ADVENTIST HEALTH LODI MEMORIAL

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 Lodi Memorial 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, Adventist Health Lodi Memorial 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 Adventist Health Lodi Memorial CHNA:

Access to Care

Financial Stability

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.

What if . . .

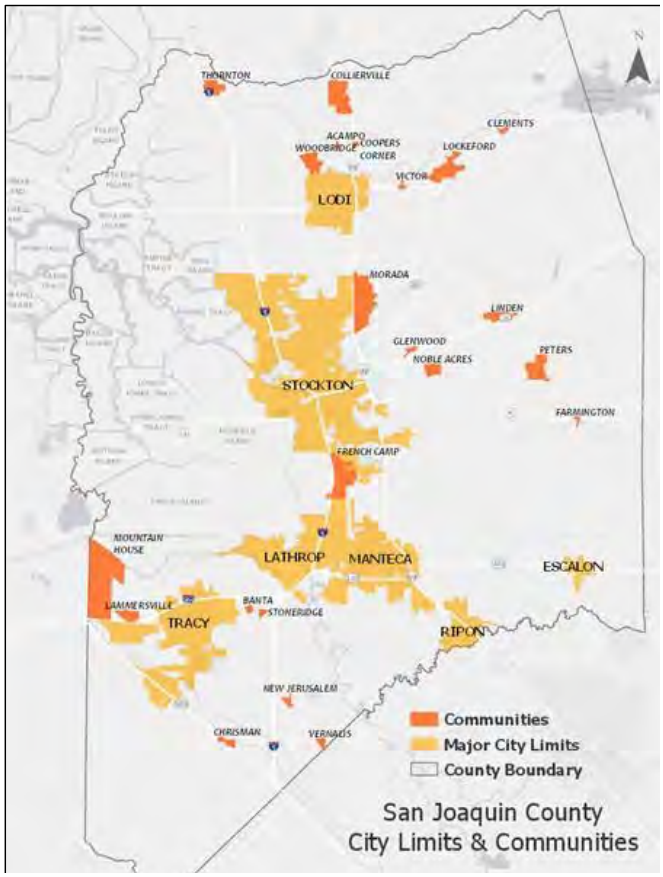
It's not a prescription that changes your health?

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

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

Definition of Community Served

Each hospital participating in our CHNA defines its hospital service area to include all individuals residing within a defined geographic area surrounding the hospital. Per the joint CHNA, the hospital partners chose San Joaquin County as the primary service area.



GEOGRAPHIC DESCRIPTION OF THE COMMUNITY SERVED

San Joaquin County, in the Central Valley of California, is roughly 60 miles east of San Francisco and 35 miles south of Sacramento, with a total population of 742,603 (2019). Historically, agriculture has been a strong driver of our economy and many migrants and immigrants have settled here to work in the fields and help with agricultural processing or shipping. The County is mostly rural, with one large urban core (Stockton) and seven smaller cities, as well as many ranching and farming communities scattered across the County.

DEMOGRAPHIC PROFILE OF THE COMMUNITY SERVED

San Joaquin County is home to a high concentration of residents at elevated risk for COVID-19 and who have experienced enormous impacts from the pandemic. A quarter of residents are foreign-born. Overall, 14.5% of residents live in poverty. Residents aged 65 years and older have a poverty rate of 9.9%. The educational attainment of San Joaquin County residents is much lower than California residents. Only 18.8% of County residents aged 25 and older have a bachelor's degree or higher, compared to 33.9% of Californians aged 25 and older that have a bachelor's degree or higher.

Race/ethnicity	
Total Population	742,603
Asian	15.2%
Black/African American	6.7%
Latinx	41.4%
Native American/Alaska Native	0.2%
Pacific Islander/Native Hawaiian	0.5%
Multiple races	3.9%
White	31.9%

Source: US Census, 2019

Socioeconomic Data	
Living in poverty (<100% Federal poverty level)	14.5%
Children in poverty	16.6%
Older adults (ages 65+) in poverty	9.9%
Employed (ages 20-64 years)	52.6%
Insured (ages 19-64 years)	90.5%
Adults with no high school diploma	20.7%
Bachelor's Education or higher	18.8%

Source: US Census, 2019

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.

About Us

Adventist Health Lodi Memorial

Adventist Health Lodi Memorial is one of central California's premier nonprofit healthcare providers that encompasses a hospital, multiple medical practice locations and wellness programs. Since we opened our doors in 1952, we have been committed to those who seek our care. Through the decades, Lodi Memorial became not just a hospital, but a pillar for the surrounding community and the people whose pasts and families are intertwined with the organization.

In the decades since we opened, our healthcare organization has expanded remarkably. What was known as Lodi Memorial Hospital for four decades is now Adventist Health Lodi Memorial, a system that encompasses not just a full-functioning hospital, but the vast scope of services available throughout Lodi and surrounding communities.

Surgery, maternity, intensive care, medical care and emergency services have always been key services available at Adventist Health Lodi Memorial, but in recent years, the organization has grown to operate five primary care medical practices, a free outreach clinic and 10 specialty medical practices.

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 Adventist Health Lodi Memorial identified as top priority health needs, or as we refer to them in this report, '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.

Access to Care

RATIONALE: WHY THIS IS A CRITICAL HEALTH NEED

Access to comprehensive, quality healthcare is important for health and for increasing the quality of life for everyone. Components of access to and delivery of care include: insurance coverage; adequate numbers of primary and specialty care providers; health care timeliness, quality and transparency; and cultural competence/cultural humility. Limited access to healthcare and compromised healthcare delivery negatively affect health and quality of life.

KEY FINDINGS AND DISPARITIES ACROSS SAN JOAQUIN COUNTY (BASED ON HEALTH DATA)

• SJC residents have access to significantly fewer health care providers than the CA average. SJC has 26% fewer primary care physicians (59 per 100,000 population) and 34% fewer dentists (58 per 100,000 population) than the state benchmarks (80 and 87 per 100,000, respectively).

• Pregnant and postpartum mothers and their babies in SJC experience significantly worse outcomes compared to CA averages: infant deaths per 1,000 live births in SJC (6) are 50% higher than CA (4), low birth weight (8%) is almost 10% higher than CA (7%), preterm births (10%) occur over 10% more often than CA as a whole (9%).

• The percentage of mothers receiving prenatal care in the first trimester in SJC (80.8%) is significantly worse than the CA benchmark (84%). In addition, Hispanic, Black and Multiracial mothers all have a significantly lower likelihood of receiving prenatal care than White mothers in SJC.

• SJC has a higher percent of insured children and adults than CA, but disparities are present; Hispanic children (16%) are more likely to be uninsured than White children, and Hispanic, Asian, Black and Multiracial adults are more likely to be uninsured than White SJC adults.

COMMUNITIES DISPROPORTIONATELY IMPACTED (BASED ON PRIORITY NEIGHBORHOOD PROFILES)

• Eleven of the 14 Priority Neighborhoods have lower access to prenatal care in the first trimester of pregnancy as compared to SJC overall.

• Over half of the Priority Neighborhoods have higher rates of low-birth-weight babies compared to the County. Low birth weight can be addressed with early access to prenatal care.

• CT 22.01(Stockton) saw a 62% increase in low-birth-weight babies since 2019. Communities Disproportionately Impacted (based on Priority Neighborhood Profiles)

• Eleven of the 14 Priority Neighborhoods have lower access to prenatal care in the first trimester of pregnancy as compared to SJC overall.

• Over half of the Priority Neighborhoods have higher rates of low-birth-weight babies compared to the County. Low birth weight can be addressed with early access to prenatal care.

• CT 22.01(Stockton) saw a 62% increase in low-birth-weight babies since 2019. What Community Stakeholders Say About Access to care (based on key informant interviews and focus groups)

OVERALL

• 45% (13 of 29) focus groups and 3 of 10 key informants identified access to care as a top priority health need in SJC.

• Many key informants and focus group participants stated that even with health insurance, access to specialty care of all kinds is problematic. Key informants cited numerous barriers to care: few local specialists, inadequate appointment availability, inadequate insurance coverage and language/cultural barriers.

• Additional financial barriers to care cited by focus group participants included high costs for medical/dental services, insurance, co-pays and prescriptions.

DISPARITIES

• Focus group participants described too few healthcare providers who speak their languages or understand their cultures, echoing a common theme expressed by key informant interviewees who cited a need for more culturally appropriate and sensitive providers. In addition, key informants emphasized the need for provider training in patient care for LGBTQ+ residents and those with diverse gender expressions.

• Several focus group participants described limited access to pharmacies, especially for residents with transportation or mobility barriers.

• One key informant identified lack of access to care as an important factor influencing birth outcomes for Black women in SJC.

IMPACT OF COVID 19

• Many focus group participants discussed the negative impact of the switch to telephone/online healthcare, perceiving the care as inadequate to address their needs and plagued by internet access issues, making online visits difficult or impossible for residents in a number of SJC communities.

Financial Stability

RATIONALE: WHY THIS IS A CRITICAL HEALTH NEED

People with steady employment are less likely to have an income below poverty level and more likely to be healthy. Strong economic environments are supported by the presence of well-resourced schools and an adequate concentration of well-paying jobs. Childhood poverty has long-term effects. Even when economic conditions improve, childhood poverty still results in poorer long-term health outcomes. The establishment of policies that positively influence economic conditions can create sustainable improvements in the physical and mental health of individuals and communities.

KEY FINDINGS AND DISPARITIES ACROSS SAN JOAQUIN COUNTY (BASED ON HEALTH DATA)

- Among employed SJC residents, average yearly income ($64,000) is almost 15% less than the CA average ($75,000); average income for White SJC residents is close to the CA average, but Hispanic ($59,000), Black ($46,000), Native American ($60,000) and multiethnic ($58,000) residents earn significantly less.
- 53% of SJC residents (ages 20-64) are employed, almost 30% lower than the CA average (74% employment); SJC Hispanic and Black residents are significantly less likely to be employed than White SJC residents.
- The poverty rate in SJC (15%) is significantly higher than the CA average (13%); Hispanic (18%), Asian (12%), Black (22%) and multiethnic residents (18%) have much higher poverty rates than White SJC residents.
- High-speed Internet access among SJC residents is significantly lower than the CA average; Hispanic (84%), Black (82%) and American Indian/Alaskan Native (80%) residents have significantly less Internet access than White SJC residents (88%).

COMMUNITIES DISPROPORTIONATELY IMPACTED (BASED ON PRIORITY NEIGHBORHOOD PROFILES)

- All 14 Priority Neighborhoods have lower average income than SJC overall.
- Adult employment is low in the Priority Neighborhoods; 12 of the 14 have lower rates of adult employment as compared to the County average.
- Census Tract 1 (Stockton) has the lowest average income ($16,289) among the Priority Neighborhoods, and almost 60% of this neighborhood's population lives in poverty. What Community Stakeholders Say About Income & Employment (based on key informant interviews and focus groups)

OVERALL

- 2 of 29 focus groups and 3 of 10 key informants identified income and employment as a top priority in SJC.
- According to the key informants, income and employment challenges in SJC influence health behaviors that exacerbate chronic disease and disability, reduce food security, limit healthy food and physical activity choices, erode mental health, and impact substance use.
- Focus group participants stated that the cost of living in their communities has substantially increased recently, and that many of the jobs available do not offer enough compensation to offset cost increases.
- Key informants suggested that targeted investments and strategic multi-sector planning are needed for the economy to benefit all residents equally. Focus group participants want more help for unemployed residents to access jobs, through employment placement programs, job fairs and employment resources available in multiple languages.

DISPARITIES

- Key informants reported that income and employment are unstable in SJC, especially for historically underserved populations. Several key informants identified factors contributing to income and employment challenges: elevated high-school drop-out rate, insufficient vocational training, and limited jobs that pay living wages.
- Key informants highlighted the food purchasing challenges faced in low-income communities, where income-earners often work multiple jobs to pay rent, bills, and provide food for their families.

IMPACT OF COVID 19

- Focus group participants reported extensive job loss as a result of the COVID-19 pandemic, impacting residents' ability to maintain housing, provide their families with healthy foods, and access medical care.
- Key informants stated that people of color in SJC were disproportionately affected by the economic insecurity caused by the pandemic and inequities became more apparent.

Mental Health

RATIONALE: WHY THIS IS A CRITICAL HEALTH NEED

Mental health affects all areas of life, including a person's physical well-being, ability to work and perform well in school and to participate fully in family and community activities. Those facing challenges related to lower economic opportunity often experience high levels of stress in their daily lives, coupled with fewer resources for coping. Children and youth experiencing stress have an increased likelihood of poorer mental and physical health. Deaths of despair — those due to suicide, drug overdose, and alcoholism — are on the rise. Communities across the country are experiencing a critical lack of capacity to meet the increased demand for mental health and substance use treatment services.

KEY FINDINGS AND DISPARITIES ACROSS SAN JOAQUIN COUNTY (BASED ON HEALTH DATA)

- Residents of SJC have access to significantly fewer mental health care providers than CA overall. SJC has 33% fewer mental health practitioners than the state.
- Rates of deaths of despair (death due to suicide, alcohol-related disease, and drug overdoses) are 25% higher among SJC residents (43 per 100,000 population) than CA as a whole (34 per 100,000 population); Asian and Hispanic residents have significantly lower rates of deaths of despair and fewer suicides than White residents.
- SJC residents experience significantly more poor mental health days per month (4.4) than the CA average (3.7).
- 15% of SJC adults are currently smokers, compared to only 11% of Californians.

OVERALL

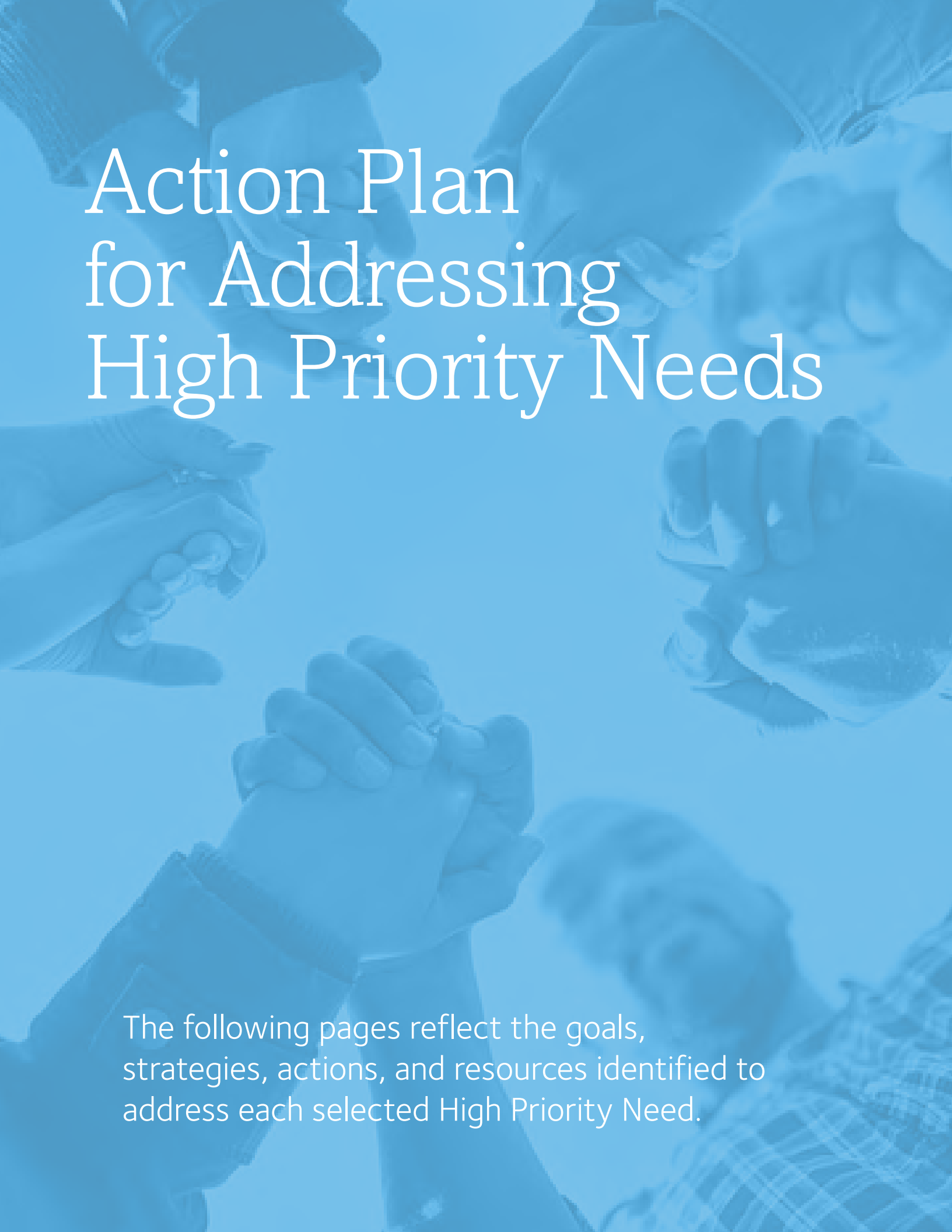
- 69% (20 of 29) focus groups and 6/10 key informants identified mental health as a top priority in SJC.
- 45% (13 of 29) focus groups and 1/10 key informants identified substance use as a top priority in SJC.
- Many focus group participants expressed concern about the increase in substance use in their communities, particularly the rise in drug and alcohol use among children/adolescents and unhoused residents.
- Existing resources for mental health care, like the San Joaquin County Pride Center, El Concilio, and other local, small non-profit organizations, need support. Key informants discussed the County's inadequate treatment capacity for substance use disorders; several key informants emphasized the importance of treating substance use while concurrently addressing mental health issues and homelessness, often co-occurring problems.
- Focus group participants frequently linked substance use with a threat to community health and safety, expressing frustration with drug-related activities in public spaces that result in trash/blight and prevent spaces being used for recreation and physical activity.

DISPARITIES

- Key informants described how every vulnerable or underserved population in San Joaquin County has been disproportionately impacted by the insufficient availability of mental health services, listing children, adolescents, the elderly, those who identify as LGBTQ+, unhoused people, people of color, immigrants, rural communities, and low-income residents as having the greatest needs around accessible mental health services. Barriers to access included cost, lack of insurance coverage, transportation, language and cultural or social stigma.
- Focus group participants stated that more needs to be done to reduce stigma around seeking mental health care, especially for people of color, non-English speakers, LGBTQ+ and unhoused individuals.

IMPACT OF COVID 19

- The pandemic has taken a toll on mental health. Focus group participants reported feelings of depression, anxiety, fear, boredom, isolation and despair.
- Focus group participants and key informants stated that many people turned to unhealthy coping strategies, such as alcohol or drug use, to manage mental health, in part because of the perception that mental health services were unavailable or inaccessible.
- A few focus group participants mentioned that the societal changes of 2020, created by the pandemic and the social unrest caused by protests against racially motivated police brutality, led to increased stress and fear of racial discrimination and social injustice.



Action Plan for Addressing High Priority Needs

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

ADDRESSING HIGH PRIORITY: Access to Care

Priority Area:	Access to Care	**Sub-Category:**	Availability - Primary care	**Defining Metric:**	Primary Care Providers

GOAL	Collaborate with community partners to provide older adults with access to routine medical and social care to alleviate isolation and timely care of non-chronic conditions.

Strategy:	Utilize Adventist Health's current Adult Daycare Services program as a one-stop hub for routine medical and psychosocial care for older adults.
Population Served:	Aging Population (Over 75)
Internal Partners:	AH Clinics Director, Director of Education, Case Management Director
External Partners:	SJC Public Health Services, SJC Department of Aging and Community Services (SJCDACS), LOEL Senior Center

Action: Program/Activity/Tactic/Policy	**Organization**	**Lead**
Explore feasibility of expanding primary care services to the aging population. Provide basic medical services at the Adult Daycare Center as a community resource, e.g. flu vaccinations.	Adult Daycare Services	Karla Barba/Teresa Whitmire
	SJCDACS	
	AH Clinics Director	Kelly Krigbaum
	Director of Education	Melissa Black
	Case Management Director	Margaret Tyndall
	LOEL Senior Center	

YEAR ONE	**YEAR TWO**	**YEAR THREE**
Meet with internal stakeholders to discuss feasibility of expanding select primary care services for 75+ population at the Lodi Adult Daycare Center. Meet with AH executive leadership to discuss and approve proposed enhancements.	If approved, implement enhancements at Lodi Daycare Center. Connect with community referral partners to increase volume and promote service.	Conduct evaluation of expanded Lodi Daycare program.

ADDRESSING HIGH PRIORITY: Financial Stability

Priority Area:	Income and Employment	Sub-Category:	Employment	Defining Metric:	Labor force participation rate

GOAL	Provide supportive environment for members of vulnerable populations to gain exposure and skills for employability in allied health professions.

Strategy:	Provide internships, externships, and apprenticeship opportunities in medical and allied health professions at our hospital.
Population Served:	Vulnerable population, primary care shortage areas
Internal Partners:	Education Director, Rehabilitation Services Manager, Imaging Director, Pharmacy Director, Medical Officer, Patient Care Executive
External Partners:	Decision Medicine, Health Force Partners, Delta College, University of the Pacific (UOP)

Action: Program/Activity/Tactic/Policy	**Organization**	**Lead**
Review existing training programs to determine opportunities to continue, enhance or revise. Collaborate with existing community high school and post-secondary institutional programs to identify eligible students. Review current learning partnerships in consultation with Health Force partners. Meet with AH executive leadership to discuss/approve changes/enhancements.	Health Force Partners	Paul I. Lanning
	UOP	Somarly Hernandez
	Education Director	Melissa Black
	Rehabilitation Services	Jennie Johnston
	Imaging Services Director	Julissa Mercado
	Pharmacy Director	Sandy Beck Atwater
	Medical Officer	Gaurav Datta
	Patient Care Executive	Donovan Stewart
	Delta College	Edward Aguilar

YEAR ONE	YEAR TWO	YEAR THREE
Review current learning partnerships and healthcare training needs in the community. Review current eligibility and enrollment for inclusion of vulnerable populations in partnership with educational institutions. Market and enroll students in the various Nursing and Allied Health Education programs currently offered at the hospital.	Meet with all stakeholders to review shared data and discuss opportunities to streamline and expand collaborative base. Explore current scholarship opportunities and funding.	Meet with all stakeholders to review shared data in light of current healthcare market training needs. Identify and expand training opportunities with additional educational partners.

Priority Area:	Income and Employment	Sub-Category:	Employment	Defining Metric:	Labor force participation rate

GOAL	Advocate for and collaborate with community partners to connect community members with services that will reduce the burden of childcare and make them available to acquire skills for employability.

Strategy:	Partner with community agencies to provide childcare services for eligible parents enrolled in schools and colleges.
Population Served:	Single parent households, children in poverty, population with limited English proficiency
Internal Partners:	ED Director, Patient Access, Camp Hutchins Child Daycare Center
External Partners:	Family Resource Center, Children's Alliance, Community Connect, Unite Us Program

Action: Program/Activity/Tactic/Policy	Organization	Lead
Ensure case managers at Lodi Memorial ED are active on the Unite Us digital referral platform in order to connect eligible patients to relevant service providers. Streamline the referral and communication process between ED case managers and Camp Hutchins Child Daycare center for parents requiring support. Increase use of Unite Us overall for better connection of patients with community services as appropriate.	Camp Hutchins Child Daycare	Karla Barba
	Unite Us Digital Platform	Ali Altman
	Community Connect Enhanced Care Program (CalAIM)	Jennifer Ramos (Lodi)
	Emergency Department	Rachel Wairimu
	Patient Access	Traci Hernden
	Family Resource Center	Lynsay Nuss

YEAR ONE	YEAR TWO	YEAR THREE
Review current implementation of Unite Us system at AHLM ED. Explore feasibility of adding child daycare referrals in the ED intake process for eligible parents. Present recommendations to executive leadership for implementation for approval.	If approved, implement childcare referral process into AHLM ED intake. Evaluate success of the program after pilot phase.	Evaluate success of the program after year two and implement improvements.

Priority Area:	Financial stability	Sub-Category:	Stability	Defining Metric:	Childhood Poverty Rate

GOAL	Collaborate with partners to connect community members with support services and education to lessen financial burden.

Strategy:	Utilize existing intake and discharge processes to connect and enroll community members experiencing financial burden into health care coverage programs and refer them to reduced or free services and programs.
Population Served:	Population without medical insurance, children in poverty
Internal Partners:	Director of Finance, Director of Health Information Management, Patient Access, Director of Case Management, ED Director
External Partners:	San Joaquin County (SJC) Public Health Services, Community Connect/Unite Us

Action: Program/Activity/Tactic/Policy	**Organization**	**Lead**
Effectively enroll uninsured patients in appropriate health plan programs such as CalAIM. Refer uninsured and underinsured patients to community resources to help address their healthcare and psychosocial needs.	SJC Public Health Services	Barbara Albertson
	Unite Us Program	Ali Altman
	Finance Director	Mario Molini
	HIM Director	Pam Phillips, Terrie Maxon
	Patient Registration	Traci Hernden
	Case Management	Margaret “Peggy” Tyndall
	Emergency Department	Rachel Wairimu
	United Way Community Connect	Kristen Birtwhistle

YEAR ONE	YEAR TWO	YEAR THREE
Evaluate current processes for identifying and enrolling eligible patients in health coverage plans during ED intake process at AHLM. Connect with internal stakeholders to determine awareness and identify any barriers to be addressed. Meet with executive leadership with proposed support enhancements for approval.	Evaluate success of patient coverage referrals and identify additional barriers to be addressed.	Evaluate success of patient coverage referrals and identify additional barriers to be addressed.

ADDRESSING HIGH PRIORITY: Mental Health

Priority Area:	Mental Health	Sub-Category:	Anxiety & Depression	Defining Metric:	Poor mental health (days)

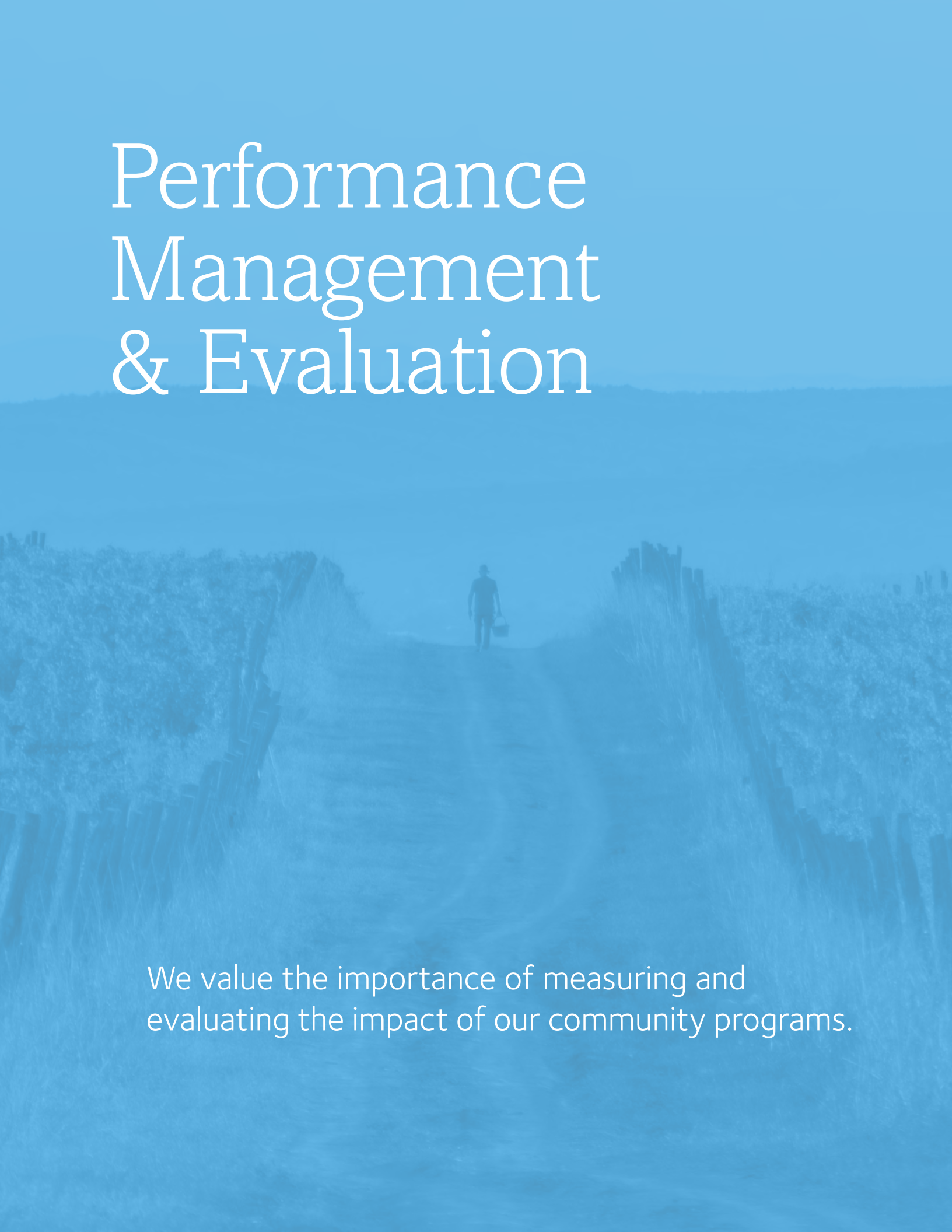
GOAL	Collaborate with community partners in addressing workplace related stress as well as mental health concerns that employees may have in the workplace.

Strategy:	Increase psychoeducational awareness in the workplace.
Population Served:	Total population: General workforce in Lodi
Internal Partners:	Director of Communication, AH primary care MDs
External Partners:	American Heart Association (AHA), Lodi Chamber of Commerce, Society of Human Resource Management (SHRM)

Action: Program/Activity/Tactic/Policy	**Organization**	**Lead**
Conduct semi-annual workplace symposia addressing burnout prevention and available resources. Goal of creating healthy workforce and sustainable productivity.	AHA	Liz Faris
	Lodi Chamber	Marina Narvarte
	SHRM	Joshua Koot
	Communications	Scott Nariyoshi
	AH Primary Care	Tiffany Trull

YEAR ONE	YEAR TWO	YEAR THREE
Co-create employer workshops and symposia with AHA. Identify subject matter experts at AHLM. Identify most effective venue: Virtual, in person or hybrid. Implement Program Evaluation processes and tools.	Continue seminars/webinars for year two. Adjust offerings and timing based on evaluation results.	Continue seminars/webinars for year three. Identify additional venues and audience expansion opportunities.

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.

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. Lodi Memorial community members were involved in the process of identifying and addressing health needs for a healthier community, completing the final report in fall of 2022.

Collaborating with community 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, at the top of this page.

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.

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. Health needs are defined as including requisites for the improvement or maintenance of health status both in the community at large and parts of the community (such as specific neighborhoods or populations experiencing health disparities). Requisites may include addressing financial and other barriers to care as well as preventing illness, ensuring adequate nutrition, or addressing social, behavioral, and environmental factors that influence health in the community. Health needs were identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.

THE FOLLOWING CRITERIA WERE USED:

- It fits the definition of a "health need" as described above.
- It was confirmed by multiple data sources (i.e., identified in both secondary and primary data).
- Indicator(s) related to the health need performed statistically significantly worse than the state average.
- It was chosen as a community priority. Prioritization was informed by the frequency with which key informants and focus groups mentioned the need. The final list included only those that informants and focus groups identified as a need.

NINE HEALTH NEEDS MET THE ABOVE CRITERIA:

HIGHEST PRIORITY

- Mental Health/Behavioral Health Including Substance Use
- Access to Care
- Income and Employment

MEDIUM PRIORITY

- Housing
- Chronic Disease/Health Eating, Active Living (HEAL)
- Community Safety

LOWER PRIORITY

- Family and Social Support
- Education
- Transportation

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.

Brooke McCollough
Adventist Health Lodi Memorial

Adventist Health