Adventist Health Lodi Memorial 2022 Community Health Plan

The following Implementation Strategy serves as the 2020-2022 Community Health Plan for Adventist Health Lodi Memorial and is respectfully submitted to the Department of Health Care Access and Information on May 19, 2023, reporting on 2022 results.

Executive Summary

Introduction & Purpose

Adventist Health Lodi Memorial is pleased to share its Community Health Implementation Strategy. This follows the development of its 2019 Community Health Needs Assessment (CHNA) in accordance with requirements in the Affordable Care Act and IRS 990 Schedule H requirements and approved by the Adventist Health Board of Directors on October 17, 2019.

After a thorough review of the health status in our community through the community health needs assessment (CHNA), we identified areas that we could address using our resources, expertise and community partners. Through these actions and relationships, we aim to empower our community and fulfill our mission of "Living God's love by inspiring health, wholeness and hope."

The results of the CHNA guided this creation of this document and a plan in how we could best provide for our community and the vulnerable among us. This Implementation Strategy summarizes the plans for Adventist Health Lodi Memorial to develop and collaborate on community benefit programs that address prioritized health needs identified in its 2019 CHNA. Adventist Health Lodi Memorial has adopted the following priority areas for our community health investments.

Building a healthy community requires multiple stakeholders working together with a common purpose. We invite you to explore how we intend to address health challenges in our community and partner to achieve change. More importantly, we hope you imagine a healthier region and work with us to find solutions across a broad range of sectors to create communities that define the well-being of people.

The purpose of the CHNA was to offer a comprehensive understanding of the health needs in Adventist Health Lodi Memorial service area and guide the hospital's planning efforts to address those needs.

Summary of Implementation Strategies

Implementation Strategy Design Process

Stakeholders from the 19 hospital facilities in the Adventist Health System were invited to participate in a Mission Integration Summit on September 26 and 27, 2019. During this two day-long event, participants were introduced to the 2019 Adventist Health Implementation Strategy Template. After the summit, each hospital was invited to participate in a series of technical assistance calls and consultation sessions with representatives from Adventist Health Community Integration and Conduent Healthy Communities Institute to further develop and refine their implementation strategy.

Adventist Health Lodi Memorial Implementation Strategy

The implementation strategy outlined below summarizes the strategies and activities by Adventist Health Lodi Memorial to directly address the prioritized health needs. They include:

- Health Need 1: Mental Health
  - Applying for behavioral health grant, which if awarded will provide a behavioral health professional in the emergency department
  - Child Abuse Prevention Council (CAPC) partnership to address patient ACEs
- Health Need 2: Economic Security
  - Partnership with Health Force Partners
  - Support Healthy Lodi Initiative through our work with the American Heart Association
- Health Need 3: Obesity/Healthy Eating and Active Living (HEAL)/Diabetes
  - Free health education classes offered to the community
  - Help all ages get more physical activity, including programs that meet language/culture needs

Under the health need of economic security, you will note, that AHLM is collaborating with partners to improve career pathways and prepare skilled workers to meet the demand of healthcare organizations. Additionally, we are trying to improve workplace health in our local businesses. When employees are healthy, absenteeism decreases, productivity increases, and both employer and employee benefit. These initiatives can be indirectly linked to homelessness. If we create opportunities for our students to succeed and prepare them to meet the needs of the workforce, and improve the health and well being of our employers,

then we are setting our community up for economic stability. Additionally, AHLM has donated funds to organizations such as the Salvation Army which provides shelter and resources for individuals in need.

The Action Plan presented below outlines in detail the individual strategies and activities Adventist Health Lodi Memorial will implement to address the health needs identified through the CHNA process. The following components are outlined in detail in the tables below: 1) actions the hospital intends to take to address the health needs identified in the CHNA, 2) the anticipated impact of these actions as reflected in the Process and Outcomes measures for each activity, 3) the resources the hospital plans to commit to each strategy, and 4) any planned collaboration to support the work outlined.

No hospital can address all the health needs identified in its community. Adventist Health Lodi Memorial is committed to serving the community by adhering to its mission, and using its skills, expertise and resources to provide a range of community benefit programs. This Implementation Strategy does not include specific plans to address the following significant health needs identified in the 2019 CHNA.

Significant Health Needs NOT Planning to Address
• Violence/Injury Prevention: Need is being addressed by others • Access to Care: Need is being addressed by others • Substance Abuse/Tobacco: Need is currently being addressed by others, however, if we are awarded the Behavioral Health Pilot Project grant, we will be able to address this need through hiring a Substance Use Navigator • Asthma: AHLM does not have the resources necessary at this time to address this need • Oral Health: Need is being addressed by others • Climate and Health: Hospital does not have expertise to effectively address the need

Adventist Health Lodi Memorial Implementation Strategy Action Plan

PRIORITY HEALTH NEED: MENTAL HEALTH						
GOAL STATEMENT: IMPROVE TRAUMA INFORMED CARE BY CREATING AWARENESS OF TRAUMA A OR CONNECTING OUR PATIENTS WITH THE PROPER RESOURCES TO ADDRESS TRAUMA.						
Mission Alignment: (Well-being of People; Well-being of Places; Equity) Well-being of people						
Strategy 1: Hire a substance use navigator in our emergency department						
Programs/ Activities	Process Measures	Results: Year 1	Short Term Outcomes	Results: Year 2	Medium Term Outcomes	Results: Year 3
Activity 1.1 Substance Use Navigator (SUN)	Behavioral Health Pilot Project grant application through the Department of Health Care Services	Previous report available upon request	Being awarded the grant # of ED/hospital encounters where a patient was seen by the SUN # of ED/hospital encounters with MAT (buprenorphine) administered or prescribed # of ED/hospital encounters where a patient was given an overdose diagnosis # of ED/hospital encounters with a diagnosis of Opioid Use Disorder (OUD)	Previous report available upon request	Hire a SUN with grant funds prior to July 1, 2021 # of patients that followed up with their Medication-Assisted Treatment (MAT) appointment in outpatient clinic within 30 days of having been discharged from the ED # of post-ED visits for 3 months # of total buprenorphine dose given in the ED	See narrative below

PRIORITY HEALTH NEED: MENTAL HEALTH						
			# of patients who accepted referrals for ongoing MAT as outpatient			
Source of Data: • AHLM Clinics & ED						
Target Population(s): High risk, individuals with substance use disorders						
Adventist Health Resources: (financial, staff, supplies, in-kind etc.) • Financial, staff, supplies, in-kind,						
Collaboration Partners: (place a "*" by the lead organization if other than Adventist Health) California Bridge Program						
CBISA Category: (A - Community Health Improvement; E - Cash and In-Kind; F - Community Building; G - Community Benefit Operations) F - Community Building						

Strategy Results 2022

AHLM continued to utilize the funds from the Behavioral Health Pilot Project (BHPP) to support a Substance Use Navigator (SUN) in the emergency department. In 2022, the Substance Use Navigator (SUN) at AHLM provided services to 286 patients in ED/inpatient care between January–December. 140 patients accepted referrals to Medicated Assisted Treatment (MAT), substance use treatment, and behavioral health with scheduled appointments as the patients were discharged from the ER (Emergency Room) or inpatient hospital setting. Out of the 140 patients that accepted referral, 50 patients were MAT (Medicated Assisted Treatment) referrals for Opiates and Alcohol. Out of 50 patients, 22 patients attended their MAT (Medicated Assisted Treatment) Program Schedule Appointments. For the year 2022, a total of 105 Buprenorphine prescriptions were written or administered in the ED/inpatient setting. A total of 120 patients were given an overdose diagnosis. Also, 278 patients were diagnosed with Opiate use.

The BHPP initiative was an important step toward reducing the severity of behavioral health issues impacting AHLM's service area, with a focus on substance use disorders (SUD) and specifically opioid use disorders (OUD). AHLM's 2019 Community Health Needs Assessment identified mental health disorders and SUD as priority health issues affecting all populations, which are also linked to higher levels of poverty, homelessness, and community violence. Deaths by suicide, drug overdose and alcohol poisoning per 100,000 residents are significantly higher in San Joaquin County (46) when compared to the state (34). Additionally, 29% of San Joaquin County residents reported insufficient resources for social and emotional support related to behavioral health issues, compared with 25% for California residents. Specific outcomes to be achieved under this pilot project will include decreasing deaths from

opioid-related overdoses, combat stigma surrounding opioid and other substance use disorders, and to improve the quality of care provided to patients with SUD/OUD.

The SUN's role is to evaluate and assess individuals in the emergency department (ED) who may have a substance use disorder. The SUN will establish a referral network within the community with the different available resources for persons with substance use disorder, including outpatient medication-assisted treatment (MAT), residential care, housing/shelter needs, etc. The SUN will work closely with ED staff to support the comprehensive care of individuals with substance use disorders, including working with ED providers, nurses, case managers, social workers, and others. Through counseling and discussion with the individual and evaluation of their health insurance status, the SUN will determine what outpatient treatment option will work best for each individual's specific needs. If the individual is on buprenorphine in the Emergency Department, the SUN will work with the ED provider to assure that the patient has a prescription for a sufficient amount of buprenorphine to last until the outpatient treatment clinic appointment.

Furtherance to AHLM signing on to become a funding partner of the United Us platform in 2020 to participate in San Joaquin County's Connected Community Network (CCN). In 2022, AHLM continued to actively support the United Us platform by disbursing the 3rd installment of the funding in the 3-year agreement.

"The CCN is built around a network of community partners working together to coordinate communication and implement processes to provide referrals and track outcomes for vulnerable populations. A key element of the CCN is United Us, a technology solution which streamlines the coordination of care in the community by electronically linking health care providers to organizations that provide direct services to their communities. A Community Advisory Group was also established that meets regularly to review utilization, discuss challenges, and decide how best to improve processes". CCN is essentially a social determinants of health referral system within our county. This platform can help connect our patients with mental health services, housing, food, and employment, which helps to address our top three
2019 Community Health Needs.

PRIORITY HEALTH NEED: ECONOMIC SECURITY
GOAL STATEMENT: IMPROVE THE ECONOMIC SECURITY IN OUR COUNTY BY IMPROVING CAREER FOR OUR RESIDENTS, INCREASING THE SUPPLY OF QUALIFIED WORKERS TO MEET THE NEEDS O HEALTHCARE INDUSTRY, AND IMPROVE THE OVERALL HEALTH OF OUR LOCAL BUSINESSES
Mission Alignment: (Well-being of People; Well-being of Places; Equity) Well-being of people, Equity
Strategy 1.1 AHLM has partnered with HealthForce Partners to improve career pathway opportunities for community reside and to increase the supply of skilled workers to meet the needs of a dynamic healthcare industry in the Northern San J Valley. Strategy 1.2 AHLM is also collaborating with the American Heart Association and the Lodi Chamber of Commerce's Health Value Action T

PRIORITY HEALTH NEED: ECONOMIC SECURITY

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PRIORITY HEALTH NEED: OBESITY/HEALTHY EATING AND ACTIVE LIVING (HEAL)/DIABETES						
GOAL STATEMENT: INCREASE PHYSICAL ACTIVITY FOR ALL AGES AND ESTABLISH PROGRAMS IN NEIGHBORHOODS						
Mission Alignment: (Well-being of People; Well-being of Places; Equity) Well-being of people, Well-being of places						
Strategy 1: Engage businesses and community organizations to improve facilities and offer programs for physical activity						
Programs/ Activities	Process Measures	Results: Year 1	Short Term Outcomes	Results: Year 2	Medium Term Outcomes	Results: Year 3
Activity 1.1 Convene a Community Faith Summit in 2020 to encourage cross-sector collaboration and improve parks/neighborhoods	Recruit 10 community leaders to join Faith Summit Advisory Board Hold 6 Advisory Board meetings beginning in May of 2020	Previous report available upon request	# of Advisory Board members recruited #of Advisory Board Meetings held	Previous report available upon request	Increase cross sector collaboration and improve In	

PRIORITY HEALTH NEED: OBESITY/HEALTHY EATING AND ACTIVE LIVING (HEAL)/DIABETES
Collaboration Partners (place a "*" by the lead organization if other than Adventist Health) • County Health Collaborative
CBISA Category (A - Community Health Improvement Services; B - Cash and In-Kind; F - Community Building; G - Community Benefit Operations) • Category A

Strategy Results 2022

In addition to the initiatives mentioned above, AHLM planned to continue participating in events, health fairs and sponsorships related to our health priorities, however, much of these efforts were halted in 2022 due to the pandemic.

The 2019 Community Health Needs Assessment (CHNA) addressed the top priority needs in SJC. Obesity, healthy eating/active living and diabetes was defined as one of the top three most pressing priorities. As part of the CHNA county collaborative team, we distributed surveys to community members in both Spanish and English. The survey results indicated that the community wished to address physical activity by helping all ages get more physical activity, including programs that meet language/culture needs.

The Adventist Health + Blue Zones Solution

Our desire to improve community well-being grew out of not only our mission at Adventist Health-to live God's love by inspiring health, wholeness and hope – but also by the sheer need as seen across our system of 23 hospitals. Overwhelmingly, we see issues related to health risk behaviors, mental health and chronic illnesses throughout the communities we serve. That is why we have focused our work around addressing behavior and the systems preventing our communities from achieving optimal health.

In an effort to meet these needs, our solution is to create a sustainable model of well-being that measurably impacts the well-being of people, well-being of places and equity.

In 2020, Adventist Health acquired Blue Zones as the first step toward reaching our solution. By partnering with Blue Zones, we will be able to gain ground in shifting the balance from healthcare – treating people once they are ill – to transformative well-being – changing the way communities live, work and play. In 2021, Adventist Health committed to launching six Blue Zone Projects within our community footprint, and as we enter 2023 these projects are active. Blue Zone Projects are bringing together local stakeholders and international well-being experts to introduce evidence-based programs and changes to environment, policy and social networks. Together, they measurably improve well-being in the communities we serve.