

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-AHPL-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

Food Security

Housing

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:

Culturally responsive health care, Educational opportunity, Physical safety in the community, Trust of the health care system, and Eliminate education disparities through early childhood access – 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
Access to care

Population(s)

The community defined as our service area.

Root Cause(s) of High Need:

- *Language barriers*
- *Cultural barriers*
- *Lack of trauma-informed care and support*
- *Economic barriers*
- *Education barriers*
- *Transportation barriers*

OBJECTIVE: Reduce barriers that prevent individuals from accessing essential health and support services by strengthening coordination between hospital care processes and community-based resources.

ACTIONS:

- **Improve care coordination:** Continue to improve processes that better integrate hospital intake and discharge workflows by understanding patients' health needs and social determinants of health, ensuring timely connection to appropriate community-based services.
- **Enhance communication and accessibility:** Create and distribute linguistically appropriate and culturally responsive communication materials to help community members, patients and families understand and access available health and human support services.
- **Strengthen community partnerships:** Evaluate and lean into partnerships with community-based organizations (CBO) that provide health and human support services to improve continuity of care and address patient needs beyond the clinical setting.

Aim Statement: *Create and maintain a system where those in our service area are communicated to in a way that is culturally sensitive and in a language they understand. Translate key patient facing materials in threshold languages and distribute to CBOs.*

PROGRAM:
Material translation

Partners:

- *Project Access Now*
- *North by Northeast*
- *Asian Health & Service Center*

Existing Initiatives/Projects

- Translation of patient facing materials in threshold languages.
- Provide financial support to Project Access Now.

Data Source(s)

- Translate five key patient collateral annually for recommended screenings and health care resources in Spanish, Russian, Chinese, Vietnamese.

Partners

Internal

- Emergency department
- Care management

External

- Project Access Now
- North by Northeast
- Asian Health & Service Center
- Local churches

Available Resources

- Volatia
- OHA Community Capacity Building Funds

PRIORITY NEED
Food security

Population(s)

The community defined as our service area.

Root Cause(s) of High Need:

- *Community lives in a food desert.*
- *Large immigrant population struggles to find culturally relevant food.*
- *Socioeconomic barriers of those living poverty such as lack of transportation and funds.*

OBJECTIVE: Expand access to nutritious and culturally relevant foods by strengthening and scaling partnerships with community-based organizations, increasing patient awareness of available resources, and supporting opportunities for individuals and families to obtain or grow their own food.

ACTIONS:

- **Strengthen awareness and resource navigation:** Continue to serve as a connector to nutritious food resources by supporting onsite whole-food and garden initiatives and promoting access to community food programs and partners.
- **Advance access to culturally relevant foods:** Collaborate with community-based organizations to increase the availability of culturally preferred food options and improve communication pathways that guide individuals to local food resources.
- **Deepen community partnerships:** Expand and nurture active relationships with food-related community-based organizations, including through leadership participation and volunteer engagement. *(Example: ongoing board service with PACS.)*

Aim Statement: *Expand the produce stand to include more culturally relevant food and provide food RX to community members to use at the produce stand.*

PROGRAM:
Medically tailored meals

Partners:

- *Outgrowing Hunger*
- *Portland Rescue Mission*
- *Blanchet House*
- *Meals on Wheels*
- *PACS*

Existing Initiatives/Projects

- Community garden
- Summer produce stand
- Trillium Community Health Plan grant with Meals on Wheels
- First Friday Events
- Celebration of Thanksgiving

Data Source(s)

- # Immigrant families use the garden
- # Community members attend the summer weekly produce stand
- # Medically tailored meals delivered to patients
- # Meals delivered

Partners

Internal

- Care management
- Spiritual care

External

- Outgrowing Hunger
- Portland Rescue Mission
- Blanchet House
- Meals on Wheels
- PACS

Available Resources

- Oregon Office of Rural Health
- Columbia Pacific CCO
- Oregon Community Foundation

Housing

Population(s)

The community defined as our service area.

Root Cause(s) of High Need:

- Lack of affordable housing.
- Rent assistance waitlists are long, and people often just miss eligibility due to small income differences.
- Lack of education around application process for loans, subsidies and/or temporary housing.
- Rent assistance programs are insufficient.

OBJECTIVE: Build on current efforts to link unhoused patients and cost-burdened residents with safe, affordable housing and coordinated support services.

ACTIONS:

- **Strengthen partnership network:** Collaborate with community-based organizations that provide housing and housing support services.
- **Improve referral pathways:** Identify patients experiencing or at risk for housing instability and connect them with community resources.
- **Integrate housing supports into care transitions:** Embed housing navigation and referrals into Emergency Department discharge workflows.
- **Advance systems change through advocacy:** Work with government partners to support policies that expand access to affordable, stable housing.

Aim Statement: Support organizations who work to provide sustainable housing and support those at risk of homelessness through funding and utilizing our volunteer squad to support CBOs at least three times a year.

Partners:

- Blanchet House
- Portland Rescue Mission
- Transitions Project
- Oregon Change Clinic

Existing Initiatives/Projects

- Annual financial support of CBOs such as Portland Rescue Mission, Blanchet House and Transitions Project.
- Purchase supplies and create hygiene kits for new residents of the Oregon Change Clinic.
- Hold multiple donation drives to support Portland Rescue Mission our community closet.

Data Source(s)

- # dollars donated to the CBOs to help provide temporary housing.
- # hours of volunteer time for CBOs.
- # pounds of clothing collected for houseless patients.

Partners

Internal

- Care management
- Emergency department

External

- Blanchet House
- Portland Rescue Mission
- Transitions Project
- Oregon Change Clinic

Available Resources

- CareOregon
- Northwest Pilot Project

Mental and behavioral health

Population(s)

The community defined as our service area.

Root Cause(s) of High Need:

- *High homelessness and housing insecurity is strongly associated with SUD, both as a risk factor and as an outcome.*
- *Poverty, unemployment, unstable housing, and other social determinants of health increase vulnerability to substance use such as limited healthcare access, and high-stress environments contribute to higher SUD incidence.*

OBJECTIVE: Deliver access to treatment referrals and support for individuals with substance use disorders (SUD) by strengthening existing community-based partnerships and actively pursuing innovative approaches to better serve this population.

ACTIONS:

- **Care coordination with treatment partners:** Strengthen coordination with treatment partners to ensure timely, low-barrier access to community SUD services for patients leaving the Emergency Department (ED).
- **Advance workforce readiness and clinical excellence:** Expand training and education for ED staff to reinforce best practices in trauma-informed, compassionate care for individuals experiencing substance use–related medical or behavioral health crises while increasing understanding of patient's unique cultural needs and experiences.
- **Broaden community partnerships and leadership engagement:** Grow relationships with community-based organizations addressing substance use and recovery—leveraging volunteerism, shared initiatives, and leadership roles (e.g., board involvement) to support unified, person-centered systems of care.

Aim Statement: *Provide staff with training and access to more resources to care for patients with mental and behavioral health needs.*

PROGRAM: IMPACT program

Partners:

- Project Access Now
- FORA
- Oregon Change Clinic
- OHSU - IMPACT

Existing Initiatives/Projects

- Annual financial support of Project Access Now.
- IMPACT program in our ED.
- Volunteer support for Oregon Change Clinic through drives and kit building.
- FORA education seminars for ED staff.

Data Source(s)

- # FORA trainings/presentations to ED staff
- # hygiene kits assembled and delivered to CBOs for residents and clients
- # patients referred to local mental and behavioral health services for SUD

Partners

Internal

- Care management
- Emergency department

External

- Project Access Now
- FORA
- Oregon Change Clinic
- OHSU-IMPACT

Available Resources

- Oregon Health Authority

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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