



**ADVENTIST HEALTH  
TULARE**

2022 COMMUNITY HEALTH  
IMPLEMENTATION STRATEGY

APPROVED APRIL 27, 2023

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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, the Central Valley Network (CVN) comprised of Adventist Health's four hospitals located in Hanford, Tulare, Reedley and Selma 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, local public health officials, community-based organizations, medical providers, students, parents, and members of selected underserved, low-income, and minority populations, the CVN intentionally developed a strategic plan to address the needs of our community.

In this CHIS, you will find strategies, tactics, and partnerships that address the following health needs identified in the 2022 CVN CHNA:

## **Financial Stability**

## **Food Security**

## **Mental Health**

We hope this report is leveraged by all local partners and community members, empowering them to own the potential of healthy living for all. 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](mailto:community.benefit@ah.org).



# What if ...

It's not a prescription that changes your health?

Instead, it's a collaboration between you and your care providers?

And it's community-based organizations working together to support you?

# Getting to know Adventist Health's Central Valley Network

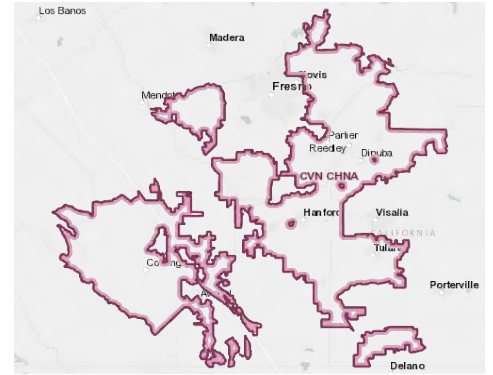
The Central Valley Network (CVN) is comprised of four cities: Hanford, Tulare, Reedley and Selma. The CVN is home to a total population of 530,375 residents with the majority age group being children (5-17), making up 22.2% of the population.

Centrally located between northern and southern California, CVN's geographic region is one of its biggest assets benefiting farmland businesses as well as residents pursuing recreational activities such as a short road trip to Yosemite National Park or the cool coastlines of Monterey Bay and Big Sur.

This young population is vibrant with festivals, events and small businesses. Of the population, 64.68% are Hispanic. The median household

income is \$60,367 of which 59.22% is spent on housing and transportation. Among this population, 27.23% of children live in poverty and 2.70% of students are unhoused, compared to the state average of 4.25% and national average of 2.77%.

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



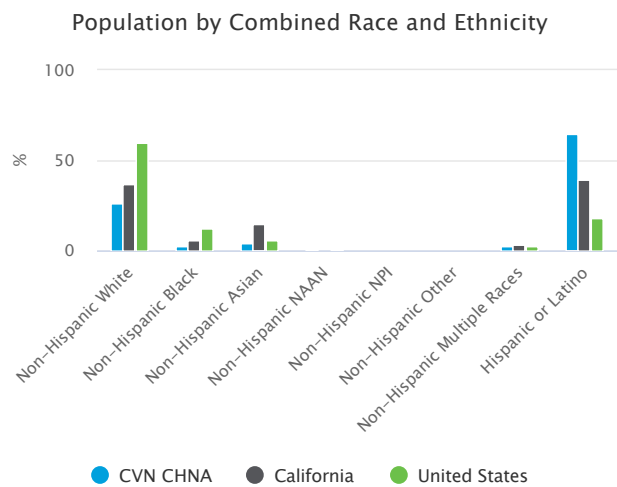
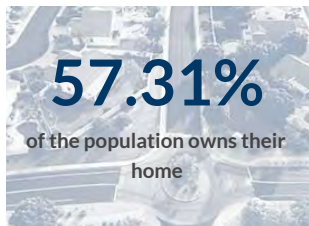
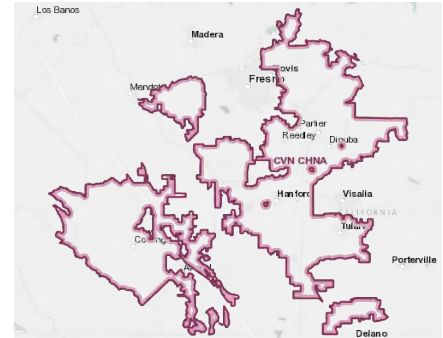
What if our community worked together and made life all-around better? What if we offered various pathways to meet our diverse needs, so every member of our community experienced better health, prosperity and longevity?

# Who We Serve

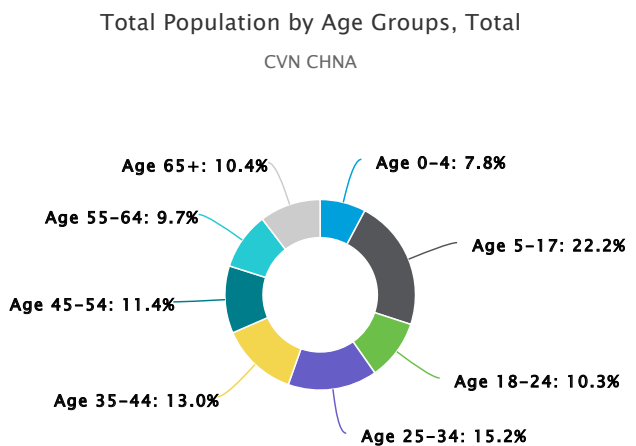
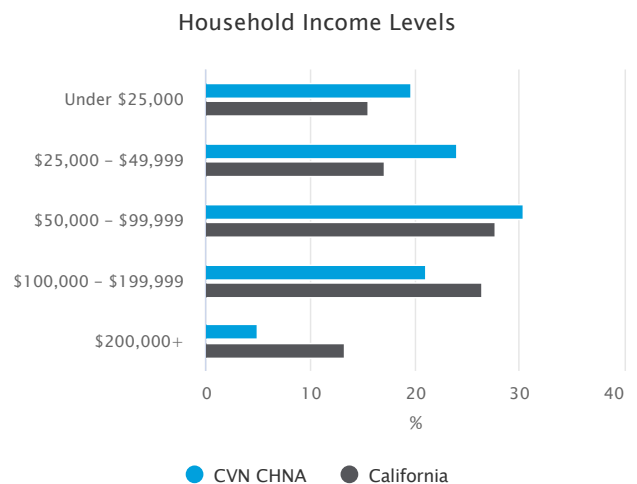
## DEMOGRAPHIC PROFILE

The following zip codes represent Adventist Health Central Valley Network's primary service area (PSA), accounting for 75% of hospital discharges. Additionally, we took a collaborative approach and expanded our PSA by inviting Steering Committee members to include the zip codes of those they serve.

The CVN CHNA market has a total population of 537,932 (based on the 2020 Decennial Census). The largest city in the service area is Tulare, with a population of 59,312. The service area is comprised of the following zip codes: 93219, 93648, 93625, 93646, 93609, 93647, 93631, 93657, 93245, 93234, 93239, 93654, 93204, 93618, 93230, 93615, 93662, 93212, 93630, 93619, 93210, 93656, 93274.



Note: NAAN = Native American or Alaska Native, NPI = Native Hawaiian or Pacific Islander.



# About Us

## Adventist Health Tulare

Located at the foot of the Sierra Nevada mountains and in the heart of the San Joaquin Valley, Tulare is a small agricultural town. Serving the town and the surrounding rural communities of Tulare County, Adventist Health Tulare is a 101-bed hospital dedicated to providing the highest level of clinical quality and safety while offering a vast range of services to those in need.



## 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's Approach to CHNA & CHIS

Adventist Health prioritizes well-being in the communities we serve across our system. We use an intentional, community centered approach when creating our hospital CHNA's to understand the health needs of each community. After the completion of the community assessment process, we address health needs such as mental health, access to care, health risk behaviors, and others through the creation and execution of a Community Health Implementation Strategy (CHIS) for each of our hospitals and their communities.

The following pages highlight the key findings the CVN CHNA Steering Committee (see page 17 for a list of CHNA Steering Committee sector participants) identified as their top priority health needs, or as we refer to them in this report, their 'High Priority Needs'. The High Priority Needs are addressed in this Community Health Implementation Strategy.

# High Priority Needs

The following pages highlight the High Priority Needs that will be addressed in this Community Health Implementation Strategy.



# Financial Stability

## COMMUNITY VOICES

- Certain parts of the community have very limited access to grocery stores, some interviewees noted.
- Low wages are seen as a driver toward fiscal insecurity.
- People stated that there are mental health consequences to not having enough money.
- Childcare costs are seen to take up a significant amount of family income.
- A college education is no longer seen as a guaranteed way to secure a good income.
- Low wages are believed to lead many to leave the area.
- It's seen as impossible to save for a house when paying very high rental costs.



Residents have much to be proud of, from agriculture that feeds families across the nation to booming warehouses filled with new employees. This vision was planted years ago, yet residents struggle to meet basic needs.

Concerns include low wages leading to fiscal insecurity and immigrant workers facing barriers to care due to work schedules. Others noted residents are faced with deciding between going to work to pay their bills or going to the doctor. Input suggested housing and insufficient funds can impact mental and physical health.

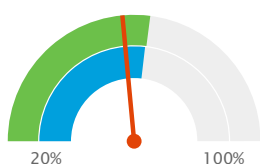
Analysis shows the labor force

participation rate (57.62%) is lower than that of California (63.29%) and the United States (62.97%). The unemployment rate (8.42%) is higher than the state and the nation. The child poverty rate is extremely high at 27.23%, higher than that of California (16.8%), and the median household income of \$60,367 is below California's rate.

Unemployment is known to create financial instability and barriers to basic services. Despite these real challenges and concerns, Central Valley residents are eager to be a part of the change that will ensure a brighter future of health, wholeness and hope.

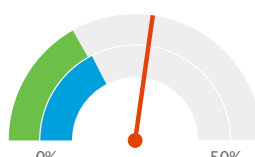
## SECONDARY DATA INFOGRAPHIC STATS:

Labor Force Participation Rate



- CVN CHNA (57.62%)
- California (63.29%)
- United States (62.97%)

Percent Population Under Age 18 in Poverty



- CVN CHNA (27.23%)
- California (16.80%)
- United States (17.48%)

Median Household Income



- CVN CHNA (\$60,367)
- California (\$78,672)
- United States (\$64,994)

# Food Security

## COMMUNITY VOICES

- Interviewees said the cost of living had increased since COVID started.
- People are paying double for food in rural communities; it requires reliable transportation to go to urban areas to shop for groceries, which is said to be a challenge for many.
- There was a worry amongst interviewees that families have to ration their food.
- Healthier food can be more expensive, which is viewed as a barrier.
- More farmers markets are seen as a way to increase local food access.



Central Valley residents are surrounded by the richness of their region and the technology that delivers farm-fresh foods. Growth also leads to job creation that supports families.

Residents were asked for input on the affordability and accessibility of food. They noted that they pay double for food in rural communities, transportation to urban areas is needed to secure groceries, food pantries don't have access to fresh veggies, and some are rationing their food. Limited choices lead to residents settling for processed foods.

Surveys documented an extremely high number of residents living

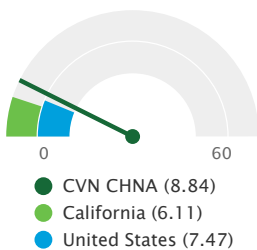
in poverty (19.22%) which is considerably higher than in California overall. Racial disparities in poverty rates exist – for example, one in three Native Hawaiian or Pacific Islanders in the community live in poverty.

Farmers' markets provide healthy foods, but residents' food budgets are low, so families still struggle. Free or reduced-price lunch programs represent 75.84% of public schools' students, which is higher than the state average of 59.18%.

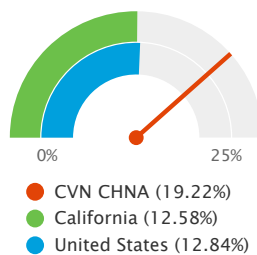
Agriculture that feeds the globe and open-minded residents are keys to working together, addressing needs today and beyond.

## SECONDARY DATA INFOGRAPHIC STATS:

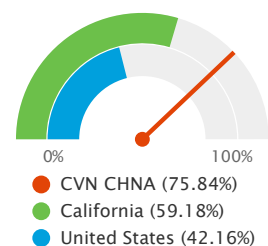
SNAP-Authorized Retailers, Rate (Per 10,000 Population)



Population in Poverty, Percent



Percentage of Students Eligible for Free or Reduced Price School Lunch



# Mental Health

## COMMUNITY VOICES

- People noted that there seems to be a lot of stigma around mental health issues.
- The educational system does not have enough people to support the kids with mental health issues, focus group participants indicated.
- Interviewees said if people are more anxious and depressed, they may turn to drugs and alcohol.
- No inpatient treatment centers are believed to be in the area.
- The social isolation that accompanied COVID is seen as a mental health challenge for some.
- COVID may have made some residents less likely to go to healthcare appointments, per interviewees.



Central Valley residents shared the mental health experiences they faced and the needs they continue to face as they struggle to overcome challenges. Thanks to input and commitment, the region is in a better position to help understand and address mental health.

Central Valley residents struggle with mental health to a greater extent than in California, in general, and the US. Deaths of despair includes deaths due to self-harm, alcohol-related disease, and drug overdose. These deaths are now at 43.4 per 100k people, and rates are higher than the rate elsewhere in California.

The rate of mental health providers

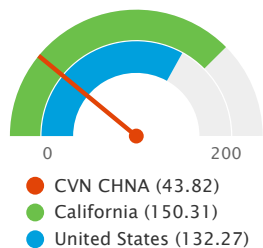
is 43.82 per 100k people, compared to 150.31 in California and 132.27 in the state. As residents noted, there are no inpatient treatment options and insufficient substance abuse rehabilitation centers.

Residents are also challenged with a shortage of credentialed professionals who provide counseling and adolescent and adult mental health care, along with inpatient treatment centers designed specifically for teenagers.

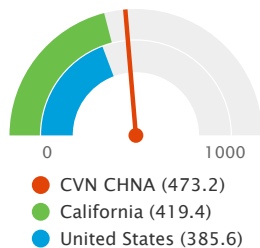
It is encouraging that community voices are being heard as residents seek to identify opportunities for change and brighter futures.

## SECONDARY DATA INFOGRAPHIC STATS:

Mental Health Care Providers, Rate per 100,000 Population



Violent Crime Rate per 100,000 Pop.



Violent Crime Rate

Report Area	Violent Crimes	Violent Crime Rate (Per 100,000 Pop.)
Adventist Health Central Valley Network	2,475	473.2
California	327,327	419.4
United States	2,445,671	385.6



# Action Plan for Addressing High Priority Needs

Committee members drew upon a broad spectrum of expertise and possible strategies to improve the health and well-being of vulnerable populations within the community.

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

**ADDRESSING HIGH PRIORITY: Financial Stability**

<b>GOAL</b>	Advocate for and collaborate with internal and external partners to identify community members experiencing poverty and connect them to support services to lessen financial burden.
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<b>Priority Area:</b>	Financial Stability	<b>Sub-Category:</b>	Income	<b>Defining Metric:</b>	Poverty
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<b>Strategy:</b>	Partner with external partners to provide financial literacy programs.
<b>Population Served:</b>	Total Population
<b>Internal Partners:</b>	Finance department, ShareCare
<b>External Partners:</b>	Valley Strong Bank, School Districts, King Community Action Organization

<b>Action:</b> Program/Activity/Tactic/Policy	<b>Organization</b>
Introduce Valley Strong Bank to School districts and other community partners to share their financial literacy program.  Create partnerships with other banks to identify educational needs such as loan acquirement, business plans, etc.	Valley Strong Bank
	Hanford School District
	Tulare School district
	Kings Canyon School District

YEAR ONE	YEAR TWO	YEAR THREE
Develop partnership with Valley Strong Bank and other banks, introduce to school districts and other organizations.	Expand program in other communities.	Expand program in more communities.

<b>Strategy 2:</b>	Provide space to collaborate with external partners to provide resources for the community.
<b>Population Served:</b>	Total Population
<b>Internal Partners:</b>	Director of Care Coordination
<b>External Partners:</b>	Champions, Tulare County Health Services

<b>Action:</b> Program/Activity/Tactic/Policy	<b>Organization</b>	<b>Lead</b>
Coordinate and socialize a resource center with external partners. Open a resource center in Tulare utilizing space allocated.	Champions	Julie Mooney
	Adventist Health	Valerie Alvarez
	Tulare Unified School District	
	Tulare county Health Services	Noah Whitaker

YEAR ONE	YEAR TWO	YEAR THREE
Establish External Partner Services and restructure space.	Expand services and increase community involvement.	Expand services and increase community involvement.

**ADDRESSING HIGH PRIORITY: Food Security**

<b>GOAL</b>	Strive to give access to current food distribution programs to the community identified by clinical screenings.
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<b>Priority Area:</b>	Food Security	<b>Sub-Category:</b>	Food Access	<b>Defining Metric:</b>	Local Food Outlets
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<b>Strategy 1:</b>	Increase clinical screenings to identify patients in need of current food distribution programs.
<b>Population Served:</b>	Vulnerable families
<b>Internal Partners:</b>	Director of Nutritional Services, Social Worker
<b>External Partners:</b>	KCAO, CalAIM Navigators

Action: Program/Activity/Tactic/Policy	Organization	Lead
Build relationships with external partners who already have an established distribution program.	Kings County Action Organization	Jeff Garner
Increase screenings for food insecurities at clinical visits.	Adventist Health CVN	Maria Nunez Valerie Alvarez

YEAR ONE	YEAR TWO	YEAR THREE
Establish relationships with external partners who are currently providing food services. Create a process/workflow for screenings that we can implement across the network.	Build on workflow to create awareness of all programs available to the community and implement in 50% of our clinics.	Build on workflow to create awareness of all programs available to the community and implement in 75% of our clinics.

<b>Strategy 2:</b>	Expand food program in all clinics (such as Nutrible, food banks).
<b>Population Served:</b>	Low-income Families
<b>Internal Partners:</b>	Clinical Social Worker, Associate Ambulatory Director
<b>External Partners:</b>	CalAIM Navigators

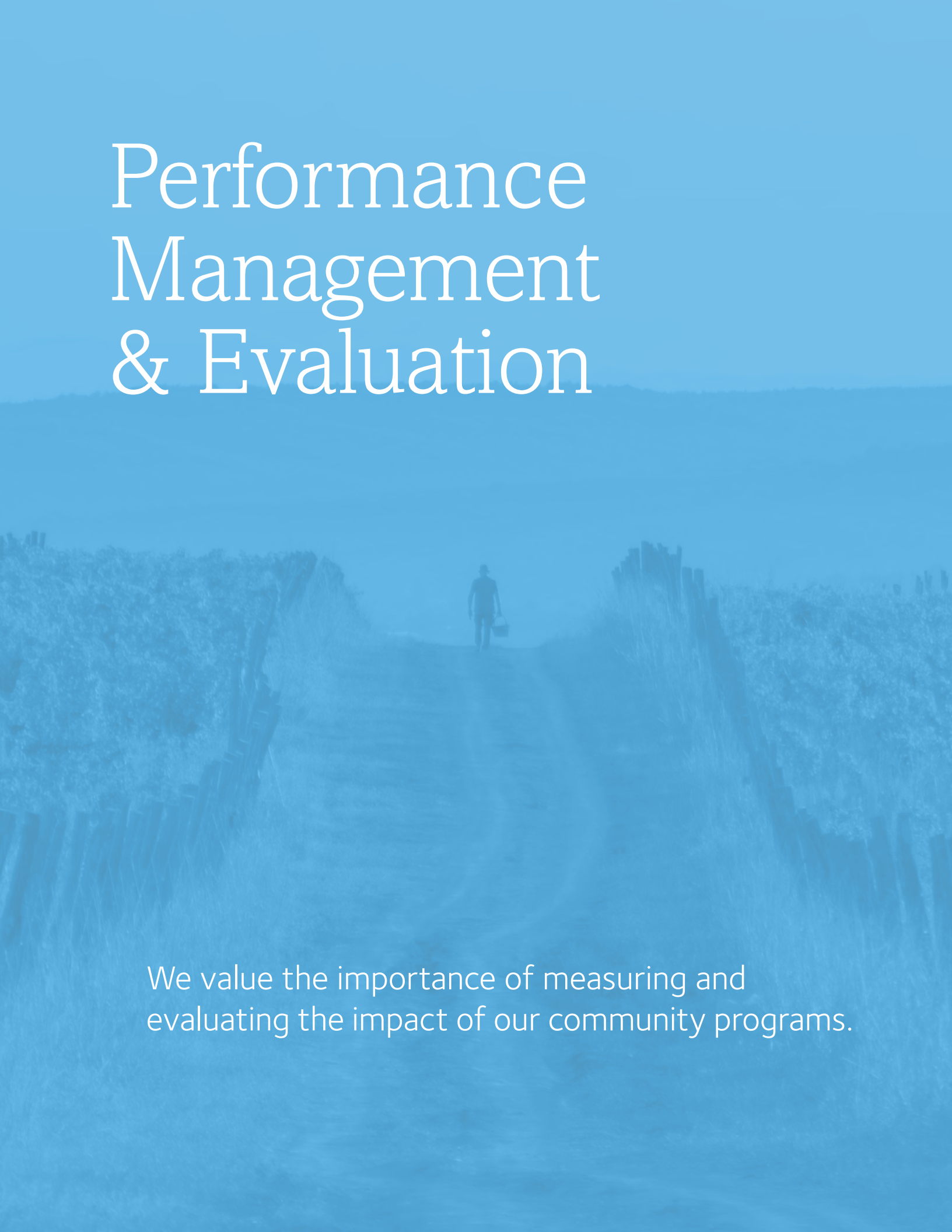
Action: Program/Activity/Tactic/Policy	Organization	Lead
Implement food programs to aid vulnerable patients, such as Nutrible. Expand to all clinics serving lower income families.	Adventist Health CVN	Maria Nunez Jennifer Duyst Valerie Alvarez Shawna Lancaster

YEAR ONE	YEAR TWO	YEAR THREE
Implement food programs in an Adventist Health Medical Office clinic.	Expand food programs in the clinics as available.	Expand food programs in the clinics as available.

**ADDRESSING HIGH PRIORITY: Mental Health**

<b>GOAL</b>		Provide mental health awareness and access to our communities.			
<b>Priority Area:</b>	Mental Health	<b>Sub-Category:</b>	Risk Factors - Access to Care	<b>Defining Metric:</b>	Mental Health Providers
<b>Strategy 1:</b>	Work with internal and external stakeholders to provide educational awareness.				
<b>Population Served:</b>	Total Population				
<b>Internal Partners:</b>	Ambulatory Director of Mental Health Services, Medical Director of Mental Health Services, Ambulatory Medical Director, Director of Well-Being, Associate Director of Ambulatory Services, Community Health Workers				
<b>External Partners:</b>	School Districts, Community Partners, County Behavioral Health Departments				
<b>Actions:</b> Program/Activity/Tactic/Policy	<b>Organization</b>		<b>Lead</b>		
<p>Create a Behavioral Health Collaborative between Kings, Tulare and Fresno County Behavioral Health Departments. Roll out initiatives created by the collaborative to provide awareness amongst adults and children.</p> <p>Utilizing current programs such as: -Kings County Mobile Crisis Unit</p>	Adventist Health Central Valley Network		Valeria Alvarez Ray Ambriz Dr. Waugh		
	Public Health – Tulare County		Natalie Bolin		
	Public health – Fresno County		Susan Holt, LMFT		
	Public Health – Kings County		Lisa Lewis, PHD		
<b>YEAR ONE</b>	<b>YEAR TWO</b>		<b>YEAR THREE</b>		
Identify collaborative members and goals.	Implement strategies and programs identified by collaborative.		Implement strategies and programs identified by collaborative.		
<b>Strategy 2:</b>	Create awareness and increase Adventist Behavioral Health virtual visits utilizing the Bridge program to help identify patients seen through emergency departments.				
<b>Population Served:</b>	Total Population				
<b>Internal Partners:</b>	Ambulatory Director of Mental Health Services, Medical Director of Mental Health Services, Ambulatory Medical Director, Director of Well-Being, Associate Director of Ambulatory Services, Director of Care Coordination, Community Health Workers				
<b>External Partners:</b>	Community Partners – Champions Recovery				
<b>Actions:</b> Program/Activity/Tactic/Policy	<b>Organization</b>		<b>Lead</b>		
<p>Provide educational materials to providers about Behavioral Health Virtual Care services. Increase knowledge and awareness about virtual visits.</p>	Adventist Health CVN		Ray Ambriz Dr. Waugh Dr. Diaz (Peds- Fowler) Trista Campos Jennifer Duyst		
	Champions Recovery		Julie Mooney Frank Ruiz		
<b>YEAR ONE</b>	<b>YEAR TWO</b>		<b>YEAR THREE</b>		
Establish goals for number of visits in 2023. Set strategy for creating awareness of Adventist Behavioral Health virtual visits.	Implement strategy in clinics and increase virtual visits.		Implement strategy in clinics and increase virtual visits.		

# Performance Management & Evaluation

A person is walking away from the viewer on a dirt path that leads into a field of tall, dry grass. The person is carrying a basket and is wearing a hat. The entire scene is overlaid with a semi-transparent blue filter. The path is the central focus, leading the eye towards the person in the distance.

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 create 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.

## CHIS Development

The development of the CHIS was directly built from the CHNA, whose goal focused on leveraging community stakeholders and data to address the most significant health needs of our community over the next three years. Members of the CHNA Steering Committee—comprised of healthcare, civic, public, and business leaders—led the process of identifying and addressing health needs for a healthier community, completing the final report in fall of 2022.

Collaborating with CHNA Steering Committee members again in early

2023, Adventist Health Community Well-Being Directors facilitated a multi-step process to outline goals and strategies for the CHIS that foster change and positive impact in each of the High Priority Need areas. Each community relied on existing programs and services, and, where necessary, identified new opportunities to pursue collectively.

Once an approach received a consensus, the Community Well-Being Directors worked with Adventist Health leadership and expert consultants to set major

annual milestones for each approach, generating outputs and outcomes that allow for ongoing performance management of this work. For further information on how success will be tracked, refer to the Performance Management and Evaluation section above.

Finally, the CHIS was presented to Adventist Health local Hospital Boards for review and feedback. In addition to this collaborative effort, we also welcome feedback at [community.benefit@ah.org](mailto:community.benefit@ah.org).



Scan the QR code for the full Secondary Data Report



# Significant Identified Health Needs

The Adventist Health Community Well-Being team and community partners collectively reviewed all relevant significant health needs identified through the CHNA process. Using a community health framework developed for this purpose, 12 significant health needs were initially considered. The list of significant needs are as follows:

- Access to Care
- Community Safety
- Community Vitality
- Education
- Environment & Infrastructure
- Financial Stability
- Food Security
- Health Conditions
- Health Risk Behaviors
- Housing
- Inclusion & Equity
- Mental Health

From this group of 12, several high priority health needs were established for CVN. High priority health needs were chosen as they had demonstrated the greatest need based on severity and prevalence, intentional alignment around common goals, feasibility of potential interventions, and opportunities to maximize available resources over a three-year period.

Using the criteria mentioned above, we were able to determine which needs were high priority, as compared to those that were significant needs. The High Priority Needs are the focus of this CHIS. The remaining significant health needs are not addressed directly but will likely benefit from the collective efforts defined in this report. The following table provides additional information on all the significant health needs that were considered.

**TABLE OF SIGNIFICANT IDENTIFIED HEALTH NEEDS**

High Priority Needs	
<b>Food Security</b>	See Sections III.C - E
<b>Financial Stability</b>	See Sections III.C - E
<b>Mental Health</b>	See Sections III.C - E
Lower Priority Needs	
<b>Housing-Unhoused</b> <a href="http://211kingscounty.org/housing">211kingscounty.org/housing</a>	54% of surveyed residents identified homelessness as a health need in the community, with many interviewees noting that being unhoused negatively affects the mental and physical health of people.
<b>Housing-Cost</b> <a href="http://211kingscounty.org/housing">211kingscounty.org/housing</a>	The limited housing stock, and high housing costs, push many into an unstably housed environment. Service needs for this group are very high, and the overall cost of living makes stable housing unrealistic for some community residents.
<b>Health Conditions</b> <a href="http://211kingscounty.org/health">211kingscounty.org/health</a>	The prevalence rates of multiple chronic diseases is higher than the state average. Similarly, mortality rates for lung and liver disease are also elevated compared to California as a whole.
<b>Education</b> <a href="http://211kingscounty.org/education">211kingscounty.org/education</a>	27% of surveyed residents said education is a health need in the community. Key informant interviewees said it is very difficult for schools in the area to provide the full range of support and services that children and families cannot get elsewhere.
<b>COVID</b> <a href="http://211kingscounty.org/health">211kingscounty.org/health</a>	46% of surveyed residents identified COVID as a community health need.
<b>Access to Care</b> <a href="http://211kingscounty.org/health">211kingscounty.org/health</a>	The number of healthcare providers per 100,000 people in this community is half the state rate. Interviewees noted transportation barriers to accessing services as well.
<b>Health Risk Behaviors</b> <a href="http://211kingscounty.org/addictions">211kingscounty.org/addictions</a>	The adult smoking rate is higher than state and national averages, and only 25% of residents 65 years or older are up-to-date on core preventative services.



Scan the QR code for the full Secondary Data Report



## 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/>.



# Glossary of Terms

**COMMUNITY ASSET**

refers to community organizations, programs, policies, activities or tactics that improves the quality of community life.

**DEFINING METRIC**

this is the metric used to define the extent of the problem faced by the target population.

**FUNDING**

can be provided by (but not limited to) government agencies, public organizations, grants and philanthropic giving.

**GOAL**

there may be several overarching goals to address each prioritized health need. This is the overarching impact we want to achieve.

**PARTNERS**

describe any planned collaboration between the hospital and other facilities or organizations in addressing health needs.

**POPULATION SERVED**

who is included within the group to receive services of the program.

**PRIORITIZED HEALTH NEED/  
PRIORITY AREA/SIGNIFICANT  
HEALTH NEEDS**

a health need that was identified in a community health needs assessment and was then selected by committee as a high priority need to be addressed.

**STAKEHOLDER- INTERNAL**

colleagues and or board members who work for or with the hospital.

**STAKEHOLDER- EXTERNAL**

community members or organizations who regularly collaborate with the hospital.

**STRATEGY**

a specific action plan designed to achieve the expected outcome.

**SUB-CATEGORY**

if needed, a more granular focus within the identified priority area may be called out.

# 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.

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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.

**Andrea Kofi**

President, Central Valley Network

ADVENTIST HEALTH  
TULARE