

# COMMUNITY HEALTH IMPROVEMENT PLAN 2020 - 2022

## St. Mary Medical Center



City recognition of St. Jude Neighborhood clinic expanding services in Adelanto and Victorville, CA

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To provide feedback about this CHIP or obtain a printed copy free of charge, please email Kevin Mahany at [Kevin.Mahany@StJoe.org](mailto:Kevin.Mahany@StJoe.org)



# CONTENTS

Executive Summary.....	3
Community Health Improvement Plan Priorities.....	3
Introduction .....	5
Mission, Vision, and Values.....	5
Who We Are.....	5
Our Commitment to Community.....	5
Health Equity.....	6
Our Community.....	7
Description of Community Served .....	7
Community Demographics .....	8
Community Needs and Assets Assessment Process and Results.....	9
Significant Community Health Needs Prioritized.....	9
Needs Beyond the Hospital’s Service Program.....	10
Community Health Improvement Plan .....	11
Summary of Community Health Improvement Planning Process .....	11
Addressing the Needs of the Community: 2020- 2022 Key Community Benefit Initiatives and Evaluation Plan.....	12
Other Community Benefit Programs and Evaluation Plan .....	15
2020- 2022 CHIP Governance Approval.....	16

# EXECUTIVE SUMMARY

Providence St. Joseph Health (PSJH) continues its Mission of service in the High Desert through St. Mary Medical Center (SMMC). SMMC is an acute-care hospital with 213 licensed beds, founded in 1956 and located in Apple Valley, California. The hospital's service area includes a population of 373,422 people and makes up 17% of San Bernardino County.

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 2019, the hospital provided \$15,736,191 in Community Benefit in response to unmet needs.

SMMC conducts a Community Health Needs Assessment (CHNA) in the communities it serves every three years to better understand the health-related needs and strengths. 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 to identify community needs. The community information collected includes state and national public health data; community resident and stakeholder survey findings from the Department of Public Health, County of San Bernardino, Community Vital Signs; and hospital utilization data.

## Community Health Improvement Plan Priorities

As a result of the findings of the [2019 Community Health Needs Assessment \(CHNA\)](#) and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, SMMC will focus on the following areas for its 2020-2022 Community Benefit efforts:

### PRIORITY 1: ACCESS TO CARE

Lack of primary and specialty care continues to challenge the region, especially smaller and rural communities. We will be creating awareness of current services and advocate with residents to increase and provide new services and outreach to under-resourced neighborhoods. We will improve the coordination of community clinics to more effectively serve the community including, rural communities and Black, Brown, Indigenous, and People of Color (BBIPOD). Expanded access shall include dental care and expansions in health services provided at local schools.

### PRIORITY 2: MENTAL HEALTH AND SUBSTANCE USE

Mental Health and substance use continue to be a priority across our communities. Mental health challenges can impede people's ability to realize their potential, cope with stresses, work productively and fruitfully, and make contributions to their communities. We will be working on creating awareness and education campaigns regarding mental health and substance use, particularly amongst the Latino/a population, and ultimately bringing resources that address these in a meaningful and dignified way. We will continue working with local schools developing student led mental health campaigns. We will partner to raise awareness of good mental health, wellness and suicide prevention. Our work with schools will examine ways to improve reaching BBIPOC children and those whose families have low incomes.

### 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. We will be working to reduce chronic homelessness, support the number of persons entering housing, and strengthen affordable housing policies in the 2021-2028 housing element plans. This work will include working with residents with low incomes who have been disproportionately hurt by failures to build low cost housing.

### PRIORITY 4: OBESITY

Addressing access to healthy foods, creating more active communities and addressing high rates of obesity and diabetes will continue to be work led in partnership with the County of San Bernardino Department of Public Health. Creating opportunities for physical activity and nutrition education will continue in partnership with city park and recreation staff. Advocating for grocery stores, parks, sidewalks and improved streets will continue in communities with low incomes.

# INTRODUCTION

## Mission, Vision, and Values

*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

## Who We Are

St. Mary Medical Center (SMMC) is an acute-care hospital founded in 1956 and located in Apple Valley, CA. The hospital has 213 licensed beds, 213 of which are currently available, and a campus that is approximately 35 acres in size. SMMC has 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

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 2019, the hospital provided \$15,736,191 in Community Benefit<sup>1</sup> in response to unmet needs. Many other health care providers also serve the region, including Desert Valley Hospital, Kaiser Permanente High Desert/Victorville, Victor Valley Global Medical Center, Borrego Federally Qualified Health Center (FQHC), and Mission FQHC.

SMMC further demonstrates organizational commitment to the Community Health Needs Assessment (CHNA) and Community Benefit through the allocation of staff time, financial resources, and

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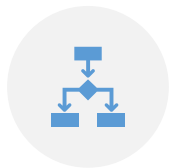
<sup>1</sup> A community benefit is an initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives: a. Improves access to health services; b. Enhances public health; c. Advances increased general knowledge; and/or d. Relieves government burden to improve health. Note: Community benefit includes both services to the economically poor and broader community. To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following: 1) community health needs assessment developed by the ministry or in partnership with other community organizations; 2) documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; 3) or the involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

participation and collaboration to address community identified needs. The Regional Director of Community Health Investment for Southern California – PSJH and Director of Community Health Investment are responsible for ensuring the compliance of Federal 501r requirements, as well as providing the opportunity for community leaders and internal hospital leadership, physicians, and others to work together in planning and implementing the resulting Community Health Improvement Plan (CHIP).

## 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 what 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 hospitals will implement when completing a CHIP. These practices include, but are not limited to the following:



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



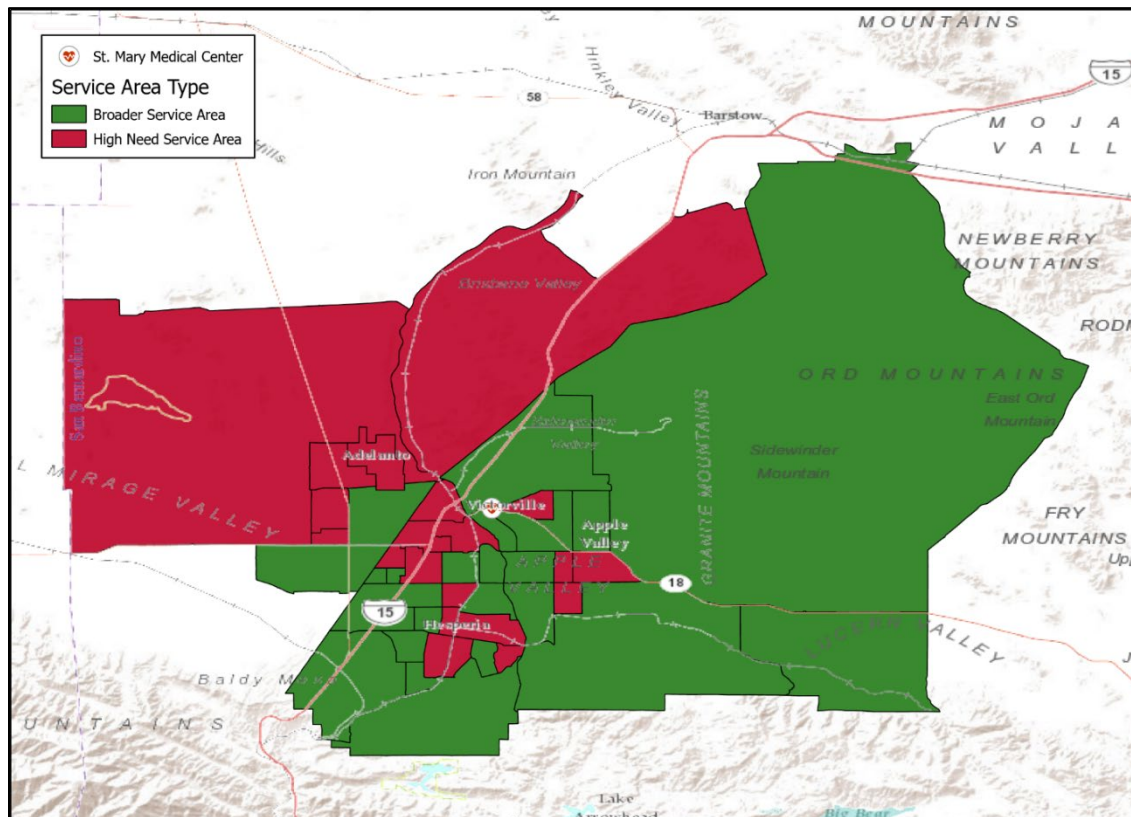
Leverage community strengths

# OUR COMMUNITY

## Description of Community Served

SMMC provides High Desert communities with access to advanced care and advanced caring. The hospital's service area includes census tracts inside the cities of Adelanto, Apple Valley, Helendale, Hesperia, Lucerne Valley, Phelan, Oro Grande, and Victorville. This is inclusive of a population of approximately 375,000 people and represents District 1 of the County's Public Health Community Vital Signs project.

**Figure 1. Mary Medical Center Total Service Area**



Of the over 370,000 permanent residents in the total service area, 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 in the total service area. For reference, 200% FPL is equivalent to an annual household income of \$51,500 or less for a family of 4. These households are more likely to regularly make spending tradeoffs regarding utilities, rent, groceries, medicine, and other basic expenses.

Adelanto in its entirety is designated as a high need service area, as well as some sections of Apple Valley, Hesperia, and Victorville.

## Community Demographics

### POPULATION AND AGE DEMOGRAPHICS

The population in the High Desert total service area makes up 17% of San Bernardino County. The high need service area has a higher percentage of people under 34 years compared to the broader service area.

### POPULATION BY RACE AND ETHNICITY

Individuals who identify as Hispanic, “other” race, and Black are more likely to live in high need census tracts. People identifying as Asian and white are less likely to live in high need census tracts.

### SOCIOECONOMIC INDICATORS

**Table 1. Socioeconomic Indicators for St. Mary Medical Center Service Area**

Indicator	High Desert Broader Service Area	High Desert High Need Service Area	High Desert Total Service Area	San Bernardino County
<b>Percent of Population Below 200% Federal Poverty Level</b> Data Source: American Community Survey Year: 2019	35.9%	59.8%	46.3%	40.0%
<b>Median Income</b> Data Source: American Community Survey Year: 2019	\$61,846	\$41,164	\$52,995	\$60,761
<b>Percent of Renter Households with Severe Housing Cost Burden</b> Data Source: American Community Survey Year: Estimate based on 2013-2017 data	25.7%	35.3%	31.1%	28.7%

The population in SMMC’s service area is more likely to be at or below 200% Federal Poverty compared to San Bernardino County overall, including nearly 60% of households in the high need service area.

The median income in the SMMC service area is almost \$8,000 lower than that of the county overall. The median income for households in the high need census tracts are approximately \$20,000 lower than the broader service area.

Severe housing cost burden represents households that spend 50% or more of their income on housing costs. A slightly greater proportion of renter households are severely housing cost burdened in SMMC’s service area compared to San Bernardino County. On average, about 31% of households in the total service area are severely housing cost burdened. In the high need service area, 35% of renter households are severely housing cost burdened, compared to 26% in the broader service area.

**Full demographic and socioeconomic information for the service area can be found in the [2019 CHNA for St. Mary Medical Center](#).**



# COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

## Significant Community Health Needs Prioritized

The list below summarizes the rank ordered significant health needs identified through the 2020 Community Health Needs Assessment process:

### PRIORITY 1: ACCESS TO CARE

*Creating awareness of current services and advocating with residents to increase or bring new services and outreach to under-resourced neighborhoods.*

The Challenge: The High Desert has many under-resourced communities and residents experiencing a variety of barriers to accessing both primary and specialty care. Noted barriers include a lack of health literacy, cost of care, lack of local public transportation, and insufficient dental providers.

Our Vision: That the residents of the High Desert living in communities with low incomes know how to connect with resources needed for themselves, their family and their neighbors and advocate for needed services.

### PRIORITY 2: MENTAL HEALTH

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

The Challenge: People living with mental health challenges need to be connected to resources in a timely manner, just as with any other medical emergency.

Our Vision: We recognize that a person is mind, body and soul. Mental health is an integral part of the well-being of a person. By creating awareness and services addressing mental health, along with substance use, we will see the betterment of individuals, families and neighborhoods.

### PRIORITY 3: HOMELESSNESS & AFFORDABLE HOUSING

*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.*

The Challenge: Local communities do not have adequate support service and housing to meet the needs of people experiencing homelessness.

The Vision: Develop a community supported campaign that expands services and shelter to people experiencing homelessness, expands the availability of housing, and improves the quality of health services provided to people experiencing homelessness. Homeless prevention and the development of affordable housing initiatives are important strategies to reduce 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.*

The Challenge: Obesity is related to many other health problems including diabetes, heart disease, knee problems, and more. Many illnesses can be alleviated by addressing an individuals' unhealthy weight.

The Vision: A neighborhood where the healthy choice is the easiest choice. If a family wants to do exercise or eat healthy together, living in a neighborhood that offers these opportunities can make this a reality.

As we develop the Community Health Improvement Plan (CHIP), we will integrate prevention and addressing racial disparities as a cornerstone of each of the priority areas.

## Needs Beyond the Hospital's Service Program

No hospital facility can address all of the health needs present in its community. We are committed to continuing our Mission through implementing county nutrition grants as well as mental health grants.

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

- Cancer: Given other priorities, this issue was not selected.
- Diabetes: Local Federally Qualified Health Centers provide primary medical care to residents with low incomes who have diabetes.
- Early Childhood Education: Given other priorities, resource constraints, and lack of expertise to offer this program, this issue was not selected.
- Economic Mobility: Given other priorities, resource constraints and lack of expertise to offer this program, this issue was not selected.
- Environment/Climate: [Providence St. Joseph Health has committed to being carbon negative by 2030](#). This effort will involve all hospital staff. The Regional Director, Community Health Investment has been appointed to the System Environmental Justice Work Group.
- Food Security: Local food programs include the High Desert Food Collaborative and the High Desert Second Chance Food Bank.
- Senior Health: Given other priorities raised during our most recent CHNA, this issue will be addressed by the hospital's partner St. Mary High Desert Medical Group.

In addition, St. Mary Medical Center will collaborate with local 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

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 Benefit Committee.

The 2020-2022 Community Health Improvement Plan (CHIP) process was disrupted 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 2019 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. This CHIP will be updated in 2021 to better document the impact of and our response to COVID-19 in our community. 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.

St. Mary Medical Center 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: 2020- 2022 Key Community Benefit Initiatives and Evaluation Plan

## PRIORITY #1: ACCESS TO CARE

### Community Need Addressed

Improve access of health services to rural populations and people experiencing vulnerability, particularly those with low incomes, those experiencing homelessness, and those with complex health and/or social needs.

### Goal (Anticipated Impact)

Expanded services to rural populations and people experiencing vulnerability, particularly those with low incomes, those experiencing homelessness, and those with complex health and/or social needs.

### Outcome Measure

- Hospital and Medical Group services supporting rural communities
- Clinic partners providing services to people with low incomes and people experiencing homelessness
- Providing navigation to patients with complex health and/or social needs

**Table 2. Strategies for Addressing Access to Care**

Strategy	Target Population
1. Develop a plan to expand access to clinical services	Youth, families, older adults
2. Assess rural communities for health and social services	Students, adults and older adults
3. Implement a navigator for the hospital Emergency Department	Patients with low incomes
4. Support St. Jude Neighborhood Clinic	Inland Empire Health Plan members; patients that are uninsured and/or undocumented

### Planned Collaboration

Key community partners: Snowline School District, Snowline Community Cabinet, St. Mary High Desert Medical Group, St Jude Neighborhood Clinic, Borrego Health, Symba Health, San Bernardino County Department of Public Health, San Bernardino County Department of Behavioral Health, City of Victorville, San Bernardino County Office of Homeless Services, Revive Our Old Town (ROOT) Institute For Public Strategies, San Bernardino County Cal-Fresh program; City of Victorville’s Homeless Task Force, Illumination Foundation.

### Resource Commitment

\$100,000 each year to develop then implement and report on providing health services to rural communities and vulnerable populations

## PRIORITY #2: MENTAL HEALTH AND SUBSTANCE USE

### *Community Need Addressed*

Mental health and substance use care

### *Goal (Anticipated Impact)*

Improve mental health treatment for youth, adults and people with a substance use disorder

### *Outcome measure*

- Implementation of a student led Work2BeWell campaign in High Desert schools
- Improved care for youth and adults in mental health crisis
- Implementation of a mental health stigma reduction campaign with community partners

**Table 3. Strategies for Addressing: Mental Health and Substance Use Care**

<b>Strategy</b>	<b>Target Population</b>
<b>1. Implement Work2BeWell and Mental Health First Aid where the # of student-led events are reported along with Care Solace services to students seeking therapy</b>	Students and young adults
<b>2. Improved Emergency Room care for patients where length of stay is reduced and the # of youth “connected to therapy” is reported</b>	Youth and adults
<b>3. A stigma reduction campaign launched with support of public and private partners</b>	Youth and adults

### *Planned Collaboration*

Key Community Partners: Hesperia and local school districts; Work2BeWell/Providence Health, St. John of God Healthcare, Snowline School District, Victor Valley College, San Bernardino County Department of Behavioral Health, Providence Health’s Behavioral Health Institute, Mind OC, Stigma Free OC, Every Mind Matters, Inland Empire Health Plan, Desert Mountain Children’s Center, Life Skills Awareness, Ron Powell Consultants, High Desert Homeless Services, Illumination Foundation, City of Victorville, National Alliance for Mental Illness – Inland Valley, St. Mary High Desert Medical Group, Kaiser Permanente’s Fontana Community Benefit program and Main Street Hesperia Mental Health Clinic.

### *Resource Commitment*

\$150,000 each year to develop, implement and report progress on each strategy

### PRIORITY #3: HOMELESSNESS AND AFFORDABLE HOUSING

#### *Community Need Addressed*

Increase in homelessness and a lack of affordable housing

#### *Goal (Anticipated Impact)*

Reduce chronic homelessness, support City of Victorville developing a comprehensive campus to address homelessness which will include housing, health and social services and expand the availability of affordable housing to populations with low incomes.

#### *Outcome measure*

- “Bend the curve” in local growth of chronic homelessness as reported in annual Point in Time Counts
- Open a City of Victorville wellness campus where shelter and healthcare replace unsheltered living, and begin care navigation to support access to appropriate services
- Launch a housing campaign including training of residents to expand access of affordable housing as proposed in local city housing plans for 2021-2028.

**Table 4. Strategies for Addressing: homelessness and affordable housing**

<b>Strategy</b>	<b>Target Population</b>
<b>1. Implement a homeless navigator position for the hospital</b>	People experiencing chronic homelessness
<b>2. Support development of a wellness campus for people experiencing homelessness by the City of Victorville to include recuperative care and mental health and social services</b>	People experiencing chronic homelessness
<b>3. Develop a housing campaign in Apple Valley and Victorville with trained residents advocating for affordable housing</b>	Families with low incomes

#### *Planned Collaboration*

Key Community Partners: City of Victorville Homeless Taskforce, San Bernardino County Office of Homeless Services, GIPS, The Family Assistance Program, Inland Empire Health Plan, Loma Linda Medical Center, Wells Fargo Bank, Habitat for Humanity, Town of Apple Valley, Housing and Community Development, City of Victorville Planning Department.

#### *Resource Commitment*

\$100,000


## Other Community Benefit Programs and Evaluation Plan

**Table 5. Other Community Benefit Programs in Response to Community Needs**

<b>Initiative (Community Need Addressed)</b>	<b>Program Name</b>	<b>Description</b>	<b>Target Population</b>
1. Food insecurity screenings	Cal Fresh Program	Conduct food insecurity screenings in a health care setting	Patients with low incomes and experiencing food insecurity
2. Lack of parks and walkable neighborhoods	Adelanto Active Transportation Plan and Safe Routes to Schools	Partner with Adelanto schools and neighborhoods to improve neighborhood walkability and increase number of parks	Adelanto residents
3. Food insecurity	High Desert Second Chance, Christ The Good Shepard Church	Providing food to people with low incomes	People with low incomes

## 2020- 2022 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the St. Mary Medical Center Community Benefit Committee on December 9, 2020. The final report was made widely available<sup>2</sup> by December 28, 2020.

  
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December 9, 2020  
Randall Castillo  
Date  
Chief Executive, St. Mary Medical Center

  
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December 9, 2020  
Paul Gostanian  
Date  
Chair, St. Mary Medical Center Community Benefit Committee

  
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December 14, 2020  
Joel Gilbertson  
Date  
Executive Vice President, Community Partnerships  
Providence St. Joseph Health

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To request a paper copy without charge, provide feedback about the CHNA or CHIP Reports, or any additional inquiries, please email [CHI@providence.org](mailto:CHI@providence.org). Appendices

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<sup>2</sup> Per § 1.501(r)-3 IRS Requirements, posted on hospital website