

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-AHMC-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:

Access to Care

Financial Stability

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:

Community Infrastructure, Food Security, Health Risk Behaviors Housing, and Social & Economic Context – 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

Mental Health

Population(s)
People experiencing homelessness (PEH).

Root Cause(s) of High Need:

- Untreated mental illness and substance use disorders.
- Economic hardship.
- Insufficient affordable housing.
- Inefficient service coordination.

OBJECTIVE: Expand access to mental health and substance use services for people experiencing homelessness (PEH).

ACTIONS:

- Continue providing primary care to PEH via a multidisciplinary care team model.
- Expand mental health access for PEH.
- Expand substance use treatment capacity for PEH.
- Convene quarterly Mendocino County Street Medicine Collaborative meetings for provider partners.
- Increase the number of multi-organization patient case conference meetings to improve coordination of care.

Aim Statement: Increase yearly the number of PEH able to access mental health and substance use services in Mendocino County

PROGRAM:

Champions: Faith Dayton, LCSW; Cara Eberhardt, MD; Jeremy Malin, FNP

Partners: Redwood Community Services, Mendocino Coast Hospitality Center, MCHC, MCAHVN, Mendocino Coast Clinics, Mendocino County Public Health, Consolidated Tribal Health Project, Northern Circle Housing Authority

Hospital-Based
Committed Resources

- COMPASS Street Medicine
- AHUV Providers
- AH ECM
- Project Restoration (CalAIM CS Medical Respite Program)
- AHUV Pharmacy

Hospital-Based
Initiatives

- Mendocino County Street Medicine Collaborative
- Medication Backpack Program

Community
Based Initiatives

- Full Service Partnership expansion
- Seventh Day Adventist EHIT Taskforce
- Continuum of Care

Data Sources

- # of access points for mental health
- # of mental health referrals
- # of staff/services treating SUD
- # of Street Medicine Collaborative meetings
- # of patient case conference attendees
- # of CBO Partners
- # of Public Partners

Local Resources

- Black Oak Coffee Roasters
- Redwood Community Services

Potential
New Resources

- BHSA Full Service Partnership contract
- Street Medicine Palliative Care

Financial Stability

Population(s)

Individuals at risk of losing their health insurance

Root Cause(s) of High Need:

- Federal legislative impacts on Medicaid eligibility.
- California (CA) legislative impacts on MediCal (CA Medicaid) eligibility.
- Mendocino County barriers to steady employment.
- Health insurance eligibility knowledge gap.

OBJECTIVE: Develop a program to improve financial stability by helping individuals maintain health insurance coverage.

ACTIONS:

- Partner with Mendocino County Social Services and Alliance for Rural Community Health to implement a county-wide strategy via the Covered Mendocino Taskforce.
- Ensure trained in-person support staff at three hospitals/ERs (AHUV, AHM, AHCL) for enrollment and re-enrollment assistance.
- Launch community education outreach through social media, radio, and local newspapers.

Aim Statement: Within three years reduce the number of Mendocino County residents losing health insurance due to eligibility gaps or lack of enrollment through education around enrollment and assist them to successfully enroll and/or re-enroll for Medi-Cal and/or other coverage programs.

PROGRAM:

Partners:

- Mendocino County Social Services
- Alliance for Rural Community Health
- Partnership HealthPlan of California

Hospital-Based

Committed Resources

- Enrollment support staff
- Training programs for front-line staff
- Collaboration with financial assistance teams
- MarCom

Data Source(s)

- Develop Program
- Implement Program
- # of Partners in Mendocino County
- # of people trained
- # of training locations
- # of PSAs, Social Media Posts, Ads placed
- # of Educational collateral pieces created
- # of people enrolled
- # of people re-enrolled

Community-Based Initiatives

- Covered Mendocino Taskforce
- Mendocino County Social Services
- Alliance for Rural Community Health
- Partnership HealthPlan of California

PRIORITY NEED

Access to Care

Population(s)

People experiencing challenges with Diabetes management.

Root Cause(s) of High Need:

- People don't have a kitchen to prepare and store food.
- Remote people don't have a car, or unable to drive or afford gas to regularly pick up or purchase fresh foods/meals.
- People don't have regular access to internet to apply and/or re-apply for programs.

OBJECTIVE: To collaborate with nutritional services, case management and population health to close nutritional gaps for people with diabetes with poor control and/or end stage renal disease.

ACTIONS: The following strategies and tactics will be implements to better understand peoples' needs, gaps in care and barriers that lead to poorly controlled diabetes.

- Create a 10-week cohort to educate people on healthy nutritional choices
- Develop a pre-questionnaire to better understand the current habits, uncover barriers (such as transportation) and gaps/need for health literacy.
- Regularly assess and evaluate the financial resources needed to sustain this program.
- Defining additional Internal and External Partners to meet the uncovered needs of people with poorly controlled diabetes.
- Create a post cohort program to connect people with community resources and support to maintain and sustain their good health.
- Create and implement a process for completed cohort participants to re-enroll and/or become connected to a community-based organization to help with cooking skills, nutritional education, and affordable physical activity opportunities.

Aim Statement: Over the next 3 years develop, implement and sustain a set process to identify people with diabetes with poor control and/or end stage renal disease and enroll them in a cohort to receive nutritional support.

PROGRAM:

Champion:

Dr. Marvin Trotter
Annie Earsley, RD, CDCES
Jeremy Malin, FNP
Christina Graves, RN

Partners:

Quality & Risk
Nutritional Services
Case Management
Population Health

Hospital-Based
Committed Resources

- CALAim - AH

Hospital-Based
Initiatives

- CALAim - AH

Data Source(s)

- Program is developed
- Program is implemented
- # of people enrolled
- # of program cohorts
- # of CBO partners
- # days of food supplied

Community-Based
Initiatives

- Public Health
- Partnership Health

Local Resources

- Nutritional Services
- Case Management
- Emergency Dept.
- The Garage
- Finance
- Population Health
- Grants Team

Potential
New Resources

- Partnership Health
- Philanthropic Partner

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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