2024 - 2026

COMMUNITY HEALTH IMPROVEMENT PLAN

Providence St. Mary Medical Center

Apple Valley, CA

To provide feedback on this CHIP or obtain a printed copy free of charge, please email Erica Phillips at erica.phillips2@providence.org.

Providence

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EXECUTIVE SUMMARY

Providence continues its mission of service in the High Desert through Providence St. Mary Medical Center. St. Mary Medical Center is an acute-care hospital founded in 1956 and located in Apple Valley, CA. The hospital's service area is the High Desert Region located in San Bernardino County, including, 419,075.

St. Mary Medical Center dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of people experiencing social inequities and health disparities. The Community Health Needs Assessment (CHNA) is an opportunity for St. Mary Medical Center 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 interviews with community stakeholders and community well-being surveys, and hospital utilization data.

Community Heath Improvement Plan Priorities

As a result of the findings of our 2023 CHNA and through a prioritization process aligned with our mission, resources, and hospital strategic plan, St. Mary Medical Center will focus on the following areas for its 2024-2026 Community Benefit efforts:

ACCESS TO CARE: One in five community members/ key informants surveyed as part of the CHNA process, indicated inadequate access to care is impacting the health of their community members and stakeholders. A key measure of health in any community is access to health care services, specifically access to quality care in a timely manner. The availability of health care providers directly impacts the community's ability to obtain timely care primary and specialized health services when a need is recognized. In addition to provider access, other factors impacting obtainment of care when needed for individuals with/without a medical home include: (1) health insurance coverage and type; (2) cost of care; (3) health literacy; (4) fear, mistrust and poor treatment; (5) transportation; and (6) technological limitations for telemedicine use.

BEHAVIORAL HEALTH: Like other communities with significant health disparities and high rates of poverty, mental health is a serious concern. Substance misuse and mental health were identified to be the top health problems in their community among individuals surveyed and interviewed. Social and emotional support is crucial for navigating the daily challenges of life. According to the Substance Abuse and Mental Health Services Administration, "mental health problems and substance use disorders sometimes occur together. This is because: (1) certain substances can cause people with an addiction to experience one or more symptoms of a mental health problem; (2) mental health problems can sometimes lead to alcohol or drug use, as some people with a mental health problem may misuse these substances as a form of self-medication; and (3) mental health and substance use disorders share some underlying causes, including changes in brain composition, genetic vulnerabilities, and early exposure to stress or trauma." Issue with substance abuse are more likely to occur with individuals depression, anxiety disorder, schizophrenia, and personality disorder.[1]

CHRONIC DISEASE PREVENTION & TREATMENT: As previously mentioned, communities with high rates of poverty and health disparities is a significant concern. Income influences the types opportunities and resources an individual has available to purchase healthy foods, secure access to housing, transportation, health care services, and fulfill other basic needs. Beyond the availability of resources, an individual's behaviors that limit development and/or promote management of chronic health conditions are further compounded by the physical environment in which they live.

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

St. Mary Medical Center is an acute-care hospital founded in 1956 and located in Apple Valley, CA. The hospital has 231-licensed beds, a staff of more than 1,000, and professional relationships with more than 300 local physicians. Major programs and services offered to the community include the following: pediatrics, cardiology, family medicine, internal medicine, obstetrics, and more.

Our Commitment to Community

St. Mary Medical Center dedicates resources to improve the health and quality of life for the communities we serve. For more information on the resources invested to improve the health and quality of life for the communities we serve, please refer to our Annual Report to our Communities: https://www.providence.org/about/annual-report.

Heath Equity

At Providence, 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 are depicted in FIG 1 .

Planning for the Uninsured/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 St. Mary Medical Center has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients.

One way St. Mary Medical Center informs the public of FAP is 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.

FIG 1

Best Practices for Centering Equity in the CHIP

OUR COMMUNITY

Providence St. Mary Medical Center (SMMC) is located within the geographically largest county in the United States, San Bernadino County, that in 2023 had an estimated population of 2,195,611 people. Due to the aforementioned an alterative method was used to determine SMMC's primary service area by zip code. A zip code was identified to be within our primary service area (aka. high need area), if 70% or more inpatient admissions were received from a particular zip code during the preceding fiscal year. As such, the primary service area for SMMC are comprised of the following 13 zip codes (FIG. 2): Adelanto (92301), Apple Valley (92307 & 92308), Helendale (92342), Hesperia (92344 & 92345), Lucerne Valley (92356), Oro Grande (92368), Phelan (92371), Pinon Hills (92372) and Victorville (92392, 92394 & 92395).SEE FIG 2

Demographic Composition

The total population for the nine towns and cities that comprise SMMC'S service area (SA) in 2021, was estimated at 419,075. From 2000 to 2021, the SA's population experienced a 1.82-fold increase (or 189K) which is faster than the county (1.27-fold) and state (1.16-fold). Adelanto (2.05-fold), Victorville (1.98-fold), and Hesperia (1.59-fold) boasted the greatest population gains within the SA during this same time period. SEE TABLE 1

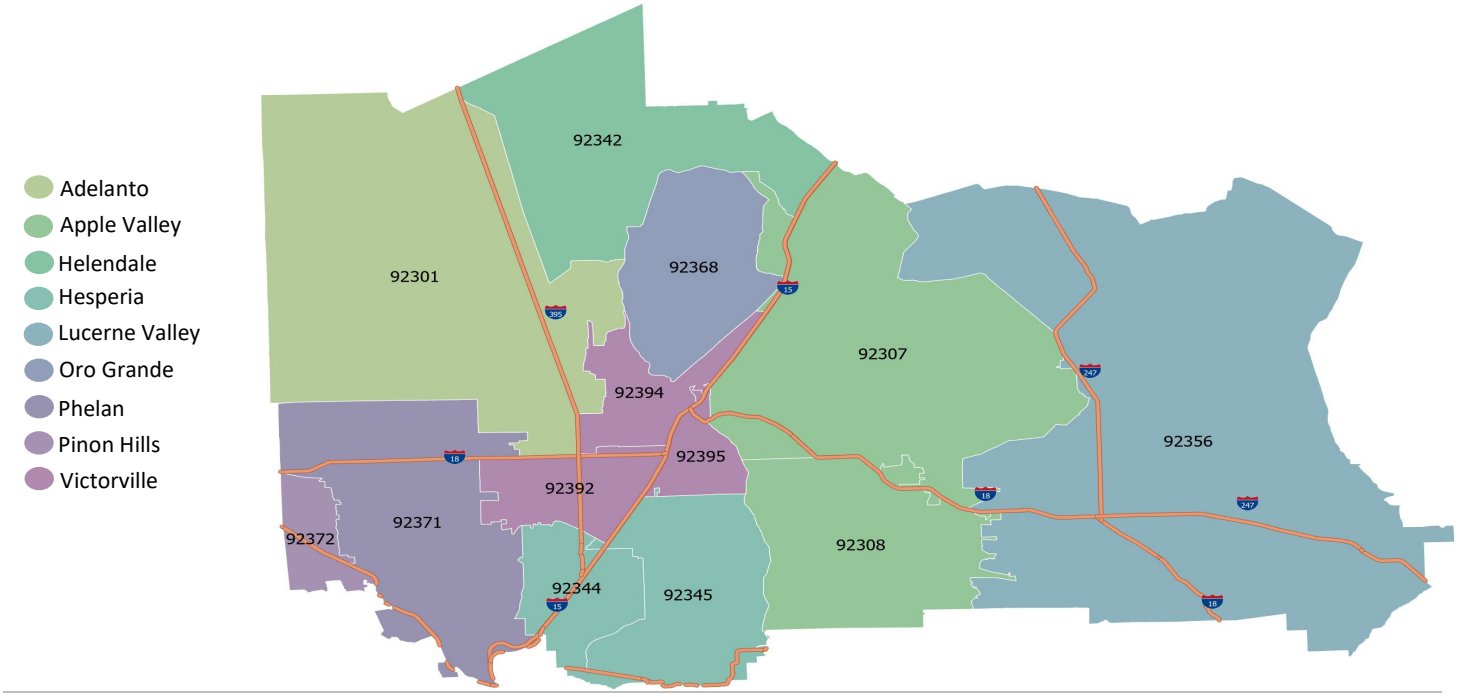
A Youthful Region

By 2030, the California Department of Finance estimates one in four Californians will be 60 years and older.[2] Despite this, the SA is aging at a slower rate evident by the:

- 11.8% individuals 65 years and older compared to the state (14.4%),
- 29.7% of individuals aged 0-17 compared to county (26.4%) and state (22.8%), and
- median age falling below the state (37 yrs.) apart from Lucence Valley (40.2 yrs.) and Helendale (42.1 yrs.) in 2021.

FIG 2

Primary Service Area By Zip Code



Diversification

Overall, the SA is more diverse compared to the state, as:

- 42.9% are Latinx (vs. 39.5%),
- one in four are White (vs. 1 in 3),
- the proportion of Multiracial individuals at 10.5% is 3.25-times greater, and
- 0.9% are American Indian/Alaska Native (vs. 0.3%).

The proportion of Black (7.6%) and Native Hawaiians/Pacific Islanders (0.2%) within the SA are consistent with the county, while the Asian population at 2.7% falls below the county (7.3%) and state (14.7%).

The most homogenous localities within the SA are Apple Valley, Helendale, Lucerne Valley, Phelan, and Pinon Hills for at least one in two residents are White (non-Latinx). Conversely, Victorville and Adelanto have the most heterogeneousness population with at least one in two are Latinx and three in twenty are Black. Lastly, Helendale and Oro Grande at 12% has the largest Multiracial population within the SA.

Age: Among individuals 24 years and younger, half are Latinx. Conversely, nearly one in two adults aged 55 years and older are White. More than two and five individuals of prime working age are Latinx. When examining the median age and race/ethnicity within the SA, the:

- White population, apart from Apple Valley (49.3 yrs.) and Helendale (55.4 yrs.), have median age below the county's (45.2 yrs.).
- Asian population is consistently the oldest, with a median age exceeding the county (39.3 yrs.) by 2.1-28.8 years.
- Multiracial population in Pinon Hills has the lowest median age at 11.6 years.

Language Spoken: The languages spoken in our SA also reflects its diversity. Approximately, 34.3% of individuals aged 5 years and older speak English less than very well compared to 15% of the county. Among individuals with limited English proficiency, nearly nine in 10 speak Spanish with the remainder speaking Asian and Pacific Islander languages in the home. SEE TABLE 2

Socioeconomic Factors

Between 2017-2021, the proportion of individuals living in poverty within the SA at 16.4% was higher than both the San Bernardino County (14.3%) and California (12.3%) benchmark. At 2.72-times the San Bernardino County benchmark, Lucerne Valley has the highest concentration of poverty followed by Oro Grande and Adelanto. Nearly a quarter of the population for whom poverty status was determined are among individuals under the age of 18. By age group, Lucerne Valley has a disproportionate share of its population that are impoverished with the proportion of all age groups at least 2.2-times greater than their respective San Bernardino County benchmarks. SEE TABLE 2

Conversely, Helendale and Pinon Hills have the least proportion of its population living in poverty by race, ethnicity, and age group. Almost one in two AIAN within the SA are improvised with the greatest concentration found in Lucerne Valley (100%), Apple Valley (90.4%) and Adelanto (87.6%). Despite only comprising 7% of the population, almost one in three Black residents within the SA are 200% below the federal poverty level.

Disparities in Median Household Income: When examining the median household income by zip code, only two areas (92342 [$81,861] and 92344 [$90,560]) exceeded the San Bernardino benchmark of $70,287; however, greater variation among census tracts were observed. SEE TABLE 2

Table 1: Community Demographics– Population Estimates, Age, Race & Ethnicity

Location	Zip Code	Population Estimates	Median Age (yrs.)	0-17 years	18-64 years	65 years & older	White	Black	American Indian/ Alaska Native	Asian	Native Hawaiian & Other Pacific Islander	Some Other Race	Multiracial	Latinx (any race)
Adelanto	92301	37,571	28.2	33.22%	60.8%	5.94%	44.38%	17.11%	10.84%	1.45%	0.45%	14.73%	21.04%	67.36%
Apple Valley	92307	40,604	36.5	27.07%	58.5%	14.4%	68.72%	6.67%	1.38%	3.47%	-	6.71%	13.01%	38.89%
	92308	43,079	37.0	29.62%	52.6%	17.79%	70.88%	6.22%	0.35%	2.83%	0.51%	8.2%	11.01%	38.82%
Helendale	92342	6,347	42.1	21.1%	59.3%	19.6%	66.99%	7.45%	-	3.15%	-	5.75%	16.65%	25.54%
Hesperia	92344	20,768	33.6	26.62%	62.9%	10.5%	65.48%	2.33%	0.37%	5.5%	0.29%	13.16%	12.86%	62.47%
	92345	87,994	33.1	30.34%	58.2%	11.5%	72.33%	3.77%	0.98%	1.8%	0.18%	10.94%	10%	59.97%
Lucerne Valley	92356	6,901	40.9	25.43%	56.2%	18.42%	71.54%	3.16%	1.48%	1.93%	0.16%	10.35%	11.39%	39.91%
Oro Grande	92368	1,017	32.9	31.66%	57.4%	10.91%	56.83%	2.36%	0.39%	4.62%	-	11.9%	23.89%	47.3%
Phelan	92371	21,123	33.5	28.64%	61.4%	10%	76.03%	1.05%	1.53%	2.14%	0.42%	5.03%	13.8%	42.47%
Pino Hills	92372	5,701	30.1	30.61%	53.1%	16.24%	78%	-	-	7.3%	0.75%	3.61%	10.33%	33.49%
Victorville	92392	61,014	32.3	31.51%	58.5%	10.02%	55.65%	14.19%	1.67%	5.12%	0.26%	11%	12.1%	53.34%
	92394	39,540	31.0	30.05%	61%	8.9%	42.75%	19.22%	1.68%	3.93%	0.09%	16.84%	15.48%	56.8%
	92395	47,416	33.6	28.79%	58%	13.1%	59.1%	12.26%	1.22%	4.03%	0.24%	11.92%	11.24%	52.36%
San Bernardino County		2,171,071	33.8	26.44%	62%	11.56%	50.72%	8.02%	1.08%	7.5%	0.32%	19.95%	12.41%	54.58%
California		39,455,353	37.0	22.79%	62.8%	14.37%	52.09%	5.66%	0.91%	14.92%	0.38%	15.3%	10.73%	39.52%
Source:		U.S. Census —American Community Survey, Table DP05, 2017 - 2021 Estimate												

When coupling race/ethnicity with zip code, the following had a median income greater than the county benchmark in 2021:

- Black households in zip code 92368 [$115,883],
- AIAN households in zip code 92301 [$73,567], 92345 [$83,320], and 92395 [$74,583];
- Asian households in zip code 92307 [$83,235], 92308 [$78,618], and 92392 [$86,475];
- Multiracial households in 92307 [$85,212] and 92392 [$73,860];
- White (non-Latinx) households in zip code 92307 [$77,690], 92342 [$83,289], 92344 [$96,111], 92392 [$75,086], and 92394 [$70,554]; and
- Latinx households in zip code 92307 [$77,690], 92342 [$83,289], 92344 [$96,111], 92392 [$75,086], and 92394 [$70,554].

The U.S. Bureau of Labor Statistics Consumer Price Index Calculator is used to determine the change in the buying power of the U.S. dollar during a specified time period for things like rent, food and other cost of living expenses.[3] From 2011 to 2021, both Asian [-$6,113] and Black [-$3,251] households in San Bernardino County experienced diminished buying power compared to other races. By zip code households in the following saw their buying power decline: 92307(-$2,075), 92345 (-$2,928), 92392 (-$6,658), and 92395 (-$450) during this same time period.

Rising Housing Costs: Affordable, quality, safe, and stable housing have a critical impact on an individual's health and well-being; particularly among those that are chronically homeless, have a chronic disease, and/or behavioral health condition.[4] When asked "What are the three(3) things most important to improve the health & well-being of people where you live?" low-crime and safe neighborhoods (16%) and homelessness and housing-affordability/quality (12%) were identified by community members/key informants. Housing shortages and high demand for available housing has resulted in persistent rising housing costs throughout California and within the SA. The lack of affordable housing can be observed in the:

- one in three homeowners with a mortgage residing in the SA except for portions of Apple Valley (92307), Hesperia (92344), Helendale, and Oro Grande that spend 30% of more of there monthly income on their mortgage; and
- more than one in two renters in the SA that pay 30% or more of their monthly income on housing costs, except for Helendale with one in four.

According to the sixth regional housing needs assessment (RHNA) conducted by the Southern California Association for Governments in 2021, a total of 24,373 housing units for various income levels in the High Desert are needed.[5] Each locality within the SA used RHNA to inform their state mandated 2021-2029 housing elements.

Full demographic and socioeconomic information for the service area can be found in the 2023 CHNA for Providence St. Mary Medical Center - Apple Valley.

Table 2: Community Demographics – Socioeconomic Indicators

Location	Zip Code	Median Household Income	Persons in Poverty	Children in Poverty	Seniors in Poverty	Severe Housing Cost Burden Homeowner	Severe Housing Cost Burden Renter
Adelanto	92301	$57,714	21.1%	27.8%	19%	31.1%	46.6%
Apple Valley	92307	$69,595	14.1%	18.7%	7%	24.3%	49.5%
	92308	$57,265	18.5%	28.9%	10.1%	25.3%	54.5%
Helendale	92342	$81,861	5.7%	-	6.9%	20.1%	18.5%
Hesperia	92344	$90,560	8.7%	5.6%	7.8%	22.7%	50%
	92345	$54,881	20.1%	25.8%	16.8%	29.8%	55.5%
Lucerne Valley	92356	$36,720	38.9%	55.6%	26.8%	28.7%	71.8%
Oro Grande	92368	$41,442	23.5%	33%	13.5%	11.8%	41.8%
Phelan	92371	$63,605	17.8%	21.3%	5%	24.4%	51.3%
Pino Hills	92372	$62,542	12.3%	11.3%	14%	24%	50.6%
Victorville	92392	$66,908	14.8%	20%	9.1%	24.9%	50.2%
	92394	$68,767	19.3%	27.2%	9.2%	30.6%	57.9%
	92395	$50,223	21.6%	30.5%	11%	29.75%	56.8%
San Bernardino County		$70,287	14.3%	19.7%	12%	27.5%	47.3%
California		$84,097	12.3%	16.2%	10.5%	29.2%	44.8%

Source: Census Bureau, American Community Survey (Table DP04), 2021 -5-year estimates

2023 CHNA PROCESS & RESULTS

Providence St. Mary Medical Center utilized the Association for Community Health Improvement and the American Hospital Association's Community Health Needs Assessment (CHNA) framework for this assessment, that is endorsed by the Centers for Disease Control.[6] The primary purpose of the CHNA completed by Providence St. Mary Medical Center is to share ownership in the health of our communities. The CHNA provides a snapshot of the health needs and strengths through review of available public health data sets and input from persons representing the broad interests of our service area. By better understanding the places where residents in our communities live, work, and play, we are able to identify the factors impacting health and develop a three-year strategy to improve future health outcomes.

Phase I: Pre-Planning

The initial work included identification of health system and community key informants in order to ensure alignment of health improvement efforts. The Community Health Investment Manager for Providence St. Mary Medical Center participates in health-focused community collaborative groups. The membership of these groups are comprised of local organizations for each of the respective communities and includes non-profits, health department, human service and other government agency representatives. Despite differences in the CHNA completion timelines among various community organizations within our SA, the Community Health Investment Manager for Providence St. Mary Medical Center aids in the completion CHNAs by other community organizations to establish mutual goals that will be used to enact comprehensive strategies in our shared service areas.

Phase II: Data Collection & Interpretation

In Phase II, a mixed methods approach was employed to better understand the health needs of our SA through collection of primary and secondary data. The data collected was integrated to generate common focus areas and health needs for our SA as a whole and on the county-level.

Primary Data: Input from people representing the broad and local communities (aka. key informants) for our SA was solicited. Additionally, to ensure any community benefit activities resulting from completion of this CHNA advance health equity, efforts were made to secure survey participation from low-income, medically underserved, and minority populations to understand the current health disparities.

Multiple attempts were made between 5/15/23 through 11/16/2023, resulting in completion of 471 surveys completed, along with 46 interviews conducted with key informants. For comparability of responses between community members and key informants, the Community Well-being Survey was orally administered to key informants during the interview process. For a summary of Community Input see the 2023 CHNA for Providence St. Mary Medical Center - Apple Valley.

Secondary Data: Over 100 public health indicators were collected to determine the demographics and health status of each location in our SA, where available. In gathering information on the communities served by Providence St. Mary, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. In addition, we recognize that there are often

geographic areas where the conditions for supporting health are poorer than nearby areas. Whenever possible and reliable, data are reported at census tract level. These smaller geographic areas allow us to better understand the neighborhood-level needs of our communities and better address inequities within and across communities.

For each health indicator, a comparison was made between the most recent available public data and benchmarks from the State of California, San Bernardino County, and Healthy People 2030 objectives. A health need was identified when an indicator failed to meet the state's comparative benchmark.

Data Limitations and Information Gaps: While care was taken to select and gather data that would tell the story of Providence St. Mary's SA, it is important to recognize the limitations and gaps in information that naturally occur, including the following:

- Not all desired data were readily available, so sometimes we had to rely on tangential or proxy measures or not have any data at all. For example, there is little community-level data on the incidence of mental health.
- While most indicators are relatively consistent from year to year, other indicators are changing quickly (such as percentage of people uninsured) and the most recent data available are not a good reflection of the current state.
- Reporting data at the county-level can mask inequities within communities. This can also be true when reporting data by race, which can mask what is happening within racial and ethnic subgroups. Therefore, when appropriate and available, we disaggregated the data by geography, and race/ethnicity.
- Data that are gathered through interviews and surveys may be biased depending on who is willing to respond to the questions and whether they are representative of the population as a whole.
- The accuracy of data gathered through interviews and surveys depends on how consistently the questions are interpreted across all respondents and how honest people are in providing their answers.

Data Interpretation: Each source used to collect data was synthesized to identify areas of need or focus areas. Focus areas were generated for the SA as a whole. Only focus areas jointly identified as an area of need by both community members and key informants, also identified in secondary data, were submitted to the Providence St. Mary's Community Health Committee for prioritization.

Phase III: Prioritization Process

The process of identifying and prioritizing health needs to determine the focus areas for our Community Health Improvement Plan occurred in three stages. During stage one, a review of public health data sets (secondary data) and survey results (primary data) was executed to identify potential health needs.

All health needs identified during stage one of the prioritization process, were then subjected to the Hanlon Method for further prioritization (stage two). The National Association of County and City Health Officials recognize the Hanlon Method for its effectiveness in prioritizing complex health needs.[7] The Hanlon Method uses a quantitative technique to rate health needs. FIG 2 shows the results of the Hanlon Method. Each health need on a scale from zero through 10 is assigned a rate based on the following criteria: (1) size of the health need, (2) seriousness of health need, and (3) perceived

community importance. Thereafter, a priority score was calculated for each health need. Each health need was then ranked by priority score, highest to lowest.

After completion of the Hanlon Method, the six health needs were presented to Providence St. Mary's Community Health Committee for approval. As many of the health needs (cancer, diabetes, cerebrovascular & cardiovascular health, obesity and respiratory health) have the same common modifiable and intermediate risk factors, the Community Health Committee agreed to focus on chronic disease prevention and treatment. On November 28, 2023 the Community Health Committee approved the following three focus areas: (1) access to care, (2) behavioral health, and (3) chronic disease prevention and treatment.

Alignment with Others: To ensure alignment with local public health improvement processes and identified needs, we reviewed the needs of other publicly available sources that engaged the community in setting priorities, including the Community Vital Signs assessment conducted by the San Bernardino County Department of Public Health in 2020 and 2023. For comparability, several question (question 5 and 6) included in our Community Well-Being Survey were taken from the Community Vital Signs Survey. Additionally, the Community Health Investment Department participated in prioritization and implementation events held by the Department of Public Health to seek alignment. The 2023 Community Vital Signs assessment selected the following priority health needs that will be the focus of their community transformation plan still underdevelopment (as of 4/30/2024) behavioral health, chronic disease, injury prevention and violence prevention.

FIG 2

Hanlon Method Prioritization Results

	SIZE OF HEALTH PROBLEM (A)	SERIOUSNESS OF HEALTH PROBLEM (B)	PERCIEVED COMMUNITY IMPORTANCE (C)	PRIORITY SCORE (D)
DIABETES	8.5	9 *Very Serious*	7 *Relatively Important*	186
BEHAVIORAL HEALTH	8	10 *Very Serious*	6 *Important*	170
ACCESS TO CARE	7.63	6 *Serious*	5.14 *Important*	101
RESPIRATORY HEALTH	7.2	5 *Serious*	5.7 *Important*	98
CEREBROVASCULAR & CARDIOVASCULAR HEALTH	7.4	6 *Serious*	4.5 *Moderately Important*	87
CANCER	2.33	10 *Very Serious*	3 *Moderately Important*	70

COMMUNITY HEALTH IMPROVEMENT PLAN

The community health needs assessment (CHNA) completed for Providence St. Mary Medical Center (SMMC) in 2023 was used to develop the 2024-2026 Community Health Improvement Plan (CHIP). A plan that outlines how SMMC will work to address the three top-ranked priority health issues identified during the assessment which are access to care, chronic disease prevention and treatment, and behavioral health. A collective impact approach was utilized in the selection of CHIP strategies through alignment with: (1) San Bernardino County's Vital Signs Community Transformation Plan for which the Community Health Investment Department is an active workgroup stakeholder; (2) and support of Reimagining Our Communities strategic plan initiatives; and/or (3) implementation of California Department of Health Care Service's Bridge and CalAIM initiatives.

This section presents initiatives SMMC intends to deliver, fund or collaborate with others to address the priority health needs identified. All planned initiatives are reflective of Providence's mission, vision, core values, and capabilities. The underlying premise for developing the CHIP is to improve the quality of life for people in our community through investments in community benefit initiatives that seek to build and sustain a culture of health. The CHIP includes the goals, objectives, and evidence-based strategies that will seek improvements in each of the three priority health issues that were approved by SMMC's Community Health Committee on April 30, 2024.

ACCESS TO CARE

Long-term Goal I: Improve the proportion of individuals within Providence St. Mary Medical Center's service area that have access to and receive health care services.

Objective I: Reduce barriers to care and community resources to promote health equity.

Strategies	Description	Target Population	Roles & Responsibilities	Resources Committed	Evaluation Measures	Anticipated Outcomes
1.1-A Provide no-cost non-emergency medical transportation	Based on the necessity of need, provide post-discharge transportation support to patients.	– Medical center patients without insurance and/or nonemergency medical transportation benefit with transportation needs	*SMMC:* Strategy sponsor charged with discernment of need, scheduling and cost of post-discharge patient NEMT.	– In-kind & financial support	• Victor Valley Transit passes - # of passes provided - SMMC's total annual expense • Other NEMT rides provided - # of rides provided - SMMC's total annual expense	*Baseline & 2026 Target(s):* Based on patient need.
1.1-B Provide no-cost home and recuperative care services	Based on the necessity of need, home and recuperative care services will be provided to Uninsured patients in needed of medical support post-discharge to support their recovery.	– Uninsured financially needy medical center patients	*SMMC:* Strategy sponsor charged with discernment of need, obtainment, cost of post-discharge medical support.	– In-kind & financial support	• Home and recuperative care services - # of individuals provided with support - SMMC's total annual expense	*Baseline & 2026 Target(s):* Based on patient need.

ACCESS TO CARE

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Strategies	Description	Target Population	Roles & Responsibilities	Resources Committed	Evaluation Measures	Anticipated Outcomes
1.1-C Provide no-cost durable medical equipment	Based on the necessity of need, durable medical equipment will be provided to patients to support their health post-discharge.	– Uninsured & underinsured financially needy medical center patients	*SMMC:* Strategy sponsor charged with discernment of need, obtainment, cost of durable medical equipment.	– In-kind & financial support – Durable medical equipment	• Durable medical equipment – # of individuals provided with support – SMMC's total annual expense	*Baseline & 2026 Target(s):* Based on patient need.
1.1–D Support St. Jude Neighborhood Health Centers (FQHC) to increase and/or expand access to health care services	Provide financial support to offset operational shortfalls experienced by the FQHC to allow underinsured/ uninsured received needed medical and dental care in Adelanto, Apple Valley, and Hesperia.	– Uninsured & underinsured High Desert residents	*FQHC:* Strategy sponsor charged with implementation and all aspects of this strategy. *SMMC:* Informed of the strategy's progress and provides financial support where needed.	– $2M in committed financial support annually; actual amount depends on the operational shortfall experienced by the FQHC	• # of uninsured/underinsured individuals and visits in which: (1) primary and maternity care were provided, (2) medication-assisted treatment/substance use were provided, (3) dental services were provided, and (4) chronic disease management services that were provided • # of new underinsured and uninsured patients served and visits • Proportion of underinsured and uninsured patients that utilized the Emergency Department for ambulatory sensitive conditions - Overall and by measure including composite scores* • Proportion of underinsured and uninsured patients readmitted to hospital within 30 days post-discharge - Overall and by measure including composite scores** • Proportion of uninsured and underinsured patients that received post-discharge primary visit in a timely manner *Asthma in younger adults, community acquired pneumonia, COPD/asthma in older adults (> 40 years old), diabetes long-term complications, diabetes short-term complications, heart failure, hypertension, lower extremity amputation w diabetes, pediatric asthma, uncontrolled diabetes, and urinary tract infection. **All causes, Acute myocardial infarction, Chronic Obstructive Pulmonary Disease, stroke, heart failure, and pneumo-nia	*Baseline & 2026 Target(s):* 3,129 under/uninsured High Desert residents provided medical care
1.1-E Promote and offer financial assistance to those unable to affordable the cost of care	The Patient Financial Assistance Program provides discounts to free care to the financially needy for qualified medical services.	– Financially needy medical center patients	*SMMC:* Strategy sponsor charged with implementation and all aspects of this strategy.	– In-kind & financial support	• # of patients provided financial assistance • Amount of financial assistance provided • # of events and # of people provided with education on SMMC's financial assistance program in the community-setting Note: Please note, SMMC must provide financial assistance to financially needy patients to maintain federal tax-exempt status; however, promotion at community events is not a requirement. Despite reporting the amount and number of patients awarded financial assistance in this section is only intended to give a well-rounded view of SMMC's financial assistance program.	*Baseline & 2026 Target(s):* Based on patient need.

ACCESS TO CARE - CONTD.

Long-term Goal I: Improve the proportion of individuals within Providence St. Mary Medical Center's service area that have access to and receive health care services.

Objective I: Reduce barriers to care and community resources to promote health equity.

Strategies	Description	Target Population	Roles & Responsibilities	Resources Committed	Evaluation Measures	Anticipated Outcomes
1.1-F Expand access to primary, behavioral and specialty care including connection with social support before/after discharge	An Emergency Department and/or inpatient community health worker will: – Perform SDOH, assessment, and/or other risk assessments – Support linkages to primary, behavioral health, and specialty care services – Determine resources to support unmet social needs – Support linkages with unmet social needs – Educate patient about Medi-Cal benefits – Schedules post-discharge and appointment transportation (as needed)	– Emergency Department patients residing with the High Desert	*SMMC:* Strategy sponsor charged with implementation and all aspects of this strategy.	– In-kind & financial support	• Proportion of ED patients in which an SDOH screening was completed • Proportion of ED Patients with at least (1, 2,3, 4, and 5) identified social needs • Proportion of ED Patients with an identified social need that accepted CHW support • Proportion of ED patient with at least one identified social need • Proportion of ED patient with at least one identified social need and substance misuse disorder • Proportion of SDOH screened ED patients: (1) with a medical home, (2) identified to be unhoused, (3) seeking care of an ambulatory sensitive condition, (4) with a chronic condition, (5) that had an inpatient hospitalization within the last 30 days, (6) that had an ED visit within the last 90 days; and (7) with a substance use disorder. • Proportion of patients in which a primary care or behavioral health visits was scheduled pre/post discharge • Proportion of patients in which a primary or behavioral health visit was scheduled that attended the scheduled appointment • Proportion of ED patients with a completed SDOH screening educated about their Medi-Cal benefit • Proportion of ED patients with a completed SDOH screening that have Medi-Cal in which post-discharge transportation (home and/or medical appointment) was scheduled • Perceptions of care among ED patient screened for SDOH • Perceptions of care among ED patients with a positive SDOH screening and accepted CHW support	*Baseline & 2026 Target(s):* Baseline and subsequent targets to be determined after the first year of implementation. **Evidence-based Sources** Peretz PJ, Vargas H, D'urso M, Correa S, Nieto A, Greca E, Mucaria J, Sharma M. Emergency department patient navigators successfully connect patients to care within a rapidly evolving healthcare system. Prev Med Rep. 2023 Jun 23;35:102292. doi: 10.1016/j.pmedr.2023.102292. PMID: 37449004; PMCID: PMC10336236. Shi, M., Fiori, K., & Chambers, E. (2023, April 21). Social Needs Assessment and Linkage to Community Health Workers in a Large Urban Hospital System. Sage Journals . https://journals.sagepub.com/doi/full/10.1177/21501319231166918 Hsieh, D. (2019). Achieving the Quadruple Aim: Treating patients as people by screening for and addressing the social determinants of health. Annals of Emergency Medicine , 74(5), S19–S24. https://doi.org/:https://doi.org/10.1016/j.annemergmed.2019.08.436

ACCESS TO CARE - CONTD.

Objective I: Reduce barriers to care and community resources to promote health equity.

Strategies	
1.1-G Explore implementation of a nicotine cessation treatment program	Same as Strategy 3.1-A
1.1-H Partner with faith-based communities to implement the	Same as Strategy 3.2-A

Objective II: Increase the future availability of care in the High Desert by creating a health professions pipeline.

Strategies	Description	Target Population	Roles & Responsibilities	Resources Committed	Evaluation Measures	Anticipated Outcomes
1.2-A Establish an Internal Medicine Residency Program	Starting in 2025, the first cohort the will be comprised of six internal medicine residents will begin a three-year training program that will focus on prevention, diagnosis, and/or treatment for acute or chronic medical conditions.	– All medical center patients	*SMMC:* Strategy sponsor charged with implementation and all aspects of this strategy.	– $2.2M donation from Rauch Family Foundation – Direct Graduate Medical Education – Financial support	• # of residents and hours of care provided • Rate of residency program attrition • # of health-related outreach and community service projects • SMMC's annual net programmatic expense • Initial obtainment and retention of Accreditation Council for Graduate Medical Education	*Baseline & 2026 Target(s):* Baseline and subsequent targets to be determined after the first year of implementation.
1.2-B Support training and deployment of community health workers (CHWs)	Partner with Victor Valley College to train future CHWs to function as a member of the care team in an acute care setting.	– All medical center patients	*SMMC:* Strategy co-sponsor charged with implementation of this strategy *VVC:* Strategy co-sponsor that provides CHW training program and assigns CHWs to SMMC for apprenticeship training	– In-kind	• # of clinical rotations and/or cohorts completed • # of community health worker students • # of clinical education hours provided • Patient navigation support outcomes	*Baseline & 2026 Target(s):* Baseline and subsequent targets to be determined after the first year of implementation. **Evidence-based Source** Shi, M., Fiori, K., & Chambers, E. (2023, April 21). Social Needs Assessment and Linkage to Community Health Workers in a Large Urban Hospital System. Sage Journals . https://journals.sagepub.com/doi/full/10.1177/21501319231166918

ACCESS TO CARE - CONTD.

Objective II: Increase the future availability of care in the High Desert by creating a health professions pipeline.

Strategies	Description	Target Population	Roles & Responsibilities	Resources Committed	Evaluation Measures	Anticipated Outcomes
1.2-C Partner with Millionaire Mind Kids (MMK) to provide a Health Equity Summer Academy for High Desert high school students	Using the Student Health Advocates Redefining Empowerment curriculum high school students will build the skills need to reduce health disparities at the personal, family, and community-level. In addition, students will learn about the bodies process and learn more about spectrum of health care careers.	– High Desert high school students from disadvantaged backgrounds	*SMMC:* Strategy co-sponsor charged with implementation of educational and immersion academy components. *MMK:* Strategy co-sponsor charged with recruitment of students and other non-education related summer camp logistics.	– In-kind & financial support	• # of participating students • Rate of program attrition • SHARE curriculum pre/post test outcomes • Community walkability audits completed • Photovoice projects completed • # of student summer caps held	*Baseline & 2026 Target(s):* – Two summer camps with at least 50 student participants each **Evidence-based Source** University of Maryland , & Brown, E. (2014, September 10). Student Health Advocates Redefining Empowerment (SHARE) Project Curriculum Released. University of Maryland Health Sciences & Human Services Library . https://www2.hshsl.umaryland.edu/hslupdates/?p=1397
1.2-D Explore implementation of ProvidenceReady - Career Exploration	ProvidenceReady aims to prepare the next generation of the health care workforce through outreach, events for high school and college students to expose students to following careers to meet community needs: • *Clinical Occupation Degree*: nurse practitioners, physician assistance, health care social workers, pharmacists, and registered nurses. • *Clinical Non-Degree*: medical assistants, respiratory therapists & technicians, clinical laboratory technologists & technicians, community health workers, and nursing assistants. • *Non-Clinical Occupations*: medical & health services manager, computer systems engineers, human resources professionals, project management specialists, and security guards.	– High Desert College & High School Students	*SMMC:* Strategy sponsor charged with implementation and all aspects of this strategy.	– In-kind & financial support	• # of ProvidenceReady outreach events and/ programs held • # of ProvidenceReady outreach event and/or program participants • # of outreach events held at High Desert high schools and colleges • # of High Desert high schools and college engaged	*Baseline & 2026 Target(s):* Baseline and subsequent targets to be determined after the first year of implementation. **Evidence-based Source** Ranelle L. Brew*, Pokorski, E., Scheidel, T., Scherf , B., Agee , K., & DeJong, P. (2022). Health career exploration through science, technology, engineering, and mathematics pipeline programming. Frontiers in Education, 7. https://doi.org/ https://doi.org/10.3389/feduc.2022.757888

BEHAVIORAL HEALTH

Long-term Goal II: Promote community well-being and improve the proportion of individuals within SMMC's service area that have access to/receive behavioral health services.

Objective I: Reduce barriers to substance use treatment and harm reduction approaches.

Strategies	Description	Target Population	Roles & Responsibilities	Resources Committed	Evaluation Measures	Anticipated Outcomes
2.1-A Provide harm reduction and overdose prevention community trainings	Provide community naloxone training in partnership with Inland Empire Opioid Coalition, San Bernardino County Department of Health, and Public Health Strategies.	– High Desert residents	*SMMC:* Strategy sponsor charged with implementation and/or training. *Inland Empire Opioid Coalition, Public Health Strategies:* Provide naloxone trainers for events San Bernardino County Department of Health: Provide naloxone and fentanyl testing strips for distribution.	– $400K UniHealth Foundation grant – In-kind & financial support	• # of harm reduction trainings completed • # of individuals trained to administer naloxone • # of individuals provided with fentanyl testing strips • # of individuals supplied with a dose of naloxone • Proportion of individuals provided with fentanyl testing strips and/or naloxone that that were provided with behavioral health resources	*Baseline & 2026 Target(s):* Baseline and subsequent targets to be determined after the first year of implementation. **Evidence-based Source** Substance Abuse and Mental Health Services Administration. (2023, April 24). Harm Reduction. https://www.samhsa.gov/find-help/harm-reduction
2.1-B Expand Emergency Department (ED) Substance Use Navigation Program	Substance use navigators based in the ED engage, link and provide continuity of care and treatment for patients with opioid, polysubstance, and alcohol-related conditions. Navigators with the aforementioned patients will provided harm reduction (i.e., naloxone and fentanyl testing strips) education and supplies.	– ED patients with a substance use disorder	*SMMC:* Strategy sponsor charged with implementation of all aspect of this strategy and grant holder. San Bernardino County Department of Health: Provide harm reduction supplies (i.e., naloxone and fentanyl testing strips) for distribution through Naloxone Distribution Project	– $400K UniHealth Foundation grant – Financial support	• Proportion of ED patients with an SUD provided with education. • Proportion of ED patients with an identified (patient record and/or provider referral) to have an SUD. • Proportion of patients in which care navigation (i.e., clinical referrals, community resources, etc.,) was implemented. • Proportion of patients that had a follow-up care appointment scheduled within seven days post ED discharge. • Proportion of patients discharged from the ED with a completed follow-up SUD appointment with seven days of discharge. • Proportion of patients discharged from the ED with a follow-up appointment completed within seven day and revisited the ED within 30 days. • Proportion of patients discharged from ED with a follow-up appointment completed within seven days of discharge and were admitted as inpatient (and reason) within 30 day. • Proportion of patients discharged from ED with a follow-up appointment completed within seven days of discharge and were treated in ED to continue MAT within 30 day. • Proportion of patients (ED/inpatient) that initiated MAT in which follow-up care is provided within 72 hours post-discharge. • Proportion of patients and/or their families provide with harm reduction education and supplies (i.e., overdoses reversal education and training, free naloxone and fentanyl testing strip, substance use navigation, etc.,). • Embedded opioid prescribing, MAT, care navigation, patient and family engagement, harm reduction clinical and operational workflows/pathways in SMMC.	*Baseline & 2026 Target(s):* Baseline and subsequent targets to be determined after the first year of implementation. **Evidence-based Sources** Public Health Institute. (2024). CalBridge Navigator Program . BRIDGE . https://bridgetotreatment.org/addiction-treatment/ca-bridge/calbridge-navigator-program/ Substance Abuse and Mental Health Services Administration. (2023, April 24). Harm Reduction. https://www.samhsa.gov/find-help/harm-reduction

BEHAVIORAL HEALTH – CONTD.

Objective II: Strengthen opportuni es to build well being and resiliency across the lifespan.

Strategies	Description	Target Audience	Roles & Responsibilities	Resources	Evaluation Measures	Anticipated Outcomes
2.2-A Support Reimaging Our Communities-Millionaire Mind Kids (ROC-MMK) to implement the Community Healing and Resilience initiative (Strategy 3.2-A is a component of this strategy)	Partner with faith-based communities to implement the American Heart Association's Empowered to Serve program to support Reimaging Our Communities-Millionaire Mind Kids (ROC-MMK) to implement the Community Healing and Resilience initiative.	– Black & Latinx High Desert residents – High Desert faith-based organizations	*SMMC:* Strategy co-sponsor that participates in Community Healing and Resiliency Steering Committee, provide financial support, engage and support implementation of Empowered to Serve. *ROC-MMK:* Strategy co-sponsor charged with implementation of Community Healing and Resilience initiative and grant holder.	– St. Joseph Partnership Fund grant – Financial & in-kind support	TBD	*Baseline & 2026 Target(s):* Determine interventions and set baseline measures in first year; ongoing implementation in the second and third years.

Evidence-based Sources

Davis, R., Cook, D., & Cohen, L. J. (2005). A community resilience approach to reducing ethnic and racial disparities in health. *American Journal of Public Health*, *95*(12), 2168–2173. https://doi.org/10.2105/ajph.2004.050146

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CHRONIC DISEASE PREVENTION & TREATMENT

Long-term Goal III: Promote community well being by improving access to preven on and treatment programs for chronic disease.

Objective I: Promote nico ne cessa on.

Strategies	Description	Target Audience	Roles & Responsibilities	Resources	Evaluation Measures	Anticipated Outcomes
3.1-A Explore implementation of a nicotine cessation treatment pathway	Through direct patient outreach (ED/inpatient/post-discharge) using medical records, patients are assessed for nicotine dependency and willingness to quit, and provided counseling, support, nicotine replace, referral to KickItCA, provide information about coming Freedom From Smoking cohorts, and symptom management medications, as needed.	All High Desert adult nicotine product users with a special focus on patients: – with a planned surgery, – that are at risk for readmission following a stroke or heart attack, – with heart disease, hypertension, diabetes, COPD, and cancer – that are expecting or new mothers and their partners	*SMMC:* Strategy sponsor charged with implementation of all aspect of this strategy and grant holder. *KickItCA:* Provide outreach and nicotine cessation support to all referred patients. *Partnered Medical Practices:* Identify, educate, and refer patients with nicotine dependency for community-based cessation services	– Financial & in-kind support	• Integration of a closed-loop e-referral system into Epic to facilitate KickItCA provider referrals and follow-up • Patient referrals to KickItCA • Proportion of referred patients that received quit kit (smoking, vaping, and smokeless) from the KickItCA • Proportion of referred patients that received free nicotine patches from KickItCA • Proportion of referred patients that received at least one phone coaching session from KickItCA • Proportion of patients referred to the KickItCA that were readmitted within 30 days (overall, by condition [hypertension, heart disease, diabetes, COPD], and/or were referred following an addition for a stroke or heart attack) • Proportion Freedom From Smoking referrals received from partnered medical practices • Rate of Freedom From Smoking program attrition • # of Freedom From Smoking cohorts and participants • Freedom From Smoking pre/post assessments	*Baseline & 2026 Target(s):* Baseline and subsequent targets to be determined after the first year of implementation.

Evidence-based Sources

Khanna, N., Klyushnenkova, E. N., Quinn, D. I., & Wolfe, S. (2022). Patient engagement by the tobacco quitline after electronic referrals. Nicotine & Tobacco Research, 25(1), 94–101. https://doi.org/10.1093/ntr/ntac190

Khanna, N., Klyushnenkova, E. N., Rao, V. N. M., Siegel, N., & Wolfe, S. (2021). Electronic referrals to the tobacco Quitline: implementation strategies in a large health system to optimize delivery of tobacco cessation to patients. Translational Behavioral Medicine, 11(5), 1107–1114. https://doi.org/10.1093/tbm/ibaa094

CHRONIC DISEASE MANAGMENT & PREVENTION - CONDT.

Objective II: Reduce risk factors through assessments, health education/promotion and chronic condition management programs.

Strategies	Description	Target Population	Roles & Responsibilities	Resources Committed	Evaluation Measures	Anticipated Outcomes
3.2-A Partner with faith-based communities to implement the American Heart Association's Empowered to Serve program (Strategy 2.2-A is component is this strategy)	A health educator (HE) will support High Desert faith-based organizations with the development, implementation, and evaluation of health ministry programs. In addition, the will provide health education prevention and management education on hypertension, heart disease, CPR/AED training, mental health first aid, cancer, etc., Lastly, the HE will provide education on Providence St. Mary Medical Center's financial assistance program, while providing primary an behavioral health care service navigation support.	– High Desert faith-based organizations (FBOs)	*SMMC:* Strategy co-sponsor charged with FBO outreach, facilitation of health education sessions, evaluation efforts, and providing technical assistance. *FBOs:* Strategy co-sponsor charged development of health ministry program.	– In-kind & financial support	Determine interventions and set evaluation measures in first year; ongoing implementation in the second and third years. **Evidence-based Sources** Cooper, J., & Zimmerman, W. (2017). The effect of a faith community nurse network and public health collaboration on hypertension prevention and control. Public Health Nursing, 34(5), 444–453. https://doi.org/10.1111/phn.12325 Ustanko, L., & Cazer, K. J. (2019). Faith community nursing: from the perspective of the health care system. In Springer eBooks (pp. 179–192). https://doi.org/10.1007/978-3-030-16126-2_12	*Baseline & 2026 Target(s):* Pilot and/or strengthen the health ministry in five Adelanto faith-based organization.

Objective III: Bring together the medical and food systems to better serve patients and the community's access to healthy foods.

Strategies	Description	Target Population	Roles & Responsibilities	Resources Committed	Evaluation Measures	Anticipated Outcomes
3.3-A Provide CalFresh nutrition education program with partnered dental and medical practices	The health educator will: (1) partner with medical practices to provide CalFresh nutrition education to patients, (2) help patient apply to receive CalFresh benefits, (3) provide resources to assist medical provider referral to food resources, and (4) expand access to USDA Summer Meals program.	– CalFresh food eligible High Desert residents – High Desert dental and medical practices located in diverse and under resourced census tracts	*SMMC:* Strategy co-sponsor charged with practice outreach, facilitation of nutrition education, and grant holder. *Practice Partners:* Strategy co-sponsor charged with nutrition session promotion and referral.	– An annual $193K CalFresh Nutrition Education grant from San Bernardino County Department of Health (Grant ends Sept. 2024) – In-kind support	• Proportion of dental and medical practice partnership cultivated • Proportion of dental and medical practice partnership expanded • # of new dental and medical practices engaged. • Proportion of new medical and dental practice partnerships among those engaged • # of direct nutrition and physical activity education workshops completed • # of direct nutrition and physical activity education workshops participants • Direct nutrition and physical activity education workshop attrition rate • Direct nutrition and physical activity education workshop pre/post participant assessments outcomes	*Baseline & 2026 Target(s):* – 40 individuals receive direct education – 500 individuals reached by CalFresh indirect education efforts – 4 health or dental clinics engaged **Evidence-based Source** Rebecca L Rivera, Melissa K Maulding, Heather A Eicher-Miller, Effect of Supplemental Nutrition Assistance Program–Education (SNAP-Ed) on food security and dietary outcomes, *Nutrition Reviews*, Volume 77, Issue 12, December 2019, Pages 903–921, https://doi.org/10.1093/nutrit/nuz013

2024-2026 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the Community Health Committee of the medical center on April 30, 2024. The final plan was made widely available by May 15, 2024.

DocuSigned by:
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5/2/2024

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To request a free printed copy, provide comments, and/or view electronic copies of current and previous Community Health Needs Assessments, please email CHI@providence.org

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