ADVENTIST HEALTH HOWARD MEMORIAL

2022 COMMUNITY HEALTH IMPLEMENTATION STRATEGY

APPROVED APRIL 27, 2023

2022

Adventist Health
Howard Memorial

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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 Howard Memorial, Mendocino Coast and Ukiah Valley conduct 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 Howard Memorial, Mendocino Coast and Ukiah Valley 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 Howard Memorial, Mendocino Coast and Ukiah Valley CHNA:

Access to Care, Financial Stability & Health Risk Behaviors

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.

Blue Zones Project Mendocino County

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 Howard Memorial, Mendocino Coast and Ukiah Valley proudly sponsors Blue Zones Project Mendocino County (BZPMC). The BZPMC 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 BZPMC 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 BZPMC sector leads come together to evaluate and update the Blueprint to ensure community alignment.

To learn more about Blue Zones Project Mendocino County and how to get involved visit: mendocinocounty.bluezonesproject.com

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 Mendocino CHNA service area*

From spectacular ocean views, redwood forests, and picturesque towns, the CHNA service area is a breathtaking community with a total population of 116,095. Throughout the County people enjoy activities such as the Mendocino Art Center, Theatre Company, and music and film festivals.

The median household income is $56,401. The largest segment of the population (37.2%) is made up of residents aged over age 55. The community is known as a location focused on the well-being of its residents with support in the built environment, grocery stores and access to care while also implementing a Blue Zones Project.

Among this population, 59.95% of an individual's income is spent on housing and transportation, while 20.66% of children live in poverty and 6.67% 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. The following pages provide a closer look into our community demographic as well as our approach to the CHIS.

**This service area represents Adventist Health Howard Memorial, Mendocino Coast and Ukiah Valley's primary service areas (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, creating the Mendocino CHNA service area.*

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 Howard Memorial, Mendocino Coast and Ukiah Valley'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 Adventist Health Howard Memorial, Mendocino Coast and Ukiah Valley CHNA market has a total population of 116,095 (based on the 2020 Decennial Census). The largest city in the service area is Ukiah, with a population of 16,075. The service area is comprised of the following zip codes: 95415, 95463, 95410, 95445, 95460, 95428, 95488, 95449, 95437, 95425, 95453, 95589, 95427, 95456, 95469, 95459, 95468, 95432, 95490, 95429, 95417, 95482, 95587, 95466, 95470, 95494, 95420, 95454, 95585.

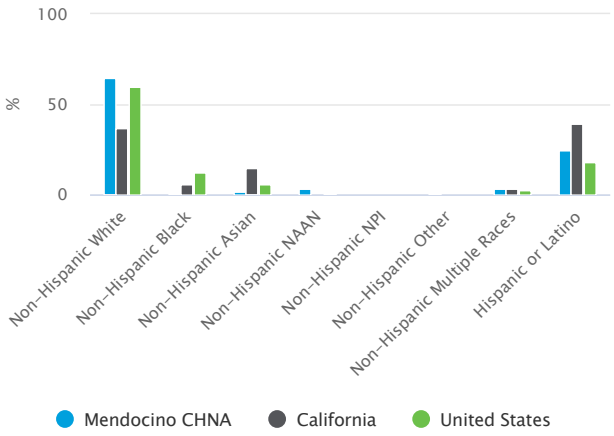
Total Population

116,095

62.33%
of the population owns their home

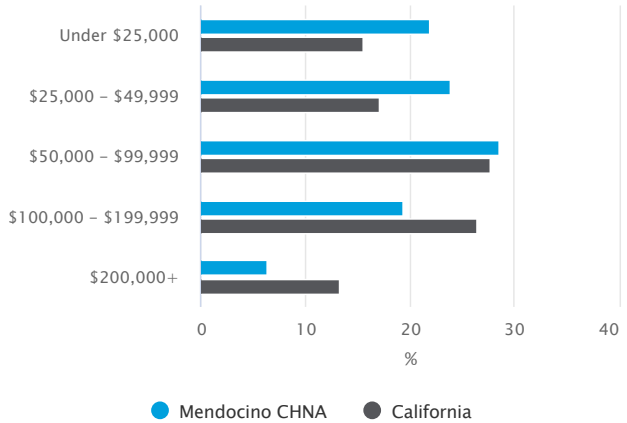
37.67%
of the population rents their home

Population by Combined Race and Ethnicity



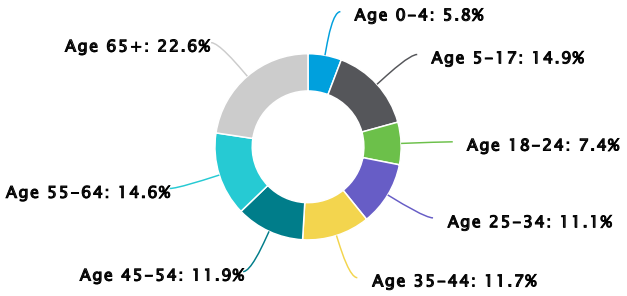
Note: NAAN = Native American or Alaska Native, NPI = Native Hawaiian or Pacific Islander.

Household Income Levels



Total Population by Age Groups, Total

Mendocino CHNA



About Us

Adventist Health Howard Memorial

Adventist Health Howard Memorial has been a staple of the Willits community since 1928 when the first patient was admitted. The 25-bed critical access hospital in Willits, California, is committed to serving Mendocino County with key service areas, including a 24-hour emergency department, intensive care, laboratory, imaging, orthopedics, rehabilitation, surgery and retail pharmacy. The hospital has been caring for community needs for nearly 100 years.

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 Howard Memorial, Mendocino Coast and Ukiah Valley CHNA Steering Committee (see page 22 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.

Access to Care

COMMUNITY VOICES

- People said it is difficult to attract doctors to this area. The clinics have bought homes and land to have apartments for doctors that come to this area. The clinic does this to help with housing needs for professionals.
- Waiting times are seen as quite long to see a primary care physician and folks on the coast struggle with this to a considerable extent.
- If a doctor doesn't understand addiction/ culture then the problem is either undertreated, not treated and then poor outcomes and then ineffective. This concern was called out by focus group participants.
- If you have a chronic condition, you can't wait 3-4 months for services, which some are expected to do, interviewees noted.

The people of Mendocino County face challenges, but they also have much to be proud of, including their willingness to search for ways to strengthen their communities.

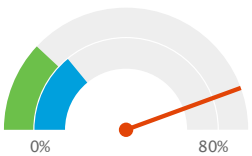
Community members recently voiced their concerns through a survey. They noted that transportation problems impact their access to medical appointments, such as primary care providers, optometry and dermatology. Wait times to see a primary care provider are long and are especially challenging for coastal residents.

Survey results revealed community members are experiencing challenges in accessing care, with 25% of respondents identifying Access to Care as a significant need. The percentage of the population living in a health professional shortage area is extremely high (71.1%). There is a shortage of mental health providers and fewer intensive care beds. The rate of uninsured residents in this area is 8.68% compared to 7.23% in California and 8.73% across the county.

The area is beautiful and, alongside with this challenge, provides opportunities for change. With awareness and commitment, families can achieve access to care and thrive.

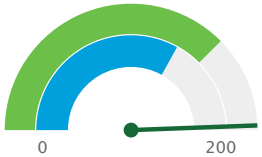
SECONDARY DATA INFOGRAPHIC STATS:

Percentage of Population Living in an Area Affected by a HPSA



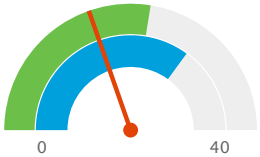
- Mendocino CHNA (71.09%)
- California (19.15%)
- United States (22.50%)

Mental Health Care Providers, Rate per 100,000 Population



- Mendocino CHNA (197.63)
- California (150.31)
- United States (132.27)

Intensive Care Unit Hospital Beds, Rate per 100,000 Population



- Mendocino CHNA (15.71)
- California (22.04)
- United States (28.05)

Financial Stability

COMMUNITY VOICES

- People said there are not enough jobs here that pay enough to afford the price of housing.
- Many noted it's difficult to find work and that this is true for nearly everyone, but especially the elderly.
- The stress of unstable housing is said to affect the health and mental health of all family members.
- Local wages do not support successfully paying rent or buying a house, community leaders stated.
- There is a belief that some youth will choose dealing marijuana rather than traditional paid employment as they can make more money that way.

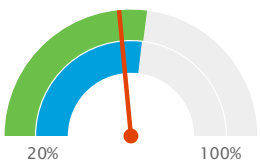
Mendocino residents of all ages and races face a variety of overwhelming concerns. Responses to their reality can then lead to physical and mental health fears, along with facing unattainable housing, high unemployment rates and low annual incomes.

With their input, the evidence becomes very clear. Lack of work, housing costs and limited housing options can create an environment of despair. In Mendocino County, 21% of children aged 0 to 17 are living in households with income below the federal poverty level. The rate of unemployment is 7.62%, which is higher than in California and the United States. Unemployment rates increase significantly for Black persons, at 22.5%. 11% of Native American or Alaska Natives live in poverty.

Shortages of housing and jobs alone unveil the impact of poverty and the heavy burden that it creates for this community. With commitment and courage, there can be health services, healthy food and affordable housing.

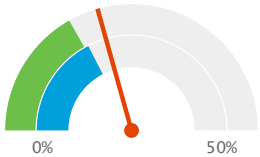
SECONDARY DATA INFOGRAPHIC STATS:

Labor Force Participation Rate



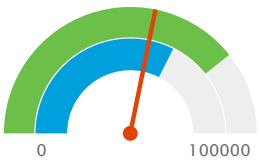
- Mendocino CHNA (57.59%)
- California (63.29%)
- United States (62.97%)

Percent Population Under Age 18 in Poverty



- Mendocino CHNA (20.66%)
- California (16.80%)
- United States (17.48%)

Median Household Income



- Mendocino CHNA ($56,401)
- California ($78,672)
- United States ($64,994)

Health Risk Behaviors

COMMUNITY VOICES

- Poor dietary habits driven by limited incomes are seen as a problem.
- Inpatient and rehab centers are typically believed to be full, requiring people to leave the area to get help.
- Mental health is the biggest cause of homelessness and addiction in the eyes of some interviewees.
- Drug and alcohol use is seen as a problem primarily for low-income residents.
- Services for Spanish-speaking residents are more difficult to find, as noted by those interviewed.

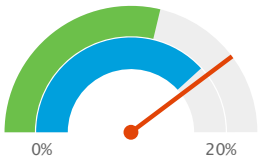
Mendocino County is known for its spectacular ocean views, redwood forests, picturesque towns and family-friendly community. With its family-friendly reputation for caring for the community, Mendocino County residents and local organizations support the well-being of its community with efforts made in the built environment, grocery stores and access to care.

Such an environment nudges individuals to engage in positive activities, helping residents' well-being stay in the higher ranks. However, some behaviors can threaten better health, such as smoking and substance use. For example, 15.9% of the population smoke tobacco, which is a higher rate than in California (11.5%). The teen birth rate is 21.4 per 1,000 females, which is greater than the state's teen birth rate of 15.6 and the national rate of 19.3. The percentage of infants with low birth weight is significantly greater, with Mendocino's rate at 15.1% compared to the state at 6.9%.

Community members have expressed concern about the future of their families', friends' and coworkers' overall well-being, sharing concerns about community members not eating well due to limited incomes, drug abusers facing a social stigma that results in avoiding help, vaping among adolescents and residents leaving the area for care due to provider shortages. Yet, despite these genuine concerns, residents are eager to roll up their sleeves and find solutions to reduce the health risk behaviors in their community.

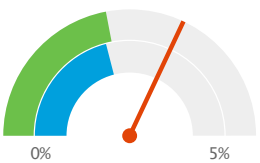
SECONDARY DATA INFOGRAPHIC STATS:

Percentage of Adults who are Current Smokers



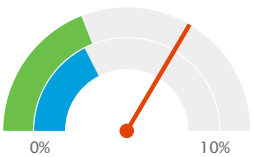
- Mendocino CHNA (15.90%)
- California (11.50%)
- United States (15.30%)

Percentage of Medicare Beneficiaries with Alcohol Use Disorder



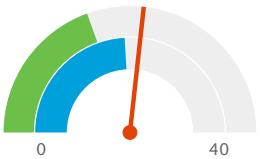
- Mendocino CHNA (3.2%)
- California (2.2%)
- United States (2.1%)

Percentage of Medicare Beneficiaries with a Drug or Substance Use Disorder

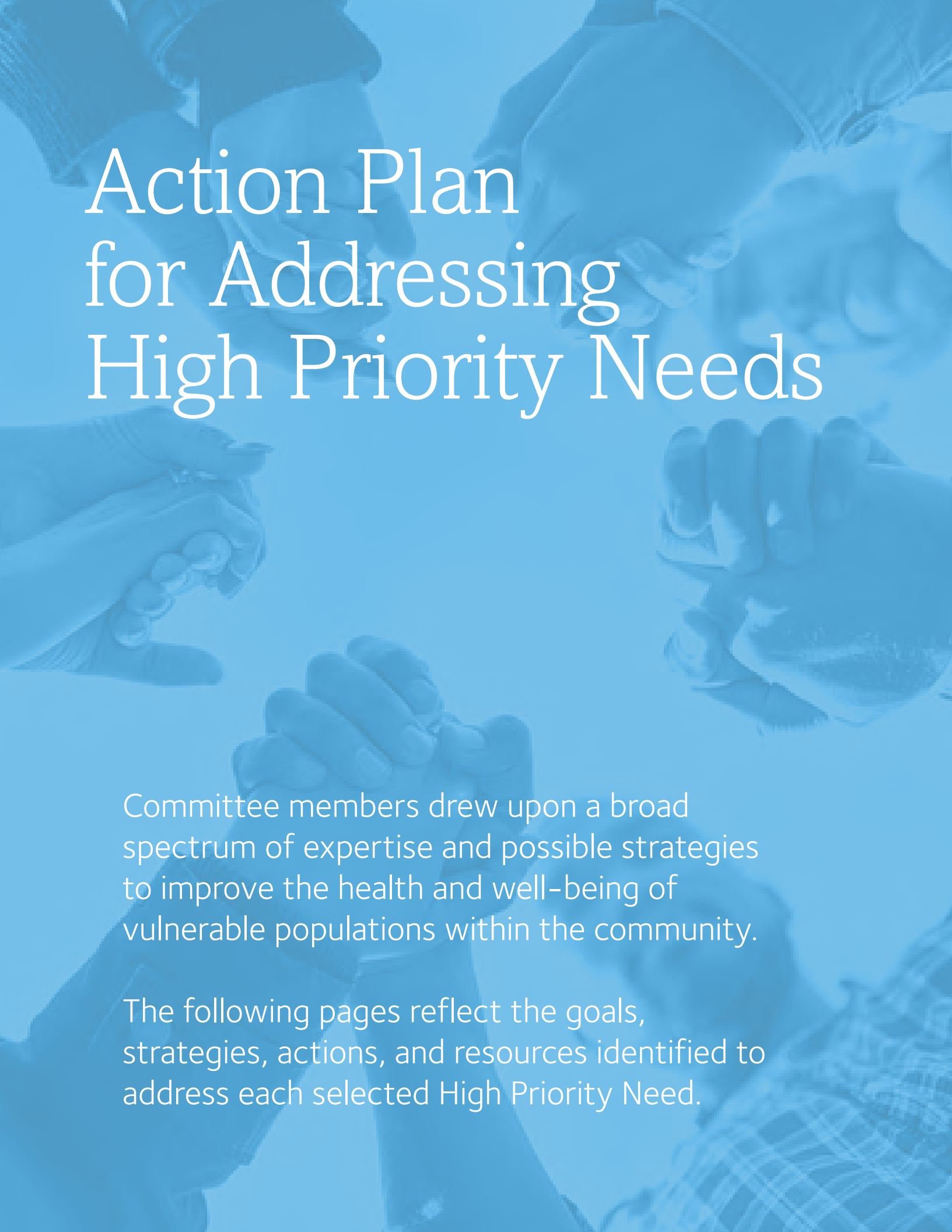


- Mendocino CHNA (6.7%)
- California (3.8%)
- United States (3.5%)

Teen birth rate per 1,000 female population, ages 15–19



- Mendocino CHNA (21.4)
- California (15.6)
- United States (19.3)



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: ACCESS TO CARE - BARRIERS

GOAL	Provide medical services to community members with no transportation.

Priority Area:	Access to Care	Sub-Category:	Barriers-Transportation	Defining Metric:	Homeless population

Strategy:	Provide medical services to the homeless population through street medicine.
Population Served:	Vulnerable populations
Internal Partners:	COMPASS Street Medicine Team
External Partners:	Coastal Street Medicine, MCC Street Medicine

Actions: Program/Activity/Tactic/Policy	**Organization**	**Lead**
1. Work with community partners with street medicine clinics to identify homeless encampments/gathering places where they can provide services. 2. Visit identified locales and provide educational and medical services/assessments for populations with no means of transportation. 3. Connect identified healthy risks for transport to medical facilities for continued care.	Adventist Health	Jeremy Malin, NP Population Health
	Coastal Street Medicine	Jillian Koski'
	FQHC	Lin Taylor MCC

YEAR ONE	YEAR TWO	YEAR THREE
1. Establish a schedule of ongoing places for street medicine services. 2. Convene and connect street medicine teams with clinic and hospital case workers.	1. Establish a schedule of ongoing places for street medicine services. 2. Convene and connect street medicine teams with clinic and hospital case workers.	1. Work with community health workers to provide services to homebound clients that have no transportation to clinics for services.

ADDRESSING HIGH PRIORITY: ACCESS TO CARE - INSURANCE

GOAL	Verify/Re-verify MediCal eligibility for vulnerable populations.

Priority Area:	Access to Care	Sub-Category:	Medical Insurance	Defining Metric:	Medicaid Reverifications

Strategy:	Provide education and outreach to medical providers (Registrars, Community Health Workers, Substance Use Navigators) to identify those medically eligible patients and help enroll or re-enroll them in available benefits and direct them to ongoing services.
Population Served:	Vulnerable populations
Internal Partners:	COMPASS Street Medicine Team
External Partners:	Public Health, Partnership Health Plan, Mendocino Community Health Centers

Actions: Program/Activity/Tactic/Policy	**Organization**	**Lead**
1. Build training and education within the All-Clinics Committee Task Force 2. Utilize existing stakeholders' processes to identify medical patients that need to reverify eligibility	Adventist Health	Jeremy Malin, NP Population Health
	Public Health	Dr. Andy Corhen
	FQHC	Lin Taylor MCC
	North Coast Opportunities	Patty Bruder - Director
	Round Valley Yuki Trials	Kenny Hanover
	Mendonoma Health Alliance	Micheline White

YEAR ONE	YEAR TWO	YEAR THREE
1. Provide education and outreach to providers to seek patients that need to reverify eligibility for coverage and help with the process for continuation. 2. Help navigate patients who become ineligible with available community services.	1. Provide education and outreach to providers to seek patients that need to reverify eligibility for coverage and help with the process for continuation. 2. Help navigate patients who become ineligible with available community services.	1. Provide education and outreach to providers to seek patients that need to reverify eligibility for coverage and help with the process for continuation. 2. Help navigate patients who become ineligible with available community services.

ADDRESSING HIGH PRIORITY: FINANCIAL STABILITY

GOAL	Identify vulnerable, unstably housed community members and connect with Community Health Workers for Support services through CalAIM funding.

Priority Area:	Financial Stability	**Sub-Category:**	Stability	**Defining Metric:**	CalAIM Support Services Usage

Strategy:	Through COMPASS Street Medicine team identify unstably housed clients and connect them with services within the county that afford financial assistance.
Population Served:	Vulnerable populations
Internal Partners:	AH COMPASS Street Medicine Team, Community Benefit Organizations (CBOs)
External Partners:	Public Health, Partnership Health Plan, Mendocino Community Health Centers, Redwood Community Services, Government

Actions: Program/Activity/Tactic/Policy	**Organization**	**Lead**
1. County-wide education regarding the support services available and the agencies directed to provide those services. 2. Deploy teams to provide connection to the appropriate agencies for individuals to receive services.	Adventist Health	Jeremy Malin, NP Population Health
	Public Health	Dr. Andy Corhen
	Federally Qualified Health Centers	Lin Taylor MCC
	North Coast Opportunities	Patty Bruder
	Redwood Community Services	Sage Wolf

YEAR ONE	YEAR TWO	YEAR THREE
1. Work with Partnership Health Plan for educational information regarding supportive services through CalAIM. Convene collaborative meetings to inform community partners about the services available. 2. COMPASS Street medicine team, MCC street medicine team and ED discharge/ hospital discharge planning teams distribute information and direct applicable community members to the correct agencies for services.	1. COMPASS Street Medicine team, MCC street medicine team and ED discharge/ hospital discharge planning teams distribute information and direct applicable community members to the correct agencies for services.	1. COMPASS Street Medicine team, MCC street medicine team and ED discharge/ hospital discharge planning teams distribute information and direct applicable community members to the correct agencies for services.

ADDRESSING HIGH PRIORITY: HEALTH RISK FACTORS – DIET

GOAL	Reduce the obesity rate among teens and adults through targeted food and diet education.

Priority Area:	Health Risk Factors	Sub-Category:	Diet and Nutrition	Defining Metric:	Obesity Rates

Strategy:	Improve Healthy food and beverage access.
Population Served:	Total Population
Internal Partners:	Blue Zones Project (BZP), AH Clinics and Hospitals
External Partners:	Schools, Community Benefit Organizations (CBOs), Government

Actions: Program/Activity/Tactic/Policy	**Organization**	**Lead**
1. Establish food insecurity screening as a formal part of patient intake at appointments with healthcare providers that do not already do so and share necessary referrals and resources to meet patient food needs (Ukiah, Fort Bragg, and Willits). 2. Adopt healthy food and beverage purchasing standards and wellness policies at all county facilities (Countywide). 3. Update and ensure implementation of food- and beverage-related school wellness policies to align with Blue Zones Project nutrition guidelines (Ukiah, Fort Bragg, and Willits).	BZP	Tina Tyler- O-Shea
	AH Emergency Department	Erica Valdovinos
	Clinics	AH – Jodi Parungao MCHC – Jill Damien
	CBO – Family Resource Center	Jayma Spence
	County	Glen McGourty – Chair BOS Nephele Barrett Mendocino, Mari Rodin Ukiah, Greta Kanne Willits Mendocino College CalFresh – Minerva Flore Mendocino County WIC Nephele Barrett
	Mendocino County Office of Education	Nicole Glentzer, Supt All School Districts FBUSD, Joe Aldridge, Supt UUSD, Deb Kubin, Supt WUSD, Mark Beebe, Supt

YEAR ONE	YEAR TWO	YEAR THREE
1. Work with AH and Community health agencies to create a common food insecurity screening during patient intake. 2. Meet with Mendocino BOS and local level government to discuss adoption of policy for the purchasing of health food and beverage options at all government facilities. 3. Meet with school districts superintendents to discuss food and beverage policies in all schools.	1. Implement food insecurity screening during patient intake at clinics and hospitals county-wide. 2. Work with Mendocino BOS and local level government to discuss adoption of policy for the purchasing of health food and beverage options at all government facilities. 3. Work with school districts superintendents to implement food and beverage policies in all schools.	1. Track food insecurity screening during patient intake at clinics and hospitals county-wide. 2. Track implementation of policies for purchasing of healthy food and beverage options at all government facilities. 3. Track implementation of food and beverage policies in all schools.

ADDRESSING HIGH PRIORITY: HEALTH RISK FACTORS – ILLICIT DRUGS

GOAL	Increase access to treatment in a community with high substance use and overdose rates.

Priority Area:	Health Risk Behaviors	Sub-Category:	Illicit Drugs	Defining Metric:	Substance Use Disorders

Strategy:	Create policies and spaces for the treatment of substance use disorders and reduce harm to people who use substances.
Population Served:	All community members needing substance use information and support
Internal Partners:	Family Medicine Clinic, Dr. Michael Young, AH Behavioral Health, Redwood Medical Clinic, COMPASS Team, ED Physician Group,
External Partners:	Public Health, Mendocino Community Health Clinic (MCHC), Sheriff's Department, Ukiah Valley Fire Department, New Life Clinic, Ukiah Recovery Center, County Substance Use Disorder Treatment (SUDT), Mendocino Coast Clinics (MCC)

Action: Program/Activity/Tactic/Policy	**Organization**	**Lead**
1. Participate in monthly SafeRX Mendocino Coalition and subcommittee meetings to design a plan to reduce substance use in Mendocino County and to remove barriers to treatment for people who use substances. 2. Work alongside community partners to provide linkages to substance use treatment services through Substance Use Navigator (SUN) program.	AH ED	Erica Valdovinos
	AH Clinics	Jodi Parungao
	Public Health	Dr. Andy Corhen
	New Life Clinic	Noah Chultz
	Federally Qualified Health Center	Lin Taylor MCC
	Ukiah Recovery Center	Jacque Williams
	Round Valley Yuki Trails	Kenny Hanover
	Mendonoma Health Alliance	Micheline White

YEAR ONE	YEAR TWO	YEAR THREE
Increase Naloxone distribution to all community members who use illicit drugs and connect them to treatment providers.	Work with community partners such as Public Health, Sherriff Department, EMS, Ukiah Fire to administer Buprenorphine in the field after an OD with Naloxone reversal, connecting community members to Navigator for SUD treatment and continued support.	Develop a robust referral process where community members can go directly from the hospital to SUD treatment. Work alongside jail discharge planning, Juvenile Hall and RCS to decrease recidivism and increase healthy outcomes for the community.

ADDRESSING HIGH PRIORITY: HEALTH RISK FACTORS – TOBACCO PREVENTION YOUTH

GOAL	Create an environment that discourages commercial tobacco and nicotine use, reduces youth access, provides tobacco-free spaces and supports prevention, cessation and enforcement efforts.

Priority Area:	Tobacco	**Sub-Category:**	Youth Tobacco Use	**Defining Metric:**	Youth Tobacco Use

Strategy 1:	Decrease youth tobacco use and availability of cigarettes, e-cigarettes and all flavored tobacco products.
Population Served:	Youth ages 0-18
Internal Partners:	Blue Zones Project, AH Well-Being, Community Well-Being Committee
External Partners:	Public Health, Board of Supervisors, City Councils, Tobacco Prevention Coalition, School Districts, Public Health

Action: Program/Activity/Tactic/Policy	**Organization**	**Lead**
1. Update Tobacco Retail Licenses (TRL) in Ft. Bragg, Ukiah and Willits to the County TRL. 2. Work with school districts to educate and reduce e-cigarettes in schools.	Blue Zones Project	Tina Tyler-O'Shea
	AH Well-Being	Judy Leach
	Mendocino County Tobacco Prevention Coalition – Public Health	Michael Frick
	Mendocino County Board Of Supervisors	Glenn McGourty, Chair
	Mendocino County Superintendent of Schools	Nicole Glentzer
	Round Valley Yuki Trails	Kenny Hanover
	Mendonoma health Alliance	Micheline White

YEAR ONE	YEAR TWO	YEAR THREE
1. Update licenses in retail establishments. 2. Provide education and support to School Systems.	1. Monitor retail locations for continued adherence to the TRL. 2. Provide education and support to school systems.	1. All incorporated cities have updated TRL ordinances. 2. Provide education and support to School Systems.

ADDRESSING HIGH PRIORITY: HEALTH RISK FACTORS – TOBACCO SECONDHAND SMOKE

GOAL	Create an environment that discourages commercial tobacco and nicotine use, reduces access, provides tobacco-free spaces, and supports the prevention, cessation and enforcement efforts.

Priority Area:	Health Risk Behaviors	Sub-Category:	Tobacco Use	Defining Metric:	Current Smoking Rates

Strategy 2:	Create systems and supports that target tobacco use prevention and cessation.
Population Served:	All Mendocino County residents
Internal Partners:	Blue Zones Project (BZP), AH providers, Chief Medical Officer
External Partners:	Public Health, School Districts, Community Benefit Organizations (CBOs)

Action: Program/Activity/Tactic/Policy	**Organization**	**Lead**
1. Identify currently trained smoking cessation program providers 2. Identify current funding for smoking cessation programs. 3. Improve education campaign for both adults and youth including providing cessation programs. 4. Support youth to engage in education and advocacy.	BZP	Tina Tyler-O'Shea
	Mendocino County Tobacco Prevention Coalition	Michael Frick
	Mendocino School Districts	FBUSD Joe Aldridge, UUSD Deb Kubin, WUSD Mark Beebe
	Redwood Community Services	Sage Wolf
	Family Resource Center	Jayma Spense
	Round Valley Yuki Trails	Kenny Hanover
	Mendonoma Health Alliance	Micheline White

YEAR ONE	YEAR TWO	YEAR THREE
1. Identify current smoking cessation programs in Mendocino County to assess gaps in availability. 2. Identify agencies with funding for smoking cessation and collaborate for best use of funds. 3. Collaborate with local agencies to improve communication strategy to inform the public about smoking cessation programs.	1. Collaborate to stand up additional smoking cessation programs in the county and communicate to the public. 2. Assess new smoking cessation funds available and collaborate to expand existing programs. 3. Update education campaign communications. 4. Work with school districts and youth organizations to engage youth in education and advocacy at schools and public events.	1. Identify new funding streams for smoking cessation. 2. Update education campaign communications. 3. Work with school districts and youth organizations to engage youth in education and advocacy at schools and public events.

ADDRESSING HIGH PRIORITY: HEALTH RISK FACTORS – TOBACCO USE EDUCATION

GOAL	Create an environment that discourages commercial tobacco and nicotine use, reduces access, provides tobacco-free spaces, and supports the prevention, cessation and enforcement efforts.

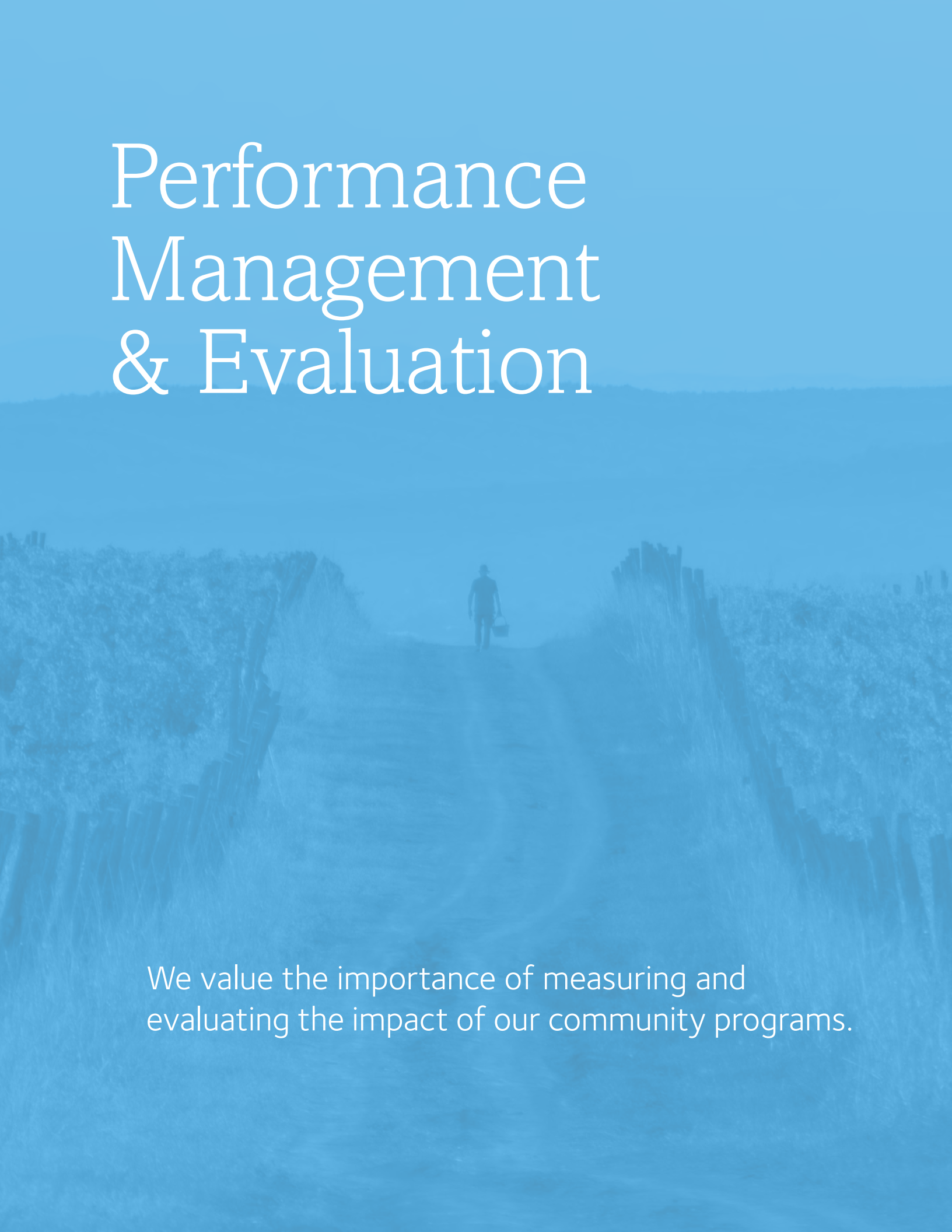
Priority Area:	Health Risk Behaviors	Sub-Category:	Tobacco Use	Defining Metric:	Current Smoking Rates

Strategy 2:	Create systems and supports that target tobacco use prevention and cessation.
Population Served:	All Mendocino County residents
Internal Partners:	Blue Zones Project (BZP), AH providers, Chief Medical Officer
External Partners:	Public Health, School Districts, Community Benefit Organizations (CBOs)

Action: Program/Activity/Tactic/Policy	**Organization**	**Lead**
1. Identify currently trained smoking cessation program providers 2. Identify current funding for smoking cessation programs. 3. Improve education campaign for both adults and youth including providing cessation programs. 4. Support youth to engage in education and advocacy.	BZP	Tina Tyler-O'Shea
	Mendocino County Tobacco Prevention Coalition	Michael Frick
	Mendocino School Districts	FBUSD Joe Aldridge, UUSD Deb Kubin, WUSD Mark Beebe
	Redwood Community Services	Sage Wolf
	Family Resource Center	Jayma Spense
	Round Valley Yuki Trails	Kenny Hanover
	Mendonoma Health Alliance	Micheline White

YEAR ONE	YEAR TWO	YEAR THREE
1. Identify current smoking cessation programs in Mendocino County to assess gaps in availability. 2. Identify agencies with funding for smoking cessation and collaborate for best use of funds. 3. Collaborate with local agencies to improve communication strategy to inform the public about smoking cessation programs.	1. Collaborate to stand up additional smoking cessation programs in the county and communicate to the public. 2. Assess new smoking cessation funds available and collaborate to expand existing programs. 3. Update education campaign communications. 4. Work with school districts and youth organizations to engage youth in education and advocacy at schools and public events.	1. Identify new funding streams for smoking cessation. 2. Update education campaign communication. 3. Work with school districts and youth organizations to engage youth in education and advocacy at schools and public events.

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 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.

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 Adventist Health Howard Memorial, Mendocino Coast and Ukiah Valley. 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	
Access to Care	**See Sections III.C - E**
Financial Stability	**See Sections III.C - E**
Health Risk Behaviors	**See Sections III.C - E**
Lower Priority Needs	
Community Safety 211mendocino.org/legal-assistance/	This community has higher rates of violent crime, death due to motor vehicle crashes, and deaths due to unintentional injury than the rest of California.
Housing-Unhoused 211mendocino.org/housing-homeless-services/	There are many drivers towards homelessness and a patchwork service system makes stable housing difficult to obtain and keep. 53% of surveyed residents identified homelessness as a health need in the com munity.
Housing-Cost 211mendocino.org/housing-homeless-services/	Inadequate housing stock and excessive housing costs affect many people in this region and influence the ability to draw in new people and retain current residents. 48% of surveyed residents identified homelessness as a health need in the community.
Health Conditions 211mendocino.org/health-care/	The prevalence rates of kidney disease and obesity are higher than the state average. Similarly, mortality rates for lung disease and the rate of people with cancer are also elevated compared to California as a whole.
Education 211mendocino.org/education/	Under-resourced and overtaxed schools make it difficult to provide adequate education for local students. This has a ripple effect throughout the community.
Employment 211mendocino.org/income-expenses/	30% of surveyed residents identified COVID as a community health need.
Food Security 211mendocino.org/food/	71% of students are eligible for free and reduced price school meals, and the overall poverty rate exceeds stand and national averages.
Mental Health 211mendocino.org/mental-health/	Increased rates of anxiety, hostility, and overall aggression are seen as signs of poor mental health throughout the community. 44% of surveyed residents consider mental health a community health need.

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.

Judson Howe
President, Adventist Health North Coast Network

Adventist Health
Howard Memorial