

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-AHSR-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 (inclusive of 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:

Community Safety, Health Conditions, Health Risk Behaviors, and Social and 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



Access to Care 1A

Population(s) *Low-Income and Uninsured/underinsured residents, rural and geographically isolated residents, American Indian / Alaska Native community members, individuals without an established primary care provider, older adults and individuals with chronic conditions*

Root Cause(s) of High Need:

- Critical Shortage of Primary Care Providers in a Rural Setting.
- Limited Healthcare Workforce Pipeline and Career Pathways.
- Transportation and Geographic Barriers Amplified by Provider Shortages.
- High Proportion of Underinsured and Financially Vulnerable Residents.
- Lack of Local “Grow-Your-Own” Physician Training.

OBJECTIVE: *Increase access to affordable, timely primary care for underinsured and rural residents by strengthening the local healthcare workforce, expanding family medicine training capacity, and creating sustainable, family-wage career pathways in healthcare. This supports improved community health outcomes, reduced out-of-county travel for care, and greater economic stability in Tuolumne County and the Mother Lode region.*

ACTIONS: Objective 1: Workforce Development & Career Pathways

Develop and implement CNA, MA, and RN training programs in collaboration with regional education and workforce partners.

Enroll ≥40 participants annually in workforce training programs and support job placement into local healthcare roles.

Formalize healthcare career pathway agreements with local high schools and higher-education partners. Host at least one annual Healthcare Career Day and support five student internship or job-shadowing cohorts per year to promote early entry into health professions.

Objective 2: Family Medicine Residency Expansion

Expand a Family Medicine Residency Program focused on rural primary care training.

Track retention outcomes

Aim Statement: *Build a local healthcare workforce pipeline that supports family-wage careers and increases access to care for underinsured populations. By 2028, expand entry-and mid-level healthcare training opportunities to increase the number of locally trained staff serving primary care and safety-net settings.*

PROGRAM: Regional Workforce Development

*Champion:
Adventist
Health
Workforce Dev
and Residency
Program*

Existing Initiatives/Projects

- Family Medicine Residency Program (in development/early implementation)
- Partnership with Columbia College and Pacific Union College
- Primary Care and Safety-Net Clinical Services

Data Source(s)

- # of CNA, MA, and RN training programs offered
- Annual enrollment and job placement rates in local healthcare roles
- # of formal career pathway agreements executed
- # of career days, internships, and job-shadowing cohorts hosted
- Residency program enrollment, graduation, and regional retention rate

Partners Internal

- Adventist Health Sonora Family Medicine Residency Program
- AH Leadership
- AH Workforce Development

External

- Columbia College (YCCD)
- Local HS Districts
- Tuolumne & Calaveras County Superintendents of Schools
- Workforce Investment Board
- Pacific Union College

Available Resources

- Columbia College has existing healthcare pathways
- Mother Lode Workforce Development Board (MLWDB) / Job Training Programs

PRIORITY NEED

Access to Care 1B

Population(s)

Low-Income and uninsured/underinsured residents, rural and geographically isolated residents, American Indian / Alaska Native community members, individuals without an established primary care provider, older adults and individuals with chronic conditions.

Root Cause(s) of High Need:

- Severe Provider Shortages in a Rural Setting.
- Transportation Barriers and Geographic Isolation.
- Lack of a Reliable Primary Care Continuity.
- Financial and Insurance-Related Barriers.
- Digital and Health-System Navigation Barriers.
- Cultural, Linguistic, and Social Barriers.

OBJECTIVE: Increase equitable access to affordable primary and specialty care for underserved residents in Tuolumne and surrounding rural communities by strengthening care capacity, coordination, and workforce sustainability.

ACTIONS:

1. Expand Primary Care Capacity through Residency Integration
 - Integrate residency clinics and interdisciplinary care teams into Adventist Health Sonora primary care sites.
 - Prioritize access for uninsured, Medi-Cal, Tribal, and rural residents.
2. Strengthen Referral Coordination and Continuity of Care
 - Coordinate referral workflows and shared care pathways.
 - Improve transitions between hospital, clinic, and community providers to ensure patients establish and maintain a primary care medical home.
3. Recruit and Retain a Sustainable Provider Workforce
 - Develop and maintain provider recruitment and retention incentive programs.
 - Collaborate with Residency Program Leadership and Human Resources to build long-term rural workforce pipelines.

Aim Statement:

By 2028, Adventist Health Sonora and its community partners will expand primary and specialty care access for underserved populations, resulting in an additional 1,500 annual patient encounters through increased clinic capacity, improved referral continuity, and strengthened provider recruitment and retention.

PROGRAM:
Residency Program

Champion:
Adventist Health Residency Program Leadership

Existing Initiatives/Projects

- Adventist Health Sonora Primary Care Clinics
- Federally Qualified Health Centers (FQHCs) & Safety-Net Clinics
- Residency Program & Teaching Clinic

Data Source(s)

of patient encounters
recruited
Placement tracking – rural, non rural

Partners

Internal

- Adventist Health Sonora Primary Care Clinics, Human Resources, Residency Program Leadership

External

- MACT Health Board
- Mathiesen Memorial Health Clinic
- Tuolumne Me-Wuk Indian Health Clinic
- Tuolumne County Public Health

Available Resources

- Adventist Health Sonora primary care
- Adventist Health Sonora residency program and teaching clinics
- MACT Health Board, Mathiesen Memorial Health, Tuolumne Me-Wuk Indian Health Clinics
- HR and Residency Leadership
- Existing referral coordination and care transition workflows
- Tuolumne County Public Health

Financial Stability 2A

Population(s) *Low-income individuals and families, uninsured and underinsured residents, residents experiencing housing instability or homelessness, rural and geographically isolated residents, seniors, individuals with chronic health conditions, individuals with mental health or substance use conditions, students, children, and families experiencing economic hardship.*

Root Cause(s) of High Need:

- High Cost of Living Relative to Income.
- Housing Instability and Homelessness.
- Transportation Barriers in a Rural Geography.
- Limited Access to Preventive and Primary Care.
- Lower Educational Attainment and Workforce Participation.

OBJECTIVE: *Decrease the incidence and impact of chronic health conditions and reduce chronic disease burden by increasing access to preventive services, health education, and supportive resources that enable early detection, timely treatment, and healthy lifestyle behaviors.*

ACTIONS

- Partner with county public health agencies, tribal health clinics, community clinics, and aging services to host health fairs and outreach events.
- Provide free or low-cost health screenings and culturally appropriate health education.
- Promote Blue Zones–aligned activities such as cooking demonstrations, walking groups, and nutrition education to support chronic disease prevention.
- Provide transportation assistance for medical appointments, screenings, and community health events.
- Collaborate with local transportation agencies and coalitions to improve transit access and safe walking routes connecting communities to care sites.

Aim Statement: *Increase participation in preventive health screenings/community-based wellness activities among underserved and at-risk populations and reduce access barriers that prevent residents from obtaining preventive care and follow-up services by at least 10% by 2028.*

PROGRAM:
Prevention-focused strategies that reduce downstream costs

Champion:
Adventist Health Well Being and Health Equity Teams

Existing Initiatives/ Projects

- Healthcare Enrollment & Coverage Assistance
- Food Assistance & Nutrition Programs (Food pantries, bank)

Data Source(s)

of individuals receiving transportation assistance annually
of transportation coordination meetings attended
of community health fairs held and total attendance
free or low-cost health screenings provided annually.
% of screening participants connected to follow-up care.
of health education events held and annual attendance growth.

Partners Internal

- Adventist Health Sonora Case Management & Care Coordination
- Adventist Health Sonora Community Benefit

External

- Amador Tuolumne Community Action Agency (ATCAA)
- TC Homeless Committee
- Continuum of Care (CoC)
- Habitat for Humanity
- Resiliency Village
- TC & Calaveras Health & Human Services Agency (HHSA)
- TC Behavioral Health

Available Resources

- Public & Dial-A-Ride Transit (no cost)
- Family & Child Stability Programs (First Five/ICES)

PRIORITY NEED

Financial Stability 2B

Population(s) *Low-income individuals and families, uninsured and underinsured residents, residents experiencing housing instability or homelessness, rural and geographically isolated residents, seniors, individuals with chronic health conditions, individuals with mental health or substance use conditions, students, children, and families experiencing economic hardship.*

Root Cause(s) of High Need:

- High Cost of Living Relative to Income.
- Housing Instability and Homelessness.
- Transportation Barriers in a Rural Geography.
- Limited Access to Preventive and Primary Care.
- Lower Educational Attainment and Workforce Participation.

OBJECTIVE: *Increase housing stability and reduce homelessness by strengthening partnerships, screening for housing insecurity, and connecting individuals and families to evidence-based housing and supportive services.*

ACTIONS:

- *Maintain and strengthen partnerships with housing agencies, homeless service providers, and community-based organizations.*
- *Support hospital-based housing navigation, referral, and care coordination efforts.*
- *Advocate for local and regional housing policies and funding strategies that improve affordability and long-term stability.*
- *Screen all admitted patients for housing instability using standardized EHR-based tools.*
- *Refer patients with positive screens to appropriate housing and supportive services.*
- *Track referrals and outcomes to improve coordination and continuity of care.*

Aim Statement: *Expand coordinated, evidence-based responses to homelessness and housing instability by connecting at least 100 individuals and families to evidence-based housing and supportive services that promote long-term housing stability.*

PROGRAM: Housing Support

*Champion:
Adventist Health
Well Being and
Health Equity
Teams*

Existing Initiatives/Projects

- Case Management Referrals
- ATCAA Housing & Homelessness Programs
- Behavioral Health–Linked Housing Supports

Data Source(s)

- # Participating in housing collaboration meetings per year
- Documented support of housing stability initiatives annually
- # of admitted patients screened for housing instability

Partners

Internal

- Adventist Health Sonora Case Management & Care Coordination
- Adventist Health Sonora Community Well Being

External

- MACT Health Board
- Mathiesen Memorial Health Clinic
- Tuolumne Me-Wuk Indian Health Center
- Area 12 Agency on Aging
- TC and Calaveras Public Health
- Tuolumne County Transit
- Modivcare
- Senior and Accessible Transportation Programs (e.g., Southside)

Available Resources

- Case Management
- Rental Assistance & Homelessness Prevention

PRIORITY NEED

Mental Health

Population(s) *Individuals with substance use and co-occurring mental health needs, children and youth, families and caregivers, residents of rural and medically underserved areas, low-income and uninsured or underinsured individuals, community members at increased risk of overdose.*

Root Cause(s) of High Need:

- Severe shortage of mental health providers.
- Rural geography and transportation barriers.
- Economic stress and financial instability.
- Limited access to timely and affordable care.
- High prevalence of trauma and adverse life experiences.
- Co-occurring substance use and behavioral health conditions.
- Stigma and cultural barriers.
- Insufficient prevention and early-intervention capacity.

OBJECTIVE: *Reduce substance and tobacco use and improve mental health outcomes by expanding access to trauma-informed behavioral health services, strengthening community and clinical capacity through training and partnerships, and improving coordination, referral, and continuity of care across healthcare and community settings.*

ACTIONS:

- Expand evidence-based screening, referral, and navigation for substance use and mental health needs across clinical settings.
- Implement and sustain trauma-informed and substance use-related clinical training to support early identification and appropriate referral.
- Improve post-discharge follow-up and care coordination to connect individuals and families to behavioral health treatment and community resources.
- Partner with schools, coalitions, and public health agencies to deliver youth-focused substance, tobacco, and vaping prevention efforts.
- Support overdose prevention and harm-reduction activities through community partnerships.

Aim Statement: *Improve mental health and well-being across the Adventist Health Sonora service area by preventing substance & tobacco use, expanding access to evidence-based behavioral health services, and strengthening community capacity through trauma-informed practices, partnerships, including providing at least 100 individuals with behavioral health education or prevention programming, facilitating 100 referrals to behavioral health/substance use treatment services, and partnering with community organizations to deliver at least 8 trauma-informed trainings during the 2025–2028 implementation period.*

PROGRAM: Substance and Tobacco Use/Mental Health Expansion

Champions:
*Well-Being
Department,
Social Workers,
ACEs Team*

Existing Initiatives/Projects

- Substance Use Navigation and Referral Pathways
- Naloxone Distribution
- Mental Health First Aid (MHFA) Training
- Youth Substance and Tobacco Prevention Programs
- ACEs Screening and Referral in Primary Care

Data Source(s)

- % of ED providers trained in SUD screening and referral.
- % of SUD referrals receiving documented outreach attempts and connection to resources when accepted.
- # of Naloxone doses distributed
- # of youth prevention campaigns

Partners

Internal

- Adventist Health Sonora Emergency Department; Well-Being Department; Live Well Be Well, Pediatrics and Respiratory Therapy

External

- CA Bridge Program
- Opioid Coalition
- Tuolumne County Public Health
- Calaveras County Public Health
- YES Partnership
- Tuolumne Tobacco Coalition
- School District Wellness Committees

Available Resources

Hospital clinical staff and care settings, Substance Use Navigator workflows, trauma-informed screening tools, community coalitions, public health partnerships, Naloxone distribution, youth prevention programs, and Community Benefit funding

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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