ADVENTIST HEALTH RIDEOUT

2022 COMMUNITY HEALTH IMPLEMENTATION STRATEGY

APPROVED APRIL 27, 2023

2022

Adventist Health

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Purpose & Summary

Non-profit health systems, community-based organizations, and public health agencies across the country all share a similar calling: to provide public service to help improve the lives of their community. To live out this calling and responsibility, Adventist Health Rideout conducts a Community Health Needs Assessment (CHNA) every three years, with our most recent report completed in 2022. Now that our communities' voices, stories, and priority areas are reflected in the CHNA, our next step is to complete a Community Health Improvement Plan (CHIP), or as we refer to it in this report, a Community Health Implementation Strategy (CHIS).

The CHIS consists of a long-term community health improvement plan that strategically implements solutions and programs to address our health needs identified in the CHNA. Together with the Adventist Health Well-Being team, Blue Zones leadership, local public health officials, community-based organizations, medical providers, and members of selected underserved, low-income, and minority populations.

In this CHIS, you will find strategies, tactics, and partnerships that address the following prioritized health needs identified in the 2022 Adventist Health Rideout CHNA: **Access to Mental/Behavioral and Substance-Use Services, Access to Quality Primary Health Care Services and Specialty Care Services and Increased Community Connections.**

This report was reviewed and approved by our Hospital Board as well as the Adventist Health System Board on April 27, 2023. The entire report is published online and available in print form by contacting community.benefit@ah.org.

Blue Zones Project Yuba Sutter

Across the globe lie blue zones areas – places where people are living vibrant, active lives well into their hundreds at an astonishing rate—and with higher rates of well-being. Attaining optimal well-being means that our physical, emotional, and social health is thriving. Blue Zones Project works with communities to make sustainable changes to their environment, policies, and social networks to support healthy behaviors. Instead of a focus on individual behavior change, it is an upstream solution focused on making healthy options easy in all the places people spend most of their time. Blue Zones Project is committed to measurably improving the well-being of community residents and through their proven programs, tools and resources, utilizes rigorous metrics to inform strategies and track progress throughout the life of the project. This includes well-being data, community-wide metrics, sector-level progress and outcome metrics, transforming community well-being by making changes to environment, policy, worksites and social networks that create healthy and equitable opportunities for all.

Adventist Health Rideout proudly sponsors Blue Zones Project Yuba Sutter (BZPYS). The BZPYS team wakes up each morning focused on partnering and collaborating with community leaders and organizations active in the sectors of built environment, education, economic and workforce development, mental and physical well-being, policy and public health. Together the BZPYS team and sector leaders develop a community Blueprint that strategically aligns and leverages the actions and resources of the sectors where we live, learn, work and play to help advance the efforts around the community's biggest Social Determinant of Health challenges while connecting them to Health-Related Social Needs organizations.

Equity is a strategic priority woven throughout the Blueprint and programs. Policies and initiatives are developed in a way that honors the local culture that is focused on reaching out to all populations. Each year BZPYS sector leads come together to evaluate and update the Blueprint to ensure community alignment.

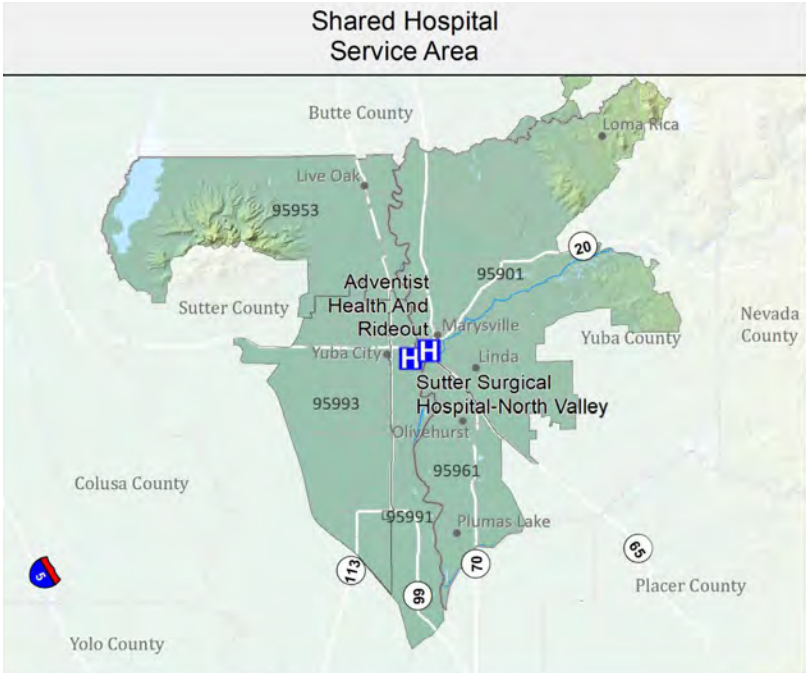
To learn more about Blue Zones Project Yuba Sutter and how to get involved visit: yubasutter.bluezonesproject.com

Description of Community Served

Marysville and Yuba City lie in Northern California's Sacramento Valley within the Greater Sacramento area, approximately 125 miles northeast of San Francisco and 125 miles west of Reno, Nevada. Nearly 11 million people live within a two-hour drive of the Yuba-Sutter area. Adventist Health and Rideout serves a region comprised of Yuba and Sutter counties, with a combined population of 181,480. Yuba and Sutter counties' population growth has outpaced the growth rate in California over the past two decades and is projected to continue. In both Yuba and Sutter counties, the largest segmentation of the population is currently 15-44 years old and senior population 65+ represent the largest growing segment, 11% and 6% respectively. The population demographics representing the largest disparities include:

- Seniors
- Non-English Speaking
- Homeless
- Youth
- Punjabi
- Migrants
- Rural Communities
- Disabled
- Those with Chronic Illnesses
- Undocumented
- Low Income
- Single Parents

For a more detailed look into community member comments, facts and numbers that are captured in the CHNA, please visit adventisthealth.org/aboutus/community-benefit. The following pages provide a closer look into our community demographic as well as our approach to the CHIS.



Community Demographics

The definition of the community served was the primary service area jointly shared by Adventist Health and Rideout (AHR) and Sutter Surgical Hospital North Valley (SSHNV). This area was defined by five ZIP Codes: 95901, 95953, 95961, 95991, and 95993. This service area was designated because the majority of patients served by both ADR and SSHNV resided in these ZIP Codes. AHR is located in Marysville, CA, and SSHNV is located in Yuba City, CA. Separated by the Feather River, these cities are located adjacent to one another and are part of the Yuba City Metropolitan Statistical Area as designated by the US Office of Management and Budget. The service area is home to over 150,000 community residents, and encompasses portions of both Sutter and Yuba Counties. The rural community is rich in diversity along a number of dimensions.

ZIP Code	Total Population	% Non-White or Hispanic\Latinx	Median Age (yrs.)	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95953	10,925	58	34.2	$57,949	18.9	6.7	8.0	29.4	35.4	15.0
95991	40,861	56.3	33.9	$50,682	18.7	9.7	8.9	24.0	42.8	13.9
95993	37,077	54.7	37.8	$69,019	12.1	7.6	7.1	19.1	29.1	12.6
Sutter	*96,109*	*53.8*	*35.7*	*$59,050*	*15.5*	*8.3*	*8.0*	*21.8*	*35.5*	*13.6*
95901	33,455	46.6	31.7	$54,851	17.3	7.5	7.3	16.9	38.1	16.2
95961	28,489	53.8	31.6	$55,590	15.9	7.5	7.6	22.8	37.0	12.7
Yuba	*76,360*	*44.8*	*32.8*	*$58,054*	*15.5*	*7.2*	*7.2*	*17.7*	*36.4*	*15.0*
California	*39,283,497*	*62.8*	*36.5*	*$75,235*	*13.4*	*6.1*	*7.5*	*16.7*	*40.6*	*10.6*

Source: 2019 American Community Survey 5-year estimates; U.S. Census Bureau.

About Us

Adventist Health Rideout

Adventist Health and Rideout is a non-profit community-based system comprised of the Adventist Health and Rideout acute care hospital; the Heart Center at Rideout; the Cancer Center affiliated with UC Davis Medical Center; outpatient clinics and a host of ancillary services including senior living services located throughout Yuba and Sutter counties. Adventist Health and Rideout employs more than 2,100 employees and has approximately 300 physicians on the medical staff.

Adventist Health

Adventist Health is a faith-inspired, nonprofit integrated health system serving more than 80 communities on the West Coast and Hawaii. Founded on Adventist heritage and values, Adventist Health provides care in hospitals, clinics, home care agencies, hospice agencies and joint-venture retirement centers in both rural and urban communities. Our compassionate and talented team of 34,000 includes associates, medical staff physicians, allied health professionals and volunteers driven in pursuit of one mission: living God's love by inspiring health, wholeness and hope. Together, we are transforming the American healthcare experience with an innovative, yet timeless, whole-person focus on physical, mental, spiritual and social healing to support community well-being.

Adventist Health Rideout's Approach to CHNA and CHIS

The purpose of the community health needs assessment (CHNA) is to identify and prioritize the significant health needs of the community served by Adventist Health and Rideout (AHRO) and Sutter Surgical Hospital North Valley (SSHNV). The priorities identified in the report will help to guide the hospitals' community health improvement programs and community benefit activities as well as their collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets the requirements of the Patient Protection and Affordable Care Act (and in California, Senate Bill 697) that nonprofit hospitals conduct a community health needs assessment at least once every three years. The CHNA was conducted by Community Health Insights (www.communityhealthinsights.com).

Community Definition

The definition of the community served was the primary service area jointly shared by AHRO and SSHNV. This area was defined by five ZIP Codes: 95901, 95953, 95961, 95991, and 95993. This service area was designated because the majority of patients served by both AHRO and SSHNV resided in these ZIP Codes. AHRO is located in Marysville, California, and SSHNV is located in Yuba City, California. Separated by the Feather River, these cities are located adjacent to one another and are part of the Yuba City Metropolitan Statistical Area as designated by the US Office of Management and Budget[1]. The service area is home to over 150,000 community residents and encompasses portions of both Sutter and Yuba Counties. The rural community is rich in diversity along a number of dimensions.

Assessment Process and Methods

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model[2]. This model of population health includes many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data-collection and analytic stages were developed. These included the collection and analysis of both primary (qualitative) and secondary (quantitative) data. Qualitative data included one-on-one and group interviews with 28 community health experts, social service providers, and medical personnel. Furthermore, 10 community residents or community service provider organizations participated in three focus groups across the service area. Finally, 16 community service providers responded to a Community Service Provider (CSP) survey asking about health need identification and prioritization.

Focusing on social determinants of health to identify and organize secondary data, datasets included measures to describe mortality and morbidity and social and economic factors such as income, educational attainment, and employment. Furthermore, the measures also included indicators to describe health behaviors, clinical care (both quality and access), and the physical environment.

At the time that this CHNA was conducted, the COVID-19 pandemic was still impacting communities across the United States, including the hospitals' service area. The process for conducting the CHNA remained fundamentally the same. However, there were some adjustments made during the qualitative data collection to ensure the health and safety of those participating. Additionally, COVID-19 data were incorporated into the quantitative data analysis and the impact of COVID-19 on health needs was a focus of qualitative data collection. These findings are reported throughout various sections of the report.

1. labormarketinfo.edd.ca.gov/definitions/metropolitan-areas.html
2. Robert Wood Johnson Foundation, and University of Wisconsin, 2021. County Health Rankings Model. Retrieved 31 Jan 2022 from.countyhealthrankings.org/.

Process and Criteria to Identify and Prioritize Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize significant health needs. This began by identifying 12 potential health needs (PHNs). These PHNs were identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the service area. Those PHNs that met a threshold of inclusion were selected as significant health needs. These significant health needs were prioritized based on rankings provided by primary data sources. Data were also analyzed to detect emerging health needs beyond those 12 PHNs identified in previous CHNAs. For this CHNA, no emergent health needs were identified.

Prioritized Health Needs - Planning to Address

Adventist Health and Rideout are committed to addressing the needs of the community. The nine priority needs identified in 2022 for the Yuba Sutter community are consistent with the last evaluation, with the addition of "community connections." Adventist Health and Rideout will continue to dedicate resources and collaborate with community partners to advance current initiatives.

Adventist Health and Rideout approached selecting the top priority needs to address by focusing on the needs that have the most significant impact and those that AHRO has the greatest influence in addressing. This selection was made using rigorous criteria that included: severity and prevalence of need, intentional alignment around common goals and initiatives, feasibility of potential interventions, community partner alignment and collaboration, and opportunities to maximize all available resources over a three-year period.

The top priority needs selected on the criteria above are not a necessarily a new focus of the organization. The goal of Adventist Health and Rideout is to expand our current efforts and invest significantly more effort to these focal areas. The three priority needs and current programs in place are featured below.

1.Access to Mental/Behavioral and Substance-Use Services

- Sun/Bridge Navigator Program (Emergency Department)
- The Behavioral Health Collaborative (Emergency Department)
- Enhanced Care Management (via Community Connect)
- Narcan Distribution

2. Access to Quality Primary Health Care Services and Specialty Care Services

- Expanded Clinics
- Expanded insurance coverage to include MediCal
- Clinic Expansion (Tharp Road & Urgent Care on Bogue Road)

3. Increased Community Connections

- Community Outreach/Sponsorship
- Blue Zones Project

Below is a list of low priority needs that will not be specifically addressed in the 2022 CHIS, due to lack of meeting criteria outlined above. Although it is important to note that as the needs of the community have been consistent year-over-year, there are a number of initiatives already in place that will continue.

1. Access to Basic Needs, such as Housing, Jobs, and Food
2. Active Living and Healthy Eating
3. Access to Functional Needs
4. Injury and Disease Prevention and Management
5. Safe and Violence-Free Environment

About the Implementation Strategy

The Community Health Implementation Strategy (CHIS) summarizes the strategies and activities to address prioritized health needs identified through the Community Health Needs Assessment (CHNA). Featured below is a more detailed description of the three priority needs and areas of focus for the next three years including: Access to Mental/ Behavioral and Substance-Use Services, Access to Quality Primary Health Care Services and Specialty Care Services, and Increased Community Connections

The Action Plan presented on the following pages outline in detail the individual strategies and activities Adventist Health and Rideout will implement to address the health needs identified though 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.

Access to Quality Primary Health & Specialty Care Services

Access to quality healthcare is critical for maintaining and improving one's quality of life at any age. A care delivery network begins and is sustained by a strong primary care foundation. Primary care services are typically the first point of contact when an individual seeks healthcare. These services are the front line in the prevention and treatment of common diseases and injuries in a community. Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, and other similar resources. The ratio of providers to the Yuba-Sutter community is an on-going challenge. Primary and specialty care go hand in hand, and without access to specialists, such as endocrinologists, cardiologists, and gastroenterologists, community residents are often left to manage chronic diseases, including diabetes and high blood pressure, on their own. The area lacks sufficient primary care and specialists to meet the community demand and as the area continues to experience growth, the need will only continue to increase. Local primary care offices have a 3-6 week waiting period to establish care and 1-3 week leeway on appointments for established patients. This leads to a significant overutilization of our hospital emergency room and a complete lack of access to care for many community members. In addition to specialty care, extended care refers to care extending beyond primary care services that is needed in the community to support overall physical health and wellness. When asked "what specific groups of community members experience health issues most?," seniors were by far the most frequent group mentioned. Additional services such as skilled nursing facilities, hospice care, and in-home healthcare will become increasingly more important as the demographic increases.

KEY FINDINGS

- Compared to state benchmarks, both counties are considered medically underserved.

- Sutter and Yuba counties are experiencing a mental health professional shortage area within the county, with less Mental health providers per 100,000 population (Sutter: 351.7, Yuba: 225) versus the state benchmark (373.4) and fewer Psychiatry providers per 100,000 population (Sutter: 7.3, Yuba: 2.6) compared to state benchmarks (13.5).

- The incidence of preventable hospitalizations per 100,000 is 1/3rd higher (Sutter: 1,223, Yuba: 1,463) versus the state (948.3).

- Deaths due to chronic lower respiratory disease, heart disease, and stroke per 100,000 are higher than state benchmarks.
    - o Chronic lower respiratory disease is almost double in Yuba County (67.2) than the state benchmark (34.8).
    - o Heart disease: Both counties are more than 20% higher (Sutter: 196, Yuba: 190.5) than California (159.5).
    - o Stroke: Sutter County skews slightly higher (Sutter: 59.9, Yuba: 45.3) than the state (41.2).

- The number of all infant deaths per 1,000 births are higher (Sutter: 5.6, Yuba: 6.8) than the state (4.2). Child mortality is more than 30% higher (Sutter: 50.8, Yuba: 56.6) than California benchmark (36).

BARRIERS

- While Adventist Health and Rideout understand the critical need for providers, recruitment continues to be a challenge for multiple reasons. In 2022 eight providers left the area and went to another hospital system or retired. At present, the hospital is currently recruiting 17 providers, and focused on filling vacancies.

- The Yuba-Sutter community can be described as rich in diversity which requires more culturally competent providers to serve, understand and communicate with non-English speaking residents.

- Many providers, including many specialists, do not accept Medi-Cal plans. An average of 8% of the population under the age of 65 are without health insurance in the Yuba-Sutter community.

Access to Mental/Behavioral & Substance-Use Services

Individual health and well-being are inseparable from individual mental and emotional outlook. Coping with daily life stressors is challenging for many people, especially when other social, familial, and economic challenges occur. Access to mental, behavioral, and substance use services is an essential ingredient for a healthy community where residents can obtain additional support when needed. Adventist Health and Rideout recognizes that the Yuba-Sutter area's struggle with providing adequate, culturally relevant mental health services is not unique; similar to other areas across the nation, the mental health system simply lacks capacity to meet the community's needs. Key informants, focus group and survey respondents also shared that there continues to be a stigma associated with seeking mental health services. And for those that do, navigating the mental/behavioral health system is a barrier for many. Furthermore, treatment options for those that are uninsured and underinsured are limited. Mental health challenges are compounded by homelessness as well as substance use including methamphetamines, opioids as well as tobacco/nicotine products in the community. These circumstances require additional support and services including treatment centers, psychiatric beds, and providers.

KEY FINDINGS

- Poor Mental Health Days: Yuba-Sutter residents experience significantly more poor mental days reported per month (Sutter: 4.9, Yuba: 4.7) than the CA average (3.7)

- Frequent Mental Distress: The percentage of adults reporting 14 or more days of poor mental health per month is significantly higher (Sutter: 14.5%, Yuba: 15%) than the CA average (11.3%)

- The number of homeless individuals per 100,000 population, exceeds (418) the California average (411).

- Overall, 87.5% of the Community Provider Survey respondents and 92% of the key informants and focus groups rated Access to Behavioral Health and Substance Use Services as the number one priority for this market.

- Community Service Providers also shared that during the COVID-19 pandemic, need for mental and behavioral health services increased over the pandemic, especially among youth and the elderly. Isolation and inability to deliver mental health services many youth had received through school prior to the COVID-19 pandemic, were contributing factors.

- The number of suicide mortalities in Sutter is higher (13.1) than California's average (11.2) and significantly higher in Yuba County (17.8).

- Drug induced deaths are over one and a half times higher (23.8) than the California average (14.3).

- Firearm fatalities per 100,000 are higher in Sutter County (10.8) and over double in Yuba County (17.2) compared to the state (7.8).

Increased Community Connections

As humans are social beings, community connection is a crucial part of living a healthy life. People have a need to feel connected with a larger support network and the comfort of knowing they are accepted and loved. Research suggests "individuals who feel a sense of security, belonging, and trust in their community have better health. People who do not feel connected are less inclined to act in healthy ways or work with others to promote well-being for all." Assuring that community members have ways to connect with each other through programs, services, and opportunities is important in fostering a healthy community. Further, healthcare and community support services are more effective when they are delivered in a coordinated fashion, where individual organizations collaborate with others to build a network of care.

Common themes provided by respondents included the need to better coordinate efforts. This included greater engagement and participation of local government leaders and better collaboration between health and social services to minimize operating in silos to maximize potential and better serve the community. The perception suggested by respondents was a lack of general interest and focus in developing community connections.

A stronger, more connected, aligned, and supportive community can collectively educate the and address challenges including the importance of preventative care, teen birth rates, juvenile arrest rates, suicide, and the benefits of high school completion among others. By coordinating efforts and creating awareness of resources, like the Yuba-Sutter food bank, individuals and the community contribute to creating a healthier, more vibrant, and sustainable community.

Additional by-products of this increased collaboration will assist with numerous growth opportunities including attracting new businesses, developers, and health care providers to the area.

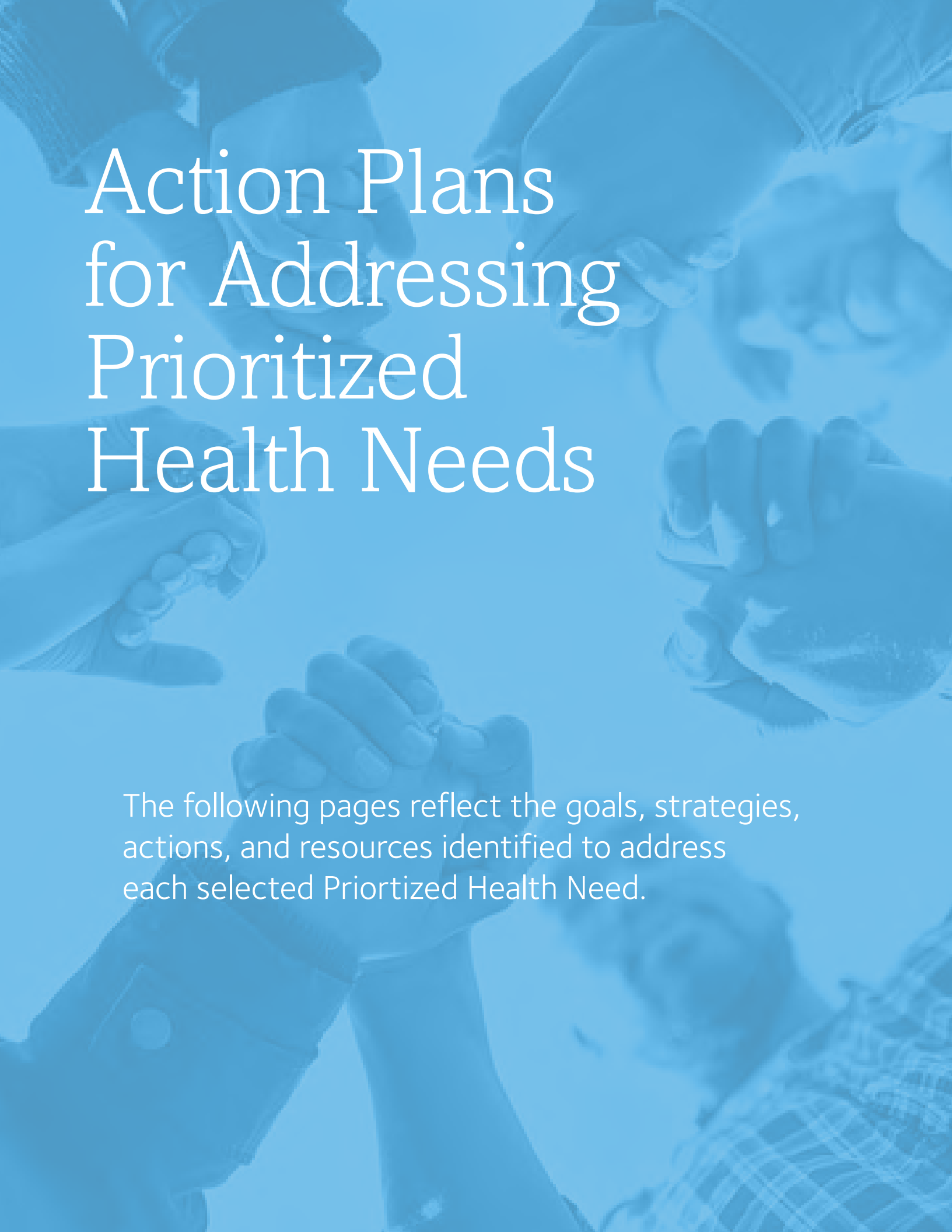
KEY FINDINGS

- Food insecurity: Although in an area abundant in produce, the Yuba-Sutter community has a higher percentage of the population who are low-income and do not live close to a grocery store (Sutter: 10.8%, Yuba: 12%) than the state benchmark (3.3%).

- Education and early detection education for the community will minimize lung and other cancer related deaths. Lung and bronchus cancers per 100,000 is higher in both counties (Sutter: 52.2, Yuba: 66.1) than the state benchmark (40.9).

- The percentage of teens and young adults ages 16-19 who are neither working nor in school is higher in Sutter County (8.4%), but on par in Yuba County with the state benchmark (6.4%)

- Yuba County's deaths due to homicide per 100,000 is almost double (7.2) the state benchmark (4.8). Improved relations between law enforcement and the community.



Action Plans for Addressing Prioritized Health Needs

The following pages reflect the goals, strategies, actions, and resources identified to address each selected Priortized Health Need.

ADDRESSING HIGH PRIORITY: ACCESS TO MENTAL/BEHAVIROAL HEALTH & SUBSTANCE USE SERVICES

GOAL	Develop infrastructure to address a significant public health need associated with providing essential Behavioral Health and Substance Use medical services that are critical to the health of our community and notably absent in our community (and beyond)

Priority Area:	Mental Health	**Sub-Category:**	Risk Factors – Access to Care Risk Factors Drugs & Alcohol	**Defining Metric:**	Access to Mental Health Providers

Strategy:	Lead an initiative focused on addressing the significant deficit in the community to meet non-acute medical and behavioral health needs by enhancing access to non-acute care services and treatment.
Population Served:	Total Population
Internal Partners:	Hospital President, CFO, CPE, COO, Community Well-Being, Real Estate/Design
External Partners:	Yuba and Sutter County Behavioral Health, FQHCs

Type of Strategy: Program/Activity/Tactic/Policy	**Organization**	**Lead**
Expand current services created/provided to treat/address behavioral health and substance use issues in the community. Build an infrastructure, via "Project Hope" – a vision to create a medical campus that has a suite of services designed to serve for our most vulnerable populations with the most complex health and social needs. These services will support the health and well-being of those we serve while complimenting and supporting our acute care hospital.	Adventist Health and Rideout	Robin Oliver
	Adventist Health Corporate	Ashten Phillips
	Sutter County Health & Human Services	Sarah Eberhardt-Rios
	Yuba County	Jennifer Vasquez

YEAR ONE	YEAR TWO	YEAR THREE
AHRO applied for a grant in October 2022 that would create the opportunity to initiate plans to develop a smaller scale "Project Hope" campus. Collect data validating the community need and opportunity. Create/continue a multi-disciplinary collaborative with community partners to shape the vision, drive change, and ensure sustainability of the program. Initiate plans to implement services and establish milestones.	Stay connected to the behavioral health needs of the community. Continue collaboration with community and county partners. Provide access to wraparound and step-down care for individuals needing assistance managing needs associated with mental, behavioral, and substance-abuse. *Goals for Years 2 and 3 dependents on progress.	Stay connected to the behavioral health needs of the community. Continue collaboration with community and county partners. *Goals for Years 2 and 3 dependent on progress.

ADDRESSING HIGH PRIORITY: ACCESS TO QUALITY PRIMARY HEALTH & SPECIALTY CARE SERVICES

GOAL	Retain and recruit primary care and specialists to meet and serve the medical needs of the community.

Priority Area:	Access to Care	**Sub-Category:**	Availability Primary and Specialty Care	**Defining Metric:**	Access to Healthcare (Insurance Disparity)

Strategy:	Redefine current physician recruitment approach and invest in new plan to actively engage and attract clinicians seeking employment.
Population Served:	Total Population
Internal Partners:	AHRO C-suite, Clinic Medical Director, Clinic Operations Leader, Physician Recruiter, Physician Champions, Greater Sac/Northern CA Network Partners
External Partners:	Residency programs, marketing agency, recruitment firms

Type of Strategy: Program/Activity/Tactic/Policy	**Organization**	**Lead**
Launch an aggressive physician recruitment plan to sustain and expand medical services in the Yuba Sutter community. (Draft plan attached)	AHRO Business Development Executive	Robin Oliver
	AHRO CFO	Heidar Thordarson
	AHRO/AHPN medical directors	Dr Heard and Dr Burt
	AH Clinic Operations	Lindsey Spencer, Stacy Laciste
	AHRO (recruitment team)	Ashley Dwello
	AH Northern CA partners	Johann Ramirez

YEAR ONE	YEAR TWO	YEAR THREE
Work with a dedicated physician recruiter to launch a robust physician recruitment campaign. Partner with other Greater Sacramento Network hospitals interested in recruitment (e.g., Clear Lake, Mendocino, Ukiah). Current focus is on addressing short-term physician needs to fill provider openings and concurrently build out an optimized, long-term physician landscape for the next five years.	Evaluate/communicate results, refresh approach, continue to focus on goals and continue to develop relationships with referral sources. Evaluate physician needs assessment, service line growth and new opportunities. Refresh list, as necessary. Evaluate key performance indicators (KPIs).	Evaluate results, refresh approach, continue to focus on goals and continue to develop relationships with referral sources. Evaluate physician needs assessment, service line growth and new opportunities. Refresh list, as necessary.

ADDRESSING HIGH PRIORITY: INCREASING COMMUNITY CONNECTIONS

GOAL	Align focus with community partners to create opportunities for increased, collaborative outreach efforts to maximize collective resources benefitting individuals living in the Yuba Sutter community.

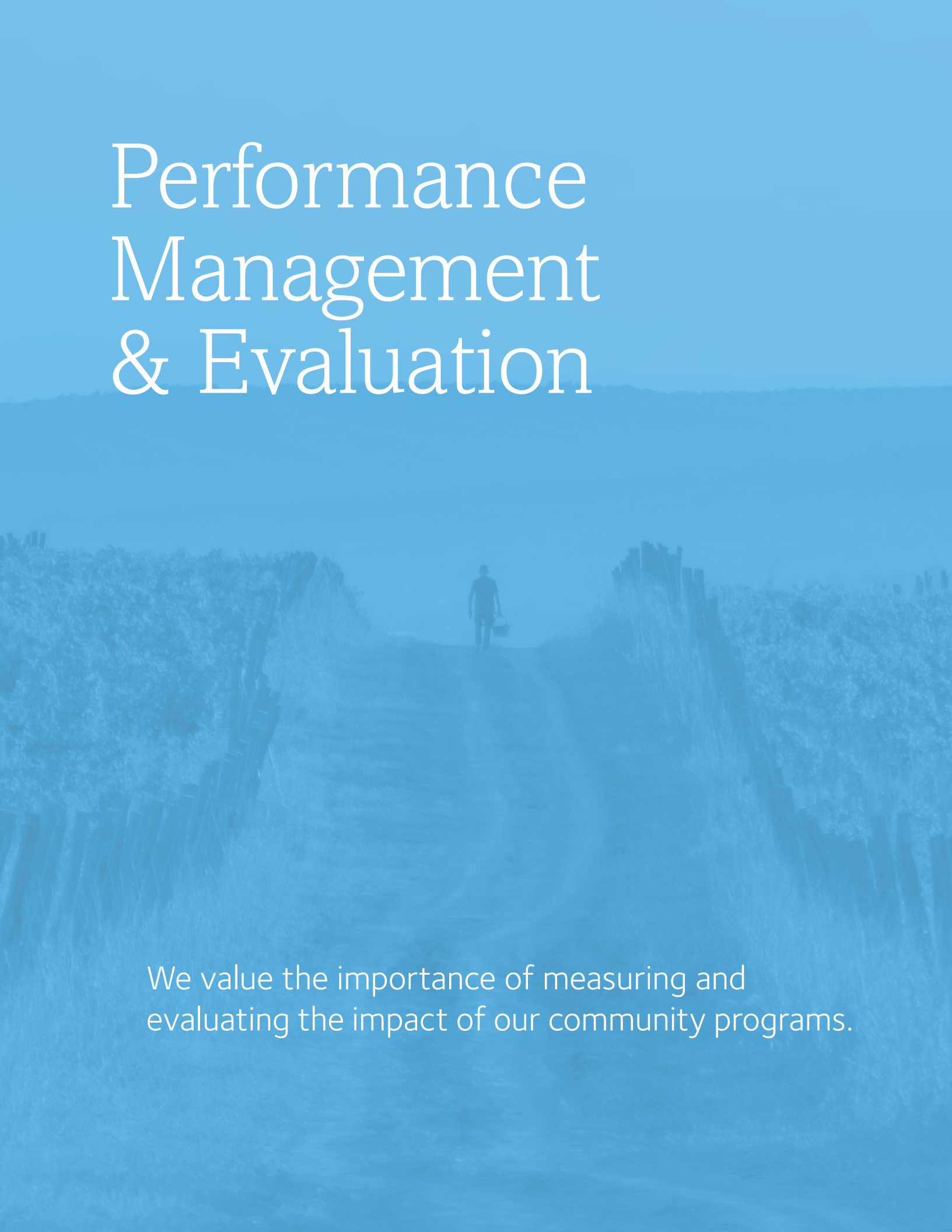
Priority Area:	Community Vitality	**Sub-Category:**	Social Inclusion	**Defining Metric:**	Theil Index (Isolation/Segregation), Business Vacancy Rate

Strategy:	Leverage and seek to develop new community partnerships (including non-profits, medical providers, county/public services) to address mutual objectives and reach target audiences.
Population Served:	Total Population
Internal Partners:	Blue Zones, Community Outreach Team
External Partners:	See attached Community Asset Map and Stakeholder list

Type of Strategy: Program/Activity/Tactic/Policy	**Organization**	**Lead**
Nurture well-being in the community by engaging established (and newly identified) community partners to develop a regular planning cadence to: - Share plans/activities to address community needs. - Identify opportunities to partner with a focus on creating increased visibility and access to healthcare, encouraging physical activity and positive interactions.	Adventist Health	Well-Being Director
	Blue Zones	Marni Sanders
	Public Health	Dr. Luu
	FQHCs	Ampla Health, Peachtree, Freedom Clinic
	Cancer Center JV partner	UC Davis
	Department of Health & Human Services (Sutter & Yuba)	Sarah Eberhardt- Rios – Sutter Co Jennifer Vasquez – Yuba Co
	First Five (Sutter & Yuba)	Michelle Branch, Ericka Summers
	Religious organizations	Francisco Cross
	Elected officials	Yuba City and Marysville
	Law enforcement	CHP, Marysville PD, Sutter Co. Sherriff, Yuba County Sheriff
	Community partners	See attached List

YEAR ONE	YEAR TWO	YEAR THREE
Identify community partners to create a Community Engagement Consortium. Develop an AHRO community engagement plan to share broadly with partners, community, and stakeholders. Develop a regular cadence for the Community Engagement Consortium to meet. Objective of meetings are to share initial plans and identify new opportunities to collaborate and add incremental activities to original plan. Develop objectives and goals for community. Develop a robust AHRO volunteer base to deploy to community events.	Evaluate year one achievements. Develop a Community Engagement Consortium annual plan and key performance indicators (KPIs). Continue to refine opportunities to maximize resources. Continue to identify new partners to add value. Create transparency. Identify opportunities to share success, opportunities to engage and benefits of outreach.	Evaluate year two achievements; refine or replace goals based on measurable results. Continue to refine opportunities to maximize resources. Continue to identify new partners to add value. Continue to focus on storytelling to increase awareness and increase community engagement and recognition.

Performance Management & Evaluation



We value the importance of measuring and evaluating the impact of our community programs.

Performance Management & Evaluation

Adventist Health will support the High Priority Need action plans identified in this CHIS by monitoring progress on an ongoing basis and adjusting the approach as needed over the course of the next three years. There are several resources in place to aid in this. All CHIS programs and initiatives will include a completed logic model to identify intended activities, outputs, and short and long-term outcomes. Establishing core metrics for each program or initiative will allow for the ongoing collection of performance management data. Actively tracking metric performance leads to the identification of strengths and challenges to the work, the local hospital, the Adventist Health Community Benefit team, and external consultants. Together, we will work to share successes and creative performance improvement plans when necessary.

In addition, Adventist Health hospitals where High Priority Needs are shared will have the opportunity to join a collaborative held by the Adventist Health Well-Being team. The collaborative will be centered on building a common approach that aligns and maximizes community benefit, thus reducing the need to manage this work independently at each hospital. Along with that, where appropriate, evaluation activities designed to measure the overall strength and success of this work at the community level will be incorporated into performance management tracking.

READ RIDEOUT'S 2022 CHNA BY VISITING:
adventisthealth.org/images/rideout/2022CHNA-Rideout-updated.pdf

Community Health Financial Assistance for Medically Necessary Care Commitment

Adventist Health understands that community members may experience barriers in paying for the care they need. That is why we are committed to providing financial assistance to those who may need support in paying their medical expense(s).

Community members can find out if they qualify for financial aid in paying medical bills by completing a financial assistance application. Applications can be filled out at the time care is received or after the bill has been administered. To access the financial assistance policy for more information or contact a financial assistant counselor, please visit https://www.adventisthealth.org/patient-resources/financial-services/financial-assistance/.

Approval Page

2023 CHIS Approval

In response to the 2022 Community Health Needs Assessment, this Community Health Implementation Strategy was adopted on April 27, 2023 by the Adventist Health System/West Board of Directors.

The final report was made widely available on May 31, 2023.

726 4th Street Marysville, CA 95901
Lic # 230000126
adventisthealth.org

Thank you for reviewing our 2023 Community Health Implementation Strategy.
We are proud to serve our local community and are committed to making it a healthier place for all.

Chris Champlin, CEO
Adventist Health Rideout

AdventistHealth