

MORE

COMMUNITY VOICES



AdventistHealth
White Memorial

Los Angeles | Montebello



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-AHWM-AHMB-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 - Transportation

Financial Stability - Food Security

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:

Climate & Natural Environment, Community Safety, Education, Health Conditions, Health Risk Behaviors, and Housing – 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):
All underserved, Immigrants, Medi-Cal, Medicare, families, community members.

- ROOT CAUSE(S) OF HIGH NEED:**
- Financial barriers, high cost of care and lack of insurance.
 - Limited or no access to providers.
 - Lack of trust in the healthcare system and misinformation (vaccination hesitancy).
 - Fear of detention/deportation and stigma.
 - Mobility issues, lack of transportation.
 - Lack of food and housing instability.
 - Lack of mental health access.
 - Language barriers.

OBJECTIVE: *Improve timely access to care by increasing the availability of physicians and allied health professionals in our community, creating a safe zone with free health and wellness resources.*

- ACTIONS:**
- Physician, Nursing, and Medical Team Recruitment: *offer needed primary and specialty screenings offered at the health fair, e.g. cancer, heart, dental, vision and preventative care.*
 - Ambulatory Clinic Services: *Partner support with dental, vision, and cancer screenings, and vaccination.*
 - Medical Health Professional Education: *Dental hygiene, eye and foot care, mental health, diabetes, nutrition, spiritual care, etc.*
 - Health Insurance: *Enrollment and Navigation. Food assistance and distribution. Housing and transportation assistance.*
 - Legal Services and Education: *By trusted partners (MAOF and CHIRLA) – Know Your Rights.*
 - Volunteer Recruitment and Activation: *More than 150 volunteers in action.*

AIM STATEMENT: *Annually improve overall health outcomes by expanding access to specialized and primary care in our community, partnering with the White Memorial Church providing a welcoming safe space to everyone during a time of need.*

PROGRAM:
Health & Wellness Health Fair

Champions:
Esther Ong, MSN/ED, RN, Pastor Manny, Dr. Hoffer, Dr. Romero, Dr. Fritz, White Memorial Church, AHWM Charitable Foundation .

- Existing Initiatives/Projects:**
- Welcome Baby
 - Workforce Development

- Data Source(s):**
- # of attendees
 - # volunteers
 - # vendors/community partners
 - # general health screenings
 - # of people provided health education (vision, podiatry, mental and spiritual health)
 - # of people assisted with health insurance navigation
 - # of food bags distributed

- Internal Partners:**
- Behavioral Health
 - Cancer Center
 - Diabetes
 - Heart & Stroke
 - NICU
 - Nutrition
 - Physical Medicine
 - Radiology
 - Welcome Baby
 - Workforce Development

- External Partners:**
- Metropolitan Transportation Authority
 - Coalition for Humane Immigrant Rights
 - L.A. Care
 - Mexican American Opportunity Foundation
 - QueensCare
 - Wellnest
 - Wesley Health Center

- Available Resources:**
- Free health screenings
 - Vaccinations

PRIORITY NEED:
Access to Care

POPULATION(S):
Newborns, Moms, Women

ROOT CAUSE(S) OF HIGH NEED:

- Lack of accessibility to Natal and Post Natal Care.
- Non-existence of breastfeeding education.
- Lack of parenting skills & confidence.
- Lack of child safety classes.
- Lack of access to community resources.
- Limited access to mental health support.

OBJECTIVE: Help patients navigate the complex healthcare system to improve their access to care and promote better health outcomes, ensuring a more positive and equitable experience.

ACTIONS: Collaboration with internal and external teams to improving access to services, documenting and monitoring success by delivering on the following actions:

- Periodic healthcare service screenings and referrals
- Social needs screenings and referrals
- Lactation classes
- Mental health support groups
- Health insurance navigation
- Dental referrals assistance
- Monthly food distributions
- Housing assistance navigation

AIM STATEMENT: Annual increase in access to support services, and community resources for moms, maximizing the baby's health, safety, and security, building a strong parent-child relationship.

PROGRAM:
Welcome Baby

Champions:

Staci Sundquist,
RN, Dr. Younis,
Marleene
Hernandez, Nadia
Gonzalez , AHWM
Charitable
Foundation.

**Existing
Initiatives/Projects:**

- Women's Services
- Maternity
- Neonatal Intensive Care Unit

Data Source(s):

of mothers who received
additional mental health
support
received dental referrals
needed health insurance
and social service navigation
of classes offering
nutrition/feeding support

Internal Partners:

- Community Resource Center
- Navigator Program

External Partners:

- CalFresh
- Women, Infants, and Children Program
- Baby2Baby
- Metropolitan Transportation Authority
- Applied General Agency

Available Resources:

- Personalized coaching
- Nursing support
- In-hospital assistance
- Home visits
- Newborn care
- Parenting skills
- Postpartum recovery
- Spiritual and emotional support

PRIORITY NEED:
Access to Care

POPULATION(S):

Patients, Immigrants, Minorities and marginalized groups, Low-income individuals, Youth, families, seniors, unhoused and in transitional housing, Individuals with limited health literacy

ROOT CAUSE(S) OF HIGH NEED:

- Low income and poverty.
- Health and age.
- Homelessness.
- Limited transportation.
- Safety concerns – ICE, crime, violence
- Fragmented health systems.
- Socioeconomic barriers.
- Language and cultural differences.
- Emotional & psychological factors.

OBJECTIVE: *To improve access to enhanced care management, social services, mobility and accessibility; enhancing independence and promoting equity for low-income communities.*

ACTIONS:

- *Door-to-door accessible transit – partnerships with medical plans and other CBOs.*
- *METRO LIFE Program – enrolling low-income community members, seniors, students and disabled to a low-cost service.*
- *Transit Voucher Program and Ridesharing Access*
- *Accessible Parking at no cost to CRC members and reduced cost to disabled patients.*
- *Promote Health and Wellness Through Movement –physical fitness classes and walking. And mental and spiritual care and balance.*
- *Support housing navigation – find transitional and long-term housing for people in need.*
- *Fight food insecurity – offer grocery bags and farmer's market vouchers to people in need.*
- *Health insurance coverage – enroll people in health insurance and navigation assistance.*

AIM STATEMENT: *To reduce barriers and increase annually referrals to care, enhance mobility, independence, and improve health outcomes; guiding individuals through the complexities of the health care system.*

PROGRAM:
Patient Navigator Program

Champions:
Social workers, AHWM Charitable Foundation, Metropolitan Transportation Authority (METRO)

Existing Initiatives/Projects:

- Community Resource Center
- Enhanced Care Management

Data Source(s):

of individuals assisted with housing
of Enhanced Care Management support
of people assisted with referrals
of people assisted with hospital rides
of people assisted with taxi vouchers
of parking for CRC active members
of flyers and social media posts

Internal Partners:

- Emergency Unit
- Neonatal Intensive Care Unit
- Workforce Development
- Welcome Baby

External Partners:

- CalFresh
- Metropolitan Transportation Authority
- UBER/LYFT
- Seeds of Hope
- Operation Stay Safe
- Los Angeles Center for Alcohol & Drug Abuse

Available Resources:

- Health insurance navigation
- Housing assistance
- Food security
- Ridesharing access
- Parking access
- Medical provider navigation
- Appointment booking
- Patient experience

PRIORITY NEED:
Access to Care

POPULATION(S):
Women, Men, Seniors

ROOT CAUSE(S) OF HIGH NEED:

- *Insufficient Insulin Production*
- *Insulin Resistance*
- *Genetics*
- *Obesity*
- *Physical Inactivity*
- *Unhealthy Diet*
- *Access to Food*
- *Age*
- *Socioeconomic Factors*
- *Health Insurance Coverage*

OBJECTIVE: *Prevent and delay the onset of the disease through lifestyle changes, effectively managing the condition for those who have it to prevent complications, and improve the overall their quality of life.*

ACTIONS:

- *Promote healthy diets – coordinate nutritional workshops , teaching people how to make healthier choices , managing diabetes and changing eating habits.*
- *Increase physical activity – provide fitness classes indoors and outdoors, promoting activity and health and wellness.*
- *Provide access to healthy food – Offer free food vouchers to our weekly farmer's market.*
- *Teach sustainability – offer workshops on farm-to-table techniques, teaching people to farm the land and harvest their own food at our community garden.*
- *Manage mental health – Offer mental healing workshops in the community garden.-*

AIM STATEMENT: *To reduce the average diabetic patient population in the community in the next 3 years by providing health and wellness education, access to care, food, and resources to make better dietary choices.*

PROGRAM:
Diabetes

Champions:
Selene Castilla, Mary D’Avila, Jose Duran, Nutrition, Spiritual Care, AHWM Charitable Foundation.

Existing Initiatives/Projects:
• *Diabetes and Nutrition Program*
• *¡Vive Bien! Program*

Data Source(s):
of food bags given
of health and wellness class offered
of people attending class
of people rides provided for appointments
of people quitting Smoking

Internal Partners:
• *Diabetes and Nutrition*
• *Spiritual Care*
• *Behavioral Health*

External Partners:
• *CalFresh*
• *Women, Infants, and Children Program*
• *Vision y Compromiso*
• *LA Food Bank*
• *American Diabetes Association (ADA)*

Available Resources:
• *Personalized coaching on diet and nutrition*
• *Health and wellness – fitness*
• *Technology-based support*
• *Mental and spiritual care*

PRIORITY NEED:
Financial Stability

POPULATION(S):
Patients, Immigrants, Minorities and marginalized groups, Low-income individuals, Youth, families and seniors, Unhoused and in transitional housing

- ROOT CAUSE(S) OF HIGH NEED:**
- Poverty and low wages.
 - High-cost of living.
 - Racial and systematic inequity.
 - Food deserts.
 - Poor nutrition and reliance on fast food.
 - Limited transportation.
 - Safety concerns – ICE, crime, and violence
 - Lack of access and barriers.

OBJECTIVE: *To improve socioeconomic conditions, and health, of underserved and marginalized groups with health and wellness education, through access to fresh, nutritious food, fitness classes, health insurance enrollment and social services navigation.*

- ACTIONS:**
- ¡Vive Bien! / Live Well Program – health and wellness education at the Community Resource Center.
 - Workshops and Classes - fitness, nutrition, mental and spiritual health, social, and extracurricular education.
 - Social Services Support – legal advice, transportation, and housing assistance, and much–more.
 - Community Garden – promoting green spaces, urban farming and food sustainability.
 - Emergency Food Assistance – Prema pantry and food drives.
 - Farmer’s Market Access – hosting a weekly farmer’s market, providing grocery vouchers to people in need (patients and community members).
 - Community Partnerships – collaborating with trusted partners in offering support to the community.

AIM STATEMENT: *To ensure that more community members in Montebello have physical and economic access to safe, nutritious, and culturally appropriate food, fitness and other social services in the next 3 years.*

PROGRAM:
¡Vive Bien!

Champions:
AHWM Hospital, AHWM Charitable Foundation and supporters.

Existing Initiatives/Projects:

- Community Resource Center

Data Source(s):

- # of workshops/classes
- # of food bags delivered
- # of insurance enrollments
- # of rides to hospital’s visits
- # of food vouchers given
- # of pounds of food harvested
- # of community events attended

Internal Partners:

- Patient Navigator Program
- Workforce Development
- Cancer Center
- Neonatal Intensive Care Unit
- Welcome Baby

External Partners:

- CalFresh
- Metropolitan Transportation Authority
- Ven a Ver
- Seeds of Hope
- Operation Stay Safe

Available Resources:

- Health insurance navigation
- Housing assistance
- Food security
- Transportation assistance
- Medical provider navigation
- Social services assistance

PRIORITY NEED:
Financial Stability

POPULATION(S):
*Students (high school and university),
Seniors, Retirees, Current Healthcare,
Professionals Community Members &
Corporate Partners*

- ROOT CAUSE(S) OF HIGH NEED:**
- Poor working conditions.
 - Staffing shortages.
 - Training gaps.
 - Insufficient training and supervision.
 - Lack of coaching and leadership.
 - Access to recruitment and retention.
 - Lack of career guidance and path to success.
 - Lack of access to volunteerism.

OBJECTIVE: *To ensure a sufficient, well trained and diverse workforce, creating a pipeline for success in the medical field and other careers to meet current and future population workforce needs, while promoting volunteerism engagement.*

- ACTIONS:**
- *Develop workforce skills through apprenticeships, training, coaching, and mentorship to enhance performance and long-term employability.*
 - *Recruit, retain, and place talent while strengthening diversity, equity, and inclusion across the workforce.*
 - *Empower youth and adults through leadership development, volunteerism, and career pathway opportunities.*
 - *Deliver community-based programs through strong partnerships and effective implementation.*
 - *Optimize workforce efficiency and program impact through continuous improvement and outcomes measurement.*

AIM STATEMENT: *Build a sustainable, skilled, and diverse healthcare workforce in the next 3-years, while simultaneously enhancing patient care and community well-being through meaningful volunteer engagement in Boyle Heights, East LA and Montebello.*

PROGRAM:
**Healthcare
Workforce
Development**

Champions:
*AHWM Hospital,
AHWM Charitable
Foundation and
supporters.*

- Existing Initiatives/Projects:**
- Mission and Spiritual Care
 - Human Resources
 - Community Resource Center

- Data Source(s):**
- # of interns
 - # of volunteers
 - # of volunteer hours
 - # of workshops and classes
 - # of tabling events

- Internal Partners:**
- Leadership
 - Board Members
 - Cancer Center
 - Welcome Baby
 - Neonatal Intensive Care Unit
 - Facilities and operations

- External Partners:**
- High School Schools and Universities
 - Churches
 - The East Los Angeles Community Union

- Available Resources:**
- Youth leadership and empowerment
 - Career guidance and support Coaching
 - Mentorship
 - Stipend program
 - Volunteerism

PRIORITY NEED:
Mental Health

POPULATION(S):

- Men/Women
- Youth/Seniors
- Patients and Community Members

ROOT CAUSE(S) OF HIGH NEED:

- Shortage of Mental Health Professionals.
- Inadequate Community Infrastructure.
- Systematic Stigma.
- Cost-shifting from Untreated Conditions.
- Environmental Factors and History.
- Health Insurance Coverage.
- Social Determinant of Health.
- High-risk Populations.
- Impact of Migration and Identity.
- Workforce Issues.

OBJECTIVE:

To increase patient and public awareness of mental health; reduce stigma; expand access to high-quality, equitable mental health programs and community-based services; and promote spiritual care to support healing and recovery for all.

ACTIONS:

- Provide accessible mental health screenings and counseling through both in-person and telehealth services.
- Create opportunities for peer support and meaningful social connection.
- Integrate therapeutic and stress-reducing activities like mental and physical fitness classes.
- Ensure mental health support is available to all individuals in their preferred language.
- Develop and implement individualized safety plans for those at risk.
- Refer identified individuals to the spiritual care team for resilience-building and self-care workshops.
- Offer substance use treatment services and ongoing recovery support.

AIM STATEMENT: *To improve the timelines and effectiveness of mental health care access to all of patients and community members in the next 3 years, particularly those affected by natural disasters and/or socio-economic and political uncertainty.*

PROGRAM:
Behavioral Health

Champions:
Behavioral Health Unit, Spiritual Care, AHWM Charitable Foundation.

Existing Initiatives/Projects:

- Community Resource Center
- Telehealth Services
- Enhanced Care Management

Data Source(s):

- # of classes to mental health and healing
- # of workshops on spiritual care
- # of mentorship classes for the youth
- # of surveys and focus Groups

Internal Partners:

- Behavioral Health
- Spiritual Care
- Human Resources
- Enhanced Care Management
- Referral Services

External Partners:

- Los Angeles Center for Alcohol and Drug Abuse
- Wellnest
- Vision y Compromiso
- Alter Care
- 211 Support

Available Resources:

- Telehealth
- Crisis response and referral networks, Mental and spiritual care
- Community and emotional support

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.

Adventist Health White Memorial
1720 E. Cesar E. Chavez Avenue,
Los Angeles, CA 90033

Adventist Health White Memorial Montebello
309 West Beverly Boulevard,
Montebello, CA 90640