Adventist Health White Memorial
2021 Community Health Plan

The following Implementation Strategy serves as the 2020 – 2022 Community Health Plan for Adventist Health White Memorial and is respectfully submitted to the Office of Statewide Health Planning and Development on May 27th, 2022 reporting on 2021 results.

Executive Summary

Introduction & Purpose

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

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

The results of the CHNA guided this creation of this document and aided us in how we could best provide for our community and the vulnerable among us. This Implementation Strategy summarizes the plans for Adventist Health White Memorial to develop and collaborate on community benefit programs that address prioritized health needs identified in its 2019 CHNA. Adventist Health White Memorial has adopted the following priority areas for our community health investments.

Prioritized Health Needs – Planning to Address
• Health Priority #1: Chronic Disease • Health Priority #2: Mental Health • Health Priority #3: Access to Health Care and Resources

Building a healthy community requires multiple stakeholders working together with a common purpose. We invite you to explore how we intend to address health challenges in our community and partner to achieve change. More importantly, we hope you imagine a healthier region and work with us to find solutions across a broad range of sectors to create communities that define the well-being of people.

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

The significant health needs were identified through an analysis of secondary data and community input. These health needs were prioritized according to a set of criteria that included: magnitude of the problem, severity of the problem, need among vulnerable population, community's capacity and willingness to act on the issue, ability to have measurable impact on the issue, availability of hospital and community resources, existing interventions focused on the issue, whether the issue is a root cause of other problems and the trending health concerns in the community. A decision tree discussion further analyzed how acute the need is, whether Adventist Health White Memorial already provides services in this area and what role the hospital would fulfill in addressing the need. For further information about the process to identify and prioritize significant health needs, please refer to Adventist Health White Memorial CHNA report at the following link: https://www.adventisthealth.org/documents/community-benefit/2019-chna/WhiteMemorial_2019_CommunityHealthNeedsAssessment.pdf

Adventist Health White Memorial and Adventist Health

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

Vision

Adventist Health will be a recognized leader in mission focus, quality care and fiscal strength.

Mission Statement

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

Adventist Health Includes:

- 23 hospitals with more than 3,600 beds
- 290 clinics (hospital-based, rural health and physician clinics)
- 15 home care agencies and eight hospice agencies
- Three retirement centers & one continuing care retirement community
- A workforce of 37,000 including associated, medical staff physicians, allied health professionals and volunteers

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

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

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

Summary of Implementation Strategies

Implementation Strategy Design Process

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

Adventist Health White Memorial Implementation Strategy

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

- Health Need 1: Chronic Disease
  - Diabetes Center
  - ¡Vive Bien! Senior Wellness Program
- Health Need 2: Mental Health
  - Welcome Baby Program
  - Community Information Center

- Health Need 3: Access to Health Care
    - Community Information Center

The Action Plan presented below outlines in detail the individual strategies and activities Adventist Health White Memorial 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.

No hospital can address all the health needs identified in its community. Adventist Health White Memorial is committed to serving the community by adhering to its mission, and using its skills, expertise and resources to provide a range of community benefit programs. This Implementation Strategy does not include specific plan to address the following significant health needs identified in the 2019 CHNA.

Significant Health Needs – NOT Planning to Address

During a meeting in August 2019, the Adventist Health White Memorial CHNA Review Committee met to review and determine the top three priorities the hospital would address. Due to the magnitude of the need and the capacity of Adventist Health White Memorial's ability to address the need, the Implementation Strategy will not address the following health needs:

- Homelessness and Poverty
- Access to Healthy Foods

COVID 19 Considerations

The COIVD-19 global pandemic has caused extraordinary challenges for Adventist Health hospitals and health care systems across the world including keeping front line workers safe, shortages of protective equipment, limited ICU bed space and developing testing protocols. They have also focused on helping patients and families deal with the isolation needed to stop the spread of the virus, and more recently vaccine roll out efforts.

Adventist Health, like other health care systems, had to pivot its focus to meet the most urgent healthcare needs of its community during the pandemic, as well as reassess the ability to continue with some community health strategies due public health guidelines for social distancing. Adjustments have been made to continue community health improvement efforts

as possible, while ensuring the health and safety of those participating. The Strategy Action Plan Grids on the following pages reflect updated activities for each strategy.

In FY2021, Adventist Health as a system took the following actions in response to the needs created or exacerbated by COVID-19:

- Began offering more virtual health care visits to keep community members safe and healthy
- Developed an online symptom tracker to help community members determine if they may have COVID-19 or some other flu type illness and what steps to take
- Was part of a communitywide effort by the local health system to vaccinate eligible community members to help stop the spread of the virus

Locally, Adventist Health White Memorial took these additional actions:

- Reopened the Community Resource Center in mid-July.
- Continued a food distribution program at AHWM Community Garden until April 2021.
- In partnership with the YMCA, we provided food deliveries for the local senior population. Tackling food insecurity due to the COVID-19 impact.
- Maintained a community COVID-19 vaccination clinic on campus and mobile clinic to reach vulnerable communities.

Adventist Health White Memorial Implementation Strategy Action Plan

PRIORITY HEALTH NEED: CHRONIC DISEASE						
GOAL STATEMENT: IMPROVE HEALTH OUTCOMES IN PATIENTS AND COMMUNITY MEMBERS WITH CHRONIC DISEASE						
Mission Alignment: Well-being of people						
Strategy 1: Mobilize patients and community members through education and tools to manage chronic disease.						
Programs/Activities	**Process Measures**	**Results: 2020**	**Short Term Measures**	**Results: 2021**	**Medium Term Measures**	**Results: 2022**
Activity 1.1 Diabetes Center	- # of participants in Telehealth Gestational Diabetes Management Care. -# of participants in HELP program:	Due to the COVID-19 pandemic the Diabetes programs had to put a greater effort in the continued education of Gestational Diabetes patients. A program was developed to easily educate pregnant woman in a virtual setting in order to avoid complications at birth or the delivery of large babies for gestational age. Number of persons served: 133	-90% of the woman met their goal of delivering babies of normal weight for gestational age. -10% of the woman delivered babies large for gestaional weight. -99% of the woman successfully attended their virtual education in spite of having literacy and technology challenges.	See Narrative Below		
Activity 1.2 ¡Vive Bien! Senior Wellness Program	# of participants in health education classes. # of participants in fitness classes	There was a decrease in participation due to the transition from in-person programming to virtual health	-% successfully sought referrals to resources -100% successfully sought referrals	See Narrative Below	-% change in knowledge as a result of education -% successfully	

	# of referrals to resources:	education programming. Conference calls was the best way to communicate with the members since many do not know how to use technological devices. # of participants in health ed. Classes: 286 # of participants in fitness classes: 732 # of referrals to resources: 3 mental health referrals. 55, food distribution referrals.			acquired referral resources -# of total participatio n in exercise classes-	
Activity 1.3 Blue Zones	(N/A, started in 2021)		Complete readiness assessment	Community listening meetings started from Aug 2021-Dec 2021	Complete Foundation Phase and create Blueprint	

Source of Data:
- Member tracking data

Target Population(s):
- Patients, patient's network and community members

Adventist Health Resources: (financial, staff, supplies, in-kind etc.)
- Diabetes Center staff and space, Community Information Center staff and space

Collaboration Partners: (place a "*" by the lead organization if other than Adventist Health)
- American Diabetes Association*, American Heart Association*

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

- A – Community Health Improvement

Strategy Results 2021:

Diabetes Center: Due to the impact of COVID-19, we needed to adjust and pivot our methods of delivering education to the community. With virtual sessions offered to the community, we were able to engage with community members in hopes to inspire them to live healthier lifestyles. Even though our number for 2021 were reduced the impact included the following:

- Virtual HELP classes from May- November 2021.
- A total of 64 people participated in the Diabetes Self-Management Education (DSME) Classes
  - 70.3% of participants were checking their blood at least 1 time per day.
  - 81% of participants met their target goal of lowering their A1c level.
  - 79% had a reduction in their weight
- A total of 105 participants participated I the HELP program.

Vive Bien: Due to the impact of COVID-19, many of the session in early 2021 were held virtually or through conference calls. In Mid-July, there was a soft reopening. Services that were offered between January through October consisted of primarily of health education classes and physical activity classes were re-introduced in November.

- A total of 17 participants participated in the the exercise classes.
- A total of 204 participants participated in the health education classes.

PRIORITY HEALTH NEED: MENTAL HEALTH						
GOAL STATEMENT: INCREASE ACCESS TO APPROPRIATE MENTAL AND BEHAVIORAL HEALTH SERVICES						
Mission Alignment: Well-being of people						
Strategy 1: Assess and refer vulnerable to populations to appropriate mental and behavioral health services						
Programs/Activities	**Process Measures**	**Results: Year 1**	**Short Term Measures**	**Results: Year 2**	**Medium Term Measures**	**Results: Year 3**
Activity 2.1 Welcome Baby Program (community program)	- Mental health assessments in pregnant women - Postpartum depression and other mental health education /support tools - Referrals to mental health resources	265 Mental Health Assessments Completed. 2,612 Postpartum depression/mental health screenings conducted. 216 Regerrals to mental health resources.	- % of referral to mental health resources: 14%	-Mental Health assessments in pregnant woman = 72 - Postpartum mental health education/support tools = 2,763 -Referrals to mental health sources = 181 (14%)		
Activity 2.3 Community Information Center Virtual Referral and resource site	-Mental health service referrals	The Community Information Center closed its doors early in 2020 seeing an impact on referrals. 14 Metal health service referrals completed.	-% successfully sought referrals to resources -% increase in awareness of mental health topics	-# mental health: CIC referred 3 people to wellnest for mental health services	-% successfully acquired mental health resources	
Source of Data: • Referral to mental health services, mental health assessments, pre and post surveys						

Target Population(s): • Patients and community members
Adventist Health Resources: (financial, staff, supplies, in-kind etc.) • Welcome Baby Program Staff, Community Information Center, space for education workshops
Collaboration Partners: (place a "*" by the lead organization if other than Adventist Health) • First 5 LA*, Los Angeles County Department of Mental Health*, Mexican American Opportunity Foundation*
CBISA Category: (**A -** Community Health Improvement; **E** - Cash and In-Kind; **F -** Community Building; **G -** Community Benefit Operations) • **A -** Community Health Improvement

Strategy Results 2021:

- Due to COVID-19, The Community Resource Center remained closed until July 2021 when it opened at a very limited capacity, affecting the number of referrals for mental health services.

PRIORITY HEALTH NEED: ACCESS TO HEALTH CARE AND RESOURCES						
GOAL STATEMENT: PROVIDE HUB OF HEALTH CARE RESOURCES AND REFERRALS TO SERVICES TO IMPROVE ACCESS						
Mission Alignment: Well-being of people						
Strategy 2: Engage local stakeholders to refer to the Community Information Center through the implementation of a referral application in addition to normal duties and responsibilities of the center						
Programs/Activities	**Process Measures**	**Results: Year 1**	**Short Term Measures**	**Results: Year 2**	**Medium Term Measures**	**Results: Year 3**
Activity 3.1 Community Information Center	-# provided on-site enrollment assistance to healthcare plan -# services and resources referred via referral pad -# services and resources referred & coordinated -# new enrollments in wellness programming through referral pad	41 136 1484 6	-% enrolled in healthcare plan: 2.76% of all the services rendered at the CIC -% participating members in wellness program: 4.4% of members enrolled into wellness programming from the referral pad.	See Narrative Below	-% successfully acquired services and resources -% return visitors previously referred	
Source of Data: • Referral pad (Wellness Prescription), Community Information Center sign-in, follow-up questionnaire,						
Target Population(s): • Patients and community members						
Adventist Health Resources: (financial, staff, supplies, in-kind etc.) • Community Information Center staff						

Collaboration Partners: (place a "*" by the lead organization if other than Adventist Health) • Department of Public Social Services*, Applied General Agency*, Covered California*, Mexican American Opportunity Foundation*, Outpatient clinic offices*
CBISA Category: (**A -** Community Health Improvement; **E** - Cash and In-Kind; **F -** Community Building; **G -** Community Benefit Operations) • **A -** Community Health Improvement

Strategy Results 2021:

Community Information Center: Services and resources referred via Referral Pad. Numberof services and resources referred & coordinated: 460. Of the 460, 181 were referred through UNITE US, 279 went through the AHWM process. Collectively, a total of 309 were successful at getting the resources and services they needed.

Additionally, a total of 81 people were enrolled into the Wellness Program and were provided health education opportunities.

The Adventist Health + Blue Zones Solution

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

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

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