FY25

COMMUNITY BENEFIT REPORT/

PROGRESS ON 2024-2026 COMMUNITY HEALTH IMPROVEMENT PLAN

Providence St. Mary Medical Center

Apple Valley, CA

Reporting Period: July 1, 2024 – June 30, 2025

HCAI ID: 106361343

To provide feedback on this community benefit report or obtain a free printed copy, please email Rosaura Ramirez at Rosaura.Ramirez@providence.org

Providence

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EXECUTIVE SUMMARY

Providence continues its mission of service in San Bernardino County through Providence St. Mary Medical Center (SMMC). Founded in 1956 and located in Apple Valley, the 213 licensed-bed medical center serves the acute care needs of more than 419,075 residents throughout the High Desert Region. The primary service area for SMMC is comprised of the following 13 zip codes: 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).

Providence 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 the economically poor and vulnerable. In Fiscal Year 2025 (July 1, 2024 – June 30, 2025), the medical center provided **$50,691,984** in community benefits to address unmet needs. This CB report is located on the following website: https://www.providence.org/locations/socal/st-mary-medical-center/about-us/community-benefit

2024-2026 Community Health 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, Providence St. Mary Medical Center will focus on the following areas for its 2024-2026 Community Benefit efforts:

PRIORITY I: ACCESS TO CARE

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

2025 Accomplishments

The medical center continued its partnership with St. Jude Neighborhood Health Center, a federally qualified health center (FQHC) established in late 2020 in the High Desert by providing **$1,095,397** in financial support that was used to provide **3,840** uninsured/underinsured individuals with free/discounted primary care, diabetes care, and counseling services at their locations in Adelanto, Apple Valley and Hesperia. During Q2 2025, the clinic began providing behavioral health services in the High Desert and recorded **18** visits with a certified addiction counselor.

PRIORITY II: BEHAVIORAL HEALTH

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

2025 Accomplishments

Millionaire Mind Kids worked on the development and implementation of a trauma informed community building workshop series pilot for parents (e.g., Addressing Trauma and Its Effect on Our Community by Supporting Parents) with 11 Parent University members and client - facing staff of Millionaire Mind Kids completing the series.

Substance Use Navigation services were offered to patients utilizing the emergency department with substance use disorders ranging from alcohol abuse to opioid addiction issues. Two staff offered support, access to resources and assessments to help individuals "where they are" on their recovery journey. During the first two quarters, **178** individuals connected with Substance Use Navigators were

accessible through the emergency department or during their in-patient stay. At the time of this report, the second and third quarters of information was not available.

PRIORITY III: CHRONIC DISEASE MANAGEMENT & PREVENTION

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

2025 Accomplishments

As part of SMMC's continued partnership with San Bernardino County Department of Public Health, 424 High Desert residents participated in the CalFresh Nutrition Education Program. In furtherance of this work, which aims to increase access and consumption of fresh produce to aid in the management and prevention of chronic disease, SMMC partnered with various health care partners in the community. This includes the Symba Wellness Center, TriState Health Care Centers, UniCare Health care clinics, and St. Jude Neighborhood FQHC clinics. These partnerships led to patients receiving nutrition education and active living tips at the point of care of their primary care provider sites. Information was also shared via social media in both English and Spanish.

About Providence

For nearly 170 years, Providence has been dedicated to supporting communities across the seven states we serve. We have always believed in the power of collaboration, recognizing that strong partnerships are essential to our vision of health for a better world.

As we focus on our core operations of delivering high-quality, compassionate care, we rely on partners in local communities to help us get upstream so we can address the social factors that affect health, especially in communities experiencing high levels of health disparities.

At the heart of this collaboration are our community benefit programs. Every year, our family of organizations identifies unmet community needs and responds with strategic contributions and partnerships. Through this work, we aim to meet basic health needs, remove barriers to health, build resilient communities, and find innovative ways to serve those who are most vulnerable.

Together, our 125,000 caregivers (all employees) serve in 51 hospitals, 1,014 clinics and a comprehensive range of health and social services across Alaska, California, Montana, New Mexico, Oregon, Texas and Washington.

For more information go to: https://www.providence.org/about/annual-report

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 1,000, 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

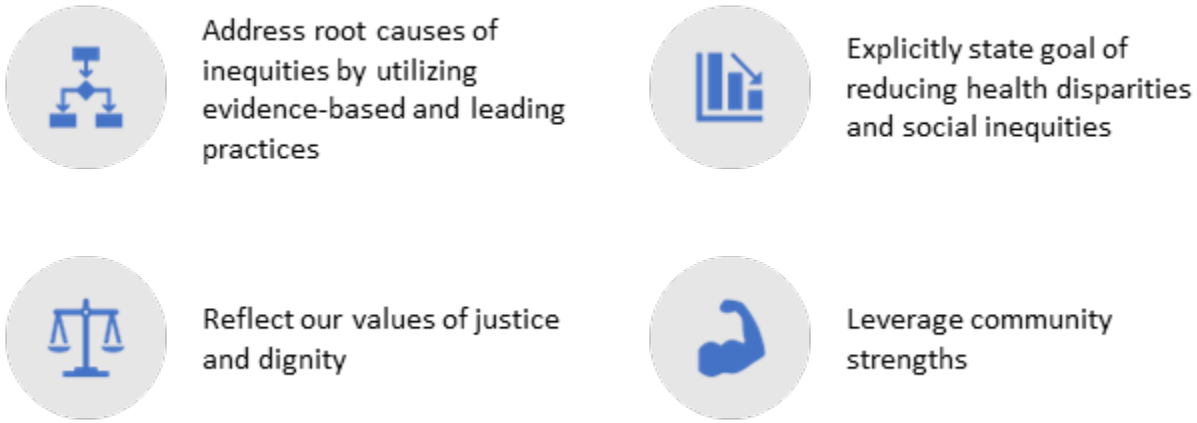
Providence St. Mary Medical Center dedicates resources to improve the health and quality of life for the communities we serve. During Fiscal Year 2025 (July 1, 2024 – June 30, 2025), Providence St. Mary Medical Center provided **$50,691,984** in Community Benefit in response to unmet needs and to improve the health and well-being of those we serve in in the High Desert Region part of San Bernardino County.

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

Figure 1. Best Practices for Centering Equity in the CHIP



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 Director of Community Health is responsible for coordinating the implementation of State regulations and Federal 501r requirements.

A charter approved in 2007 and revised in 2020 established the formation 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 and Community Health Improvement Plan, and overseeing and directing the community benefit activities.

The Community Health Committee has a minimum of eight members, including three members from the Board of Trustees. Current membership includes four members from the Board of Trustees and two 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 biannually.

ROLES & RESPONSIBILITIES

Senior Leadership

- Chief Executive and senior leaders, including the medical center's Chief Mission Integration Officer, are directly accountable for community benefit performance.

Community Health Committee (CHC)

- Community Health Committee 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 Community Benefit (CB) efforts and coordination between CH and Finance Department on reporting and planning.
- Manages data collection, program tracking tools and evaluation.
- Develops specific outreach strategies to access identified disproportionate unmet health needs populations.
- Coordinates with clinical departments to ensure care is received at the right time and location to reduce inappropriate Emergency Department utilization.
- Champions investments in programs aimed to reduce health disparities with local executive regional, and system leadership to reduce health disparities.

Local Community

- Partners to implement and sustain collaborative activities.
- Creates and sustains formal links with community partners.
- Provides community input to identify community health issues.
- Engages local government officials in strategic planning and advocates for health-related issues at the 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 Providence St. Mary Medical Center has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients.

One way Providence 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 medical center'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. In FY25, Providence St. Mary Medical Center provided **$15,698,453** in financial assistance- at cost (referred to as Traditional Charity Care).

Medi-Cal (Medicaid)

Providence St. Mary Medical Center provides access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California. In FY25, Providence St. Mary Medical Center provided **$33,430,737** in Medicaid shortfall.

OUR COMMUNITY

Description of Community Served

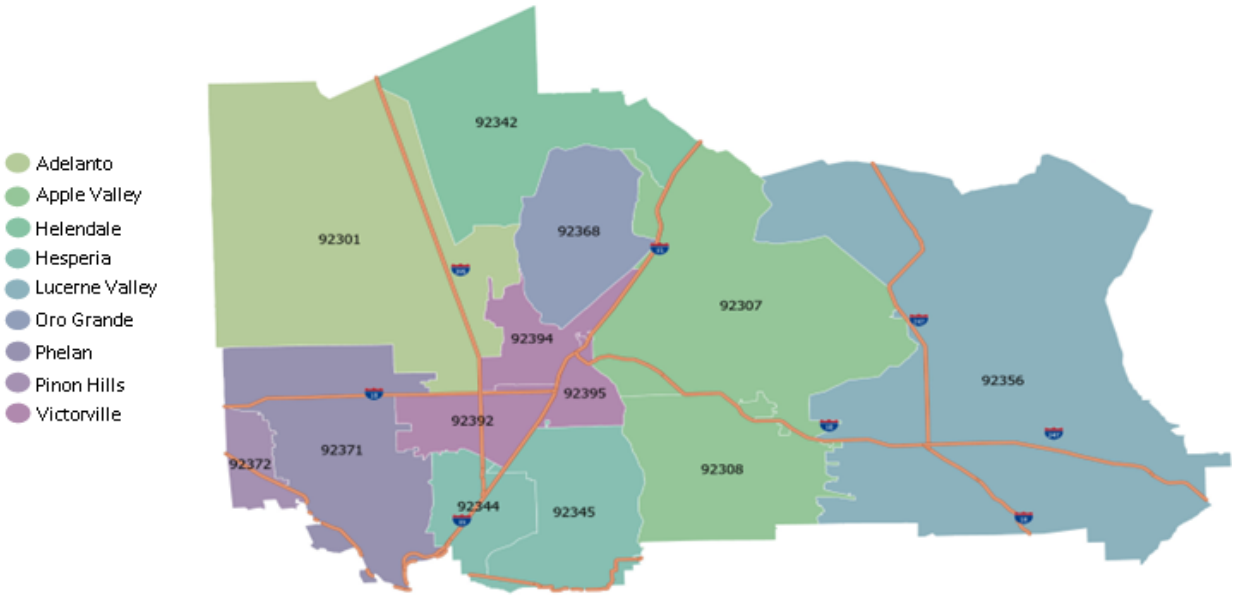
Providence St. Mary Medical Center (SMMC) is located within the geographically largest county in the contiguous United States, San Bernadino County, that in 2023, had an estimated population of 2,195,611 people. Due to the aforementioned, the method used to determine SMMC's primary service area by zip code is the following: a zip code was identified to be within our primary service area as a "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 is 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

Community Demographics

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

FIG 2

Primary Service Area By Zip Code



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.

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 reflect 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 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 impoverished 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.

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	33.2%	60.8%	5.9%	44.4%	17.1%	10.8%	1.5%	0.5%	14.7%	21%	67.4%
Apple Valley	92307	40,604	36.5	27.1%	58.5%	14.4%	68.7%	6.7%	1.4%	3.5%	-	6.7%	13%	38.9%
	92308	43,079	37.0	29.6%	52.6%	17.8%	70.9%	6.2%	0.4%	2.8%	0.51%	8.2%	11%	38.8%
Helendale	92342	6,347	42.1	21.1%	59.3%	19.6%	66.9%	7.5%	-	3.2%	-	5.8%	16.7%	25.5%
Hesperia	92344	20,768	33.6	26.6%	62.9%	10.5%	65.5%	2.3%	0.4%	5.5%	0.3%	13.2%	12.9%	62.5%
	92345	87,994	33.1	30.3%	58.2%	11.5%	72.3%	3.8%	0.9%	1.8%	0.2%	10.9%	10%	59.9%
Lucerne Valley	92356	6,901	40.9	25.4%	56.2%	18.4%	71.5%	3.2%	1.5%	1.9%	0.2%	10.4%	11.4%	39.9%
Oro Grande	92368	1,017	32.9	31.7%	57.4%	10.9%	56.8%	2.4%	0.4%	4.6%	-	11.9%	23.9%	47.3%
Phelan	92371	21,123	33.5	28.6%	61.4%	10%	76%	1.1%	1.5%	2.1%	0.4%	5%	13.8%	42.5%
Pino Hills	92372	5,701	30.1	30.6%	53.1%	16.2%	78%	-	-	7.3%	0.8%	3.6%	10.3%	33.5%
Victorville	92392	61,014	32.3	31.5%	58.5%	10%	55.7%	14.2%	1.7%	5.1%	0.3%	11%	12.1%	53.3%
	92394	39,540	31.0	30.1%	61%	8.9%	42.8%	19.2%	1.7%	3.9%	0.1%	16.8%	15.5%	56.8%
	92395	47,416	33.6	28.8%	58%	13.1%	59.1%	12.3%	1.2%	4%	0.2%	11.9%	11.2%	52.4%
San Bernardino County		2,171,071	33.8	26.4%	62%	11.6%	50.7%	8%	1.1%	7.5%	0.3%	19.9%	12.4%	54.6%
California		39,455,353	37.0	22.8%	62.8%	14.4%	52.1%	5.7%	0.9%	14.9%	0.4%	15.3%	10.7%	39.5%

Source: U.S. Census—American Community Survey, Table DP05, 2017 - 2021 Estimate

Disparities in Median Household Income:

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 rent, food and other cost of living expenses. 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. 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 following ways:

- 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 their monthly income on their mortgage; and
- more than one in two renters in the SA 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 of Governments in 2021, a total of 24,373 housing units for various income levels in the High Desert are needed. 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

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and 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. 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. The CHNA can be located here: https://www.providence.org/about/annual-report/reports/chna-and-chip-reports under Southern California -> Apple Valley. The direct CHNA is located here: https://www.providence.org//media/project/psjh/providence/socal/files/about/community-benefit/pdfs/2023/2023-chna-stmarymedicalcenter.pdf?rev=5a006f4b84734c1da54050301a36a379&hash=88BA822B7FF409F160CD51F9E5BFAFB7

Significant Community Health Needs Prioritized

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 Manager for Providence St. Mary Medical Center participates in health-focused community collaborative groups. The membership of these groups is comprised of local organizations for each of the respective communities and includes non-profits, health departments, human service and other government agency representatives. Despite differences in the CHNA completion timelines among various community organizations within our SA, the Community Health Manager for Providence St. Mary Medical Center aids in the completion of 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 Service Area (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 (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.

Community members from across the High Desert region participated in the Community Health Needs Assessment. This included vulnerable populations who are at medical or financial risk due to being uninsured, underinsured, indigent, or low financial resources. Also included were individuals from diverse ethnic and racial backgrounds that comprise the community experiencing health disparities. In this community this is largely Hispanic/Latino population and African Americans. In addition, with input from advocates serving the unhoused, individuals residing in economically challenged neighborhoods, geographically and environmentally- vulnerable areas had representation.

Another strategy for engaging wide representation was by providing language access. Language access was provided as part of the Needs Assessment focus groups and resident conversations to include those with limited English proficiency.

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 is 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.

2024-2026 Priority Needs

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. 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 ten 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 a 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.

Based upon the scoring system and discussion, On November 28, 2023, the Community Health Committee approved the following three focus areas:

PRIORITY 1: ACCESS TO CARE

Access to care goes beyond medical care, and includes dental, vision, primary care, transportation, culturally appropriate care, and care coordination. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

PRIOIRTY 2: BEHAVIORAL HEATH

Covers all areas of emotional, behavioral, and social well-being for all ages. Includes issues of stress, depression, coping skills, stigma, as well as more serious health conditions such as mental illness and adverse childhood experiences. Substance use pertains to the misuse of all drugs, including alcohol, marijuana, opiates, prescription medication, and other legal or illegal substances. It does not encompass cigarette smoking, which was considered separately. Mental health challenges can impede people's

abilities to realize their potential, cope with stress, work productively and fruitfully, and make contributions to their communities.

PRIORITY 3: CHRONIC DISEASE PREVENTION AND TREATMENT

Chronic disease prevention focuses on reducing risk factors such as poor nutrition, physical inactivity, and tobacco use to prevent conditions like heart disease, diabetes, and cancer. Effective prevention strategies include community education, early screenings, and access to healthcare services to improve long-term health outcomes.

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 questions (question 5 and 6) included in our Community Well-Being Survey were taken from the Community Vital Signs Survey. Additionally, the Community Health Department participated in prioritization and implementation of events held by the Department of Public Health to seek alignment.

The San Bernardino County, Community Vital Sign Health Assessment Report for 2024, identifies three health improvement priorities that continue to align with Providence St. Mary Medical Center Community Health Needs Assessment needs. Behavioral Health and addressing Chronic Conditions continue to be core areas for impact. Access to care continues to be a focus for St. Mary because this is how we help individuals receive the information, care, treatment, and resources for health improvement.

Needs Beyond the Hospital's Service Program

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.

San Bernardino County has also identified Injury and Violence Prevention as a priority in response to increasing crime rates impacted by the COVID pandemic and aftermath. St. Mary was also approached by law enforcement and community groups to help address the lack of forensic examination services for High Desert victims of sexual assault. St. Mary has taken steps to address violence and injury by beginning planning for a sexual assault response program to launch in Fall 2025.

In 2024 community mobilizing efforts began to address the lack of services for victims of sexual assault in the region. although The High Desert community has four hospitals in this expansive region ranging from Barstow's small 30-bed hospital to St. Mary Medical Center with 216 beds, none of the hospitals currently have capacity to partner with law enforcement and victim advocacy services to offer specialized care and forensic services to support sexual assault victims from this community.

St. Mary brough together faith based, education, non-profit and civic leaders to educate them about the need, seek their collaboration and partnership to help establish sexual assault resiliency services.

More than 60 partners attended educational and affinity group meetings from various sectors, thus generating support to address this need. Victims in the High Desert, whose trauma of a sexual assault is compounded by the lack of local services cannot access services they need in their own community. If a victim in the High Desert summons the courage to report the crime, they are transported in a police vehicle or must drive themselves out of their home community to hospitals “down the hill” for this specialized care. Travel time can range from one hour to five. The only route is through the Cajon Pass, a route that is often congested or closed due to inclement weather, serious traffic accidents, and wildfires. Once victims arrive at the distant hospital, there is more waiting. This time it is for a nurse trained to perform specialized examinations. This wait is long because there are only two specialized and certified Sexual Assault Nurse Examiners who serve the expansive San Bernardino County area.

Planning and mobilization of community partners in 2024 have positioned Providence St. Mary Medical Center to establish a Sexual Assault Resiliency program in 2025. This will address the unique physical, emotional, clinical, and justice needs of survivors by establishing a forensic examination site in the High Desert where none currently exists. Victims from this area will have equitable access to forensic services, coordinated mobilization of victim advocate services, linkages to counseling and mental health resources. By providing a safe environment closer to home, we will be able to facilitate access and guide victims towards healing of mind, body, and spirit on their path to becoming a survivor.

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

Summary of Community Health Improvement Planning Process

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 initiative; and/or (3) implementation of California Department of Health Care Service's Bridge and CalAim Initiatives.

This section presents initiative SMMC intends to deliver, fund or collaborate with others to address the priority health needs identified. All planned initiatives reflect Providence's mission, vision, core values, and capabilities. The underlying premise for developing CHIP is to improve the quality of life for people in our communities through investment 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 improvement in each of the three priority health issues that were approved by SMMC's Community Health Investment Committees on April 30,2024.

Addressing the Needs of the Community:2024-2026 Key Community Benefit Initiatives and Evaluation Plan

Priority I - 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	Resource Committed	Evaluation Measures	FY25 Accomplishment
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-discharged 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	Data not available. Transportation vouchers and assistance is provided to patients requesting or needing it through Case Management /Social Work and other Departments and programs.
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-discharged to support their recovery.	• Uninsured financially needy medical center patients	*SMMC*: Strategy sponsor charged with discernment of needs, obtainment, cost of post-discharged medical support.	• In-kind & financial support	•Home and recuperative care services - # of individuals provided with supports - SMMC's total annual expense	In FY 25, there were **180** patients needing home - based or recuperative care services that were not covered by insurance and that patients could not afford. A total of **$76,463** in care was provided to support health recovery.

Strategies	Description	Target Population	Roles & Responsibilities	Resource Committed	Evaluation Measures	FY25 Accomplishment
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.	• Durable medical equipment	• Durable medical equipment - # of individuals provided with support - SMMC's total annual expense	In FY 25, there were **27** patients who were unable to secure durable medical equipment to assist them with mobility, patient safety and care upon hospital discharge. A total of **$15,064** was used to provide needed equipment and supplies to these patients.
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 shortfall 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.	• $3.5M 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* • Proportion of underinsured and uninsured patients readmitted to hospital within 30 days post-discharged-Overall and by measure including composite scores** • Proportion of uninsured and underinsured patients that received post-discharged primary visit in a timely manner *Asthma in younger adults, community acquired pneumonia, COPD/asthma in older adult (> 40 years old), diabetes long term complications, diabetes short term complication, heart failure, hypertension, lower extremity amputation with diabetes, pediatric asthma, uncontrolled diabetes, and urinary tract infection **All causes, Acute myocardial infarction, Chronic Obstructive Pulmonary Disease, Stroke, heart failure, and pneumonia	In FY 25, SMMC donated **$1,075,397** for accessible community-based health care services to **3,840** uninsured and/or underinsured individuals. The number of patient visits for Obstetrics was **604** for **117** unique OB patients, the number of pediatric visits was **207 for 104** unique pediatric patients and the number of adult medical visits was **3,603** for **862** unique adults. During the second quarter, the FQHC began offering behavioral health services in the High Desert and addressing substance use disorders by engaging a certified drug and alcohol addiction counselor. A total of **18** unique patients have been served. Recruitment for a licensed clinical social worker (LCSW) or other licensed behavioral health professional is underway to expand these services.

Strategies	Description	Target Population	Roles & Responsibilities	Resource Committed	Evaluation Measures	FY25 Accomplishment
1.1-E Promote and offer financial assistance to those unable to afford the cost of care	The Patient Financial Assistance Program provides discounts to free care to the financially needy for qualifies 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	A total of $7,849,227 in financial assistance was provided to patients throughout the FY 25 period. Going forward this financial data point will be found in the total community benefit investment financials.
1.1-F Expand access to primary, behavioral and specialty care including connection with social support before/after discharge	An Emergency Department 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 linkage with unmet social needs • Educate patient about Medi-Cal benefits • Schedule post-discharge and appointment transportation (as needed)	• Emergency Department patients residing within the High Desert	*SMMC:* Strategy sponsor charged with implementation and all aspects of this strategy.	•In-kind & financial support	• Proportioned of ED patients in which an SDOH screening was completed • Proportion of ED patients with at least (1,2.3,4, and 5) identifies social needs • Proportion of ED patients with an identified social need that accepted CHW support • Proportion of ED patients with at least one identifies 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) identifies to be unhouse, (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 patient in which a primary care or behavioral health visit was scheduled pre/post discharged • 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 schedule • Perceptions of care among ED patient screened for SDOH • Perceptions of care among ED patients with a positive SDOH screening and accepted CHW support	Due to lack of funding availability, a dedicated Community Health Worker for the ED was not hired. However, Social Workers/Case Managers and CHW/Navigators assist patients with referrals and linkages upon discharge as needed.

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

Strategies	Description	Target Population	Roles & Responsibilities	Resource Committed	Evaluation Measures	FY25 Accomplishment
1.2-A Establish an internal Medicine Residency Program	Starting in 2025, the first cohort 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 implementing 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	The Graduate Medical Education program is new to Providence- St. Mary Medical Center and efforts have bene underway to stand this program up. Although the program curriculum was initially accredited in April of 2024, the work to launch the program happened in FY 25. This included more than $500,000 in infrastructure costs to accommodate residency program space needs including enhancing a patient care simulation lab. During this period, the program was promoted through marketing and outreach to draw applicants to the High Desert community from throughout the country. This successfully resulted in more than **2,117** applicants. All of these applications were reviewed, and ranked for alignment with Providence St. Mary mission, vision and values. An estimated **1000** people hours were dedicated to screening applications, interviewing and selection. A total of 10 medical residents were selected for the first cohort of medical residents in Internal Medicine who began their residency July 1, 2025. This cohort of physicians will increase access to care during their 3- year residency. A new cohort of **10** physicians is anticipated in FY 26.
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 apprenticeships training.	•In-kind	• # of clinical rotations and/or cohorts completed • # of community health workers students • # of clinical education hours provided • Patient navigation supported outcomes (TBD)	The launch of this strategy was contingent upon pursuing grant funding however with staff transitions, this did not move forward during the FY 25 period. We anticipate offering 4 CHW practice rotations in FY 26 with Victor Valley Community College and other community partners.

Strategies	Description	Target Population	Roles & Responsibilities	Resource Committed	Evaluation Measures	FY25 Accomplishment
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 disadvantage backgrounds	*SMMC*: Strategy co-sponsor charged with implementation of education 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/posttest outcomes • Community walkability audits completed • Photovoice projects complete	In FY 25, conversations were started on how to build a summer health academy with this partner which serves a low-income community in the High Desert. This work was contingent upon grant funding , however with staff transitions funding was not sought or secured during this period. However, in FY 26, with possible support from the Medical Residents and St. Mary staff, the curriculum will be developed.
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 career to meet community needs: • *Clinical Occupation Degree*: nurse practitioners, physicians assistance, health care social workers, pharmacists, and registered nurses. • *Clinical Non-Degree:* medical assistants, respiratory therapist & technicians, clinical laboratory technologist & technicians, community health workers, and nursing assistants. • *Non-Clinical Occupations*: medical & health service 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 health at High Desert high schools and colleges • # of High Desert high schools and college engaged	The ProvidenceReady program was a system- based initiative to engage with high schools and colleges to promote careers in health and ancillary support roles. This was not implemented due to discontinuation of the program at the system level. We are exploring ways to support this initiative through alternative strategies.

PRIORITY II – 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 ad harm reduction approaches

Strategies	Description	Target Population	Roles & Responsibilities	Resource Committed	Evaluation Measures	FY25 Accomplishment
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 strips for distribution.	•$400K UniHealth Foundation grant •In-kind & financial support	• # of harm reduction training completed • # of individuals trained to administered 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 were provided with behavioral health resources	Harm reduction and Naloxone training was offered to **300 individuals** during Overdose Awareness and Substance Use Recovery Months. Discussions began to identify where to promote Naloxone Access in the community. This is underway with a community partnership including the City of Victorville - Symba Wellness Center. Through participation at community events, information on substance use disorders and resources was provided to **1800** community members. (This information is for the period July 1, 2024 thru December 31, 2024 only, data for the second half is not available at the time of this report)

Strategies	Description	Target Population	Roles & Responsibilities	Resource Committed	Evaluation Measures	FY25 Accomplishment
2.1-B Expand Emergency Department (ED) Substance Use Navigation Program	Substance use navigator based in the ED engage, link and provided continuity of care and treatment for patients with opioid, polysubstance, and alcohol-related conditions. Navigators with the aforementioned patients will provide 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. *DHCS:* Provide harm reduction supplies (i.e., naloxone and fentanyl testing strips) for distribution through Naloxone Distribution Project	• $400K Unihealth Foundation grant • CA BRIDGE $71K grant • In-Kind 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.,) 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 the ED with a follow-up appointment completed within seven days of discharge and were admitted as inpatient (and reason) within 30 days. •Proportion of patients discharged from the ED with a follow-up appointment completed within seven day of discharge and were treated in ED to continue MAT within 30 days. •Proportion of patients (ED/inpatient) that initiated MAT in which follow-up care is provide 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 strips, substances use navigation, etc.,). •Embedded opioid prescribing, MAT, care navigation, patient and family engagement, harm reduction clinic and operational workflows/pathways in SMMC.	In FY 25, we increased the number of substance use navigators from 1 full time staff person to 2 full time navigators. During these period work was focused on not only integrating the substance use navigation into the ED but also working with the OB-ED to build capacity to serve perinatal women. In addition, navigators began seeing trauma patients and provided SBIRT screenings for admitted patients with identified alcohol use. A total of **178** patients with substance use disorders from both the ED and OB-ED were seen. The information provided covers the period from January 1, 2025. through June 30, 2025. Data for the period July 1, 2024, through December 31, 2024, was not available.

PRIORITY II – 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 II: Strengthen opportunities to build well-being and resiliency across the lifespan

Strategies	Description	Target Population	Roles & Responsibilities	Resource Committed	Evaluation Measures	FY25 Accomplishment
2.1 C 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 organization	*SMMC:* Strategy co-sponsor that participates in Community Healing and Resiliency Sterring 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 initative and grant holder.	•St. Joseph Partnership Fund grant •Financial & in-kind support	•Development of a community action plan to improve resiliency and social cohesion •Understanding the barriers to social cohesion and methods to increase resiliency •# of faith-based organizations engaged •# of partners organizations	$20,500 awarded in October 2024. 100 Community Members participated in Trauma - resiliency training. Parent Academy Curriculum Developed and replicable.

PRIORITY III – CHRONIC DISEASE

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

Objective I: Promote nicotine cessation

Strategies	Description	Target Population	Roles & Responsibilities	Resource Committed	Evaluation Measures	FY25 Accomplishment
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 astroke 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 aspects 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	• Patient referrals to KickItCA • Proportion of referred patients that received quit kit (smoking, vaping, and smokeless) form the KickItCA • Proportion of referred patients that received free nicotine patches from KickItCA • Proportion of referred patients that received at least one phone coaching sessions from KickItCA • Proportion of patients referred to the KickItCA that were readmitted within 30 days (overall, by conditions [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	Staff transitions impacted ability to pursue grant funding to support this effort. In FY 26 we will work with community partners to promote smoking / vaping cessation.

PRIORITY III – CHRONIC DISEASE

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

Objective II: Promote healthy lifestyles

Strategies	Description	Target Population	Roles & Responsibilities	Resource Committed	Evaluation Measures	FY25 Accomplishment
3.2-A Partner with faith-based communities to implement the American Heart Association's Empowered to Serve program (Strategy 2.2-A is components 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 HE 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 and behavioral health care service navigation support	• High Desert faith-based organization (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.	•Financial & in-kind support	• Proportion FBOs partnership cultivated • Proportion of FBOs partnership expanded • # of new FBOs engaged • # of FBO that form or expand their health ministry • # of health education workshops/activities completed • # of health education workshops/activity participants • Health education workshops/activity attrition rate • Health education workshop/activity pre/post participant assessments outcomes	Staff transition impacted ability to pursue grant funding to enable this effort. However, health education around stroke and heart disease prevention were offered to the community at large. This included participation in **10 community events** throughout the High Desert with direct encounters with **1,234 High Desert residents.** In addition, 11 educational support groups were offered with a total of 149 attendees. 1,000 educational packets were distributed that included information on risk factors for stroke, identifying signs and symptoms of stroke and early heart attack care (EHAC).

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

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

Strategies	Description	Target Population	Roles & Responsibilities	Resource Committed	Evaluation Measures	FY25 Accomplishment
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.	• Cal Fresh food eligible High Desert residents • High Desert dental and medical practices located in diverse and under-resourced census tract	*SMMC:* Strategy co-sponsor charged with practice outreach, facilitation of nutrition, education, and grant holder. *Practice Partners*: Strategy co-sponsor charged with nutrition sessions 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 partnership 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 workshops attrition rate • Direct nutrition and physical activity education workshop pre/post participants assessments outcomes	**424** individuals reached through CalFresh direct and indirect education efforts providing information on healthy eating and active living. Worked with three health systems including FQHCs, Tri-State health and Unicare. This led to more than 6 sites for education by end of the reporting period. Although grant funding was awarded in the amount of $371,650, from San Bernardino County Department of Public Health, we were advised that funding for the funding period 10/1/25 - 9/30/25 in the amount of $185,825 will not be available thus terminating the grant as of 9/30/26.

Other Community Benefit Program

Initiative (Community Need Addressed)	Program Name	Description	Population Served (Low Income, Vulnerable or Broader Community)	FY25 Accomplishment
Access to Prescription	Access to Prescription	Provide Need Rx to patients upon discharged from the hospital	Low-income	8
Access to clothing, shoes, and basic hygiene items	Clothing for unhoused patients	Provide clothing, shoes, blankets, and basic needs	Low-income	70

FY25 COMMUNITY BENEFIT FINANCIALS

In FY25, Providence St. Mary Medical Center provided a total of **$42,842,758** in vital community benefit programs. **$42,807,758** specifically supported community benefit programs for the poor and vulnerable. **$7,849,227** in traditional charity care was provided at cost, **$33,430,738** in unpaid cost of Medi-Cal. See table below for detailed break out in alignment with state requirements.

Providence St. Mary Medical Center applies a ratio of cost to charge to quantify financial assistance at cost, unreimbursed Medicaid, and other means-tested government programs. The cost to charge ratio is aligned with the IRS Form 990, Schedule H Worksheet. Our community benefit program expenses are reported in alignment with the total cost incurred to run our programs, and we offset any restricted revenue received to arrive at our net community benefit expense.

FY2025 PROVIDENCE ST. MARY MEDICAL CENTER, APPLE VALLEY, CA
(July 1, 2024 - June 30, 2025)

Financial Assistance and Means-Tested Government Program	Vulnerable Population	Broader Community	Total
Traditional Charity Care	$7,849,227	$0	**$7,849,227**
Medi-Cal	$33,430,738	$0	**$33,430,738**
Other Means-Tested Government (Indigent Care)	$0	$0	**$0**
Sum Financial Assistance and Means-Tested Government Program	**$41,279,965**	**$0**	**$41,279,965**
Other Benefits			
Community Health Improvement Services	$96,177	$0	**$96,177**
Community Benefit Operations	$356,219	$0	**$356,219**
Health Professions Education	$0	$15,000	**$15,000**
Subsidized Health Services	$0	$0	**$0**
Research	$0	$0	**$0**
Cash and in-kind Contributions for Community Benefits	$1,075,397	$20,000	**$1,095,397**
Other Community Benefits	$0	$0	**$0**
Total Other Benefits	**$1,527,793**	**$35,000**	**$1,562,793**
Community Benefits Spending			
Total Community Benefits	$42,807,758	$35,000	**$42,842,758**
Medicare (non-IRS)	$41,381,539	$0	**$41,381,539**
Total Community Benefits with Medicare	**$84,189,297**	**$35,000**	**$84,224,297**

Telling Our Community Benefit Story: Non-Financial Summary of Accomplishments

St. Mary Medical Center sought funding to expand its behavioral health and substance use interventions through the implementation of substance use navigators in both the general and obstetric emergency departments. These navigators play a vital role in addressing the critical needs of perinatal women experiencing mental health crises and substance use disorders. St. Mary has also been an active participant in the statewide California Bridge program pilot, launched in response to the rising opioid use crisis. Currently, the emergency department (ED) sees over 4,400 visits annually involving a mental health or substance use diagnosis—yet the existing program can only reach a small fraction of these patients.

The hospital's obstetrics emergency department (OB-ED) has seen a 30% rise in babies born to mothers with substance use histories. These infants often suffer from withdrawal symptoms, premature birth, and other serious complications. While the hospital provides immediate clinical care, the support many mothers need goes beyond the hospital'slls. To bridge this gap, St. Mary has embedded a community health navigator within its labor and delivery unit. This navigator engages with expectant mothers at a critical time, offering support, education, and consistent follow-up throughout pregnancy and delivery. Often, seeing their newborns in the neonatal intensive care unit inspires mothers to seek help—the on-site navigator can nurture this motivation, acting as a coach and support system to guide them into recovery services.

Since the hiring of a second full-time community health worker/navigator on October 7, 2024, St. Mary has strengthened its outreach. During this reporting period, 461 unique individuals received initial consultations, follow-up care coordination, or outreach services, 15 of whom were perinatal patients from the labor & delivery unit. To further reach perinatal populations, St. Mary is now collaborating with the high desert maternal & birth workers collective to identify at-risk women earlier and strengthen referral pathways. Together, we aim to ensure that every mother and baby receive the support necessary for a healthier start.

2025 CB REPORT GOVERNANCE APPROVAL

This 2025 Community Benefit Report was adopted by the Community Health Committee of Providence – St. Mary Medical Center on October 8, 2025. The final report was made widely available by November 20, 2025.

Signed by:
Paul Gostanian
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11/4/2025

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

DocuSigned by:
Randall Castillo
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11/4/2025

Randall Castillo — Date
Chief Executive, Providence, St. Mary Medical Center

Signed by:
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11/4/2025

Michael Robinson — Date
Chief Community Health Officer, South Division Providence

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