

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 our 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. Together, we can empower our community to own the potential of healthy living for all.

Scan QR code or
<https://www.adventisthealth.org/documents/community-benefit/2025-AHRO-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: Quality Primary Care, Specialty, & Extended Care Services**
- **Increased Community Connections**
- **System Navigation**

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 Mental/Behavioral Health and Substance Use Services; Access to Basic Needs Such as Housing, Jobs, and Food; Access to Functional Needs; Injury and Disease Prevention and Management; Active Living and Healthy Eating, and Healthy Physical Environment** – will not be directly addressed but are expected to benefit from the existing community partnerships and organizations who are currently addressing the need. Adventist Health + Rideout will continue to collaborate with these community partners and participate in regional initiatives.



Criteria for Prioritizing Significant Health Needs

Adventist Health + Rideout utilized a structured prioritization process to determine which of the significant health needs identified in the 2025 Community Health Needs Assessment (CHNA) would be addressed through the Community Health Implementation Strategy (CHIS). The prioritization process incorporated input from hospital leadership, community stakeholders, and the hospital's Community Board. Each identified health need was evaluated using the following criteria:

Severity and Prevalence of the Need

The extent to which the health issue affects the community, including the magnitude of the problem, trends over time, and the impact on vulnerable populations.

Disparities and Equity Considerations

The degree to which the health need disproportionately affects specific populations, including low-income residents, rural communities, and individuals experiencing barriers to care.

Ability to Influence and Impact Change

The hospital's capacity to meaningfully address the issue through direct services, partnerships, programs, or policy initiatives.

Feasibility of Potential Interventions

The availability of evidence-based strategies, community partnerships, and organizational resources that could support effective implementation.

Alignment with Organizational Mission and Core Services

Consistency with Adventist Health + Rideout's mission, strategic priorities, and clinical expertise.

Continuity with Existing Programs and Community Initiatives

Opportunities to build upon existing programs, leverage community assets, and collaborate with local organizations already working in the priority areas.

Availability of Resources

Consideration of financial, staffing, and community resources that could support implementation and long-term sustainability.

These criteria were applied collectively to guide discussion and inform decision-making regarding which needs would be prioritized during the three-year CHIS implementation period.

Adventist Health & Rideout Community Health Implementation Strategy

The development of Adventist Health + Rideout's Community Health Implementation Strategy (CHIS) is informed by the findings of the 2025 Community Health Needs Assessment (CHNA). The CHNA engaged community stakeholders and incorporated both quantitative and qualitative data to identify the most significant health needs within the service area. Through this process, ten priority health needs were identified and serve as the foundation for this strategy.

To support the prioritization process, Adventist Health + Rideout staff and the CHNA lead consultant presented the results of the data collection and analysis to the hospital's Community Board during their August 21, 2025 meeting. This board includes both internal leadership and external community and health sector representatives who provide guidance on community health needs and priorities.

Based on the findings of the CHNA, recommended areas of focus were presented for consideration. These recommendations reflected a prioritization of the identified community health needs using several criteria, including the feasibility of potential interventions and the hospital's ability to influence meaningful change; the severity and prevalence of the need; continuity with existing initiatives and alignment with shared community goals; and opportunities to maximize available resources over the three-year CHIS implementation period.

The prioritization process also incorporated a review of current hospital and community strategies, existing programs, and other community assets to ensure the most effective and efficient use of resources. In addition, Adventist Health + Rideout considered the organization's core clinical services and strategic areas of focus. While the hospital provides treatment for behavioral health and substance use conditions in the emergency department and inpatient settings, the organization determined that these services are not a primary strategic focus or core competency for long-term programmatic investment within the CHIS.

Following review of the CHNA findings and discussion regarding the prioritization rationale, a formal outline and recommended approach for the new CHIS was presented by the hospital's Chief Strategy Officer to the Adventist Health + Rideout Executive Team in December 2025. The Executive Team includes the Hospital President and Chief Medical Officer, Chief Nursing Executive, Chief Operating Officer, and Chief Financial Officer. Upon approval, the proposed strategy was also presented to the Adventist Health + Rideout Medical Executive Committee at their December 2025 meeting.

PRIORITY NEED

Access to Care

Population(s)

All residents.

Root Cause(s) of High Need:

- Yuba-Sutter counties represent medically underserved areas.
- County clinical care indicators compared to state benchmarks indicate there are fewer primary care and specialties than CA average.
- Recruitment challenges due to the unique rural/agricultural area
- AHRO also competes with four large, established hospital systems in the Greater Sacramento Area.
- As a result of not enough primary care providers in the area, patients use the ER for primary care needs.
- Additional feedback: minimal after hour options, few MediCal providers.

OBJECTIVE: Improve access to healthcare services in the community by improving the number and availability of physicians, both primary care and specialists, and other allied health professionals in our community to minimize lack of services or utilizing services outside the community.

ACTIONS:

Physician recruitment: Recruitment efforts are focused on key specialties:

- Cardiac
- Gastroenterology
- Ob/Gyn
- Urology
- Vascular

Physician Engagement:

- Develop medical staff communication to keep providers informed and aware of hospital’s progress and needs.
- Provide opportunities for providers to engage with referring and community providers
- Develop provider outreach referral opportunities to engage their peers to relocate and practice to serve AHRO’s rural community.

Partner with sister Adventist Health facilities to leverage their pool of doctors to address specialty gaps and meet the needs of our inpatients, minimizing transfers outside of the area.

Aim Statement: In 2026-2028, focus on provider retention and expanding access via the addition of new providers both in the hospital and in the clinics to meet the needs of the community.

PROGRAM:

Provider Recruitment

Champion:

Robin Oliver, VP,
Business Executive

Business
Development Team

Existing Initiatives/Projects

- Adventist Health Provider Recruitment
- Develop and launch an AH GSN provider recruitment event
- Partner with sister facilities to create a pool of providers to cover immediate needs
- CNA training
- Yuba-Sutter College

Data Source(s)

- County clinical care indicators compared to state benchmarks
- # of provider applicants
- # of provider interviews
- # of providers contracted
- Providers on-boarded
- Provider turnover
- RN turnover (9%)
- Graduating classes

Partners
Internal

- Business Development/Provider Recruitment team
- AHMG CMO
- AHRO CMO
- Medical Staff
- AH Provider Onboarding Team
- AH Provider Outreach Team

External

- Korn Ferry
- FQHCs

System Navigation

Population(s)

Yuba- Sutter community, emphasis on MediCal/FQHC patients and AHMG patients

Root Cause(s) of High Need:

- *Lack of awareness by community of the services they are eligible for or understanding their insurance benefits.*
- *Difficult to navigate multiple, different health care systems.*
- *Medical and insurance paperwork can be overwhelming.*
- *More navigators are needed to connect people to services.*
- *Individuals don't know how to begin to access their health benefits.*

OBJECTIVE: Improve patients/the community's ability to improve their health by effectively understanding their medical benefits and how to utilize services that are available.

ACTIONS:

- *Partner with insurance plans during open enrollment to discuss AH's offerings, explain their benefits and how AH can meet their needs.*
- *Partner with the medical group to develop patient engagement opportunities to raise awareness of AHMG's offerings and ensure patients*
- *Support the Yuba-Sutter Healthcare Council initiatives, specifically the Telehealth Resource toolkit that will be launched in Q2 2026 to create awareness and increase usage of Partnership's specialty telehealth services.*
- *Partner with FQHCs to align with messaging and discharge information.*
- *Leverage patient advocacy group to solicit feedback and suggestions for improvement.*
- *Evaluate patient navigator tools used throughout the community as an opportunity to align and simplify for consumers' use.*

Aim Statement: In 2026-2028, partner with local community healthcare providers to remove barrier and make accessing healthcare services easier to understand and utilize.

PROGRAM:
Name Here

Champion:

Robin Oliver, VP,
Business Executive

Existing Initiatives/Projects

- Follow up appointments made at time of discharge
- Leverage the Yuba-Sutter Healthcare Council toolkit to educate MediCal patients about Partnership's telehealth specialty options to launch in 2026.
- Sutter County CHIP contributor; promote initiatives to coordinate FQHC mobile services throughout the region

Data Source(s)

- # of follow up post discharge appointments made
- Track appointment compliance (AHMG, FQHCs)
- Track clicks to website/social media associated with education
- Coordinate with FQHCs to track mobile clinic visits (measure improvement)
- # specialty telehealth visits (YOY)
- Track attendees at local, educational events

Partners Internal

- Mission Integration
- Case Management
- Health Equity Committee
- AHRO ECM Team
- Executive Team
- Communications

External

- Y-S Co. Public Health
- Y-S Behavioral Health
- Y-S Healthcare Council
- Homeless Consortium
- FQHCs (Ampla, Harmony Health, Peachtree)

PRIORITY NEED

Increased Community Connections

Population(s)

Beneficiaries: All Residents, Non-Profit agencies
Participants: Local non-profit, government agencies and healthcare providers/systems

Root Cause(s) of High Need:

- Building community connections doesn't seem like a priority.
- Relations between law enforcement and the community need to be improved.
- The community reflects and serves a diverse population, many times cultural barriers may exist.

OBJECTIVE: Develop a strategic plan that integrates healthcare and community support service organizations' initiatives to achieve a more collaborative and coordinated approach to meeting the needs of the community.

ACTIONS: Launch a Community Collective (or Collaborative) to jointly address the community's needs via a strategic plan with smart goals to more effectively and efficiently manage local resources, minimize redundancies, and maximize collective efforts.

- Launch Community Connections, hosted by AH, inviting all non-profit organizations that address the health needs of the community to leverage current initiatives in progress individually to develop an integrated plan that aligns smart goals and KPIs to measure holistic effectiveness and outcomes. Establish a quarterly cadence for all to share progress, barriers and new opportunities.
- Continue AH's newly developed Interfaith Summit and Faith Council to expand awareness and develop stronger integration of additional, broad services available to our community to create increased access to services to their constituents.
- Increase visibility to resources for the community; consider leveraging the public health and local government websites as an information hub (translated in multiple languages for ease of access).

Aim Statement: In 2026-2028, identify and convene all local resources to develop a collaborative, coordinated, comprehensive plan to ensure resources are maximized and redundancies are minimized with the intent to reduce working in silos and provide services to the broad, diverse community we serve equally.

PROGRAM:

Community Connect

Champion:

Robin Oliver, VP,
Business Executive

Heather Davis,
Community
Integration Manager

Existing Initiatives/Projects

- Yuba-Sutter Healthcare Council
- Yuba-Sutter Homeless Consortium
- Sutter Co. CHIP
- AHRO's Interfaith Summit and Interfaith Council
- Addition of a Community Integration Manager to the AHRO team (March 2026)

Data Source(s)

- # of meals provided by YS Food Bank
- # of individuals served by Homeless Consortium
- Meetings conducted + participants
- Initiatives identified + outcomes (e.g. FQHC mobile clinic coordination)
- Local presentations
- PR/social media metrics

Partners

Internal

- Mission Integration
- Case Management
- Executive Team
- Communications

External

- 256 community resources identified in CHNA

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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