AT A GLANCE:

St. Mary-Corwin Medical Center

AREA SERVED: PUEBLO COUNTY

PRIORITIES:

Behavioral Health
Food Security

PARTNERS:

Pueblo County Department of Public Health & Environment, Pueblo Community Health Center, Health Solutions-Community Mental Health Center, Regional Health Connector, Health Solutions-Regional Accountable Entity, Pueblo Fire Department, Pueblo Triple Aim, Health Solutions, Pueblo Senior Resource Development Agency, African American United Methodist Church, and Center for Health Progress.
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Mission
We extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities.

Vision
Every community, every neighborhood, every life – whole and healthy.

Values
Compassion
Respect
Integrity
Spirituality
Stewardship
Imagination
Excellence
Executive Summary

On June 25, 2019, the St. Mary-Corwin Medical Center Board of Directors approved the 2019 St. Mary-Corwin Medical Center Community Health Needs Assessment (CHNA) priorities of Behavioral Health (Mental Health and Substance Abuse) and Obesity. The CHNA was the third iteration of our process to strategically ignite whole person health in each community we touch. At Centura Health, we are a diverse community of caregivers connected and fueled by our individual passions and purposes to change the world around us. While individually inspired, we are collectively unified by our Centura Health mission. The CHNA process presents an opportunity for St. Mary-Corwin Medical Center to fulfill our commitment to our organizational mission to extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities. Based upon the input we received during the CHNA process and by reviewing community assets and gaps, we developed our Community Health Implementation Plan (CHIP), setting our path forward to building wholeness and flourishing communities. This plan is designed to continue to amplify meaningful collaboration among St. Mary-Corwin Medical Center, local public health, community leaders, and partner organizations.

The St. Mary-Corwin Medical Center Community Health Implementation Plan (CHIP) recognizes the health needs prioritized in our CHNA as tough health issues that cannot be solved by any single organization on its own. To positively impact the health priorities requires a collaborative and strengths-based approach. The CHIP elevates those strategies a hospital can implement on its own and with community partners to impact community health.

The strategies St. Mary Corwin Medical Center plans to use to address the health priorities leverages our role as a large business and employer, a health care organization and a nonprofit hospital partner. Like our approach toward medicine, we are committed to using evidence-based strategies to address the health needs of the community.

On October 29, 2019, our Board of Directors approved Food Security as a priority and the St. Mary-Corwin Medical Center Community Health Improvement Plan for FY2020-FY2022. In this plan, we determined that the community priority of Obesity would be addressed through Food Security. While Obesity is an important health need to address, we heard from our community that in order to impact this issue, we must first address Food Security, or access to healthy, affordable food. This Social Determinant of Health is an essential building block toward health and well-being. Food Security enables people with limited income to focus on healthy eating by removing cost and transportation barriers related to purchasing healthy food. Additionally, it removes the stressor of whether and how food will be on the table.
BEHAVIORAL HEALTH GOALS

• **Goal 1:** Reach 80% of school-aged youth with a social cohesion and/or resiliency strategy.

• **Goal 2:** Increase capacity of community to support Behavioral Health needs through increased awareness of Behavioral Health and reduced stigma.

• **Goal 3:** Increase people reporting access to Behavioral Health services by 40%.

FOOD SECURITY GOALS

• **Goal 1:** Increase by 20% the number of produce sites which accept SNAP/WIC.

• **Goal 2:** Decrease number of food deserts by 20%.

• **Goal 3:** Decrease the number of community members who are eligible but not enrolled in SNAP by 60%.

• **Goal 4:** Increase use of locally sourced healthy, affordable food within Centura Health by 50%.
Our Services and Community

CENTURY LONG LEGACY OF AWARD WINNING SERVICES TO HEAL, INSPIRE AND CONNECT OUR COMMUNITY.

In 1882, a two-story boarding house in Pueblo was converted into St. Mary’s Hospital by the Sisters of Charity while at the same time Colorado Fuel & Iron Company established a hospital for its employees and their families under the medical leadership of Dr. Richard Corwin. The company transferred ownership of Corwin Hospital to the sisters in the late 1940s creating St. Mary-Corwin Medical Center. Today, the hospital continues its legacy of compassionate, outstanding care with an accredited and nationally recognized cancer center, designated Breast Center of Excellence, state of the art robotic-assisted surgical technology, a dedicated Joint Replacement Center and more.

**Distinctive Services** *Noteworthy areas of care include:*

**Orthopedic department and Joint Replacement Center** — Named a Women’s Choice Award® recipient as an America’s Best Hospital for Orthopedics

**The Breast Center of Excellence** — Received the Women’s Choice Award®

**The Cancer Assessment Resource Education Survivorship (C.A.R.E.S.) Program for patients with head and neck cancers** — Received an Innovator Award from the Association of Community Cancer Centers

**The Dorcy Cancer Center’s radiation oncology program** — Received dual accreditation by the American College of Radiology (ACR) and the American Society for Radiation Oncology (ASTRO)

**Hospital Services** — Received the prestigious American Diabetes Association Education Recognition Certificate for diabetes education and wound care

**Healthgrades Honors** — St. Mary-Corwin Medical Center is a proud recipient of seven Five-Star Ratings from Healthgrades, the leading online resource helping consumers make informed decisions in order to find the right doctor, the right hospital and the right care. In addition, the hospital was recognized by Healthgrades as being among the top 10 percent in the nation for general surgery as measured by lowest risk-adjusted mortality.
OUR COMMUNITY

At Centura Health and St. Mary-Corwin Medical Center, we remain committed to advancing vibrant and flourishing communities. The CHNA and CHIP help to fuel our caregivers to continuously engage with, understand, and contribute to whole person health in our shared neighborhoods. By focusing on Behavioral Health and Food Security for the next three years, we are excited to continue to live out our Mission, Vision, and Values every day.

To define St. Mary-Corwin Medical Center’s service area for the CHNA, we followed a process focused on ensuring that the defined service area was inclusive of medically underserved, low-income and minority populations in the geographical areas from which the hospital draws its patients. We considered four factors:

- Opportunities to viably expand outreach of programs to medically underserved populations
- Inpatient admissions
- Coverage of the County by another Centura facility
- Opportunities for collaboration among facilities and with community-based organizations

After considering the factors above, we compared the defined geographical service area of the 2016 CHNA to this one to ensure no disadvantaged populations included in the 2016 CHNA were excluded in the 2019 CHNA.

To understand the profile of St. Mary-Corwin’s community we analyzed the demographic and health indicator data of the population within the defined service area. The service area has a total population of 158,294. The demographic makeup of these communities is on the following page.
POPULATION DEMOGRAPHICS IN ST. MARY-CORWIN MEDICAL CENTER’S SERVICE AREA

Race

- White 77.4%
- Black 2.2%
- Asian 0.9%
- Native American/Alaska Native 2.1%
- Native Hawaiian/Pacific Islander 0.1%
- Other 13.1%
- Multiple races 4.1%

Ethnicity

- Non-Hispanic 56%
- Hispanic 44%

Some College

- St. Mary-Corwin Service Area 62.7%
- State Average 71%

High School Graduation Rate

- St. Mary-Corwin Service Area 74.9%
- State Average 77.6%

Limited English Proficiency

- St. Mary Corwin Service Area 1.4%
- State 2.8%

Ratio of households in the 80th percentile to income at the 20th percentile

- St. Mary Corwin Service Area 4.7
- State 4.5

Unemployment Rate

- St. Mary Corwin Service Area 5.7%
- State 4.0%
Prioritized Needs and Plans

WORKING WITH COMMUNITY

St. Mary-Corwin Medical Center collaborated with Pueblo County Department of Public Health & Environment with their representation on our Advisory Subcommittee. In addition to serving on our Advisory Subcommittee, we agreed with the public health department to align community-based efforts in order to address community health holistically and to avoid duplication. We leveraged their qualitative data collected through focus groups to inform our CHNA. We have intentionally aligned strategies, as applicable, to ensure greater movement toward same goals with complementary efforts.

We created a hospital subcommittee to solicit and take into account input from individuals and organizations representing the broad interest of our community to assess the needs of our community. Please see Appendix A for a list of St. Mary-Corwin Medical Center’s subcommittee members. Our subcommittee:

- Reviewed the quantitative data and provided insight; and
- Prioritized health needs using the Centura Health Prioritization Method;

Our subcommittee met three times for two hours each meeting in order to rank and prioritize health needs, assets and gaps and to design the overarching strategies to be used to address the health needs. After careful consideration of the available quantitative and qualitative indicators and our Centura Health Mission, Vision and Values, St. Mary-Corwin Medical Center identified Behavioral Health (Substance Abuse/Mental Health) and Obesity as priority focus areas.

After identifying our priorities, we reviewed the assets and gaps identified by the subcommittee to develop the St. Mary-Corwin Medical Center Community Health Implementation Plan (CHIP). It was at this point in time at which we identified Food Security as the priority necessary to address Obesity in our community. The CHIP recognizes the health needs prioritized in our CHNA as tough health issues that cannot be solved by any single organization on its own. To positively impact the health priorities requires a collaborative and strengths-based approach. The CHIP elevates those strategies a hospital can implement on its own and with community partners to impact community health.

HOW WE MAKE A DIFFERENCE

The strategies St. Mary-Corwin Medical Center will use to address the health priorities leverages our role as a large business and employer, a health care organization and a nonprofit hospital partner. (See Figure 1) Like our approach toward medicine, we are committed to using evidence-based strategies to address the
health needs of the community. Our intent in every strategy is to leverage our strengths and community partnerships, fill gaps and use strategies that catalyze community change.

Our CHNA and CHIP processes integrated in the Colorado Hospital Transformation Program (HTP) Community and Health Neighborhood Engagement process. We value the time and voices of our community. We also believe our community health priorities and strategies should align with and complement HTP clinical strategies to yield the greatest outcomes for those in our communities. To that end, there are HTP metrics included in our CHIP to leverage our role as a health care provider to impact community health priorities.

FIGURE 1: Centura’s Role

**HOW WE INVEST IN COMMUNITY HEALTH**

- **Business in Community**
  How we support our associates and the practices we use to conduct business with the community

- **Health Care Organization**
  The health care services we provide to our patients and how we transition our patients from our walls to the community

- **Nonprofit Community Partner**
  How we invest our time, talent, testimony and treasure to make change in the community.

In order to support whole person health, we recognize that health is more than the choices an individual makes. Rather, a person’s health is their community, requiring a healthy ecosystem to supporting the mind, body and spirit of individuals.

We use the socioecological model to address the health of our communities. This model recognizes the complex interplay between individual, relationship, community and societal factors. Individuals are responsible for making and maintaining lifestyle choices, such as eating healthy foods and refraining from substance use. However, the ability to make these choices is determined largely by the social environment in which we live (e.g., community norms, laws and policies). It is important to be surrounded by a community supportive of a person’s overall wellbeing. Communities should not have barriers to being healthy based upon a person’s race, ethnicity, income, or where they live, work, play or learn.
Each part of the wheel illustrates the contributing factors to whole person health, each factor influencing the others. Without all portions, the wheel does not smoothly move in a positive direction for whole person health. (See Figure 2) Therefore, the most effective approach to impacting health outcomes is a combination of efforts at the individual, interpersonal, organizational, community and public policy levels.

FIGURE 2: Socioecological Model for Whole Person Health

PRIORITIZED NEEDS AND PLANS

After careful consideration of the available quantitative and qualitative indicators and our Centura Health Mission, Vision, and Values, St. Mary-Corwin Medical Center identified Behavioral Health and Food Security as priority focus areas.

At St. Mary-Corwin Medical Center, we are collectively unified by our Centura Health Mission: We extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities. This Mission guides and inspires our shared desire to make a difference – one whole person and one healthy neighborhood at a time. We believe that our focus on Behavioral Health and Food Security will have the greatest impact on our organizational commitment to whole person health.
PRIORITIZED NEED: BEHAVIORAL HEALTH

Mental health is a priority because stressors such as living in households with income below 200% of the federal poverty level (43%) drives mental health hospitalizations to nearly double the state rate. Pueblo County ranks 54th out of 58 Colorado counties for social and economic factors such as educational achievement, unemployment, crime and poverty. Suicide rates are disproportionally high in Pueblo County, with a growing epidemic among high school students. Additionally, the rate for adult suicide hospitalization in 2016 was 108 per 100,000 as compared to Colorado at 52 per 100,000.

Potential resources include:

- St. Mary-Corwin’s Southern Colorado Family Medicine residency clinic offers integrated physical and behavioral health with two therapists and eight psychiatric liaisons to triage and refer patients who present at the hospital emergency room.
- Pueblo StepUp program, sponsored by Centura Health, helps connect families with behavioral health providers.
- Pueblo County Department of Public Health and Environment Behavioral Health Workplan
- Mental Health First Aid Training classes
- Pueblo County mental health and substance use response ecosystem
- Pueblo County Fire Department recently began the Directing Others To Service (DOTS)
Pueblo County, like the rest of the state of Colorado, has experienced significant increases in substance use conditions in the last few years. From 2013-2017, there were 61 prescription opioid-related overdose deaths in Pueblo County. This translates to a rate of 13.6 deaths per 100,000 residents, higher than the state average of 10 deaths per 100,000 residents. Between 2013-2017, Colorado’s heroin-related overdose deaths increased by 77 percent. Pueblo County ranked in the highest quintile of heroin-related overdose deaths in the state with 7.9-10.7 deaths per 100,000 residents. The rate of heroin-related overdose deaths in Pueblo County is more than double the statewide average of 3.2 deaths per 100,000 residents.

_Potential resources include:_

- St. Mary-Corwin’s Southern Colorado Family Medicine residency clinic offers integrated physical and behavioral health with two therapists and eight psychiatric liaisons to triage and refer patients who present at the hospital emergency room.
- St. Mary-Corwin’s ALTO program continues to reduce prescription writing for opioids in the hospital.
- Pueblo County is served by one in-patient unit with limited Medicaid beds, and Crossroads, Inc., which treats addiction-related mental health issues and out-patient clinics at Health Solutions.
- The county increased the number of medical assisted treatment providers from four to 22.
- Pueblo County coalition on prescription drug misuse, abuse and overdose prevention.
- The Pueblo Regional Health Connector (RHC) is providing Question, Persuade and Refer suicide training to groups across the county.
- St. Mary-Corwin’s partnership with the Pueblo County Department of Public Health and Environment to align and engage in new efforts around substance use.
### Goal 1: Reach 80% of school-aged youth with a social cohesion and/or resiliency strategy.

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<th>Strategy</th>
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| Develop with the school district and partners a plan to support youth resiliency and social cohesion within the school setting, Pre-K-12. Strategy will include the following: 1) Stakeholder engagement 2) Policy strategy 3) Specific plan for Y2 and Y3 4) Community input 5) Role of Centura Health/St. Mary-Corwin Medical Center 6) Method for evaluation of success | School-age youth | • Convene stakeholders to develop comprehensive plan.  
• Develop 3-5 year plan for school and community. | Plan to reach youth with appropriate social cohesion and/or resiliency strategies. |
| Implement strategy to reach youth with social cohesion and resiliency strategy for Y2 and Y3. | School-age youth | To be included after strategy designed for Y2 and Y3. | • # of youth reached through resiliency and social cohesion programs  
• Measure of youth resiliency and/or behavioral health status |
| Work with state and local officials to support social cohesion and resiliency policies to sustain programming to support youth. | School-age youth | • Develop a list of policy solutions related to youth resiliency and social cohesion.  
• Work with community partners to identify the best policies for our community. | • Policies passed to reach children and sustain best practices.  
• Increase in youth resiliency and/or behavioral health status |
**Goal 2: Increase capacity of our community to support behavioral health needs through increased awareness of behavioral health and reduced stigma associated with behavioral health.**

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| Develop a community strategy for MHFA to reach youth and other identified target populations. | Community members              | • Review current MHFA plan for community and identify populations of focus for community.  
  • Identify MHFA trainers within community and coordinate outreach.  
  • Develop outreach strategy to reach key audiences for MHFA training.  
  • Provide MHFA training to people serving youth within community.          | • # of people working with youth who receive MHFA training  
  • # of people not working with youth who receive MHFA training             |
| Work with state and local leaders to create a sustainable model for MHFA.    | Local and State Leaders        | • Meet with key coalitions to identify policy strategy for MHFA.  
  • Identify barriers and opportunities related to providing MHFA within CO.  
  • Develop strategy for sustained MHFA within the community.                | Policies passed to sustain MHFA (organizational, state or local policies) |
| Integrate Let’s Talk Stigma Campaign messaging into all work related to behavioral health. | Community Members              | • Integrate messaging into Centura Health communications.  
  • Integrate messaging through coalitions.  
  • Use messaging with decision-makers.  
  • Develop a plan to sustain stigma campaign for 3-5 years.                 | • State survey of stigma associated with behavioral health  
  • # of people reached with messaging                                      |
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<tr>
<td>Implement SBIRT and/or MAT in Emergency Department to identify people with behavioral health needs.</td>
<td>Hospital patients with Mental Health or Substance Use Disorder Diagnosis</td>
<td>• Evaluate resource requirements for SBIRT/MAT in ED.</td>
<td># of people screened and referred to Tx</td>
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<td>• Establish plan for implementation of SBIRT/MAT in ED along with key partnerships for follow-up treatment</td>
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<td>Develop care program for patients with MH or SUD Dx (primary or secondary) that involves a collaborative discharge planning process with the RAE or consent to notify RAE within one business day.</td>
<td>Hospital patients with Mental Health or Substance Use Disorder Diagnosis</td>
<td>• Map out process for patients identified with MH/SUD Dx with RAE.</td>
<td># of people referred to mental health services</td>
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<td>• Identify how to efficiently and effectively transition patients from hospital to RAE and BH services.</td>
<td>% of people connected to mental health services</td>
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<td>Map behavioral health system of care within the community and develop a system to help people navigate through the system of care.</td>
<td>Community members with behavioral health needs</td>
<td>• Engage partners in resource mapping process.</td>
<td>Behavioral Health screening, referral and access map developed</td>
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<td>• Identify opportunities to support people in the community (vs. hospitals) and ways to navigate them to the right treatment at the right time.</td>
<td>% of people connected to mental health services</td>
</tr>
<tr>
<td>Track and share data re: mental health service needs within the community with state and local leaders to identify systems to increase access.</td>
<td>Policy makers Community members with MH/ SUD Dx</td>
<td>• Develop policy strategy for Behavioral Health with local and state coalitions.</td>
<td>% of people connected to mental health services</td>
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<tr>
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<td></td>
<td>• Work with local communities to identify policy priorities.</td>
<td>Systems established with state agencies to sustain effective mental health programming</td>
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PRIORITIZED NEED: FOOD SECURITY

Food insecurity is defined as the state of being without reliable access to a sufficient quantity of affordable, nutritious food. This priority will focus on removing barriers that create food insecurity. As written above, the SMC CHNA Subcommittee also identified obesity as a prioritized health need. Addressing food insecurity will address obesity because an essential tool in fighting obesity is having access to healthy food.

Food Security, a Social Determinant of Health, has also been identified as a priority for Centura Health as a health system serving much of Colorado and western Kansas. As we listened to our communities, we heard frequently the barriers people face related to meeting their basic needs and the impacts on people’s health and well-being. As a large employer and a non-profit health system, we can impact access to healthy, affordable foods as an anchor institution whose mission and vision includes our communities.

Obesity is a priority health need for the Pueblo community because more than a quarter of our residents are obese, compared to the statewide average of 20.1%. Obesity was also selected as a top health need for the Pueblo County Department of Public Health and Environment Community Health Improvement Plan. Pueblo County ranks 51st of 58 counties in Colorado for health outcomes. Nineteen percent of Pueblo’s population has poor to fair health compared to 15% statewide. Pueblo also has significantly higher rates of high blood pressure and high cholesterol. Congestive heart failure and COPD are top diagnoses for Medicaid patients at St. Mary-Corwin Medical Center. This obesity data combined with Pueblo's unemployment rate of 5.7% (vs. 4% for Colorado) and the ratio of households at 80th percentile of income to 20th percentile of income at 4.7 (vs. 4.5 in Colorado) led to Food Security being a critical component to ensuring the community is able to address Obesity through healthy food access.

Potential resources include:

- St. Mary-Corwin’s Southern Colorado Family Medicine Farm Stand food prescription program.
- Pueblo County Alliance for Food Access and Insecurity.
- Pueblo County Department of Public Health and Environment Obesity Work Plan.
- Supplemental Nutrition Assistance Program (SNAP) is available to eligible families.
- Women Infants and Children (WIC) program supports mothers with young children.
- Colorado has developed the Colorado Blueprint to End Hunger, providing a strategy for Colorado to address food insecurity.
- Pueblo County food pantries and healthy food access programs.
- Pueblo County School District healthy breakfast programs.
- Pueblo County Department of Public Health and Environment Healthy Food and Beverage group.
Goal 1: Increase by 20% the number of produce sites which accept SNAP and WIC at point of purchase.

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<tr>
<td>Develop a strategy to increase SNAP and WIC acceptance in the community within Year 1. Strategy will include the following: 1) Stakeholder engagement 2) Policy strategy 3) Specific plan for Y2 and Y3 4) Community input 5) Role of Centura Health/St. Mary-Corwin Medical Center</td>
<td>SNAP and WIC eligible community members Community Stakeholders</td>
<td>• Map food source locations and those which accept SNAP and WIC. • Convene stakeholders to identify strategies to address gaps within community and key stakeholders to engage</td>
<td>• Strategy to increase SNAP and WIC acceptance in community. • Community map of food resources and SNAP/WIC</td>
</tr>
<tr>
<td>Implement strategy to increase SNAP and WIC within Y2 and Y3.</td>
<td>SNAP and WIC eligible community members</td>
<td>To be included after strategy designed for Y2 and Y3.</td>
<td>• # of SNAP and WIC sites within community • Ability of SNAP and WIC participants to purchase fruits and vegetables.</td>
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<td>Integrate food access strategies into St. Mary-Corwin Medical Center community partnerships.</td>
<td>Partner Organizations Business Partners</td>
<td>• Integrate SNAP and WIC EBT use into partnerships in community • Identify key locations for food distribution partnerships to increase access</td>
<td>% of sponsorships/partnerships that increase food access through location and/or SNAP/WIC acceptance</td>
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<tr>
<td>Work with state and local officials to identify policies to increase and sustain number of SNAP and WIC sale sites and ability to purchase fruits/vegetables through SNAP/WIC.</td>
<td>SNAP and WIC eligible community members</td>
<td>• Develop a list of policy solutions related to SNAP and WIC sales. • Work with community partners to identify the best policies for our community.</td>
<td>• Policies passed to increase access to healthy, affordable foods through SNAP and WIC. • SNAP/WIC purchases for fruits/vegetables</td>
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| Identify locations at which affordable food access needs to be increased based upon race/ethnicity and income to increase access for food insecure communities. | Low-income community members living in food deserts  | • Map food source locations and those which accept SNAP and WIC by race/ethnicity and income.  
• Identify ways to add access to healthy, affordable food in food deserts.  
• Work with partners to eliminate food deserts through identified strategies. | • Community map of food resources and SNAP/WIC  
• # of produce distribution sites and food distribution sites within community by race/ethnicity and income |
| Work with state and local officials to identify strategies to reduce food deserts within the community. | Low-income community members living in food deserts  | • Develop a list of policy solutions related to SNAP and WIC sales.  
• Work with community partners to identify the best policies for our community. | Policies passed to increase access to healthy, affordable foods |
| Increase access to healthy, affordable food through Centura Health food production processes. | Centura associates  
Food Insecure Community Members | • Review hospital food production processes and identify ways to distribute safe, unused food into community. | • Policies and processes developed  
• Pounds and nutrient value of food distributed to community |
| Explore Centura Health and community land use opportunities for local food production and identify how to increase production of locally sourced fruits and vegetables. | Centura Health  
Food Insecure Community Members  
Hospital Community | • Conduct assessment of Centura Health land and community land and ability to grow food on identified locations.  
• Identify locations where gardening is possible on Centura Health land and community land.  
• Work with state and local policy makers to address barriers to gardening on Centura and community land, as necessary. | • # of Centura Health facilities producing food  
• # of new community gardens  
• Pounds and nutrient value of food distributed to community from Centura gardens |
### Goal 3: Decrease the number of community members who are eligible but not enrolled in SNAP by 60%.

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| Screen households for food insecurity and refer them to food resources in their communities, including identifying eligibility for all available public assistance programs. | SNAP and WIC eligible community members, Food Insecure Patients | • Update Centura’s Electronic Health Record to assist in identifying Social Determinants of Health, including food insecurity  
• Train associates on Social Determinant of Health screening and referral process  
• Implement screening for Social Determinants of Health within hospital/ambulatory practices | • % of patients screened for food insecurity  
• % of patients screened successfully referred to community resources |

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| Partner with community to increase awareness of impact of hunger on whole person health and identify state and local policies to increase access to SNAP and WIC. | Decision Makers at State and Local Levels | • Participate in state and local coalitions addressing food insecurity  
• Participate in Metro Denver Partnership for Health to address social determinants of health  
• Implement Blueprint to End Hunger strategies applicable to health care | • # of groups and meetings attended  
• Policies adopted at state and local levels to increase access |

### Goal 4: Increase use of locally sourced healthy, affordable food within Centura Health by 50%.

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| Implement food procurement practices to prioritize local food sourcing. | Centura associates, Hospital community | • Review current Centura Health food procurement practices and identify food sources.  
• Review best practices related to local food procurement and identify local food sources.  
• Establish plan for Centura Health implementation of local food procurement for hospital facility.  
• Implement local food procurement purchasing practices. | • % of locally sourced food used by Centura Health |
Conclusion

On June 25, 2019, the St. Mary-Corwin Medical Center Board of Directors, a board made up of community members, approved our Community Health Needs Assessment. On October 29, 2019, the Board of Directors approved Food Security as a priority and our Community Health Implementation Plan. The CHNA process presents an opportunity for St. Mary Corwin Medical Center to fulfill our commitment to Centura’s organizational mission to *extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities*. The Community Health Implementation Plan (CHIP), sets our path forward to building wholeness and flourishing communities.

We look forward to reporting back annually on the work we do to improve the health of our communities. Together, we can realize our Centura Health Vision that every community, every neighborhood, every life is whole and healthy.
## APPENDIX A: LIST OF SUBCOMMITTEE MEMBERS

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<th>Organization</th>
<th>Name of Representative</th>
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<tbody>
<tr>
<td>Pueblo County Department of Public Health &amp; Environment</td>
<td>Randy Evetts</td>
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<tr>
<td>Pueblo Department of Public Health &amp; Environment</td>
<td>Shylo Dennison</td>
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<tr>
<td>Pueblo Community Health Center</td>
<td>Justin McCarthy</td>
</tr>
<tr>
<td>Regional Health Connector</td>
<td>Ryan Turner</td>
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<tr>
<td>Pueblo Fire Department</td>
<td>Rick Potter</td>
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<tr>
<td>Pueblo Triple Aim</td>
<td>Alexis Ellis</td>
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<tr>
<td>Health Solutions</td>
<td>Sandy Gutierrez</td>
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<tr>
<td>Health Solutions</td>
<td>Jason Chippeaux</td>
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<tr>
<td>Pueblo Senior Resource Development Agency</td>
<td>Tara Maro</td>
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<tr>
<td>African American United Methodist Church</td>
<td>Rev. Olga Copeland</td>
</tr>
<tr>
<td>Center for Health Progress</td>
<td>Chris Kline</td>
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<tr>
<td>Centura Health</td>
<td>Carl Patten</td>
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<tr>
<td>St. Mary-Corwin, CEO</td>
<td>Mike Cafasso</td>
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<tr>
<td>St. Mary-Corwin Foundation</td>
<td>Linda Russell</td>
</tr>
<tr>
<td>St. Mary Corwin-Manager Mission/Spiritual Care</td>
<td>Marco Vegas</td>
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