

— 2021 - 2023 —

COMMUNITY HEALTH IMPROVEMENT PLAN

St. Mary Medical Center

Apple Valley, CA



To provide feedback on this CHIP or obtain a printed copy free of charge, please email Judy Wagner at Judy.Wagner@stjoe.org.



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EXECUTIVE SUMMARY

Providence continues its Mission of service in San Bernardino County through Providence St. Mary Medical Center (SMMC). SMMC is an acute-care hospital with 213 licensed beds, founded in 1956 and located in Apple Valley, CA. The hospital's service area is the High Desert region, part of San Bernardino County, including 373,422 people.

SMMC dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. During the most recent fiscal year, the hospital provided \$9,474,269 in Community Benefit in response to unmet needs.

The Community Health Needs Assessment (CHNA) is an opportunity for SMMC to engage the community every three years with the goal of better understanding community strengths and needs. The results of the CHNA are used to guide and inform efforts to better address the needs of the community. Through a mixed-methods approach, using quantitative and qualitative data, the CHNA process relied on several sources of information: state and national public health data, qualitative data from community resident and stakeholder survey findings from the Department of Public Health, County of San Bernardino, Community Vital Signs (CVS), and hospital utilization data.

Providence St. Mary Medical Center's Community Health Improvement Plan Priorities

As a result of the findings of our [2021 CHNA](#) and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, SMMC will focus on the following areas for its 2021-2023 Community Benefit efforts:

PRIORITY 1: ACCESS TO CARE

Access to Care – Creating awareness of current services and advocate together with residents to increase or bring new services and outreach to high need neighborhoods.

PRIORITY 2: MENTAL HEALTH AND SUBSTANCE USE

Mental Health and Substance Use – Creating awareness and education regarding mental health and substance use, particularly among the Latino/a youth population, and ultimately bringing resources that address these in a meaningful and dignified way.

PRIORITY 3: HOMELESSNESS & HOUSING INSTABILITY

Homelessness and Housing Instability – Partnering in housing and services to support those experiencing homelessness to increase access to housing and meet the chronic health needs of populations experiencing homelessness.

PRIORITY 4: OBESITY

Obesity – Addressing access to healthy foods, creating more active communities, and addressing high rates of obesity and diabetes. Creating opportunities for physical activity and nutrition education.

Advocating for more supermarkets in neighborhoods with low incomes and increasing access to parks that will lead to healthier communities.

INTRODUCTION

Who We Are

Our Mission As expressions of God’s healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Vision Health for a Better World.

Our Values Compassion — Dignity — Justice — Excellence — Integrity

Providence St. Mary Medical Center is an acute-care hospital founded in 1956 and located in Apple Valley, CA. The hospital has 213 licensed beds, a staff of more than 1,750, and professional relationships with more than 450 local physicians. Major programs and services offered to the community include the following: care for breast cancer, care for diabetes, cardiology, emergency services, imaging, maternity care, outpatient testing, rehabilitation, respiratory services, stroke care, surgical services, vascular services, care for women and children and wound care.

Our Commitment to Community

Providence, St. Mary Medical Center dedicates resources to improve the health and quality of life for the communities we serve. During 2020, SMMC provided \$9,474,269 in Community Benefit¹ in response to unmet needs and to improve the health and well-being of those we serve in the High Desert Region, part of San Bernardino County.

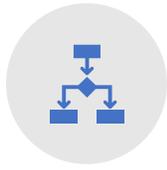
Health Equity

At Providence St. Joseph Health, we acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. Our Vision is “Health for a Better World,” and to achieve that we believe we must address not only the clinical care factors that determine a person’s length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes.

To ensure that equity is foundational to our CHIP, we have developed an equity framework that outlines the best practices that each of our hospital will implement when completing a CHIP. These practices include, but are not limited to the following:

¹ Per federal reporting and guidelines from the Catholic Health Association.

Figure 1. Best Practices for Centering Equity in the CHIP



Address root causes of inequities by utilizing evidence-based and leading practices



Explicitly state goal of reducing health disparities and social inequities



Reflect our values of justice and dignity



Leverage community strengths

Community Benefit Governance

Providence, St. Mary Medical Center demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation, and collaboration with community partners. The Chief Mission Integration Officer and Director, Community Health Investment are responsible for coordinating implementation of State and Federal 501r requirements.

The Community Health (CH) Management Team informs all hospital employees on community benefit activities through its weekly internal caregiver publication, including for community participation.

A charter approved in 2007 and revised in 2020 established the formulation of the SMMC Community Health Committee. The role of the Community Health Committee is to support the Board of Trustees in overseeing community benefit issues. The Committee acts in accordance with a Board-approved charter. The Community Health Committee is charged with developing policies and programs that address identified needs in the service area particularly for underserved populations, overseeing development and implementation of the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP), and overseeing and directing the Community Benefit (CB) activities.

The Community Health Committee has a minimum of eight members including three members of the Board of Trustees. Current membership includes four members of the Board of Trustees and three community members. A majority of members have knowledge and experience with the populations most likely to have disproportionate unmet health needs. The Community Health Committee generally meets quarterly.

ROLES AND RESPONSIBILITIES

Senior Leadership

- Chief Executive and senior leaders including the hospital's Chief Mission Integration Officer, are directly accountable for CB performance.

Community Health Committee (CHC)

- CHC serves as an extension of trustees to provide direct oversight for all charitable program activities and ensure program alignment with “Advancing the State of the Art of Community Benefit” (ASACB) Five Core Principles. It includes diverse community stakeholders. Trustee members on CHC serve as ‘board level champions.’
- The Committee provides recommendations to the Board of Trustees regarding budget, program targeting and program continuation or revision.

Community Health (CH) Department

- Manages CB efforts and coordination between CH and Finance departments on reporting and planning.
- Manage data collection, program tracking tools and evaluation.
- Develops specific outreach strategies to access identified Disproportionate Unmet Health Needs (DUHN) populations.
- Coordinates with clinical departments to reduce inappropriate ER utilization.
- Advocates for CB to senior leadership and invests in programs to reduce health disparities.

Local Community

- Partnership to implement and sustain collaborative activities.
- Formal links with community partners.
- Provide community input to identify community health issues.
- Engagement of local government officials in strategic planning and advocacy on health-related issues on a city, county, or regional level.

Planning for the Uninsured and Underinsured

Our Mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why SMMC has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients.

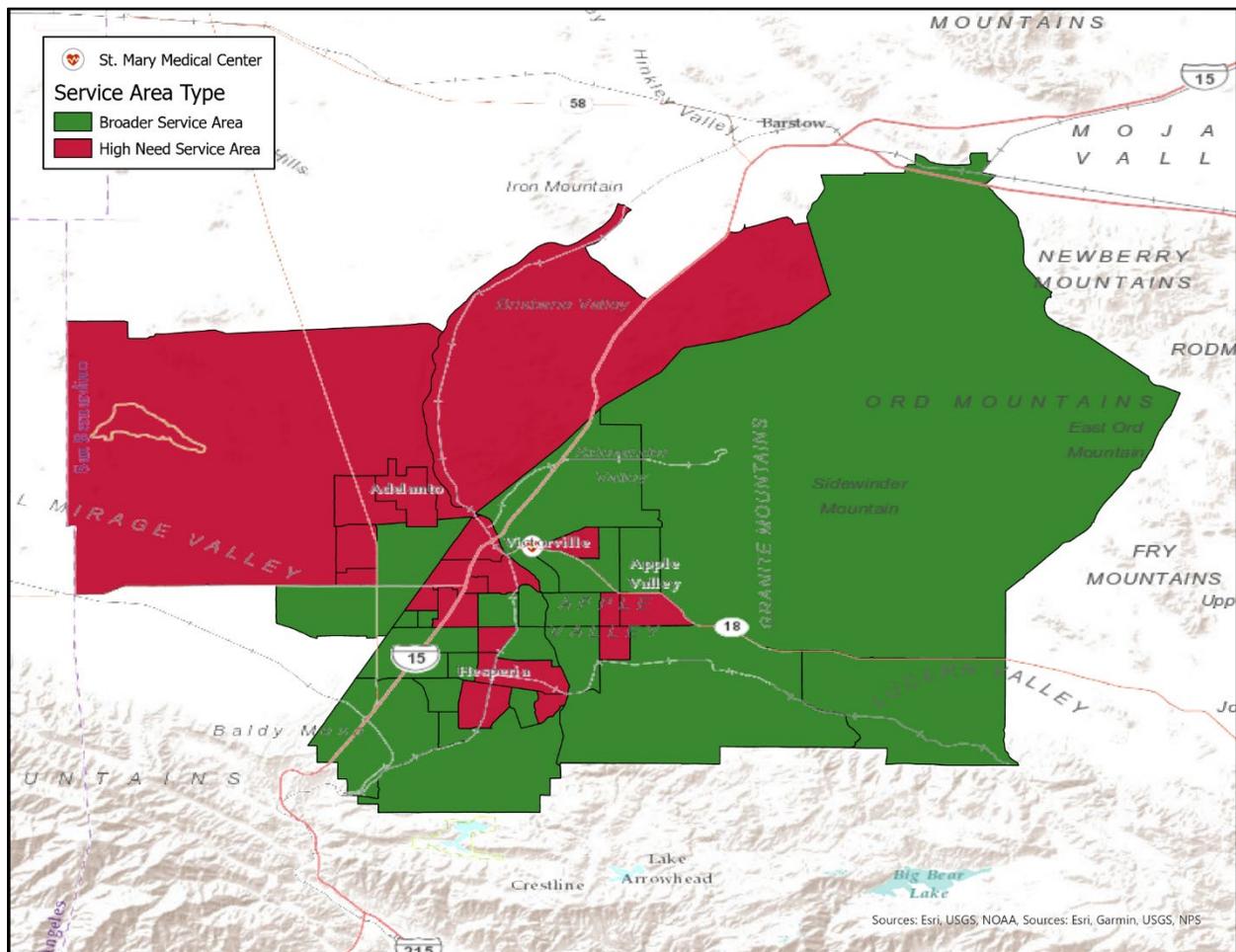
SMMC informs the public of FAP by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital’s service area. All patients who demonstrate lack of financial coverage by third party insurers are offered an opportunity to complete the Patient Financial Assistance Application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible. For information on our Financial Assistance Program click <https://www.providence.org/obp/ca>.

OUR COMMUNITY

Description of Community Served

St. Mary Medical Center’s service area is in the High Desert part of San Bernardino County and includes a population of approximately 373,422 people. The population in the High Desert total service area makes up 17% of San Bernardino County.

Figure 2. St. Mary Medical Center’s Total Service Area



Of the over 373,422 permanent residents of the High Desert, part of San Bernardino County roughly 44% live in the “high need” area, defined by lower life expectancy at birth, lower high school graduation rates, and more households at or below 200% FPL compared to census tracts across the county. For reference, in 2020, 200% FPL represents an annual household income of \$52,400 or less for a family of four. These households are more likely to regularly make spending tradeoffs regarding utilities, rent, groceries, medicine, and other basic expenses.

Community Demographics

POPULATION AND AGE DEMOGRAPHICS

Of the over 373,422 permanent residents in the total service area, the percentage of female to male population living in high need areas is split 50/50.

The high need service area has a higher percentage of people under 34 years of age, 66.9%, compared to 58% in the broader community.

POPULATION BY RACE AND ETHNICITY

Individuals identifying as Hispanic had a higher percentage living in high need service areas, 56.3% versus the broader service area, 45.8%. Blacks also had a higher percentage living in high need service areas, 12.9% in comparison to 9.2% living in broader service areas. The same was noted for individuals identifying as “other” race, 27.3% versus 20.8%.

People identifying as Asian, and white were less likely to live in high need census tracts. For Asians, 2.5% lived in high need service areas and 4.1% in the broader service area. For whites, 49.0% lived in high need service areas, and 58.6% in the broader community.

SOCIOECONOMIC INDICATORS

Table 1. Income Indicators for High Desert Service Area

Indicator	Broader Service Area	High Need Service Area	San Bernardino County
Median Income Data Source: American Community Survey Year: 2019	\$61,846	\$41,164	\$60,761
Percent of Renter Households with Severe Housing Cost Burden Data Source: American Community Survey Year: Estimates based on 2013 – 2017 data	25.7%	35.3%	28.7%

The San Bernardino County and Broader Service Area median income is almost the same. What is striking, is that the median income earned in the high need service area is almost \$20,000 lower than that of the broader service area and county median income.

Severe housing cost burden represents households that spend 50% or more of their income on housing costs. A greater proportion of renter households are severely housing burdened in the high need service area (one out of every three households, 35.3%) in comparison to the broader service area (one out of every four households, 25.7%).

Full demographic and socioeconomic information for the service area can be found in the [2021 CHNA for SMMC](#).

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

Improving the health of our communities is foundational to our Mission and deeply rooted in our heritage and purpose. Our Mission calls us to be steadfast in serving all, with a special focus on our most economically poor and vulnerable neighbors. This core belief drives the programs we build, investments we make, and strategies we implement.

Knowing where to focus our resources starts with our Community Health Needs Assessment (CHNA), an opportunity in which we engage the community every three years to help us identify and prioritize the most pressing needs, assets, and opportunities. The 2021 CHNA was approved by the SMMC Community Health Committee on April 28, 2021.

Significant Community Health Needs Prioritized

Through a collaborative process engaging Community Health Committee and the Director of Community Health Investment, the hospital worked from a list of the eighteen (18) health and social needs identified by the CVS process. Staff developed a point system to assign each of the eighteen (18) identified needs to gain perspective and develop a hierarchy of which top needs have the potential to offer the highest impact in the High Desert. Each need was listed, and assessed based on the following:

- Trend over time (Getting “Worse” or “Better”)
- Impact on low-income or communities of color (“Very High” to “Very Low”)
- Are “High Need Areas” worse off than state averages? (“Yes” or “No”)
- Opportunity for Impact (“Low” to “Very High”)
- Alignment with System Priorities (“Yes” or “No”)
- Community Vital Signs Priority (“Yes” or “No”)
- Attorney General Requirement (“Yes” or “No”)

Based upon the scoring system and discussion, SMMC Community Health Committee identified the following priorities:

PRIORITY 1: ACCESS TO CARE

Creating awareness of current services and advocate with residents to increase or bring new services and outreach to high need neighborhoods.

PRIORITY 2: MENTAL HEALTH AND SUBSTANCE USE

Creating awareness and education regarding mental health and substance use, particularly amongst the Latino and African American populations, and ultimately bringing resources that address these in a meaningful and dignified way.

PRIORITY 3: HOMELESSNESS & HOUSING INSTABILITY

Investing in housing and services to support those experiencing homelessness to increase access to housing and meet the chronic health needs of populations experiencing homelessness.

PRIORITY 4: OBESITY

Creating opportunities for physical activity and nutrition education. Advocating for more supermarkets in neighborhoods with low incomes and increasing access to parks will lead to healthier communities.

SMMC also assists the community as it addresses crime and economic development initiatives led by county and city governments, law enforcement and the education community.

Needs Beyond the Hospital's Service Program

No hospital facility can address all the health needs present in its community. We are committed to continuing our Mission by partnering with like-minded partners that count with the capacity and expertise to address the needs of High Desert Residents.

Furthermore, SMMC will endorse local non-profit organizations to apply for funding through the St. Joseph Community Partnership Fund. Organizations that receive funding provide specific services and resources to meet the identified needs of underserved communities.

The following community health needs identified in the ministry CHNA will not be address and an explanation is provided below:

- **Diabetes:** This need is tied closely to the Identified Priority, "Obesity." The hospital's grant to St. Jude Neighborhood Health Center, a local Federally Qualified Health Center, supports its *American Diabetes Association Certified* program serving mostly uninsured and underinsured residents. Additionally, the community helped start a free clinic named the *Symba Center*. *Symba* provides care from a clinic operated within a Victorville homeless shelter. Services include testing, access to low cost and free medications, diabetes and nutrition education, follow-up, and navigation.
- **Food and Nutrition:** This need is tied closely to the Identified Priority, "Obesity." Like-minded partners have integrated a regional approach to address issues associated to living in food deserts, through the *High Desert Food Collaborative*. The hospital's service area has been identified by county public health as having 17 high poverty/ low healthy food access census tracts, the most in the county. To increase the supply of healthy foods, the Los Angeles based non-profit *Food Forward* is donating farmer market recovered fresh produce to residents of Adelanto, Apple Valley, Barstow, Hesperia, Phelan, and Victorville. In 2020, Food Forward provided 3,000,000 pounds fruits and vegetables to 96 partners serving residents living in both High Need and Broader communities.
- **Physical Activity:** This need is tied closely to the Identified Priority, "Obesity" and will be addressed by the Department of Public Health, County of San Bernardino grant. The hospital will continue its advocacy schools expanding the US Department of Transportation's Safe Routes

to Schools and US Department of Agriculture’s Summer Meals programs. Additionally, the hospital will support city Park and Recreation departments to expand their park programs.

- **Poverty:** the hospital collaborates with a local San Bernardino County Workforce Development office encouraging job fairs in High Need communities like Adelanto and old town Victorville. Additionally, as a Catholic institution we follow Catholic Social Teaching, and regarding jobs and salaries believe that “the economy must serve people, not the other way around. Work is more than a way to make a living; it is a form of continuing participation in God’s creation. If the dignity of work is to be protected, then the basic rights of workers must be respected – the right to productive work, to decent fair wages, to the organization and joining of unions, to private property and to economic initiative.” To this end the hospital is the most active healthcare partner in a regional high school student career initiative named *Mountain Desert Career Pathways and Mountain Desert Economic Partnership* and provides grant support to *Millionaire Minds Kids*, an old town Victorville initiative helping at-risk students access to college and high wage career opportunities.
- **Environmental Pollution:** Organizations working to address air quality include The Mojave Desert Air Quality Management District and the City of Victorville. The City’s April 2021 Environmental Justice Existing Conditions Assessment reports the southeastern portion of the city (old town Victorville) have higher asthma rates compared to the rest of the city. The city averages 82 asthma emergency department visits per 10,000 people where the average asthma prevalence for the County of San Bernardino is 67 visits per 10,000 people. The city plans to help address this condition by renovating the community with new housing and improved street circulation. The hospital will advocate that the county’s mobile *Breathmobile* visit old town schools providing services to students and the community.
- **Crime:** A project funded by the *St. Joseph Health Community Partnership Fund*, addresses crime and safety. Residents of Old Town Victorville have formed *Revive Our Old Town (R.O.O.T.)*, a grassroots efforts addressing public safety, crime, and homelessness. *R.O.O.T.* advocates to city and business leaders that reviving old town attracts investors and improves the area’s quality of life. In November 2020, Victorville residents passed *Measure P* authorizing an additional 1% local tax generating up to \$15 million per year. An oversight committee was formed in April 2021 to begin addressing crime, fire, upgrading the library and park resources and addressing homelessness. In August 2021, Victorville approved formation of a Community Revitalization Investment Board (CRIA). The CRIA is authorized to spend tax increment in old town Victorville to include infrastructure improvements, assistance to businesses and land acquisition and development of affordable housing. The city also seeks state of California *Project Homekey* funds that, if awarded, would convert five to six motels into housing.
- **Smoking/Tobacco/Vaping:** The *California Health Collaborative* is active in the High Desert. This organization educates, informs, and promotes policy change to reduce tobacco related health disparities, improve health equity and reduce secondhand smoke in public and non-recreational places. The campaign works through youth who advocate and educate. Youth groups are currently working with Hesperia law enforcement in a decoy operation designed to identify establishments selling to underage youth. A youth group has formed to begin addressing

tobacco and vaping issues for the City of Victorville including the old town community previously mentioned as having elevated air particulate and asthma induced hospital Emergency Room visits. The city plans to improve housing and traffic circulation as strategies that may help reduce the burden of airborne particulate levels.

In addition, the hospital will collaborate with local non-profit, like-minded organizations that address the aforementioned community needs to coordinate care and referrals to address these unmet needs.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

SMMC developed a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs in collaboration with community partners, considering resources, community capacity, and core competencies. The Regional Director and local Program Director developed strategies based on insights from the quantitative and qualitative data, as well as local Community Health Investment caregivers, and input and feedback were provided by the Community Health Committee. The 2021-2023 CHIP was approved on October 20, 2021 and made publicly available no later than December 28, 2021.

The 2021-2023 Community Health Improvement Plan (CHIP) process was impacted by the SARS-CoV-2 virus and COVID-19, which has impacted all of our communities. While we have focused on crisis response, it has required a significant re-direction of resources and reduced community engagement in the CHIP process.

This CHIP is currently designed to address the needs identified and prioritized through the 2021 CHNA, though COVID-19 will have substantial impacts on our community needs. These impacts are likely to exacerbate some of the needs identified, and cause others to rise in level of priority. While this is a dynamic situation, we recognize the greatest needs of our community will change in the coming months, and it is important that we adapt our efforts to respond accordingly. We are committed to supporting, strengthening, and serving our community in ways that align with our Mission, engage our expertise, and leverage our Community Benefit dollars in the most impactful ways.

SMMC anticipates that implementation strategies may change and therefore, a flexible approach is best suited for the development of its response to the CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by SMMC in the enclosed CHIP.

Addressing the Needs of the Community: 2021- 2023 Key Community Benefit Initiatives and Evaluation Plan

COMMUNITY NEED ADDRESSED #1: ACCESS TO CARE

Initiative Name

Health services at Hesperia High School

Population Served

Adults and youth living in Hesperia

Long-Term Goal(s)/ Vision

Community school providing comprehensive health and social services for Hesperia residents

Table 2. Strategies and Strategy Measures for Health Services at Hesperia School

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
Partner with St. Mary Heritage Medical Group to open a health clinic serving the Hesperia High School community	Students & Adults	Clinic open, # of services offered	None	Medical, mental health and access to social support services provided
School based campaign promoting access to health and community services	Students & Adults	# Of services promoted	None	At least 5 services promoted to school community

Evidence Based Sources

www.Communityschools.org

Resource Commitment

Approval by Hesperia High School to build community center with health clinic space

Key Community Partners

Hesperia Unified School District, Hesperia High School, St. Mary High Desert Medical Group, community partners offering health and social services

Initiative Name

Build Community Capacity providing COVID-19 vaccine testing, vaccine, and food resources

Population Served

Unvaccinated youth, teens, and adults across the High Need and Broader communities

Long-Term Goal(s)/ Vision

Increase COVID-19 vaccination rates across High Desert communities to meet county, state and national goals while also addressing social needs including access to food.

Table 3. Strategies and Strategy Measures for Building Community Capacity

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
Community Capacity Building developing a coordinated plan addressing COVID-19 vaccine needs across High Desert	Adults and Youth	Plan with data dashboard informing COVID-19 vaccine strategy	No coordinated community vaccine plan in place	Vaccine plan implemented
Advertising Vaccine Campaign	Adults and Youth	# of persons reached	0	200,000 community members reached
Service agreements in place for testing, vaccination and other education	Shelters and Schools, older adults	# of service agreements in place # of tests # of resource lists distributed	0	Minimum of 12 service agreements in place 9,600 COVID tests 20,000 pieces distributed

Evidence Based Sources

www.cdc.gov

www.sbcovid19.com

Resource Commitment

Grant funding from San Bernardino County Public Health

Key Community Partners

San Bernardino County Public Health, High Desert school districts, community partners providing food, COVID health education, testing, and vaccines

Initiative Name

Assist immigrant populations improve access and use of health and social resources

Population Served

Limited English Proficient patients and Uninsured and Undocumented Seniors

Long-Term Goal(s)/ Vision

Increased awareness among immigrant populations accessing health services

Table 4. Strategies and Strategy Measures for Assisting Immigrant Populations

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
Outpatient navigation of Limited English Proficient patients post hospital discharge (Equity initiative)	Low income and uninsured Spanish speaking adults with chronic health and social conditions	# Of patients active in navigation	1,040	2,000
Health4All (Equity initiative)	Uninsured/undocumented older adults	# Of persons age 50+ enrolled into health insurance and assigned a Primary care Physician	none	300

Evidence Based Sources

<https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality>

Resource Commitment

Funding to support Outpatient navigators

Key Community Partners

Hospital’s inpatient interpreter; FQHC clinics and physician partners, Medi-Cal offices

El Sol Health Navigation service, health insurance enrollers, churches

Initiative Name

Support coordination of FQHC clinic partners serving vulnerable populations

Population Served

Uninsured and low-income persons

Long-Term Goal(s)/ Vision

Increased use and expansion of health care services for low income and uninsured populations

Table 5. Strategies and Strategy Measures for Supporting coordination of FQHC Clinic Partners

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
Support the affiliation with St. Jude Neighborhood Health Centers by partnering with them on a plan to increase number served, obtain an IEHP contract and add dental services.	Residents that are uninsured and have low incomes	# of patient visits	8,671 visits	10,405 visits IEHP contract Dental services added in the High Desert Revitalize Mobile Clinic Program
The Symba Center will provide mental health services in the High Desert	Residents that are uninsured and have low incomes	Mental health services provided	No services provided	Mental health services available
Borrego Health will provide a fixed site clinic in the High Desert	Residents that are uninsured and have low incomes	# of fixed site clinics in High Desert provided by Borrego Health	0	1
Tri State Community Health Center offers consistent services in Adelanto	Adelanto residents	# of hours of primary care and other services available in Adelanto	TBD	40 hours per week

Evidence Based Sources

www.healthypeople.gov

Resource Commitment

Clinic operations, staffing

Key Community Partners

St. Jude Neighborhood Clinic, The Symba Center, Borrego Health, Tri Community

COMMUNITY NEED ADDRESSED #2: MENTAL HEALTH AND SUBSTANCE USE

Initiative Name

Work2BeWell mental health campaign

Population Served

Middle and High School aged teens

Long-Term Goal(s)/ Vision

Student developed mental health and wellness campaign

Table 6. Strategies and Strategy Measures for the Work2BeWell Mental Health Campaign

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
Recruit school districts to participate in Work2Be Well	Middle and High School aged students	# of school districts implementing program	None	Operating in Two school districts
Implement Work2Be Well resources & curriculum in 2 school districts	Middle and High School aged students	# of school districts implementing and the number of students and teachers participating in program	None	Operating in Two school districts

Evidence Based Sources

www.sciencedaily.com/2017/08/170810173331.html

Resource Commitment

Access to school staff, students, school, and district resources

Key Community Partners

Hesperia Unified School District and school staff

Initiative Name

Help is Here Campaign

Population Served

High Desert youth and residents

Long-Term Goal(s)/ Vision

Expanding community awareness to availability of local mental health and substance use resources

Table 7. Strategies and Strategy Measures for the Help is Here Campaign

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
Engage funders in a social media campaign led by youth in mental health	Youth	# of funders supporting campaign	None	Multiple funders (at least 3) support campaign
Reduce Stigma thru messaging by on-line influencers	Youth & Adults	# of online influencers promoting anti-stigma messages	None	At least 10 online influencers promote anti-stigma messaging
Mental Health Summit	Youth & Adults	# of school districts engaged	One	5 school districts

Evidence Based Sources

www.sprc.org

Resource Commitment

Funding to maintain social media campaign and host annual summit

Key Community Partners

School Districts and students recruited as influencers

Initiative Name

Screening, Brief Intervention and Referral to Treatment for Substance Use Disorders

Population Served

Hospital patients in Emergency Room and Labor and Delivery

Long-Term Goal(s)/ Vision

Increase the hospital's identification and treatment of substance use disorders

Table 8. Strategies and Strategy Measures for Screening, Brief Intervention, and Referral to Treatment for Substance Use Disorders

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
Screen ED and Women and Children's patients for substance use and refer to treatment partners	Hospital ED and Women and Children's patients	# Of patients screened and in treatment	0	200 per year
Build community partners providing mental health and substance use services	Inpatient and outpatient providers	# Of community partners treating patients	1	3
Improve emergency room psychiatric interventions	Adults and youth in acute crisis	Average length of stay of Psychiatric patients in the ED	5 days	3

Evidence Based Sources

www.samhsa.gov

Resource Commitment

Funding of staff trained to conduct screenings, refer patients, and provide patient navigation

Key Community Partners

Hospital departments, Vituity physicians, community partners providing substance treatment services, operation of Arrowhead Regional Medical Center's Behavioral Health Transfer Center

COMMUNITY NEED ADDRESSED #3: HOMELESSNESS & AFFORDABLE HOUSING

Initiative Name

Homelessness Solutions

Population Served

Persons who are housing insecure, housing burdened and those in a state of chronic homelessness

Long-Term Goal(s)/ Vision

A community reducing its number of chronic homeless and expanding the availability of affordable housing to its workforce

Table 9. Strategies and Strategy Measures for Homelessness Solutions

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
Reduce number of administrative days for persons experiencing homelessness by use of a homeless care navigator	Patients experiencing homelessness treated at hospital or outpatient physician offices	# of administrative days	TBD	Current number minus 25%
Community coalition advocating for expanding housing and pro housing policies	Families with low and very-low incomes	# of low and very low income new housing units developed	0	100 New Housing “under construction” in old town Victorville
		# of pro affordable housing policies	0	3
Support the City of Victorville’s Homeless Task Force and County’s Desert Region Steering Committee to open the Victorville Wellness Campus	People experiencing chronic homelessness	Campus open	0	1 center operational
Senior Housing in Apple Valley	Seniors on limited income	# of projects approved	0	Town approved 1 project

Evidence Based Sources

www.navigationroundtable.org

www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Resource Commitment

Funding for patient navigator, Senior Housing project, homeless coalition

Key Community Partners

County of San Bernardino, City of Victorville, Town of Apple Valley, resident housing advocates, non-profit housing partners, Housing Authority of San Bernardino, Inland Empire Health Plan

COMMUNITY NEED ADDRESSED #4: OBESITY

Initiative Name

Cal Fresh Healthy Living in the High Desert

Population Served

Engage the community, food system and health providers to improve healthy food access to residents with emphasis on persons eligible for Cal Fresh benefits, physician partners screening patients for food as a social determinant of health and improving local access to healthy foods serving the community.

Long-Term Goal(s)/ Vision

Bringing together the medical and food systems to better serve patients and the community's access to healthy foods.

Table 10. Strategies and Strategy Measures for Cal Fresh Health Living in the High Desert

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
Recruit four health partners to screen patients for food insecurity	Adult and youth patients	# of health partners	1	4
Increase Cal Fresh eligible residents enrolled in program	People with low incomes	# of persons enrolled	2,600	3,000
Referrals for food resources by physician partners	People with low incomes	# of referrals	0	100
Expand access to USDA Summer Meals	Youth with low incomes	# of sites providing meals	9	15

Evidence Based Sources

www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

www.wp.sbcounty.gov/wp-content/uploads/sites/7/2018/01/Food-Security-and-Obesity-in-SanBernardino-County-2017-pdf

Resource Commitment

Staff and funding to implement campaign engaging physicians, food system, residents, and schools

Key Community Partners

County Department of Public Health Nutrition Department, St. Mary High Desert Medical Group, Physicians, FQHC clinics, local schools, Community Health Action Network

Other Community Benefit Programs and Evaluation Plan

Table 11. Other Community Benefit Programs in Response to Community Needs

Initiative (Community Need Addressed)	Program Name	Description	Population Served (Low Income, Vulnerable or Broader Community)
Maternal Infant Health (Access to care)	Lactation Services	Lactation consultants support every mother’s infant feeding needs including home visit follow-up	Broader Community
Workforce Development (Economic insecurity)	Health Career Pipeline	College nursing students and high school students engaged in health careers	Broader Community
Food donations (Obesity and nutrition)	Food donations	Donations of hospital food to shelters and feeding programs	Low Income

2021- 2023 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the Providence St. Mary Medical Center Community Health Committee of the hospital on October 20, 2021. The final report was made widely available by December 28, 2021.

 10-20-2021

Randall Castillo
Chief Executive
St. Mary Medical Center
Date

 10-20-2021

Paul Gostanian
Chair, St. Mary Medical Center Community Health Committee
Date

 12-17-2021

Justin Crowe
Senior Vice President, Community Partnerships
Providence
Date

CHNA/CHIP Contact:

Judy Wagner
Chief Mission Integration Officer
Providence St. Mary Medical Center
18300 Highway 18
Apple Valley, CA 92307
Judy.Wagner@stjoe.org

To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Improvement Plans please email CHI@providence.org.