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Adventist Health Overview

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

Adventist Health entities include:

- 20 hospitals with more than 3,200 beds
- More than 280 clinics (hospital-based, rural health and physician clinics)
- 13 home care agencies and seven hospice agencies
- Four joint-venture retirement centers
- Compassionate and talented team of 35,000 includes associates, 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 other faiths to enhance the health of the communities we serve.

Our commitment to quality health care stems from our heritage, which dates back to 1866 when the first Seventh-day Adventist health care 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.
Dear Friends and Colleagues,

Improving the health of our communities is the reason Adventist Health exists and what you and I are collectively working toward achieving.

A few years ago, Adventist Health in the Central Valley formed a Population Health team to delve into the community to understand our greatest health threats and find solutions to improve outcomes. What we found were opportunities to join hands with others working toward the same goal. Together, we can target areas that are preventing our community members from seeking care, provide them with the best education and help them toward their journey to better health.

Our mission of living God’s love by inspiring health, wholeness and hope, calls us to improve the lives of those we serve in five counties across the San Joaquin Valley. We want to inspire our friends and families to live healthier lives, nurture their mind, body and spirit and hope for a future of better health.

The Community Health Plan is one way we put our mission into action. In this annual document, we report to the public on our activities and programs from the past year that we hope will address the needs of our communities. This is not an undertaking that can be done alone. We recognize that we are a part of the San Joaquin Valley and only through partnerships and alignment with community organizations and the people who live here, can we truly improve the health and wellness of those we serve. We thank you for your partnership and hope to continue our shared work in creating healthier communities.

Sincerely,

Andrea Kofl,
President of Adventist Health in the Central Valley
Adventist Health Reedley

Number of Beds: 49

Mailing Address: 372 Cypress Ave, Reedley, CA 93654

Contact Information: Andrea Kofl, President

Existing healthcare facilities that can respond to the health needs of the community:

35 Rural Health Clinics in 25 Communities spanning 5 counties (Fresno, Kings, Tulare, Kern and Madera)
24-hour Emergency Services
Cardiopulmonary Services
Chaplain Services
Family Birthing Center
Family Medicine Residency Programs
Inpatient and Outpatient Imaging
Inpatient and Outpatient Laboratory
Inpatient and Outpatient Surgery
Medical/Surgical Nursing Care
Physical Therapy
Social Services
Community Health Development Team

Nina Cornell Plata, RN, BSN, MS
Vice President Population Health

Ed Ammon MA, CFRE
Regional Vice President, Mission Integration

Rebecca Russell, MPH, RD
Community Wellness Director

Maricela Gonsalves, CPHW
Perinatal Program Educator Specialist

CHNA/CHP contact:
Rebecca Russell, MPH, RD
Community Wellness Director
1524 W Lacey Blvd, Suite 205, Hanford CA 93230
Request a paper copy from Administration/President’s office. To provide comments or view electronic copies of current and previous community health needs assessments go to: https://www.adventisthealth.org/about-us/community-benefit/
Invitation to a Healthier Community

Fulfilling the Adventist Health Mission

Where and how we live is vital to our health. We recognize that health status is a product of multiple factors. To comprehensively address the needs of our community, we must take into account health behaviors and risks, the physical environment, the health system, and social determinants of health. Each component influences the next and through strategic and collective action, improved health can be achieved.

The Community Health Plan marks the second phase in a collaborative effort to systematically investigate and identify our community’s most pressing needs. After a thorough review of health status in our community through the Community Health Needs Assessment (CHNA), we identified areas that we could address through the use of our resources, expertise, and community partners. Through these actions and relationships, we aim to empower our community and fulfill our mission, “Living God’s love by inspiring health, wholeness and hope.”

Identified Community Needs

The results of the CHNA guided the creation of this document and aided us in how we could best provide for our community and the most vulnerable among us. As a result, Adventist Health Reedley has adopted the following priority areas for our community health investments for 2017-2019:

- Access to Care
- Breathing Problems (Asthma)
- Diabetes
- Mental Health and Substance Abuse
- Obesity

Additionally, we engage in a process of continuous quality improvement, whereby we ask the following questions for each priority area:

- Do our interventions make a difference in improving health outcomes?
- Are we providing the appropriate resources in the appropriate locations?
- What changes or collaborations within our system need to be made?
- How are we using technology to track our health improvements and provide relevant feedback at the local level?
- Do we have the resources as a region to elevate the population’s health status?

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 though, we hope you imagine a healthier region and work with us to find solutions across a broad range of sectors to create communities we all want for ourselves and our families.
Connecting Strategy and Community Health

As hospitals move toward population health management, community health interventions are a key element in achieving the overall goals of reducing the overall cost of health care, improving the health of the population, and improving access to affordable health services for the community both in outpatient and community settings. The key factor in improving quality and efficiency of the care hospitals provide is to include the larger community they serve as a part of their overall strategy.

Health systems must now step outside of the traditional roles of hospitals to begin to address the social, economic, and environmental conditions that contribute to poor health in the communities we serve. Bold leadership is required from our administrators, healthcare providers, and governing boards to meet the pressing health challenges we face as a nation. These challenges include a paradigm shift in how hospitals and health systems are positioning themselves and their strategies for success in a new payment environment. This will impact everyone in a community and will require shared responsibility among all stakeholders.

Population health is not just the overall health of a population but also includes the distribution of health. Overall health could be quite high if the majority of the population is relatively healthy—even though a minority of the population is much less healthy. Ideally such differences would be eliminated or at least substantially reduced.

Community health can serve as a strategic platform to improve the health outcomes of a defined group of people, concentrating on three correlated stages:
1) The distribution of specific health statuses and outcomes within a population;
2) Factors that cause the present outcomes distribution; and
3) Interventions that may modify the factors to improve health outcomes.

Improving population health requires effective initiatives to:
1) Increase the prevalence of evidence-based preventive health services and preventive health behaviors,
2) Improve care quality and patient safety and
3) Advance care coordination across the health care continuum.

Our mission as a health system is Living God’s love by inspiring health, wholeness and hope. We believe the best way to re-imagine our future business model with a major emphasis of community health is by working together with our community.
2018 Community Benefit Inventory

In 2016 Adventist Health Reedley conducted a community health needs assessment which was followed by a 2017 Community Health Plan (Implementation Strategy) that identified the priority needs listed below. The prioritized needs were chosen based on community health data and the voices of our community. Working together with our community is key to achieving the necessary health improvements to create the communities that allow each member to have safe and healthy places to live, learn, work, play, and pray. Below you will find an inventory of additional interventions that will help support the health of our communities.

Priority Need – Access to Care

Intervention: Central Valley Transport Services provides round trip transportation to our clinics for patients that do not have transportation to their appointments. Services are provided to the following Adventist Health Medical Offices: Hanford, Healthy Beginnings, Hanford Residency, Hanford Specialty, Hanford Dentistry, Hanford Behavioral Health, Home Garden, Lemoore, Dinuba, Dinuba Plaza, Dinuba West, Orosi, Reedley, Reedley Children’s, Reedley Cypress, Reedley Jefferson, Reedley Women’s Selma Campus and Selma Central.

  o Number of Community Members Served: 13,909

Intervention: Our Hanford Medicine Residency clinic offered clinical assessment services at free diabetes pop up clinics and a Project Homeless Connect event in Kings County. Our residency clinic not only offered these free services to those in need, but by providing training and residency opportunities to medical students, we hope to increase the number of medical providers practicing in the Central Valley.

  o Number of Community Members Served: 300

Intervention: A big barrier to care in the Central Valley is an overall lack of providers. Physician and provider recruitment including nurse practitioners and physician assistants is critical to meeting the healthcare needs of our patients and communities.

  o Number of Providers Added in 2018: 43

Partners

- CalViva/HealthNet
- KARELink
- Anthem
- Kings Canyon Unified School District
- Kings Tulare Homeless Alliance
- Kings United Way
Priority Need – Diabetes

Intervention: Diabetes Pop Up Clinics in Hanford and Lemoore provided free diabetes and prediabetes screening, blood pressure and blood glucose checks, education on nutrition, lifestyle and physical activity, as well as connections with residency clinic, clinic schedulers, Covered California agent and Anthem and CalViva for management medical plan information.

  o Number of Community Members Served: 100

Intervention: Diabetes Among Friends, a five-week diabetes self-management education curriculum in English and Spanish from Scripps University, debuted in our rural health clinics in July 2017. This program is approved by the American Diabetes Association and covers all diabetes self-management topics including understanding blood sugars, nutrition, physical activity, medication management, stress management, foot care, ongoing screening tests and exams, etc.

  o Number of Community Members Served: 102

Intervention: Diabetes Case Management - Certified Diabetes Educators work as case managers for high risk rural health clinic patients with diabetes. High risk is defined as HgA1c greater than 9.0, LDL greater than 100 and blood pressure greater than 140/90. Educators work to help patients manage their diabetes including education and support with medications and clinic appointments.

  o Number of Community Members Served: 62

Partners

- Scripps Whittier Diabetes Institute
- Kings County Diabesity Coalition
- Kings Partnership for Prevention
- CalViva/HealthNet
- Anthem
- KARELink

What was the impact in 2018 for your priority area?

<table>
<thead>
<tr>
<th>Objective</th>
<th>Baseline Measurement</th>
<th>2018 Impact</th>
<th>Performance Target</th>
<th>Indicator</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase number of patients with HgbA1c ≤ 8%</td>
<td>32%</td>
<td>45.3%</td>
<td>59%</td>
<td>% of patients with a HgbA1c indicating controlled diabetes</td>
<td>HEDIS measure</td>
</tr>
<tr>
<td>Diabetes admissions</td>
<td>189</td>
<td>239</td>
<td>Decrease</td>
<td>Admission rates</td>
<td>Adventist Health admission data</td>
</tr>
</tbody>
</table>
Our Mission:
Living God's love by inspiring health, wholeness and hope

Program Highlight

One of our Diabetes Among Friends participants was a young man in his 30s. Diagnosed in 2016 with diabetes, he started our classes in October 2018. He never managed his diabetes due to work, lack of insurance and lack of interest in changing his lifestyle. When he began classes, he stated he did not have time for exercise and eating healthy was not his thing. Once he started the classes and started making lifestyle changes, his HgA1c went from 12.4 to 7.9 within 4 months. He started feeling better and was able to find a job that provided health insurance. He maintains his gains by continuing with healthy eating habits and taking low doses of insulin.

Priority Need—Obesity

Intervention: CREATION Health teaches women how to incorporate healthy lifestyle habits like nutrition, physical activity, rest, faith and even financial planning to improve overall health and wellness for families in our Reedley community.

- Number of Community Members Served: 142

Partners

- Kings Canyon Unified School District
- Orange Cove High School
- Parent Academy Program - Reedley

What was the impact in 2018 for your priority area?

<table>
<thead>
<tr>
<th>Objective</th>
<th>Baseline Measurement</th>
<th>2018 Impact</th>
<th>Performance Target</th>
<th>Indicator</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease Obesity Rates</td>
<td>Fresno County: 26.5%; Kings County: 26.4% (CDC 2013 data)</td>
<td>Fresno County 27%</td>
<td>California Average: 22.4%</td>
<td>Percentage of adults with BMI &gt; 30</td>
<td><a href="http://www.countyhealthrankings.org">www.countyhealthrankings.org</a></td>
</tr>
</tbody>
</table>

Objectives: Decrease Obesity Rates
Priority Need – Breathing Problems (Asthma)

Intervention: Respiratory Warriors Support Group – a monthly support group for those living with chronic lung diseases including asthma, COPD, pulmonary fibrosis, sleep apnea, allergies and any other lung health issue. Each month provides an opportunity for members to connect and catch up with each other while learning about resources and health topics that will help them lead healthier lives.

- Number of Community Members Served: 120

Intervention: Respiratory Therapy Educator who works with patients from the inpatient setting through outpatient and home visits. This educator has been able to provide educational support through the continuum of care for some of our sickest patients to ensure that they receive the medications they need and know how to use them to help them achieve their health goals as well as decrease readmission rates.

Intervention: In cooperation with the Kings County Asthma Coalition, AH hosted a community open house for clinic providers and the public to learn about asthma interventions. Topics included updates on current asthma medications, administration and inhaler use, air quality education, asthma triggers and abatement ideas and resources.

- Number of Community Members and Providers Served: 30

Intervention: Bubble Fun Run in Kings County increased awareness for community members about asthma and available resources. This free family activity raised awareness of asthma and community resources available to support families and community members dealing with asthma.

- Number of Community Members Served: 135

Partners

- Central California Asthma Collaborative
- Kings County Asthma Coalition
- Kings Partnership for Prevention

What was the impact in 2018 for your priority area?

<table>
<thead>
<tr>
<th>Objective</th>
<th>2017 Measurement</th>
<th>2018 Impact</th>
<th>Performance Target</th>
<th>Indicator</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma admissions</td>
<td>61</td>
<td>48</td>
<td>Decrease</td>
<td>Admission rates</td>
<td>Adventist Health admission data</td>
</tr>
<tr>
<td>COPD Admissions</td>
<td>92</td>
<td>73</td>
<td>Decrease</td>
<td>Admission rates</td>
<td>Adventist Health admission data</td>
</tr>
</tbody>
</table>
Program highlight

One of the members of the Respiratory Warriors Support Group was able to make so many health improvements even with her diagnosis for Pulmonary Fibrosis, that she was able to qualify and receive a lung transplant in 2018. She credits the providers at Adventist Health and the Respiratory Warriors Support Group for keeping her alive and helping her get her transplant. She went from being oxygen dependent and gasping for air to breathe to a vibrant woman who now participates in cardio workouts a couple times a week.

Priority Need – Mental Health and Substance Abuse

Intervention: Specialty behavioral health clinics are located in Kings and Fresno counties for our patients. Partnership with Dr. Marc Lasher to provide addiction medicine services to patients in Kings County in the hospital and clinics.

Intervention: As part of the annual Point in Time Survey to identify and count all homeless individuals, Kings and Tulare Counties host Project Homeless Connect. This annual event in Kings County provides services for the homeless including medical care, hygiene, dog vaccinations, bike repair, haircuts, state ID and social services, food, resource tables etc

  - Number of Community Members Served: 278

Intervention: Adventist Health partners with Kings United Way for promoting 2-1-1 and the 2-1-1 Intelliful© mobile app in our clinics and patient care areas. 2-1-1 connects people in need to resources in the community available to them – including mental health, substance abuse and homelessness resources. Anybody can access 2-1-1 by phone, email and in Kings and Tulare counties, through the phone app.

Intervention: Respite care for our homeless or inadequately housed inpatients provided for safe discharge. In 2018, we switched partners from Champions Recovery Alternative Programs Inc., which was a 30 day program in a substance use treatment facility to a 90-day board and care program with Kings Gospel Mission. Since the switch occurred in 4th quarter 2018, we have seen an increase in the number of homeless patients asking for and utilizing the respite care. Patients who are homeless and have substance abuse or mental health issues, receive wrap-around care while residing at the Kings Gospel Mission.

Partners

- Kings Tulare Homeless Alliance
- Kings United Way
- United Way of Tulare County
- Kings County Behavioral Health
- Champions Recovery Alternatives Programs Inc
- Kings Gospel Mission
- Kings County Wellness Bridge
- KARELink
Other Community Benefits

Intervention: Inspire Hope, a partnership with World Vision, allows us to distribute new-returned merchandise from Costco to community-based organizations that can utilize the items to improve the health and lives of those who live in our communities. Each month, a semi-truck delivers goods to the hospital storage area and items delivered are distributed to community partner agencies as appropriate. Items include everything from diapers, food, furniture, clothing, appliances, and more. Each delivery is a surprise but our community partners are always happy to receive what we can give.

- Number of Community Members Served: 1,595

Intervention: Car safety seat checks are conducted by our certified car safety seat technicians in the Security department. These safety seat checks make sure that the car seat is current and appropriate for the child. They also check to make sure the safety seat is properly installed in the vehicle. These checks are provided at no cost at our hospitals and clinics.

- Number of Community Members Served: 24

Intervention: Our Nutritional Services department provides the meals for the Kings County Commission on Aging Senior Meal Program which includes meals at congregate sites in Hanford, Corcoran and Avenal. They also provide frozen meals for the Meals on Wheels Program. Meals are provided to seniors at a suggested donation of $2.50 per meal, but payment is not required.

- Number of Meals Served: 31,313

Partners

- World Vision
- Champions Recovery Alternative Programs Inc
- Kings County Commission on Aging
- Kings Gospel Mission
- Safe Kids Kings County
- Reedley Teen Challenge
- Community Youth Ministries – Teen Mom Program
- Selma Community Outreach Ministry
- Life House Valley Church
- Parent Academy Program – Reedley
- Missionary Supply Line – Kingsburg
- Reedley Faith House
- Cruising for Jesus – Reedley
- One Blood Ministry – Selma
- Reedley Firemen’s Association
- LVC Home Builders Marriage Ministry
- Hope Now Ministries – Reedley
- Proteus
Changes in 2018

The Community Health Needs Assessment requires that each hospital listen to the voices of the communities that they serve. In 2018, the Central California Hospital Council’s hospitals worked together on a combined Community Health Needs Assessment. Primary data collection was completed throughout 2018 as updated CHNAs will be published during 2019 for all hospitals in the region including Fresno, Madera, Kings and Tulare counties. This primary data collection included 48 key informant interviews, and 24 focus groups (15 English, 8 Spanish, 1 Hmong) in all 4 counties as well as 348 online surveys.

Our voices in the community identified the following health needs:

<table>
<thead>
<tr>
<th>Health Need</th>
<th>Number of Mentions</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic Security/ Homelessness</td>
<td>210</td>
<td>High</td>
</tr>
<tr>
<td>Access to Care</td>
<td>168</td>
<td>High</td>
</tr>
<tr>
<td>Obesity/HEAL/Diabetes</td>
<td>132</td>
<td>High</td>
</tr>
<tr>
<td>Mental Health</td>
<td>75</td>
<td>High</td>
</tr>
<tr>
<td>Substance Abuse/Tobacco</td>
<td>55</td>
<td>Medium</td>
</tr>
<tr>
<td>Climate and Health</td>
<td>49</td>
<td>Low</td>
</tr>
<tr>
<td>Oral Health</td>
<td>34</td>
<td>Low</td>
</tr>
<tr>
<td>Violence/Injury Prevention</td>
<td>32</td>
<td>Low</td>
</tr>
<tr>
<td>Asthma</td>
<td>30</td>
<td>Low</td>
</tr>
<tr>
<td>CVD/Stroke</td>
<td>19</td>
<td>Very Low</td>
</tr>
<tr>
<td>Maternal and Infant Health</td>
<td>12</td>
<td>Very Low</td>
</tr>
<tr>
<td>HIV/AIDS/STIs</td>
<td>9</td>
<td>Very Low</td>
</tr>
<tr>
<td>Cancer</td>
<td>7</td>
<td>Very Low</td>
</tr>
</tbody>
</table>

While Adventist Health is still comparing this primary data to other health indicators and resources to determine our primary focus areas for our 2019-2022 CHNA, this preliminary data is so impactful that our 2019 community benefit operations will reflect the following changes:

Homelessness will be a priority focus.

Obesity, Healthy Eating Active Living and Diabetes will be combined into one focus area.

Mental Health and Substance abuse will be separated into two focus areas.

Access to Care remains a top priority with transportation barriers and provider recruitment for all health services as primary focuses within this category.

Breathing problems and asthma interventions will still be tracked but not reported in the next CHP as a priority area.