizations, local employers and other nonprofit health and social service agencies.

## **C. Community Health Assessment**

In collaboration with community partners, SHS and its affiliated hospitals participate in regular assessments of community health assets and needs with special attention to geographical areas and population sectors with disproportionate unmet health-related needs.

## **D. Resource Allocation**

The SHS budget shall include adequate financial resources to hire competent and effective staff to assess, plan, develop, implement, manage and report on community benefit initiatives.

## **E. Program Development**

SHS community benefit programs are developed in response to the health issues identified in the community health assessments and prioritized by a representative group of hospital/service area and community stakeholders. Community benefit staff work with site-based colleagues to ensure successful outcomes of community benefit programs.

## **F. Performance Measurement**

Recognizing that impact on health status is usually realized in the long term, the community benefit plan includes clinical and administrative objectives for community benefit initiatives that are measurable and that can serve as indicators of progress toward the achievement of desired health outcomes.

## **G. Uniform Reporting**

SHS hospitals shall conform to a uniform method of accounting community benefit expenses, using the Community Benefit Inventory for Social Accountability (CBISA software) program and guidelines outlined in OAR 409-023-0100.

## **H. Dissemination of Community Benefit Reporting**

SHS shall develop an annual community benefit report, and shall assure that diverse community stakeholders are aware of the report. The report will also be posted on the SHS website for the general public.

## **V. GRANTS AND FUNDING**

### **1. Social Accountability Grants**

As part of the community benefit program, SHS maintains a grants program called the Social Accountability Budget. Funds may be distributed to the local hospitals to support community health initiatives that contribute to the priorities identified in the SHS community benefit plan.

### **2. Funding Process and Decisions**

Grant decisions, including invitations to apply, are made by a site-based committee at each hospital consisting of representation from the following areas: hospital board of directors, the hospital CEO, social/pastoral services, finance, physician services, and marketing/public relations. Each of the five committees is facilitated by SHS Community Benefit staff.

Programs/projects to be considered for Social Accountability grants must address priorities identified in the Community Benefit Plan and also meet the following criteria:

- Focus on unmet needs in underserved populations;
- Be collaborative, involving partnerships with Samaritan Health Services and other organizations;
- Focus on prevention, with an emphasis on improving the health status in the community;
- Use quality indicators to measure progress and outcomes, reporting results and sharing them widely to attract more resources;
- Plan for self-sufficiency, where appropriate;
- Be fiscally responsible (preferably with administrative overhead of 15 percent or less).

The site-based Social Accountability Committees will review the proposals and submit their funding recommendations to the respective hospital boards of directors prior to July 1 distribution. The Samaritan Health Services board will be advised of each hospital board's decision.

Funds are primarily designed to be used for one-time efforts, though limited multi-year projects may be considered. Funds will be released on a quarterly basis to organizations that are allocated \$6,000 or more. Funds will be released on an annual basis to organizations that are allocated less than \$6,000. Funds that are not expended in each year will not carry over to future years.

### **3. Reporting**

Organizations receiving Social Accountability grants will be required to submit a mid-year report to the Community Benefit Director that demonstrates progress toward the project outcomes. In June of each year, the funded organizations will be asked to submit

a final report/evaluation of the project and its outcomes/results. The Community Benefit Director will prepare and present an overall Community Benefit report to the SHS Community Benefit Advisory Committee by July of each year.

Established: 2/16/98

Reviewed: 4/11/06

Revised: 4/25/06



It is our mission to provide exemplary health care services to all, regardless of ability to pay. If you qualify, your care may be provided free or at a reduced cost. The determination is based in part on poverty income guidelines issued by the U.S. Department of Health and Human Services. Once a completed financial questionnaire has been submitted, families at or below 200 percent of the established Federal Poverty Level (FPL) could be eligible to receive free or discounted care.

To apply for assistance, you must complete a financial questionnaire and submit proof of income. Download the questionnaire (English | Spanish) or request one by calling (541) 768-4392 or (800) 640-5339.

Persons in Family Unit	Annual Income 150% FPL	Annual Income 200% FPL
1	\$15,600	\$20,800
2	\$21,000	\$28,000
3	\$26,400	\$35,200
4	\$31,800	\$42,400
5	\$37,200	\$49,600
6	\$42,600	\$56,800
7	\$48,000	\$64,000
8	\$53,400	\$71,200
For each additional person, add:	\$5,100	\$6,800

**Uninsured discount program**

With the growing number of uninsured patients seeking care, we recognize the strain of paying medical bills without insurance coverage. Therefore, we have developed a discount program for our patients who do not have health insurance. Regardless of economic status, self-paying uninsured patients will receive a 10 percent discount. This discount will appear on your SHS billing statement.

**CHAPTER 409**  
**DEPARTMENT OF HUMAN SERVICES,**  
**OFFICE FOR OREGON HEALTH POLICY AND RESEARCH**  
**DIVISION 23**  
**HOSPITAL REPORTING**  
**Community Benefit Reporting Program**

**409-023-0100**

**Definitions**

The following definitions apply to OAR 409-023-0100 to 409-023-0105:

(1) “Charity care” means free or discounted health services provided to persons who cannot afford to pay and from whom a hospital has no expectation of payment. Charity care does not include bad debt, contractual allowances, or discounts for quick payment. Charity care is reported on the basis of cost, not gross charges by adjusting charges by a ratio of cost to charges (RCC).

(2) “Community” means the geographic service area and patient population that the health care institution serves as defined by the hospital.

(3) “Community benefits” mean programs or activities that provide treatment or promote health and healing as a response to identified community needs. They are not provided primarily for marketing purposes or to increase market share.

(a) Community benefit must meet at least one of the following criteria:

- (A) Generate negative margin;
- (B) Improve access to health services;
- (C) Enhance population health;
- (D) Advance knowledge;
- (E) Demonstrate charitable purpose.

(b) Community benefit activities must be counted in only one of the following categories:

- (A) Charity care;
- (B) Losses related to Medicaid, Medicare, State Children’s Health Insurance Program, or other publicly funded health care program shortfalls;
- (C) Community health improvement services;
- (D) Health professionals’ education;
- (E) Subsidized health services;
- (F) Research;
- (G) Financial and in-kind contributions to the community;
- (H) Community building activities;
- (I) Community benefit operations.

(4) “Cost” means the total expense incurred by the hospital minus any offsetting revenue (e.g. grants, payments).

(5) “Hospital” has the meaning provided in ORS 442.015.

(6) “Office” means the Office for Oregon Health Policy and Research.

Stat. Auth.: ORS 442.205

Stats. Implemented: ORS 442.205, 442.011, 442.200, 442.425, 442.445

## **409-023-0105**

### **Reporting**

- (1) Hospital reporting required pursuant to this rule shall begin with hospital fiscal years beginning on or after January 1, 2008 and must be consistent with generally accepted accounting principles.
- (2) The hospital must submit a community benefit report to the Office within 240 days from the close of the hospital's fiscal year. The report will be deemed submitted as of the date the report is postmarked or electronically delivered to the Office, whichever is first.
- (3) Hospitals may submit an amended report after submission of original report to the Office within 30 days of the report submittal deadline. The amended report must include a written explanation for the reason for the amendment.
- (4) Hospitals that are part of a multi-hospital system may submit reports for all system hospitals in one submission, but each hospital must be separately reported and clearly identified in any submission. Nothing in this section removes the requirement that hospitals report their individual community benefit report
- (5) If the ownership of the hospital changes during the reporting year, each hospital owner shall be required to submit a community benefit report for the hospital for the portion of the year owned.
- (6) Each hospital must submit, on an annual basis, a community benefit report on form CBR-1 as defined by the Office. The report must be completed in accordance with instructions published in the Community Benefit Reporting Guidelines (CBR-2). The Office shall inform each hospital subject to reporting of any changes for the subsequent year by July 1.
  - (a) Reporting only includes activities under the direct control and management of hospital management and occurring during the fiscal year of the report.
  - (b) Hospitals must not include a community benefit cost in more than one category as defined by the Community Benefit Reporting Guidelines (CBR-2). These guidelines shall be posted on the Office web site. The Office must inform each hospital subject to this reporting of any changes in guidelines for the subsequent year by July 1.
- (7) A hospital may submit, in addition to the reporting required in section (6), its financial assistance policy or any additional qualitative documents it deems appropriate. Any submission should be clearly identified for explanation of one of the community benefit categories defined in CBR-1.
- (8) A parent company or academic health center may submit quantitative and qualitative information about the community benefit provided by the parent company or academic health center and should comply with the definition of community benefit as defined in this rule. Any information provided should clearly identify the hospitals included.
- (9) Any information provided to the Office pursuant to this reporting will be publicly available and may be included in the annual report produced by the Office.
- (10) The Office shall produce and publicly report, by hospital, an annual report of the community benefit information submitted to the Office.
- (11) A hospital that fails to report as required in these rules may be subject to a civil penalty not to exceed \$500 per day.

Stat. Auth.: ORS 442.205

Stats. Implemented: ORS 442.205, 442.011, 442.200, 442.425, 442.445

**Federal Regulations**  
**Revenue Ruling 69-545, 1969-2 C.B. 117**

Rev. Rul. 69-545, 1969-2 C.B. 117

Examples illustrate whether a nonprofit hospital claiming exemption under section 501(c)(3) of the Code is operated to serve a public rather than a private interest; Revenue Ruling 56-185 modified.

Advice has been requested whether the two nonprofit hospitals described below qualify for exemption from Federal income tax under section 501(c)(3) of the Internal Revenue Code of 1954. The articles of organization of both hospitals meet the organizational requirements of section 1.501(c)(3)-1(b) of the Income Tax Regulations, including the limitation of the organizations' purposes to those described in section 501(c)(3) of the Code and the dedication of their assets to such purposes.

Situation 1. Hospital A is a 250-bed community hospital. Its board of trustees is composed of prominent citizens in the community. Medical staff privileges in the hospital are available to all qualified physicians in the area, consistent with the size and nature of its facilities. The hospital has 150 doctors on its active staff and 200 doctors on its courtesy staff. It also owns a medical office building on its premises with space for 60 doctors. Any member of its active medical staff has the privilege of leasing available office space. Rents are set at rates comparable to those of other commercial buildings in the area.

The hospital operates a full time emergency room and no one requiring emergency care is denied treatment. The hospital otherwise ordinarily limits admissions to those who can pay the cost of their hospitalization, either themselves, or through private health insurance, or with the aid of public programs such as Medicare. Patients who cannot meet the financial requirements for admission are ordinarily referred to another hospital in the community that does serve indigent patients.

The hospital usually ends each year with an excess of operating receipts over operating disbursements from its hospital operations. Excess funds are generally applied to expansion and replacement of existing facilities and equipment, amortization of indebtedness, improvement in patient care, and medical training, education, and research.

Situation 2. Hospital B is a 60-bed general hospital which was originally owned by five doctors. The owners formed a nonprofit organization and sold their interests in the hospital to the organization at fair market value. The board of trustees of the organization consists of the five doctors, their accountant, and their lawyer. The five doctors also comprise the hospital's medical committee and thereby control the selection and the admission of other doctors to the medical staff. During its first five years of operations, only four other doctors have been granted staff privileges at the hospital. The applications of a number of qualified doctors in the community have been rejected. Hospital admission is restricted to patients of doctors holding staff privileges. Patients of the five original physicians have accounted for a large majority of all hospital admissions over the years. The hospital maintains an emergency room, but on a relatively inactive basis, and primarily for the convenience of the patients of the staff doctors. The local ambulance services have been instructed by the hospital to take emergency cases to other hospitals in the area. The hospital follows the policy of ordinarily limiting admissions to those who can pay the cost of the services rendered. The five doctors comprising the original medical staff have continued to maintain their offices in the hospital since its sale to the nonprofit organization. The rental paid is less than that of comparable office space in the vicinity. No office space is available for any of the other staff members.

Section 501(c)(3) of the Code provides for exemption from Federal income tax for organizations organized and operated exclusively for charitable, scientific, or educational purposes, no part of the net earnings of which inures to the benefit of any private shareholder or individual.

Section 1.501(c)(3)-1(d)(1)(ii) of the regulations provides that an organization is not organized or operated exclusively for any purpose set forth in section 501(c)(3) of the Code unless it serves a public rather than a private interest.

Section 1.501(c)(3)-1(d)(2) of the regulations states that the term 'charitable' is used in section 501(c)(3) of the Code in its generally accepted legal sense.

To qualify for exemption from Federal income tax under section 501(c)(3) of the Code, a nonprofit hospital must be organized and operated exclusively in furtherance of some purpose considered 'charitable' in the generally accepted legal sense of that term, and the hospital may not be operated, directly or indirectly, for the benefit of private interests.

In the general law of charity, the promotion of health is considered to be a charitable purpose. Restatement (Second), Trusts, sec. 368 and sec. 372; IV Scott on Trusts (3rd ed. 1967), sec. 368 and sec. 372. A nonprofit organization whose purpose and activity are providing hospital care is promoting health and may, therefore, qualify as organized and operated in furtherance of a charitable purpose. If it meets the other requirements of section 501(c)(3) of the Code, it will qualify for exemption from Federal income tax under section 501(a).

Since the purpose and activity of Hospital Z, apart from its related educational and research activities and purposes, are providing hospital care on a nonprofit basis for members of its community, it is organized and operated in furtherance of a purpose considered 'charitable' in the generally accepted legal sense of that term. The promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community. Restatement (Second), Trusts, sec. 368, comment (b) and sec. 372, comments (b) and (c); IV Scott on Trusts (3rd ed. 1967), sec. 368 and sec. 372.2. By operating an emergency room open to all persons and by providing hospital care for all those persons in the community able to pay the cost thereof either directly or through third party reimbursement, Hospital A is promoting the health of a class of persons that is broad enough to benefit the community.

The fact that Hospital A operates at an annual surplus of receipts over disbursements does not preclude its exemption. By using its surplus funds to improve the quality of patient care, expand its facilities, and advance its medical training, education, and research programs, the hospital is operating in furtherance of its exempt purposes.

Furthermore, Hospital A is operated to serve a public rather than a private interest. Control of the hospital rests with its board of trustees, which is composed of independent civic leaders. The hospital maintains an open medical staff, with privileges available to all qualified physicians. Members of its active medical staff have the privilege of leasing available space in its medical building. (See Rev. Rul. 69-464, page 132, this Bulletin.) It operates an active and generally accessible emergency room. These factors indicate that the use and control of Hospital A are for the benefit of the public and that no part of the income of the organization is inuring to the benefit of any private individual nor is any private interest being served.

Accordingly, it is held that Hospital A is exempt from Federal income tax under section 501(c)(3) of the Code.

Hospital B is also providing hospital care. However, in order to qualify under section 501(c)(3) of the Code, an organization must be organized and operated exclusively for one or more of the purposes set forth in that section. Hospital B was initially established as a proprietary institution operated for the benefit of its owners. Although its ownership has been transferred to a nonprofit organization, the hospital has continued to operate for the private benefit of its original owners who exercise control over the hospital through the board of trustees and the medical committee. They have used their control to restrict the number of doctors admitted to the medical staff, to enter into favorable rental agreements with the hospital, and to limit emergency room care and hospital admission substantially to their own patients. These facts indicate that the hospital is operated for the private benefit of its original owners, rather than for the exclusive benefit of the public. See *Sonora Community Hospital v. Commissioner*, 46 T.C. 519 (1966), *aff'd*, 397 F.2d 814 (1968).

Accordingly, it is held that Hospital B does not qualify for exemption from Federal income tax under section 501(c)(3) of the Code. In considering whether a nonprofit hospital claiming such exemption is operated to serve a private benefit, the Service will weigh all of the relevant facts and circumstances in each case. The absence of particular factors set forth above or the presence of other factors will not necessarily be determinative.

Even though an organization considers itself within the scope of Situation 1 of this Revenue Ruling, it must file an application on Form 1023, Exemption Application, in order to be recognized by the Service as exempt under section 501(c)(3) of the Code. The application should be filed with the District Director of Internal Revenue for the district in which is located the principal place of business or principal office of the organization. See section 1.501(a)-1 of the regulations.

Revenue Ruling 56-185, C.B. 1956-1, 202, sets forth requirements for exemption of hospitals under section 501 (c) (3) more restrictive than those contained in this Revenue Ruling with respect to caring for patients without charge or at rates below cost. In addition the fourth requirement of Revenue Ruling 5-185 is ambiguous in that it can be read as implying that the possibility of ‘shareholders’ or ‘members’ sharing in the assets of a hospital upon its dissolution will not preclude exemption of the hospital as a charity described in section 501 (c) (3) of the Code. Section 1.501 (c) (3)-1 (b) (4) of the regulations promulgated subsequent to Revenue Ruling 56-185 makes it clear, however, that an absolute dedication of assets to charity is a precondition to exemption under section 501 (c) (3) of the Code.

Revenue Ruling 56-185 is hereby modified to remove there from the requirements relating to caring for patients without charge or at rates below cost. Furthermore, requirement four has been modified by section 1.501 (c) (3)-1 (b) (4) of the regulations.

**HOUSE RESOLUTION 3590**  
**SEC. 9007. ADDITIONAL REQUIREMENTS FOR CHARITABLE HOSPITALS.**

(a) REQUIREMENTS TO QUALIFY AS SECTION 501(C)(3) CHARITABLE HOSPITAL ORGANIZATION.—Section 501 of the Internal Revenue Code of 1986 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (r) as subsection (s) and by inserting after subsection (q) the following new subsection:

“(r) ADDITIONAL REQUIREMENTS FOR CERTAIN HOSPITALS.—

“(1) IN GENERAL.—A hospital organization to which this subsection applies shall not be treated as described in subsection (c)(3) unless the organization—

“(A) meets the community health needs assessment requirements described in paragraph (3),

“(B) meets the financial assistance policy requirements described in paragraph (4),

“(C) meets the requirements on charges described in paragraph (5), and

“(D) meets the billing and collection requirement described in paragraph (6).

“(2) HOSPITAL ORGANIZATIONS TO WHICH SUBSECTION APPLIES.—

“(A) IN GENERAL.—This subsection shall apply to—

“(i) an organization which operates a facility which is required by a State to be licensed, registered, or similarly recognized as a hospital, and

“(ii) any other organization which the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption under subsection (c)(3) (determined without regard to this subsection).

“(B) ORGANIZATIONS WITH MORE THAN 1 HOSPITAL FACILITY.—

If a hospital organization operates more than 1 hospital facility—

“(i) the organization shall meet the requirements of this subsection separately with respect to each such facility, and

“(ii) the organization shall not be treated as described in subsection (c)(3) with respect to any such facility for which such requirements are not separately met.

“(3) COMMUNITY HEALTH NEEDS ASSESSMENTS.—

“(A) IN GENERAL.—An organization meets the requirements of this paragraph with respect to any taxable year only if the organization—

“(i) has conducted a community health needs assessment which meets the requirements of subparagraph (B) in such taxable year or in either of the 2 taxable years immediately preceding such taxable year, and

“(ii) has adopted an implementation strategy to meet the community health needs identified through such assessment.

“(B) COMMUNITY HEALTH NEEDS ASSESSMENT.—A community health needs assessment meets the requirements of this paragraph if such community health needs assessment—

“(i) takes into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and

“(ii) is made widely available to the public.

“(4) FINANCIAL ASSISTANCE POLICY.—An organization meets the requirements of this paragraph if the organization establishes the following policies:

“(A) FINANCIAL ASSISTANCE POLICY.—A written financial assistance policy which includes—

- “(i) eligibility criteria for financial assistance, and whether such assistance includes free or discounted care,
- “(ii) the basis for calculating amounts charged to patients,
- “(iii) the method for applying for financial assistance,
- “(iv) in the case of an organization which does not have a separate billing and collections policy, the actions the organization may take in the event of nonpayment, including collections action and reporting to credit agencies, and
- “(v) measures to widely publicize the policy within the community to be served by the organization.

“(B) POLICY RELATING TO EMERGENCY MEDICAL CARE.— A written policy requiring the organization to provide, without discrimination, care for emergency medical conditions (within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd)) to individuals regardless of their eligibility under the financial assistance policy described in subparagraph (A).

“(5) LIMITATION ON CHARGES.—An organization meets the requirements of this paragraph if the organization—

“(A) limits amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy described in paragraph (4)(A) to not more than the lowest amounts charged to individuals who have insurance covering such care, and

“(B) prohibits the use of gross charges.

“(6) BILLING AND COLLECTION REQUIREMENTS.—An organization meets the requirement of this paragraph only if the organization does not engage in extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy described in paragraph (4)(A).

“(7) REGULATORY AUTHORITY.—The Secretary shall issue such regulations and guidance as may be necessary to carry out the provisions of this subsection, including guidance relating to what constitutes reasonable efforts to determine the eligibility of a patient under a financial assistance policy for purposes of paragraph (6).”.

(b) EXCISE TAX FOR FAILURES TO MEET HOSPITAL EXEMPTION REQUIREMENTS.—

(1) IN GENERAL.—Subchapter D of chapter 42 of the Internal Revenue Code of 1986 (relating to failure by certain charitable organizations to meet certain qualification requirements) is amended by adding at the end the following new section:

**“SEC. 4959. TAXES ON FAILURES BY HOSPITAL ORGANIZATIONS.**

“If a hospital organization to which section 501(r) applies fails to meet the requirement of section 501(r)(3) for any taxable year, there is imposed on the organization a tax equal to \$50,000.”.

(2) CONFORMING AMENDMENT.—The table of sections for subchapter D of chapter 42 of such Code is amended by adding at the end the following new item:

“Sec. 4959. Taxes on failures by hospital organizations.”.

(c) MANDATORY REVIEW OF TAX EXEMPTION FOR HOSPITALS.—

The Secretary of the Treasury or the Secretary’s delegate shall review at least once every 3 years the community benefit activities of each hospital organization to which section 501(r) of the Internal Revenue Code of 1986 (as added by this section) applies.

(d) ADDITIONAL REPORTING REQUIREMENTS.—

(1) COMMUNITY HEALTH NEEDS ASSESSMENTS AND AUDITED FINANCIAL STATEMENTS.—Section 6033(b) of the Internal Revenue Code of 1986 (relating to certain organizations described in section 501(c)(3)) is amended by striking “and” at the end of paragraph (14), by redesignating paragraph (15) as paragraph (16), and by inserting after paragraph (14) the following new paragraph:

“(15) in the case of an organization to which the requirements of section 501(r) apply for the taxable year—

“(A) a description of how the organization is addressing the needs identified in each community health needs assessment conducted under section 501(r)(3) and a description of any such needs that are not being addressed together with the reasons why such needs are not being addressed, and

“(B) the audited financial statements of such organization (or, in the case of an organization the financial statements of which are included in a consolidated financial statement with other organizations, such consolidated financial statement).”.

(2) TAXES.—Section 6033(b)(10) of such Code is amended by striking “and” at the end of subparagraph (B), by inserting “and” at the end of subparagraph (C), and by adding at the end the following new subparagraph:

“(D) section 4959 (relating to taxes on failures by hospital organizations),”.

(e) REPORTS.—

(1) REPORT ON LEVELS OF CHARITY CARE.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall submit to the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives and to the Committees on Finance and Health, Education, Labor, and Pensions of the Senate an annual report on the following:

(A) Information with respect to private tax-exempt, taxable, and government-owned hospitals regarding—

(i) levels of charity care provided,

(ii) bad debt expenses,

(iii) unreimbursed costs for services provided with respect to means-tested government programs, and

(iv) unreimbursed costs for services provided with respect to non-means tested

government programs.

- (B) Information with respect to private tax-exempt hospitals regarding costs incurred for community benefit activities.

(2) REPORT ON TRENDS.—

- (A) STUDY.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall conduct a study on trends in the information required to be reported under paragraph (1).

- (B) REPORT.—Not later than 5 years after the date of the enactment of this Act, the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall submit a report on the study conducted under subparagraph (A) to the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives and to the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

(f) EFFECTIVE DATES.—

- (1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

- (2) COMMUNITY HEALTH NEEDS ASSESSMENT.—The requirements of section 501(r)(3) of the Internal Revenue Code of 1986, as added by subsection (a), shall apply to taxable years beginning after the date which is 2 years after the date of the enactment of this Act.

- (3) EXCISE TAX.—The amendments made by subsection (b) shall apply to failures occurring after the date of the enactment of this Act.





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