ADVENTIST HEALTH SONORA

2022 COMMUNITY HEALTH IMPLEMENTATION STRATEGY

APPROVED APRIL 27, 2023

2022

Adventist Health
Sonora

Table of Contents

Purpose & Summary

Non-profit health systems, community-based organizations, and public health agencies across the country all share a similar calling: to provide public service to help improve the lives of their community. To live out this calling and responsibility, Adventist Health Sonora conducts a Community Health Needs Assessment (CHNA) every three years, with our most recent report completed in 2022. Now that our communities' voices, stories, and priority areas are reflected in the CHNA, our next step is to complete a Community Health Improvement Plan (CHIP), or as we refer to it in this report, a Community Health Implementation Strategy (CHIS).

The CHIS consists of a long-term community health improvement plan that strategically implements solutions and programs to address our health needs identified in the CHNA. Together with the Adventist Health Well-Being team, local public health officials, community-based organizations, medical providers, students, parents, and members of selected underserved, low-income, and minority populations, Adventist Health Sonora intentionally developed a strategic plan to address the needs of our community.

In this CHIS, you will find strategies, tactics, and partnerships that address the following health needs identified in the 2022 Adventist Health Sonora CHNA:

Financial Stability

Housing

Mental Health

We hope this report is leveraged by all local partners and community members, empowering them to own the potential of healthy living for all. This report was reviewed and approved by our Hospital Board as well as the Adventist Health System Board on April 27, 2023. The entire report is published online and available in print form by contacting community.benefit@ah.org.

Blue Zones Project Tuolumne County

Across the globe lie blue zones areas – places where people are living vibrant, active lives well into their hundreds at an astonishing rate—and with higher rates of well-being. Attaining optimal well-being means that our physical, emotional, and social health is thriving. Blue Zones Project works with communities to make sustainable changes to their environment, policies, and social networks to support healthy behaviors. Instead of a focus on individual behavior change, it is an upstream solution focused on making healthy options easy in all the places people spend most of their time. Blue Zones Project is committed to measurably improving the well-being of community residents and through their proven programs, tools and resources, utilizes rigorous metrics to inform strategies and track progress throughout the life of the project. This includes well-being data, community-wide metrics, sector-level progress and outcome metrics, transforming community well-being by making changes to environment, policy, worksites and social networks that create healthy and equitable opportunities for all.

Adventist Health Sonora proudly sponsors Blue Zones Project Tuolumne County (BZPTC). The BZPTC team wakes up each morning focused on partnering and collaborating with community leaders and organizations active in the sectors of built environment, education, economic and workforce development, mental and physical well-being, policy and public health. Together the BZPTC team and sector leaders develop a community Blueprint that strategically aligns and leverages the actions and resources of the sectors where we live, learn, work and play to help advance the efforts around the community's biggest Social Determinant of Health challenges while connecting them to Health-Related Social Needs organizations.

Equity is a strategic priority woven throughout the Blueprint and programs. Policies and initiatives are developed in a way that honors the local culture that is focused on reaching out to all populations. Each year BZPTC sector leads come together to evaluate and update the Blueprint to ensure community alignment.

To learn more about Blue Zones Project Tuolumne County and how to get involved visit: tuolumnecounty.bluezonesproject.com

What if . . .

It's not a prescription that changes your health?

Instead, it's a collaboration between you and your care providers?

And it's community-based organizations working together to support you?

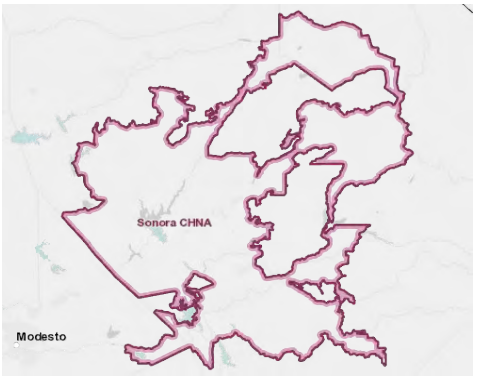
Getting to know our CHNA Sonora service area*

Located in the heart of California's gold country, Tuolumne County is nestled in the Sierra Nevada Foothills and is the gateway to the world-famous Yosemite National Park. Founded during the California Gold Rush, Sonora, has a rich heritage, small town feel, and historic charm. These are all communities represented in the Sonora CHNA service area where the largest age group is over age 55 (45.13%). The community is vibrant and cultured with art, galleries, festivals, events and small businesses. Of the population, 12.57% are Hispanic and 74.74% own their home.

The median household income is $58,959 of which 58.6% is spent on housing and transportation. Among this population, 15.2% of children live in poverty and 5.45% of students are unhoused, compared to the state average of 4.25% and national average of 2.77%.

For a more detailed look into community member comments, facts and numbers that are captured in the CHNA, please visit adventisthealth.org/about-us/community-benefit. The following pages provide a closer look into our community demographic as well as our approach to the CHIS.

**This service area represents Adventist Health Sonora's primary service areas (PSA), accounting for 75% of hospital discharges. Additionally, we took a collaborative approach and expanded our PSA by inviting Steering Committee members to include the zip codes of those they serve, creating the Sonora CHNA service area.*



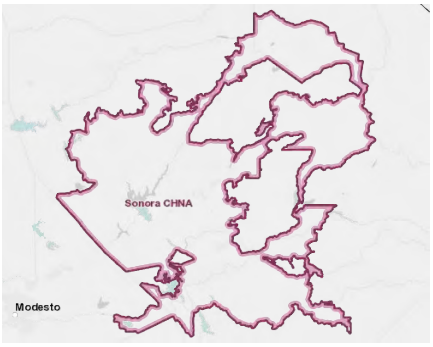
What if our community worked together and made life all-around better? What if we offered various pathways to meet our diverse needs, so every member of our community experienced better health, prosperity and longevity?

Who We Serve

DEMOGRAPHIC PROFILE

The following zip codes represent Adventist Health Sonora's primary service area (PSA), accounting for 75% of hospital discharges. Additionally, we took a collaborative approach and expanded our PSA by inviting Steering Committee members to include the zip codes of those they serve.

The Adventist Health Sonora CHNA market has a total population of 84,499 (based on the 2020 Decennial Census). The largest city in the service area is Sonora, with a population of 4,904. The service area is comprised of the following zip codes: 95311, 95310, 95248, 95251, 95224, 95318, 95223, 95370, 95383, 95321, 95364, 95247, 95329, 95222, 95372, 95305, 95346, 95379, 95375, 95233, 95327, 95335, 95228, 95249, 95246.



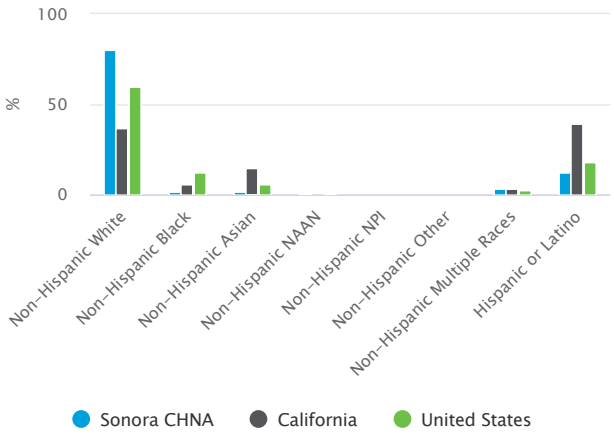
Total Population

84,499

74.74%
of the population owns their home

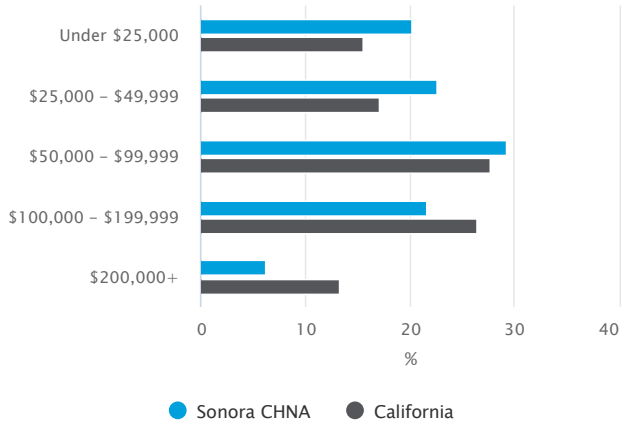
25.26%
of the population rents their home

Population by Combined Race and Ethnicity



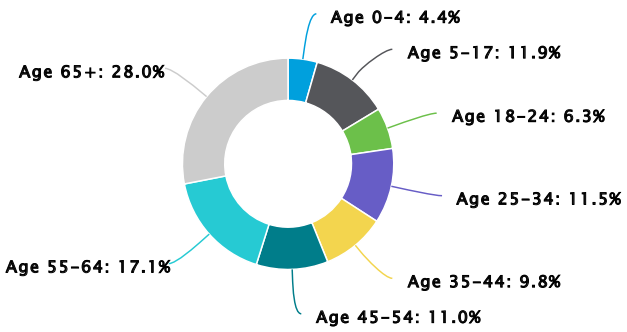
Note: NAAN = Native American or Alaska Native, NPI = Native Hawaiian or Pacific Islander.

Household Income Levels



Total Population by Age Groups, Total

Sonora CHNA



About Us

Adventist Health Sonora

Adventist Health Sonora (AHSR) is located in the city of Sonora in Tuolumne County. Tuolumne County is in the beautiful Sierra Nevada foothills and is at the gateway to Gold Country. A 152-bed medical center in Sonora, California, serving the residents of Calaveras and Tuolumne counties with key health care services and a large network of primary care, rapid care and specialty medical offices.

Adventist Health

Adventist Health is a faith-inspired, nonprofit integrated health system serving more than 80 communities on the West Coast and Hawaii. 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 34,000 includes associates, medical staff physicians, allied health professionals and volunteers driven in pursuit of one mission: living God's love by inspiring health, wholeness and hope. Together, we are transforming the American healthcare experience with an innovative, yet timeless, whole-person focus on physical, mental, spiritual and social healing to support community well-being.

Adventist Health's Approach to CHNA & CHIS

Adventist Health prioritizes well-being in the communities we serve across our system. We use an intentional, community centered approach when creating our hospital CHNA's to understand the health needs of each community. After the completion of the community assessment process, we address health needs such as mental health, access to care, health risk behaviors, and others through the creation and execution of a Community Health Implementation Strategy (CHIS) for each of our hospitals and their communities.

The following pages highlight the key findings the Adventist Health Sonora CHNA Steering Committee (see page 23 for a list of CHNA Steering Committee sector participants) identified as their top priority health needs, or as we refer to them in this report, their 'High Priority Needs'. The High Priority Needs are addressed in this Community Health Implementation Strategy.

High Priority Needs

The following pages highlight the High Priority Needs that will be addressed in this Community Health Implementation Strategy.

Financial Stability

COMMUNITY VOICES

- Rental assistance, developed with landlords, is seen as an important way to help people out.
- The low median income is pointed to as an indicator of the financial struggles of many residents.
- The limited housing supply, and excessive costs, cause many to move from the region.
- Families are forced to live in areas that are not safe, an interviewee noted.
- Low wages are also seen as a driver to economic instability.

Financial stability in Sonora is a challenge. Concerns regarding health, income and labor force participation impact whether a community will thrive or struggle. Sonora is not unusual, still there are areas of concern that the community is working to address for families of today and tomorrow.

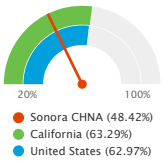
A community survey provided important yet concerning information, including families sharing that they are forced to live in unsafe areas. Residents have been forced to move due to limited housing supply and excessive costs. The low median income is an additional indicator of financial struggles.

The labor force participation rate in Sonora is 48.4%, which is much lower than that of California (63.3%) and the United States (63%). The unemployment rate is 6.54%, which is higher than the United States as a whole (5.4%). Participants in this survey reported that 76% of respondents selected financial stability as a significant need due to low wages.

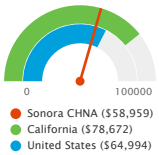
While the data may be daunting, residents know what their families need to thrive. Collaboration is the key today to a brighter tomorrow.

SECONDARY DATA INFOGRAPHIC STATS:

Labor Force Participation Rate



Median Household Income



Unemployment by Race, Percent

Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Some Other Race	Multiple Race
Sonora CHNA	6.86%	0.00%	7.79%	11.03%	0.97%	7.18%
Alpine County, CA	8.65%	100.00%	14.43%	No data	0.00%	1.82%
Calaveras County, CA	5.21%	47.95%	0.00%	1.77%	0.00%	7.20%
Mariposa County, CA	7.07%	85.34%	5.35%	3.03%	1.12%	13.05%
Stanislaus County, CA	6.82%	8.63%	8.18%	7.82%	10.39%	12.84%
Tuolumne County, CA	7.30%	0.00%	10.83%	15.65%	1.04%	3.87%
California	5.36%	10.08%	9.25%	4.65%	6.79%	8.32%
United States	4.38%	9.20%	9.70%	4.26%	6.43%	7.76%

Housing

COMMUNITY VOICES

- There may be some resistance in the community to increasing shelter beds in new locations.
- Mistrust in the population needing help was identified as a barrier to addressing this issue.
- Homeless shelters have restriction on who can be in the shelter, limiting access for some in need.
- It takes years off your life. Poverty charges interest, one interviewee stated.

Sonora is a charming community featuring local restaurants, galleries, events and festivals. Beyond the downtown area are parks, trails and beautiful mountains, yet the community faces very real challenges.

Securing stable housing and facing the increased risk of homelessness are realities for many Sonora residents. Housing is limited, so available homes come with high home and rental costs.

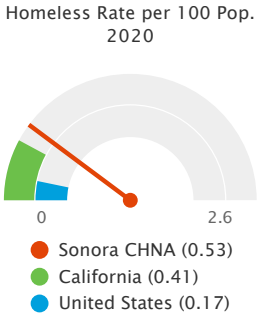
The rate of homelessness is 0.53 per 100 people, which is higher than that of California (0.41) and the U.S. (0.17). Homelessness among public school students is 5.5%, compared to California at 4.3% and 2.8%.

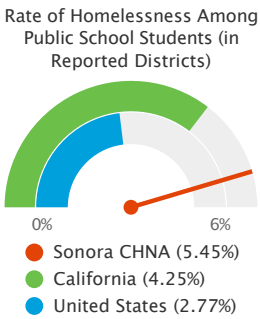
The percentage of income spent on housing and transportation in Sonora is higher (58.6%) than in California (50%).

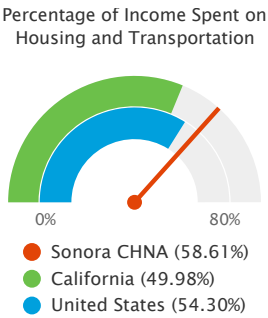
Residents share their concerns, including growth in unhoused populations and shelter restrictions that limit access. Poverty "takes years off your life," one resident noted, and another reflected on the need for programs designed to help people who have been released from jail

The range of concerns is daunting. But there is hope and help available for those in need, leading to revived, restored lives.

SECONDARY DATA INFOGRAPHIC STATS:







Mental Health

COMMUNITY VOICES

- People noted a disconnect between available services and the kids who need them, but no clear explanation why access has been difficult.
- Resources within rural and small communities are limited.
- Mental health professionals are struggling with the demand on services.
- Some are not seen until there is a full-blown mental health crisis due to a lack of lower-level care.

An in-depth review of community data provides important information on how to help and understand the impacts of mental health issues.

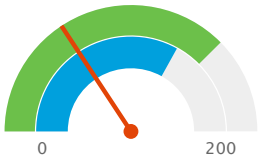
In Sonora, there are 62.9 mental health care providers per 100,000 people, compared to 150.31 in California and 132.27 in the United States. The lack of providers is a problem due to the reality of how mental health issues can impact home, work and community life.

Publicly available data shows that 13.9% of the adult population in Sonora reports having poor mental health, compared to 12.5% in California and 13.6% in the United States. Instability in the home life can create mental health and substance abuse concerns, some interviewees noted.

According to surveys, 49% of respondents selected mental health as a significant need, but the community's commitment is real and focused on making change.

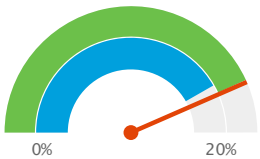
SECONDARY DATA INFOGRAPHIC STATS:

Mental Health Care Providers, Rate per 100,000 Population



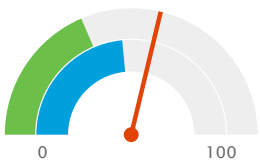
- Sonora CHNA (62.92)
- California (150.31)
- United States (132.27)

Percentage of Adults Binge Drinking in the Past 30 Days

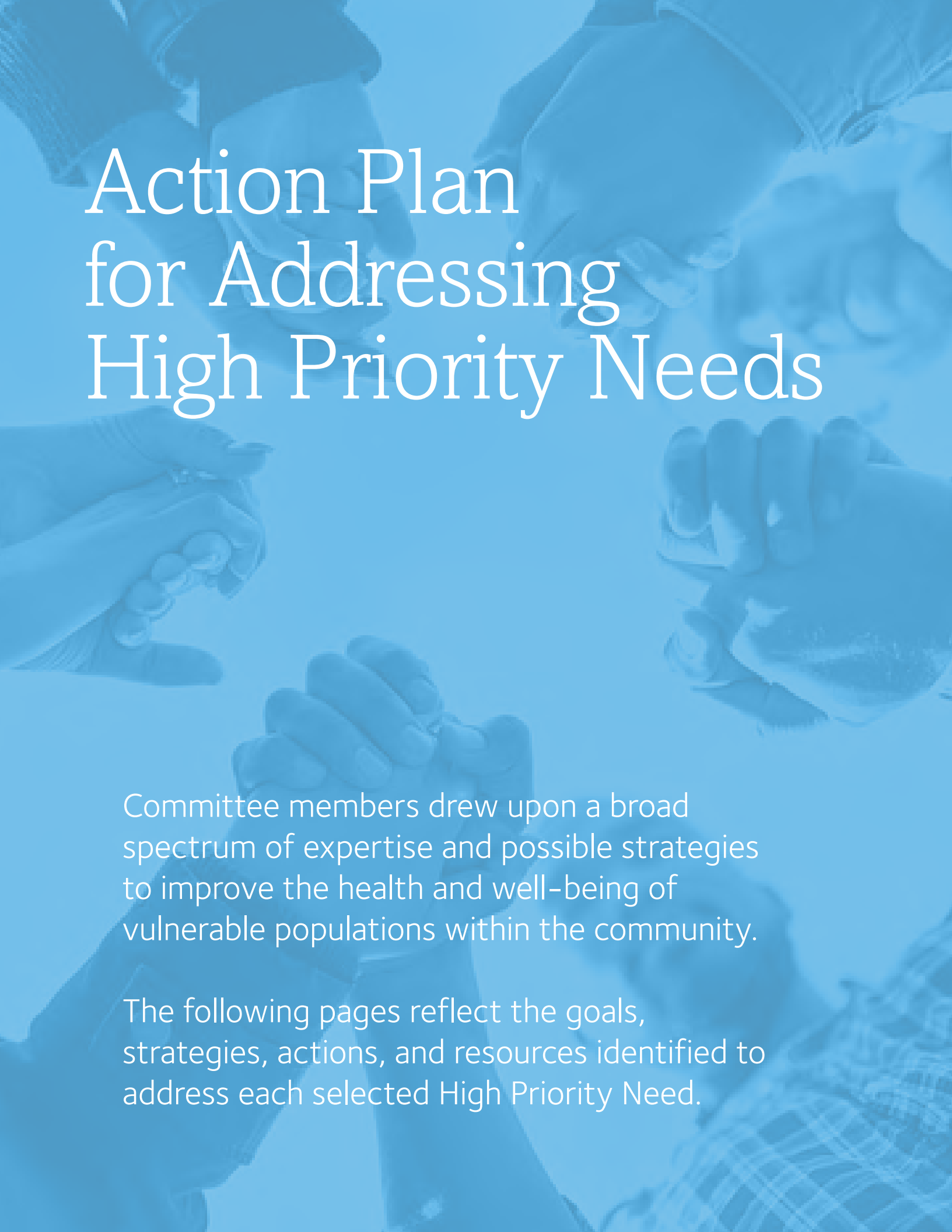


- Sonora CHNA (17.38%)
- California (17.27%)
- United States (16.70%)

Deaths of Despair, Age-Adjusted Death Rate (Per 100,000 Population)



- Sonora CHNA (57.5)
- California (37.1)
- United States (47.0)



Action Plan for Addressing High Priority Needs

Committee members drew upon a broad spectrum of expertise and possible strategies to improve the health and well-being of vulnerable populations within the community.

The following pages reflect the goals, strategies, actions, and resources identified to address each selected High Priority Need.

ADDRESSING HIGH PRIORITY: Financial Stability

GOAL	Increase financial stability by reducing the negative impacts caused by chronic health conditions that lead to lost work time and increased health care costs.

Priority Area:	Financial Stability	**Sub-Category:**	Stability – Delinquent Debt	**Defining Metric:**	Unemployment – US Bureau of Labor Statistics; Labor Force Participation Rate – US Census Bureau; Delinquent Debt – Debt in America

Strategy:	Support community programs and events that promote healthy lifestyle choices and reduce the worsening of chronic health conditions.
Population Served:	Low Income; seniors; high school students; all populations
Internal Partners:	Rehabilitation Staff; Live Well Be Well Center Staff; Living Well Fitness Center Staff
External Partners:	School Districts' Athletic Directors, Blue Zone Project Tuolumne, Public Health Officer and Director; Area 12 Agency on Aging Director

Action: Program/Activity/Tactic/Policy	**Organization**	**Lead**
AHSR will offer and partner with community partners to provide the following educational, screening, and support group opportunities. These may include: • Diabetes Awareness & Heart Health events to highlight the importance of early detection and lifestyle choices that impact the development of chronic diseases. • Establishing the annual cadence for the Tuolumne Health Fair or identify other opportunities for screenings. • Support Blue Zones Cooking Classes to provide affordable, healthy meal options. • Promote low-to-no-cost fitness classes offered by partners including Blue Zone Project and AHSR Living Well Fitness Center. • Resume the HS physicals program so all youth can participate in school-based low/no cost sports. • Identify tobacco cessation programs for youth & adults. • Sponsor community health films at the local theatre.	Adventist Health – Rehabilitation Dept	TBD
	Living Well Fitness Center	Krista Howell, Julie Mena
	Live Well Be Well Center	Crystal Anderson
	Blue Zone Project Tuolumne	Tyler Summerset
	Tuolumne Public Health	Dr. Kimberly Freeman/Michelle Jachetta
	High School Districts	N/A
	Area 12 Agency on Aging	Kristin Millhoff
	First Five Tuolumne	Sarah Garcia

YEAR ONE	YEAR TWO	YEAR THREE
Create and implement schedules. Dependent upon the programming example metrics may include: Number of trainings, number of participants, number of health screenings, number of classes/support groups, and number of athletes served.	Continue to create and implement schedules. Dependent upon the programming example metrics may include: Number of trainings, number of participants, number of health screenings, number of classes/support groups, and number of athletes served.	Continue to create and implement schedules. Dependent upon the programming example metrics may include: Number of trainings, number of participants, number of health screenings, number of classes/support groups, and number of athletes served.

Strategy:	Reduce barriers that are preventing the most at-risk individuals from seeking treatment and screenings.
Population Served:	Unhoused; Low Income; Seniors
Internal Partners:	Clinic Directors; Adventist Health Case Manager Director, Case Workers and Social Workers; Well-Being Director
External Partners:	Tuolumne County Transit Agency: Dial a Ride; Tuolumne Trip Program; Transportation Council, Anthem Blue Cross

Action: Program/Activity/Tactic/Policy	**Organization**	**Lead**
Provide transportation vouchers and assistance at clinics and at the main hospital to help patients access appointments, screenings, and services.	Adventist Health – Case Management	Valerie Shuemake
	Anthem Blue Cross	Jared Martin
	Tuolumne County Transit Agency	TBD
	Adventist Health - Clinic Services	Teddy Griffin
	Adventist Health – Well Being	Cathy Parker
	Adventist Health (Cancer Center) – Social Worker	Susan Endter

YEAR ONE	**YEAR TWO**	**YEAR THREE**
AHSR will continue to evaluate the impact of transportation vouchers biannually. Evaluation will include the number of people served (unduplicated), and number of rides provided including locations. Provide vouchers to 100% of patients making less than 250% of Federal Poverty Level (FPL) while also exploring Cal AIM and MediCal related support services. Establish baseline of missed appointments at Rural Health Clinics due to transportation barriers. Develop data tracking system.	AHSR will continue to evaluate the impact of transportation vouchers biannually. Evaluation will include the number of people served (unduplicated), and number of rides provided including locations. Provide vouchers to 100% of patients making less than 250% of FPL and continue to work with CalAIM and MediCal to provide related support services. Review data gathered of missed appointments at Rural Health Clinics due to transportation barriers.	AHSR will continue to evaluate the impact of transportation vouchers biannually. Evaluation will include the number of people served (unduplicated), and number of rides provided including locations. Provide vouchers to 100% of patients making less than 250% of FPL and continue to work with CalAIM and MediCal to provide related support services. Review data gathered of missed appointments at Rural Health Clinics due to transportation barriers.

Strategy:	Increase access to method of safe and affordable transportation for individuals who are in need of receiving care.
Population Served:	Low Income; Seniors
Internal Partners:	Clinic Directors; Adventist Health Case Manager Director, Case Workers and Social Workers; Well-Being Director
External Partners:	Tuolumne County Transit Agency: Dial a Ride; Tuolumne Trip Program; Transportation Council, Anthem Blue Cross

Action: Program/Activity/Tactic/Policy	**Organization**	**Lead**
Advocate for safe walking and public transportation routes to link communities and increase access to services. Examples may include promoting the development of walking pathways, adding sidewalks to transportation projects, and creating safe bus stops/routes in the region.	Blue Zones Project	Tyler Summerset/Kristi Conforti
	Adventist Health, Well Being	Cathy Parker
	Vision Sonora	Rachelle Kellogg/Mayor Mark Plummer
	Transportation Council	Peter Rei
	Calaveras Connect	TBD

YEAR ONE	YEAR TWO	YEAR THREE
Identify opportunities to support safe walking and transportation projects. Identify sponsorship opportunities to financial support development, maintenance, or expansion of projects. Metrics include the number of projects supported, and the number of projects sponsored.	Identify opportunities to support safe walking and transportation projects. Identify sponsorship opportunities to financial support development, maintenance, or expansion of projects. Metrics include the number of projects supported, and the number of projects sponsored.	Identify opportunities to support safe walking and transportation projects. Identify sponsorship opportunities to financial support development, maintenance, or expansion of projects. Metrics include the number of projects supported, and the number of projects sponsored.

ADDRESSING HIGH PRIORITY: Financial Stability

GOAL	Expand the number of staff and providers able to see underinsured patients and increase the number of family practice practitioners in our community to reduce expensive travel and delayed treatment, which can lead to financial instability. These strategies will also improve outcomes for community members seeking to improve career opportunities.

Priority Area:	Financial Stability	**Sub-Category:**	Income/Employment	**Defining Metric:**	Median Household Income – US Census Bureau ACS; Labor Force Participation Rate – US Census Bureau ACS

Strategy:	Provide opportunities for workforce development so individuals can pursue local, family wage careers.
Population Served:	All populations
Internal Partners:	Operations Director; Adventist Health Program Director & Residency Program Coordinator
External Partners:	Community and Private Colleges, High Schools, Workforce Development Board

Action: Program/Activity/Tactic/Policy	**Organization**	**Lead**
Develop and implement local Certified Nursing Assistant (CNA), Medical Assistant (MA), and Registered Nurse (RN) training programs. Develop career technical education pathways with high schools and the community college to encourage the development of health career pathways.	Adventist Health, Operations Executive	Tyler Newton
	Yosemite Community College District (Columbia & Modesto Junior College)	CTE Staff
	California Prep College	TBD
	Local High Schools	District Superintendents
	Mother Lode Job Training, Executive Director	Dave Thoeny

YEAR ONE	YEAR TWO	YEAR THREE
Establish programs to provide CNA, MA, and RN certifications/licensures. Establish partnerships with high school and community college to plan pathways. Establish baseline data.	Graduate first MA cohort • Track retention rate – AHSR and community Continue to track data established Year 1.	Graduate first RN cohort • Track retention rate; the amount who follow health career pathway to RN program Continue to track data established Year 1.

Action: Program/Activity/Tactic/Policy	**Organization**	**Lead**
Establish a residency program for family care providers to train physicians in rural primary care. (Hanford Sonora Family Medicine Residency Rural Training Track)	Adventist Health Sonora – Program Director	Dr. Matthew Personius, Carlene Maggio
	Adventist Health Hanford	TBD

YEAR ONE	YEAR TWO	YEAR THREE
Review program and establish baseline criteria. Eventual metrics include the number of medical residents trained and the number of patients visits.	Begin first year students – 4 residents.	Second cohort begins first year – track retention across all cohorts.

ADDRESSING HIGH PRIORITY: Housing

GOAL	Residents have access to safe, affordable, and stable housing and resources that provide the conditions necessary for health and well- being.

Priority Area:	Housing	**Sub-Category:**	Homelessness; Housing Costs	**Defining Metric:**	Homeless Point in Time – HUD; H+T affordability index – EPA Smart Location Database

Strategy:	Develop and maintain partnerships to address unhoused individuals/families and housing using evidence-based strategies.
Population Served:	Unhoused; medically fragile individuals in substandard housing; all populations
Internal Partners:	Well Being Director; Case Management Director;
External Partners:	Amador Tuolumne Community Action Agency (ATCAA) Housing Navigator; Area 12 Director; Nancy's Hope Director; Director of Interfaith; Housing Coordinator – Tuolumne County; Director Habitat for Humanity; Tuolumne County Homeless Services Coordinator; Resiliency Village Executive Director

Action: Program/Activity/Tactic/Policy	**Organization**	**Lead**
Support a "housing first" approach which prioritizes access to permanent (non-time-limited) housing with minimal preconditions, thereby reducing barriers to housing for people experiencing homelessness. Provide outreach, navigation, and support services for individuals and families currently experiencing homelessness. Investments made through grants and sponsorships related to housing needs are decided annually and based on community health need. Explore opportunities for homeless respite and recuperative care beds linked with complex care management services with community partners.	Adventist Health, Well Being and Case Management	Cathy Parker, Val Shuemake
	ATCAA Housing	Joe Bors/Denise Cloward
	Area 12 Agency on Aging	Kristin Millhoff
	Nancy's Hope	Nancy Scott
	Tuolumne County	Michael Roberson
	Interfaith	Cathie Peacock
	Tuolumne County Habitat for Humanity	Trinity Abila
	Resiliency Village	Mark Dyken

YEAR ONE	YEAR TWO	YEAR THREE
Identify areas where grants and sponsorships can support housing needs for short term, transitional, and long-term needs. Continue to serve on commissions, boards, and organizations that address housing issues.	Identify areas where grants and sponsorships can support housing needs for short term, transitional, and long-term needs. Continue to serve on commissions, boards, and organizations that address housing issues.	Identify areas where grants and sponsorships can support housing needs for short term, transitional, and long-term needs. Continue to serve on commissions, boards, and organizations that address housing issues.

ADDRESSING HIGH PRIORITY: Mental Health

GOAL	To prevent substance and tobacco use and improve health outcomes and recovery

Priority Area:	Mental Health	Sub-Category:	Risk Factors – Drugs & Alcohol	Defining Metric:	Substance Use Disorder - CMS Chronic Conditions; Deaths of Despair (Suicide, overdose,…)

Strategy :	Complete screening for substance use disorders (SUD) and co-occurring disorders in the community. Link individuals assessed as needing additional services to treatment and other resources. This will include but is not limited to referrals from AHSR's Emergency Department.
Population Served:	Unhoused; total population
Internal Partners:	ED Director; Admin Director, Operations; SUD Navigator; Chief Medical Officer; AH Board Members, CWB Committee, Hospital Board
External Partners:	Public Health Officer and Director, Mathiesen Clinic Director, Mi Wuk Clinic Director, Opioid Coalition Representative, Behavioral Health Director

Actions: Program/Activity/Tactic/Policy	**Organization**	**Lead**
Implement the CA Bridge program, leading to increased navigation to ongoing care and community resources. The CA Bridge program links individuals who have SUD and who present in hospital emergency departments (EDs) to a Substance Use Navigator (SUN) to provide resources and immediate access to medication for addiction treatment (MAT).	Adventist Health ED	Thomas Cook
	Public Health – Tuolumne County	Dr. Kimberly Freeman/Michelle Jachetta
	Mathiesen Clinic	Dr. John Voss
	Opioid Coalition	
	Adventist Health - Case Management	Valerie Shuemake
	Tuolumne Me-Wuk Indian Health Center	Stephanie Love/Dr. Murdock
	Behavioral Health – Tuolumne County	Tami Mariscal

YEAR ONE	YEAR TWO	YEAR THREE
Work with partners to establish program goals and baseline data. Metrics may include: number of persons served (unduplicated), number of encounters and location of services, number of persons who received mental health referrals or services directly from the program, number of persons who received referrals or substance use services directly from the program, number of persons who received case management services directly from the program, number of persons referred out to social services. Create a navigation resource guide. AHSR to maintain membership on Opioid Coalition. Identify grants to support navigation services.	Work with partners to evaluate program efficacy. Metrics may include: number of persons served (unduplicated), number of encounters and location of services, number of persons who received mental health referrals or services directly from the program, number of persons who received referrals or substance use services directly from the program, number of persons who received case management services directly from the program, number of persons referred out to social services. Implement navigation resource guide. AHSR to maintain membership on Opioid Coalition. Identify grants to support navigation services.	Work with partners to evaluate program efficacy. Metrics may include: number of persons served (unduplicated), number of encounters and location of services, number of persons who received mental health referrals or services directly from the program, number of persons who received referrals or substance use services directly from the program, number of persons who received case management services directly from the program, number of persons referred out to social services. Implement navigation and create a navigation resource guide. AHSR to maintains membership on Opioid Coalition. Identify grants to support navigation services.

ADDRESSING HIGH PRIORITY: Mental Health

Strategy:	Increase community knowledge of the risks associated with alcohol, tobacco, and drug use in youth and at-risk populations and provide resources.
Population Served:	All children 0-18, pregnant & parenting minors and adults; parents; total population
Internal Partners:	Well-Being Director, Chaplain, Community Well-Being Committee
External Partners:	School Districts TUPE Director, Public Health Tobacco staff, Blue Zones Project Tuolumne - Staff, YES Partnership – Exec Director, Jamestown Family Resource Center Coordinators

Actions: Program/Activity/Tactic/Policy	**Organization**	**Lead**
Partner with the Tuolumne Tobacco Coalition and YES Partnership to create and implement programs to prevent and reduce substance use especially involving tobacco and vaping products.	Adventist Health – Well Being	Cathy Parker
	Blue Zones Project Tuolumne	Kristi Conforti
	Public Health – Tuolumne County and the Tobacco Coalition	Katie Johnson/Emily Fishburn
	TUPE – Calaveras County Schools Office	Karen Sells
	TUPE – Tuolumne County Superintendent of Schools	Rob Egger
	First Five Tuolumne	Sarah Garcia
	YES Partnership	Bob White
	Jamestown Family Resource Center (JFRC)	Patty Aguira and Kristen Youngman

YEAR ONE	YEAR TWO	YEAR THREE
Establish goals and identify baseline metrics using data from Tobacco Coalition. AHSR to maintain membership in Tobacco Coalition. Use California Healthy Kids Survey Data (CHKS) to identify baseline for youth vaping and tobacco use trends. Metrics may include: number of persons served (unduplicated), number of persons who received substance use/tobacco cessation or prevention services directly from programs, number of class, workshop, or support group sessions provided by the program, number of persons referred out to services	Increase the number of Tobacco Cessation programs offered in the community. Review CHKS and other data sources for downward trend in tobacco and vape use. Metrics may include: number of persons served (unduplicated), number of persons who received substance use/tobacco cessation or prevention services directly from programs, number of class, workshop, or support group sessions provided by the program, number of persons referred out to services	Maintain tobacco cessation programs and evaluate efficacy for participants in Year 2 programs. Review CHKS and other data sources for downward trend in tobacco and vape use. Metrics may include: number of persons served (unduplicated), number of persons who received substance use/tobacco cessation or prevention services directly from programs, number of class, workshop, or support group sessions provided by the program, number of persons referred out to services

ADDRESSING HIGH PRIORITY: Mental Health

GOAL	Providers, staff, community members, and trainees increase their knowledge of and skills in evidenced-based, culturally responsive, and/or trauma-informed behavioral health resources and services with a focus on childhood and youth.

Priority Area:	Mental Health	**Sub-Category:**	Risk Factors – Stress & Trauma/Health; Outcomes – Deaths of Despair	**Defining Metric:**	Violent Crime Rate – FBI Crime/NAJCD; US Bureau of Labor Statistics; Poor mental health days – CCMS Chronic Conditions; Deaths of Despair -CDC NVSS; Wonder; Suicide Mortality – CDC NVSS; Wonder

Strategy 1:	Increase access to support services and interventions for families who have experienced trauma and expand community centered activities.
Population Served:	0-18 years old; parents/caregivers; all populations
Internal Partners:	Director of Clinic Services, Chaplains, Chief Medical Officer, Well Being Director
External Partners:	Tuolumne Resilience Coalition Director, Tuolumne County Superintendent of Schools Director of SEL, Sonora Union High School Counselors, Blue Zones Project Tuolumne Staff, Sonora Police Department Chief, Tuolumne County Sheriffs Department – TBD, First Five Director

Actions: Program/Activity/Tactic/Policy	**Organization**	**Lead**
Build and expand Adverse Childhood Experiences (ACEs) screening program across local clinics with a focus on youth and families.	Adventist Health – Clinics	Teddy Griffin
	YES Partnership – Tuolumne Resilience Coalition	Annie Hockett
	Adventist Health – Chaplain Services	Mario DeLise, Cathi Ruiz
	Adventist Health – Well Being	Cathy Parker
	Adventist Health – Physicians	Dr. Stephanie Stuart
	Sonora Union High School District	Counseling Staff
	Tuolumne County Superintendent of Schools – Director/SEL	Rob Egger
	First Five Tuolumne	Sarah Garcia

YEAR ONE	YEAR TWO	YEAR THREE
Create multiyear ACEs expansion plan. Establish new data tracking for program review including number of referrals, number of individuals served, ranking of intensity of services, and ACE scoring over time. Identify opportunities for training with AHSR staff and physicians measured by amount of trauma informed trained staff and demonstrated increase in knowledge of available resources. Establish health metrics to track for program effectiveness.	Increase screenings to include parenting age individuals at the Rural Health Clinic. Continue tracking with metrics which may include number of referrals, number of individuals served, ranking of intensity of services, and ACE scoring over time. Increase opportunities for training with AHSR staff and physicians measured by number of ACEs, Pediatric ACE's, and Related Life-events Screener (PEARLS) trained staff and demonstrated increase in knowledge of available resources.	Conduct program analysis to determine program effectiveness. Continue tracking with metrics which may include number of referrals, number of individuals served, ranking of intensity of services, and ACE scoring over time. Continue to provide opportunities for training AHSR staff and physicians.

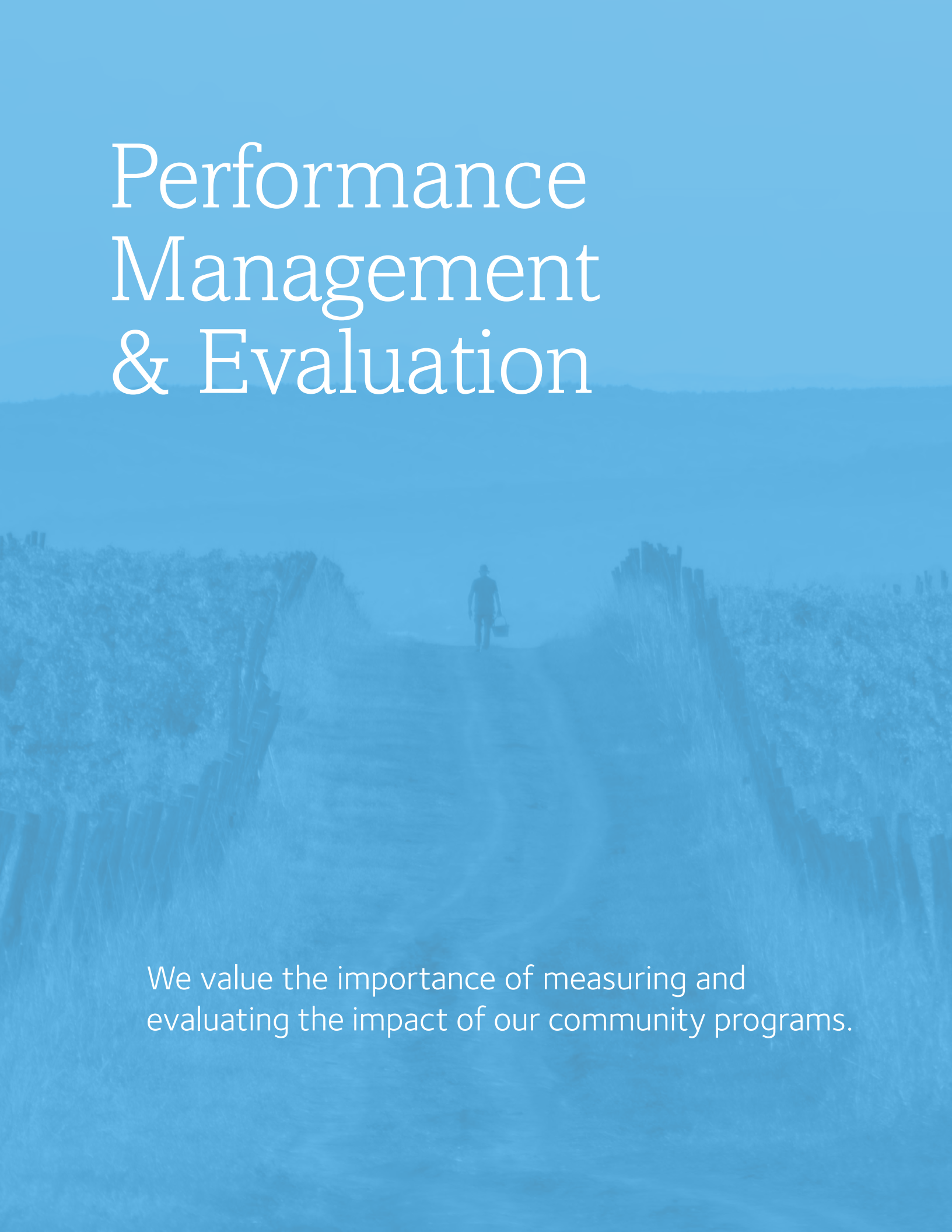
Actions: Program/Activity/Tactic/Policy	**Organization**	**Lead**
Provide Mental Health First Aid (MHFA) and Youth Mental Health First Aid (YMHFA) training to community members to build peer to peer support networks. Identify and provide grief counseling supports in partnership with schools.	Adventist Health, Well-Being	Cathy Parker
	ATCAA – YES Partnership	Bob White
	Jamestown Family Resource Center	Patty Aguira and Kristen Youngman
	Center for a Non-Violent Community	TBD
	Adventist Health – Chaplain Services	Cathi Ruiz
	Sonora Police Department	Chief Vanderwiel
	Tuolumne County Sheriff	Sheriff Pooley
	Grief Busters Calaveras	TBD

YEAR ONE	**YEAR TWO**	**YEAR THREE**
Identify and train individuals to become trainers in MHFA and YMHFA Record the number of trainers fully completing the training Track the number of MHFA trainings and the number of trained individuals. The goal for 2023 is 3 trainings. Identify resources that can be accessed to provide grief counseling support to schools. Record the number of sessions led and the number of participants.	Identify and train individuals to become trainers in MHFA and YMHFA Record the number of trainers fully completing the training. Increase by 4 trainers from the previous year. Track the number of MHFA trainings and the number of trained individuals. Increase the number of trainings to 10 per year. Establish program to help train peer support providers to lead grief counseling support to schools/parents. Record the number of sessions led and number of participants.	Identify and train individuals to become trainers in MHFA and YMHFA Record the number of trainers fully completing the training. Increase the number of qualified trainers to 8 more from the previous year. Track the number of MHFA trainings and the number of trained individuals. Increase the number of trainings to 12 per year. Evaluate effectiveness of peer supports in providing grief counseling support in schools. Record the number of sessions led and number of participants.

Actions: Program/Activity/Tactic/Policy	**Organization**	**Lead**
Provide Purpose Workshops through the Community Blue Zones Project and AHSR Blue Zones Certification process.	Adventist Health – Well Being	Cathy Parker
	Blue Zones Project Tuolumne	Kristi Conforti/Tyler Summerset
	Adventist Health – Chaplain Services	Mario DeLise

YEAR ONE	**YEAR TWO**	**YEAR THREE**
Identify Purpose Workshop opportunities. Record the number of workshops hosted for the community and the number hosted for AHSR associates.	Identify Purpose Workshop opportunities. Record the number of workshops hosted for the community and the number hosted for AHSR associates.	Identify Purpose Workshop opportunities. Record the number of workshops hosted for the community and the number hosted for AHSR associates.

Performance Management & Evaluation



We value the importance of measuring and evaluating the impact of our community programs.

Performance Management & Evaluation

Adventist Health will support the High Priority Need action plans identified in this CHIS by monitoring progress on an ongoing basis and adjusting the approach as needed over the course of the next three years. There are several resources in place to aid in this. All CHIS programs and initiatives will include a completed logic model to identify intended activities, outputs, and short and long-term outcomes. Establishing core metrics for each program or initiative will allow for the ongoing collection of performance management data. Actively tracking metric performance leads to the identification of strengths and challenges to the work, the local hospital, the Adventist Health Community Benefit team, and external consultants. Together, we will work to share successes and create performance improvement plans when necessary.

In addition, Adventist Health hospitals where High Priority Needs are shared will have the opportunity to join a collaborative held by the Adventist Health Well-Being team. The collaborative will be centered on building a common approach that aligns and maximizes community benefit, thus reducing the need to manage this work independently at each hospital. Along with that, where appropriate, evaluation activities designed to measure the overall strength and success of this work at the community level will be incorporated into performance management tracking.

CHIS Development

The development of the CHIS was directly built from the CHNA, whose goal focused on leveraging community stakeholders and data to address the most significant health needs of our community over the next three years. Members of the CHNA Steering Committee—comprised of healthcare, civic, public, and business leaders—led the process of identifying and addressing health needs for a healthier community, completing the final report in fall of 2022.

Collaborating with CHNA Steering Committee members again in early 2023, Adventist Health Community Well-Being Directors facilitated a multi-step process to outline goals and strategies for the CHIS that foster change and positive impact in each of the High Priority Need areas. Each community relied on existing programs and services, and, where necessary, identified new opportunities to pursue collectively.

Once an approach received a consensus, the Community Well-Being Directors worked with Adventist Health leadership and expert consultants to set major annual milestones for each approach, generating outputs and outcomes that allow for ongoing performance management of this work. For further information on how success will be tracked, refer to the Performance Management and Evaluation section above.

Finally, the CHIS was presented to Adventist Health local Hospital Boards for review and feedback. In addition to this collaborative effort, we also welcome feedback at community.benefit@ah.org.

Scan the QR code for the full Secondary Data Report

Significant Identified Health Needs

The Adventist Health Community Well-Being team and community partners collectively reviewed all relevant significant health needs identified through the CHNA process. Using a community health framework developed for this purpose, 12 significant health needs were initially considered. The list of significant needs are as follows:

- Access to Care
- Community Safety
- Community Vitality
- Education
- Environment & Infrastructure
- Financial Stability
- Food Security
- Health Conditions
- Health Risk Behaviors
- Housing
- Inclusion & Equity
- Mental Health

From this group of 12, several high priority health needs were established for Adventist Health Sonora. High priority health needs were chosen as they had demonstrated the greatest need based on severity and prevalence, intentional alignment around common goals, feasibility of potential interventions, and opportunities to maximize available resources over a three-year period.

Using the criteria mentioned above, we were able to determine which needs were high priority, as compared to those that were significant needs. The High Priority Needs are the focus of this CHIS. The remaining significant health needs are not addressed directly but will likely benefit from the collective efforts defined in this report. The following table provides additional information on all the significant health needs that were considered.

TABLE OF SIGNIFICANT IDENTIFIED HEALTH NEEDS

High Priority Needs	
Mental Health	**See Sections III.C - E**
Financial Stability	**See Sections III.C - E**
Housing	**See Sections III.C - E**
Lower Priority Needs	
Access to Care tuolumnecounty.ca.gov/DocumentCenter/View/14454/ResourceDirectoryForWebsite	There is a limited number of primary care doctors in the community, and even fewer specialists. This requires people to travel long distances to get services.
Health Risk Behaviors tuolumnecounty.ca.gov/DocumentCenter/View/14454/ResourceDirectoryForWebsite	Only 30% of residents 65 years or older are up-to-date on core preventative services, and the average spending on fruits and vegetables is below state averages. There is a belief among interviewees that illicit drug use is a pervasive community problem.
Health Conditions tuolumnecounty.ca.gov/DocumentCenter/View/14454/ResourceDirectoryForWebsite	Obesity, heart disease, cancer, and diabetes rates are higher than state averages, as are rates of liver and lung disease mortality.
Education tuolumnecounty.ca.gov/DocumentCenter/View/14454/ResourceDirectoryForWebsite	More than half of 4th graders tested below the proficiency level, and one-third of the population has some kind of college degree.
COVID tuolumnecounty.ca.gov/DocumentCenter/View/14454/ResourceDirectoryForWebsite	46% of surveyed residents identified COVID as a community health need.
Food Security tuolumnecounty.ca.gov/DocumentCenter/View/14454/ResourceDirectoryForWebsite	The high cost of living and low wages makes food security a challenge for many. Only 78% of the population has adequate food access.

Scan the QR code for the full Secondary Data Report

Community Health Financial Assistance for Medically Necessary Care Commitment

Adventist Health understands that community members may experience barriers in paying for the care they need. That is why we are committed to providing financial assistance to those who may need support in paying their medical expense(s).

Community members can find out if they qualify for financial aid in paying medical bills by completing a financial assistance application. Applications can be filled out at the time care is received or after the bill has been administered. To access the financial assistance policy for more information or contact a financial assistant counselor, please visit https://www.adventisthealth.org/patient-resources/financial-services/financial-assistance/.

Glossary of Terms

COMMUNITY ASSET

refers to community organizations, programs, policies, activities or tactics that improves the quality of community life.

DEFINING METRIC

this is the metric used to define the extent of the problem faced by the target population.

FUNDING

can be provided by (but not limited to) government agencies, public organizations, grants and philanthropic giving.

GOAL

there may be several overarching goals to address each prioritized health need. This is the overarching impact we want to achieve.

PARTNERS

describe any planned collaboration between the hospital and other facilities or organizations in addressing health needs.

POPULATION SERVED

who is included within the group to receive services of the program.

PRIORITIZED HEALTH NEED/ PRIORITY AREA/SIGNIFICANT HEALTH NEEDS

a health need that was identified in a community health needs assessment and was then selected by committee as a high priority need to be addressed.

STAKEHOLDER- INTERNAL

colleagues and or board members who work for or with the hospital.

STAKEHOLDER- EXTERNAL

community members or organizations who regularly collaborate with the hospital.

STRATEGY

a specific action plan designed to achieve the expected outcome.

SUB-CATEGORY

if needed, a more granular focus within the identified priority area may be called out.

Approval Page

2023 CHIS Approval

In response to the 2022 Community Health Needs Assessment, this Community Health Implementation Strategy was adopted on April 27, 2023 by the Adventist Health System/West Board of Directors.

The final report was made widely available on May 31, 2023.

1000 Greenley Rd. Sonora, CA 95370
Lic #030000365
adventisthealth.org

Thank you for reviewing our 2023 Community Health Implementation Strategy.
We are proud to serve our local community and are committed to making it a healthier place for all.

Michelle Fuentes
Adventist Health Sonora

Adventist Health
Sonora