

MORE

COMMUNITY VOICES





Adventist Health

Adventist Health is a faith-based, nonprofit, integrated health system serving more than 100 communities on the West Coast and Hawai'i, with over 440 sites of care, including 27 acute care facilities. 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 more than 38,000 includes employees, physicians, allied health professionals and volunteers driven in pursuit of one mission: living God's love by inspiring health, wholeness and hope. Guided by our mission, Adventist Health supports purposeful work to address the social drivers of health, with a special focus on underserved members of the communities in which we operate. Together, we are transforming the healthcare experience of our communities with a whole-person focus on physical, mental, spiritual and social healing to support well-being.

2026 Community Health Implementation Strategy

Building upon the communities' voices, stories, and priority areas shared in the 2025 Community Health Needs Assessment (CHNA), in the following pages you will find the 2026 Community Health Implementation Strategy (CHIS).

This CHIS is a long-term community health improvement plan that strategically implements programs to address the high priority health needs identified in the CHNA.

We welcome collaboration with all local partners and community members, empowering our community to own the potential of healthy living for all.

Scan QR code or visit

<https://www.adventisthealth.org/documents/community-benefit/2025-AHCG-CHNA.pdf> to read about the latest findings and high priority needs identified in the 2025 CHNA.



High Priority Health Needs That Will Be Addressed

After conducting our CHNA, we identified priority areas where our resources, expertise, and partnerships can make a meaningful impact.

In partnership with community stakeholders, our hospital has strategically prioritized efforts to address:

Health Conditions

Health Risk Behaviors

Mental Health

Needs Hospital Plans Not To Address

Concentrating our resources on the above health needs will strengthen our ability to deliver effective interventions that are aligned with our operational capacity. The remaining lower identified health needs:

Access to Care, Housing, and Workforce Development – will not be addressed but are expected to benefit from the existing community partnerships and organizations who are currently addressing the need.

Scan QR code to learn more about our collaborative approach for selecting our high needs for the 2025 CHNA:

Section V. Process And Methods To Conduct The CHNA

H. Criteria & Process Used for Identification & Prioritization of Health Needs



PRIORITY NEED

Health Risk Behaviors

Population(s)

- Low-income
- Underserved
- People living with health conditions

Root Cause(s) of High Need:

- The tobacco industry spends \$137 million a year to promote or sell products in Oregon.
- The tobacco industry targets people with lower incomes and that face racism and other forms of discrimination. 1 in 5 people smoke who have an income of \$25,000 or less compared to 1 in 20 who have an income of \$150,000 or higher
- Injuries ranked 3rd leading cause of death in the U.S.
- In 2022, there were 2,448 children ages 0-14 who were in fatal and injury crashes, 10 were killed, and 2,435 were injured.
- In 2022, 24.94% of injured passengers were children aged 0-14.

OBJECTIVE: Strengthen the pathway to the health department’s tobacco cessation program and ensure the safety of children by engaging parents to connect with Care Seat Technicians.

ACTIONS:

- Leverage the Tobacco Cessation Program that is offered by North Central Public Health District (NCPHD) by referring individuals to this program to quit smoking.
- Conduct 2-3 community educational sessions that explain the link between health risk behaviors and health conditions.
- Develop a service that uses staff that are Car Seat Technicians to help ensure care seat injury prevention in the primary care setting.
- Have care seat technician participate in bi-annual childbirth education classes.

Aim Statement:

- Provide 2-3 community events annually to provide education abo health risk behaviors and their link to health conditions and the prevention of injuries.
- Ensure the safety of children by engaging parents to connect with Care Seat Technicians.

PROGRAM:
Healthy Horizons

Definition of Need

Health Risk Behaviors
Health Risk Behaviors are actions that increase the likelihood of adverse health outcomes, such as chronic disease, injury, or premature death. Common examples include tobacco use, excessive alcohol consumption, physical inactivity, poor diet, and risky sexual behaviors.

Metrics

- # of people referred to NCPHD’s Tobacco Cessation Program
- # of educational sessions hosted
- # of children riding in properly secured seats post intervention

Partners

Internal

- OP Case Management
- Primary Care Clinics
- Certified Car Seat Technicians
- Obstetrics
- Women’s clinic

External

- North Central Public Health District (NCPHD)

PRIORITY NEED

Health Conditions

Population(s)

- Underserved
- Medicaid
- People living with Diabetes
- People living with Obesity

Root Cause(s) of High Need:

- Limited access to nutritional education, health foods (incl. high cost), and community resources
- Socioeconomic conditions
- Lack of access to affordable care
- Lifestyle factors (tobacco use, lack of physical activity, food choices)

OBJECTIVE: Educate community members to prevent chronic health conditions and/or improve their overall health.

ACTIONS:

- Work with Patient Navigators to help individuals access primary care services and address barriers to care such as housing, food insecurity, tobacco cessation programs, and online education courses about healthy eating and physical activity.
- Create and provide at least 2-3 community educational sessions annually focused on disease prevention and management.
- Provide free blood glucose checks to migrant farmworkers.

Aim Statement: Increase the number of social needs provided by Patient Navigators on an annual basis while providing education about health conditions (cancer, diabetes, and heart disease) during community engagement events.

PROGRAM Name:

Pathways to Prevention

Definition of Need:

Health Conditions

Chronic Health Conditions are defined as long-lasting illnesses that persist for at least one year and require ongoing medical attention, lifestyle adjustments, or both. These conditions include heart disease, diabetes, cancer and chronic respiratory diseases, which are among the leading causes of death and disability worldwide.

Metrics

- # of social needs services addressed by Patient Navigators.
- # of educational events hosted
- # of free blood glucose checks provided to the migrant farmworker community
- # of chronic health booklets

Partners

Internal

- OP Case Management
- Primary Care
- Cardiology
- Celilo Cancer Center

External

- Migrant Education Program

PRIORITY NEED

Mental Health

Population(s)

- Underserved
- People experiencing Substance Use Disorders (SUD) and houselessness

Root Cause(s) of High Need:

- Oregon ranks 51st in mental health prevalence and access.
- 1 in 3 adults Oregonians experience mental health illness.
- Lack of rural Mental Health practitioners in the Columbia Gorge.
- Lack of basic resources like food and housing.
- Complex insurance navigation.

OBJECTIVE: Make strides toward improving our communities mental and behavioral health status through increased education, advocacy, workforce development, and access to care

ACTIONS:

- Increase access to crisis support by fully developing, implementing, and evaluating program focused on providing psychiatric assessments and referrals to mental health resources.
- Increase specialty training around mental health and suicide.
- Advocate by taking part in the Columbia Gorge Behavioral Health Consortium.
- Increase access of mental health practitioners by being a host site to interns interested in the behavioral health field.

Aim Statement:

Implement multi-faceted strategies to support the mental health crisis that our community is facing by increasing annually the number of mental health appointments available and explore the feasibility of being a host site for aspiring mental health practitioners.

PROGRAM:

Beacon for Mental Health

Definition of Need:

Mental Health

Mental Health, within public health and community health frameworks, is understood as a state of well-being in which individuals can cope with life's challenges, work productively, and contribute meaningfully to their communities.

Data Source(s)/ Metrics

- # of interns hosted
- # of mental health and suicide trainings completed by the Community Health Workers
- Increase volume of mental and behavioral health appointments available using 2025 as a baseline.
- # of assessments completed
- # of referrals sent to Mid-Columbia Center for Living (MCCFL).

Partners

Internal

- Behavioral Health
- Lead Social Worker
- Community Health Workers

External

- Columbia Gorge Behavioral Health Consortium (CGBFC)

Existing Initiatives Projects

- Social Work Interns

APPROVAL PAGE

2026 CHIS Approval

In response to the 2025 Community Health Needs Assessment, this Community Health Implementation Strategy was reviewed and approved by our Hospital Board as well as the Adventist Health System Board on April 23, 2026.

The entire report is published online and available in print form by contacting community.benefit@ah.org.

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