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Providence
Community Health Investment

May 30, 2020

Mr. Harry Dhami
Office of Statewide Health Planning and Development
Accounting and Reporting Systems Section
2020 West El Camino Ave. Suite 1100
Sacramento, CA 95833

Dear Mr. Dhami,

On behalf of our three Medical Centers, Providence Holy Cross, Providence St. Joseph, and Providence Cedars-Sinai Tarzana, I am pleased to provide you the 2019 Update to our Community Benefit Plan. Please let me know if I can be of any further assistance.

Sincerely,

Ismael Aguila, MS
Director of Community Health Investment and Partnerships

# 2019 ANNUAL UPDATE TO COMMUNITY BENEFIT PLAN

## PROVIDENCE HOLY CROSS, PROVIDENCE ST. JOSEPH, AND PROVIDENCE CEDARS-SINAI TARZANA

**Submitted to OSHPD by:**

Providence
HOLY CROSS MEDICAL CENTER
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Providence | Cedars Sinai
TARZANA MEDICAL CENTER
Tarzana, Calif.

# 2019 ANNUAL UPDATE TO COMMUNITY BENEFIT PLAN

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***Attachments:***


*Appendix 1:* *Providence Holy Cross, St. Joseph and Cedars-Sinai Tarzana Medical Centers 2017-19 Implementation Strategy – 2019 Progress Matrix*

*Appendix 2:* *Providence Holy Cross, St. Joseph and Cedars-Sinai Tarzana Medical Centers 2019 Detailed Listing of Community Benefit Services*

*Appendix 3:* *Providence Holy Cross Medical Center 2019 Detailed Listing of Community Benefit Services*

*Appendix 4:* *Providence St. Joseph Medical Center*

*2019 Detailed Listing of Community Benefit Services*

*Appendix 5:* *Providence Cedars-Sinai Tarzana Medical Center*
*2019 Detailed Listing of Community Benefit Services*

# I. Executive Summary

The Hospital Community Benefit Program (HCBP), commonly referred to as "SB 697," is a result of a 1994 State law that mandates private, not-for-profit hospitals, including Providence Holy Cross, Providence St. Joseph and Providence Cedars-Sinai Tarzana Medical Centers in the San Fernando Valley, to "assume a social obligation to provide community benefits in the public interest" in exchange for their tax-exempt status. Senate Bill 697 requires that non-profit hospitals throughout California conduct a triennial community needs assessment and develop a Community Benefits Plan based on the findings. This 2019 Annual Update describes progress towards measurable objectives set forth in the 2016 Joint Community Health Needs Assessment. In addition, this document includes the recently completed 2019 Community Health Needs and Assessment and the related 2020-22 Implementation Strategy, both of which have been adopted by their respective governing boards.

The Providence San Fernando Valley (hereafter SFV Service Area) is comprised of the geographically contiguous Service Areas of the three Providence Medical Centers: namely, Providence Holy Cross Medical Center (PHCMC; Mission Hills); Providence St. Joseph Medical Center (PSJMC; Burbank); and Providence Cedars-Sinai Tarzana Medical Center (PCSTMC; Tarzana). Within their respective service area boundaries, each medical center has an identified Community Benefit Service Area (CBSA) which are the communities with the greatest need, indicated in orange on the map below. Similarly, each Medical Center has a grouping of communities (in blue) within their Service Areas which are better resourced, with primarily middle/upper income demographics. The 2019 Joint Community Health Needs Assessment and 2020-22 Measurable Objectives focuses programs and resources on the CBSA of the three Providence Medical Centers.

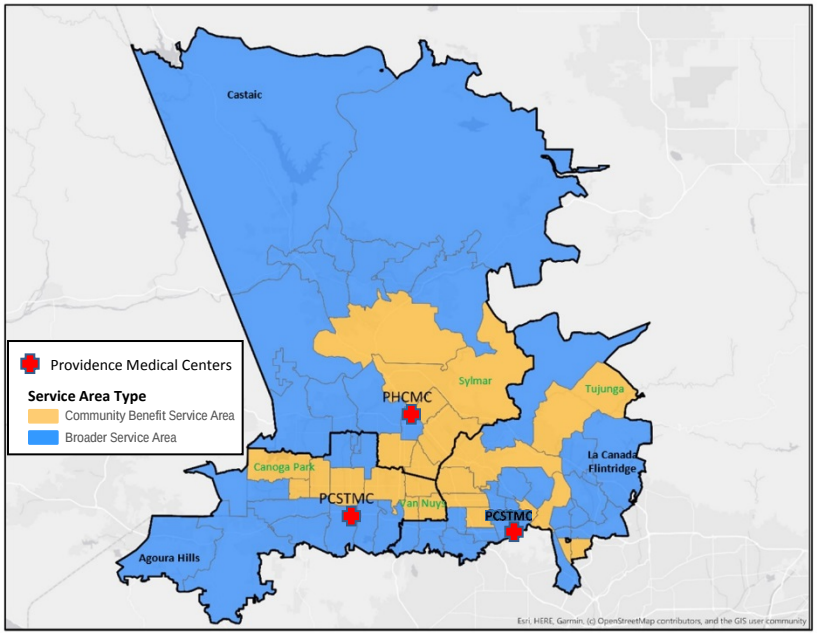



Figure 1. Community Benefit Service Area of the three Providence Medical Centers

Health disparities within the CBSA include age-adjusted death rates due to diabetes and hypertension that are higher than Countywide rates and the United States. Adverse social determinants of health include low-income status, food insecurity, housing affordability, poor access to medical care challenges, high rates of health risk behaviors, low educational achievement, and low English language proficiency. Almost one-half (48.6%) of CBSA residents are low-income or impoverished, living on 200% or less of the Federal Poverty Guidelines. More than one-half (55.8%) of households commit more than 30% of their household income to housing costs, which is the eligibility threshold set by the US Dept. of Housing and Urban Development for affordable housing.

The Community Health Department builds and sustains collaborative relationships on behalf of the three Providence Medical Centers, which are governed by the VSA Community Ministry Board and the Providence Cedars-Sinai Tarzana Medical Center Board of Managers. In addition, Community Health works with community safety net partners, including the Los Angeles County Department of Public Health, and designs, implements and evaluates programs and services that are responsive to the community health needs identified and prioritized during the triennial needs assessment adopted by the VSA Community Ministry Board and the Providence Cedars-Sinai Tarzana Medical Center Board of Managers.

**Incorporating Mission Philosophy into Community Benefits**

Today, the three Medical Centers are part of the larger Renton-based Providence St. Joseph Health System that was formed in 2016 when Providence Health & Services and St. Joseph Health combined into a single organization. As the two health systems came together, they developed a new a Mission Statement that continues to direct special attention for the poor and vulnerable:

***"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."***

This statement of organizational purpose reaffirms our commitment to underserved communities and simultaneously creates new opportunities to work collaboratively with community partners based on the reality that no single organization can meet all of the health care needs of high-need communities. Accordingly, we continue to partner with nonprofit organizations and public entities that share our commitment to serving the community.

**2019 Needs Assessment**

To ensure that the Providence Medical Centers in the San Fernando Valley comply with CB697, the Community Health staff recommended the Community Ministry Board (CMB) authorize the creation of an ad hoc CHNA Oversight Committee made up of an equal number of Providence representatives and external Stakeholders to prioritize the identified health needs. At its March 25, 2019 meeting, the CMB authorized this CHNA Oversight Committee. The CHNA Oversight Committee, authorized by the governing boards in March 2019, met twice in the fall of 2019 to prioritize and recommend the top identified health needs to be addressed over the next three years.

There is increasing recognition that many other factors beyond the health care system impact health. These factors are often referred to as Social Determinants of Health and play an important

role in the health of the individual and entire communities. For example, the neighborhood and physical environment where a person grows up, as well as the education they receive, the food they eat, and their social support systems all contribute to the health of that individual. The CHNA took a close look at these factors, the disparities that exist between high need communities and neighborhoods, compared to the better-resourced, often higher income "broader communities" in the SFV Service Area. The top prioritized health needs are as follows:

**Table 1. Health-Related Needs in Order of Priority**

| Rank | Health-Related Need |
|---|---|
| 1 | Homelessness and Housing Instability |
| 2 | Behavioral Health, including Mental Health and Substance Use |
| 3 | Food Insecurity |
| 4 | Prevention and Management of Chronic Diseases |
| 5 | Access to Healthcare and Resources |
| 6 | Senior Care |
| 7 | Immunization/School Health |
| 8 | Violence Prevention |

**Measurable Objectives 2020-22**

As a result of the findings of our 2019 Community Health Needs Assessment (CHNA) and through a prioritization process aligned with our Mission, resources, and Medical Center strategic plans, the four initiative below will become the focus of the 2020-22 Community Health Improvement Plan for Providence Holy Cross, Providence Saint Joseph and Providence Cedars-Sinai Tarzana Medical Centers:

- **Initiative #1:** Strengthen infrastructure of continuum of care for patients experiencing homelessness: Our goal with this initiative is to strengthen the infrastructure that is serving the needs of individuals experiencing homelessness, many of who come to Providence Wellness Centers for care. Our focus with this priority is to implement strategies that will support systems navigation, prevention, and recuperative care/temporary housing for patients experiencing homelessness.
- **Initiative #2:** Increase reach and utilization of community based wellness and activity centers: Our goal with this initiative is to increase the reach and utilization of two Providence Wellness and Activity centers in the San Fernando Valley. The purpose of these Centers is to bring together children and adults to participate with our staff, community volunteers and collaborative partners in free programs that promote social connections among neighbors, encourage participants to participate in education programs, and link people to public and private community resources. We seek to improve the health of the community by encouraging participants to learn, and grow and succeed in life.

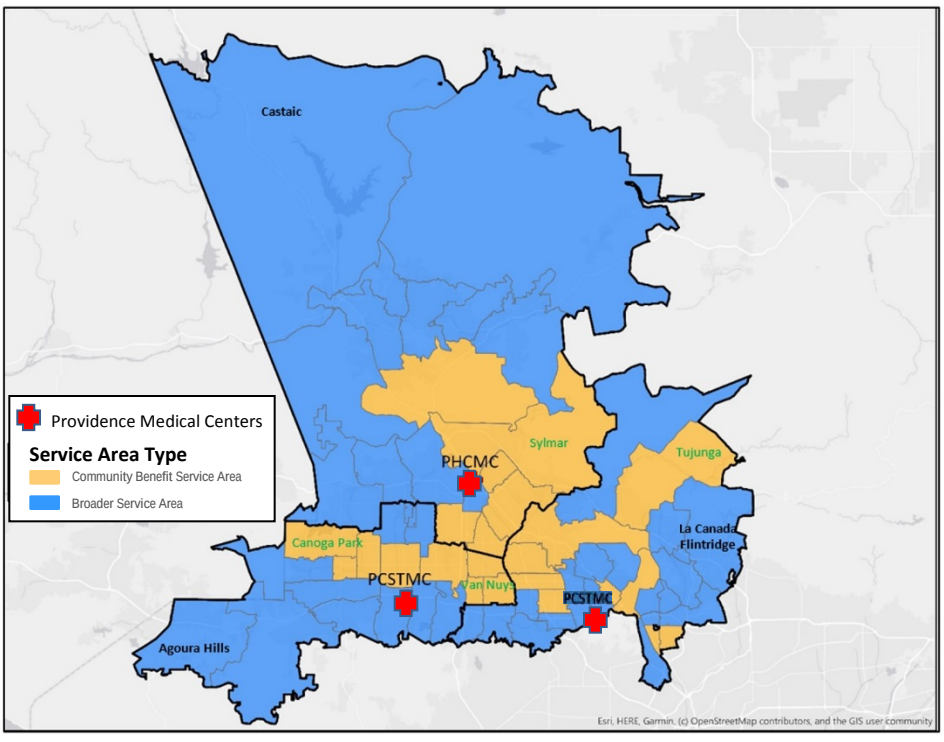
- **Initiative #3:** Improve access to healthcare services and preventative resources: Our goal with this initiative is to improve access to health care and prevention resources in the most vulnerable San Fernando Valley communities, especially the poor and underserved. This initiative will work to expand access to healthcare and preventative resources by deploying programs to assist in the navigation of the health and social services, provide skills based educational programs, and enrollment assistance into programs that provide health insurance, food and social programs.
- **Initiative #4:** Support collaborative partnerships for better health: This initiative will address the need for immunizations and forge collaborative partnerships with nonprofit hospitals and health care organizations, community clinics and schools to improve immunization compliance across the San Fernando Valley for children and families. We will start with flu shots for children, adults, and seniors and childhood immunizations for children. We are hopeful a COVID vaccine will be available to administer broadly by the end of this three-year cycle.

## II. Overview of San Fernando Valley Community

### A. Community Benefit Service Area

The Providence San Fernando Valley Community (hereafter SFV Service Area) is comprised of the geographically contiguous Service Areas of the three Providence Medical Centers: namely, Providence Holy Cross Medical Center (PHCMC; Mission Hills); Providence St. Joseph Medical Center (PSJMC; Burbank); and Providence Cedars-Sinai Tarzana Medical Center (PCSTMC; Tarzana). Within their respective service area boundaries, each medical center has an identified Community Benefit Service Area (CBSA) which are the communities with the greatest need, indicated in orange on the map below. Similarly, each Medical Center has a grouping of communities (in blue) within their Service Areas which are better resourced, with primarily middle/upper income demographics. The 2019 Joint Community Health Needs Assessment and 2020-22 Measurable Objectives focuses programs and resources on the CBSA of the three Providence Medical Centers.

Figure 1. Community Benefit Service Area of the three Providence Medical Centers



Health disparities within the CBSA include age-adjusted death rates due to diabetes and hypertension that are higher than Countywide rates and the United States. Adverse social determinants of health include low-income status, food insecurity, housing affordability, poor access to medical care challenges, high rates of health risk behaviors, low educational achievement, and low English language proficiency. Almost one-half (48.6%) of CBSA residents are low-income or impoverished, living on 200% or less of the Federal Poverty Guidelines. More than one-half (55.8%) of households commit more than 30% of their household income to housing costs, which is the eligibility threshold set by the US Dept. of Housing and Urban Development for affordable housing.

The San Fernando Valley Community served by the three Providence Medical Centers is dynamic and diverse with a population that spans the socioeconomic spectrum. The two million residents of the region include resource-rich communities such as Porter Ranch, Calabasas, Encino, and Studio City, and many low-income, under-resourced communities like San Fernando, Pacoima, Sylmar, Canoga Park, Reseda, and North Hollywood, amongst others. Collectively, the individual service areas of the three Providence Medical Centers roughly align with Los Angeles County Department of Public Health's Service Planning Area (SPA) 2.

## B. Overview of Medical Centers

**Providence Holy Cross Medical Center (PHCMC)** was founded in 1961 by the Sisters of the Holy Cross to serve a growing population in the northern San Fernando Valley. In 1996, the medical center was purchased by Providence Health & Services, which was founded by the Sisters of Providence. These Sisters have been serving the western United States since the mid-1800s and the San Fernando Valley since 1943. PHCMC, a nonprofit health organization, has expanded its facility to 377 beds, serving the health care needs of residents in San Fernando, Santa Clarita and Simi Valleys. To these communities, PHCMC offers a state-of-the-art Cancer Center, a Heart Center, Orthopedics, Neurosciences, and Rehabilitation Services, Women's and Children's Services, as well as a Level II Trauma Center.

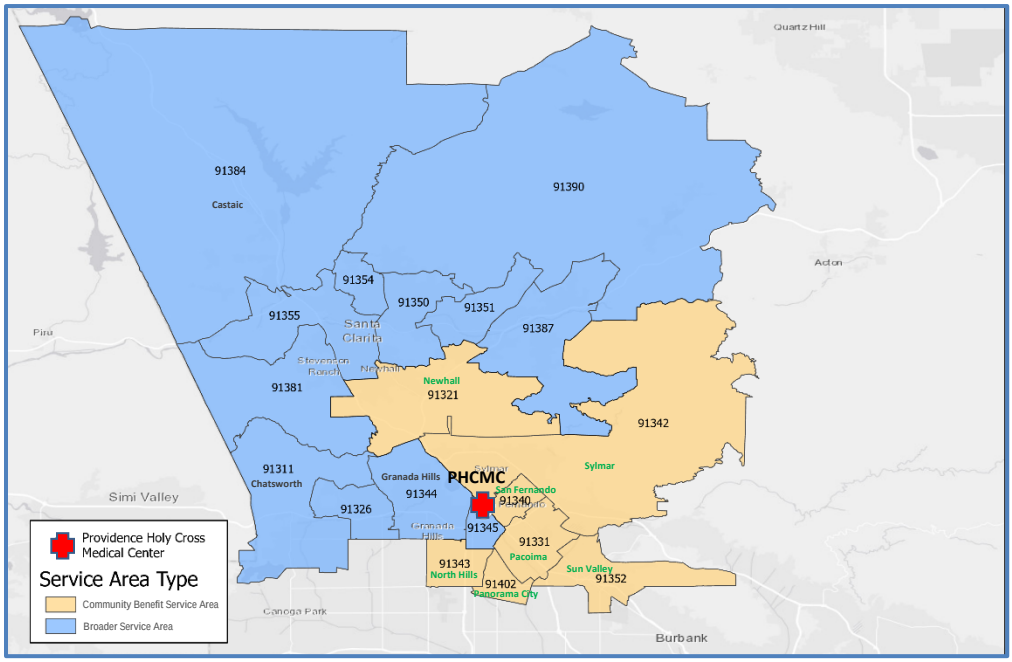


Figure 2. Providence Holy Cross Medical Center Community Benefits Service Area

**Providence Saint Joseph Medical Center (PSJMC)** was opened in 1944 by the Sisters of Providence to serve a growing population in the San Fernando Valley. Starting from a small 100-bed facility, PSJMC has grown over the years to become a major health care facility serving the residents of northern Los Angeles County. Providence Saint Joseph Medical Center is a 392-bed licensed acute care facility serving the San Fernando and Santa Clarita Valleys. PSJMC is known for its state-of-the-art technology and high-quality, compassionate care. The 2,500 employees, 400 volunteers, guild members, and over 800 physicians at the medical center share a commitment to provide quality care for all through the Roy & Patricia Disney Family Cancer Center, Bariatric Wellness Center, Stroke Services, Heart and Vascular Institute, Howard and Hycy Hill Neuroscience Institute, Orthopedics Department, Women's Services, and Breast Health Center.

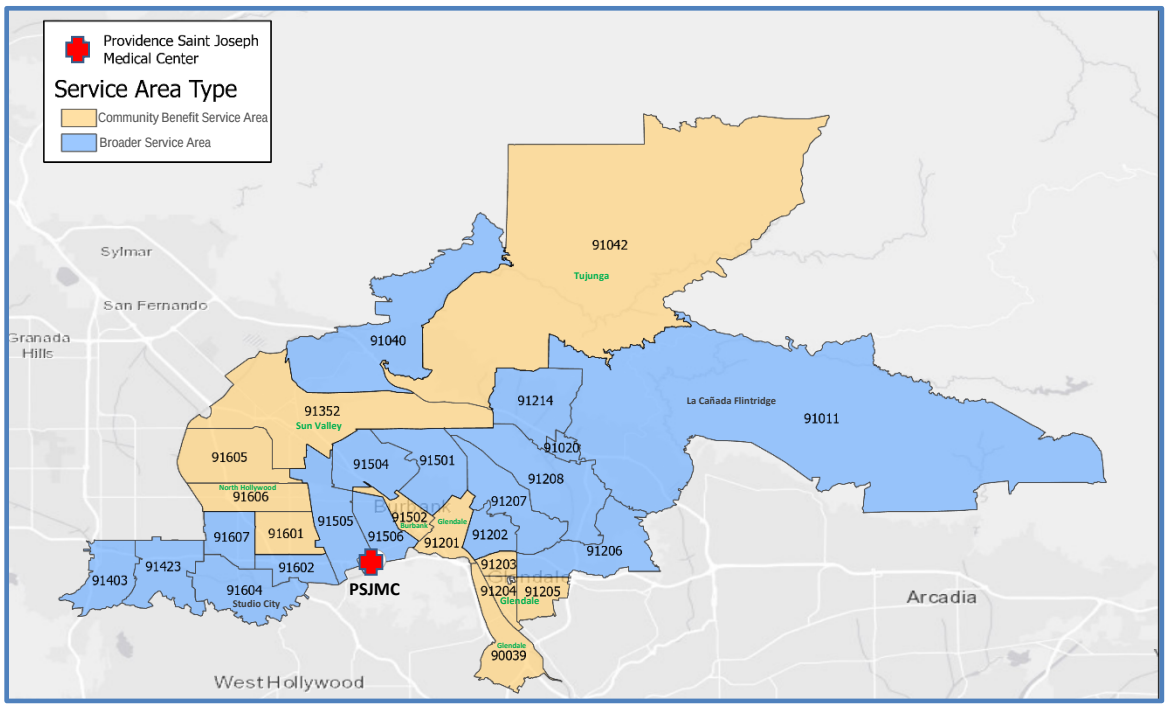


Figure 3. Providence Saint Joseph Medical Center Community Benefits Service Area

**Providence Cedars-Sinai Tarzana Medical Center (PCSTMC)** was founded in 1973 and has been serving a rapidly growing West San Fernando Valley community since it opened. The 249-bed hospital is known in the area as a leading health care provider for quality care by delivering babies, providing emergency life-saving care, and performing surgeries and other procedures to improve the health of the community. In 2008, the hospital was purchased by Providence Health & Services. As a non-profit medical center, their community health outreach programs address the needs of underserved communities. In 2019, Providence and Cedars-Sinai Medical Center partnered to operate the medical center jointly, now known as the Providence Cedars-Sinai Tarzana Medical Center.

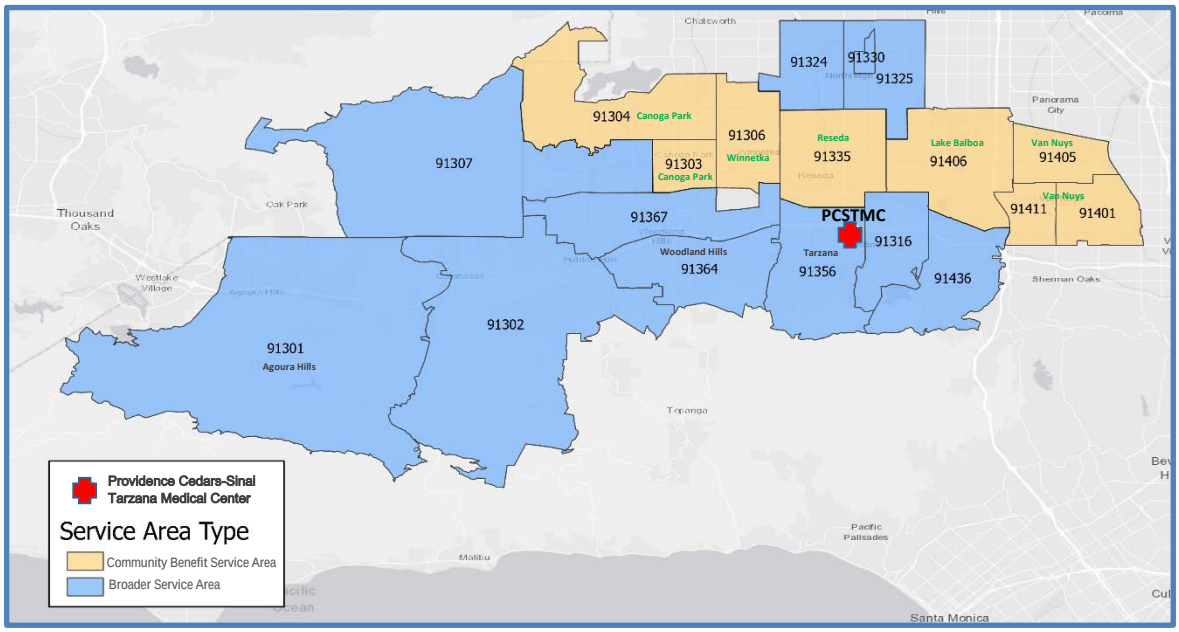


Figure 4. Providence Cedars-Sinai Tarzana Medical Center Community Benefits Service Area

## C. Organization of Community Health Resources

Historically, the Providence Valley Service Area Community Ministry Board (VSA) served as the governing board for the three Providence Medical Centers in the San Fernando Valley Community and conducted its joint Community Health Needs Assessments to identify and prioritize the greatest health needs across the San Fernando Valley every three years as required by SB697. In early 2019, Providence Tarzana Medical Center entered into a joint venture with Cedars Sinai Health System which resulted in a new governing board. The VSA is now composed of Providence Holy Cross Medical Center (Mission Hills) and Providence St. Joseph Medical Center (Burbank). The newly formed Providence Cedars-Sinai Tarzana Medical Center Board of Managers, agreed in 2019 to conduct a Joint Community Health Needs Assessment. Both governing boards adopted the CHNA in December 2019.

The Community Health Department builds and sustains collaborative relationships on behalf of the three Providence Medical Centers Community Health works with community safety net partners, to design, implement and evaluate programs and services that are responsive to the prioritized community health needs identified by the needs assessment and adopted by the respective governing boards.

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Community Health operates from the premise that:

- Diversity of language, culture, and perspective is an asset
- Disparities can best be reduced through collaboration
- Targeted direct services facilitate health improvements in underserved communities
- Limited resources should be targeted to communities with the greatest need

Simply stated, the Community Health Department is committed to both collaboration with community partners and the delivery of services and programs that address the health needs of residents in the service area of each Providence Medical Center in the San Fernando Valley.

## III. Mission and Community Benefit.

### A. Incorporating Mission Philosophy into Community Benefit

Providence St. Joseph Health has a tradition of caring that the Sisters of Providence began 160 years ago. They took inspiration from the phrase, "Caritas Christi Urget Nos," which meant the love of Christ moves us, compels us, to follow his example in providing healing, education and service to all we encounter, with a special concern to those who are most poor and vulnerable. The Sisters have always kept in mind the most poor and vulnerable. Through their courage and determination, they established the first schools, hospitals, orphanages and other institutions of care to serve their communities. In addition, they incorporated their works of charity in 1859, creating the forerunner for the current network of health care services known as Providence St. Joseph Health.

In 2016, two health systems joined together: Providence Health & Services and St. Joseph Health. The Sponsors of each system also came together and were tasked with creating a mission statement that reflects the values and purpose of this new organization, Providence St. Joseph Health. Today, Providence Holy Cross, Providence St. Joseph and Providence Cedars-Sinai Tarzana Medical Centers are fully aligned with both the Mission and Core Values of the Renton-based health system

***"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."***

Within this statement of organizational purpose lies the commitment to pay special attention to the poor and vulnerable, reaffirming our commitment to underserved communities. Providence operates from the premise that no single organization can meet all of the health care needs of high-need communities. Accordingly, we design work in collaboration with nonprofit organizations and public entities that share our commitment to serving the community.

### B. Allocation of Community Outreach Resources Reflect the Mission

Central to community-based outreach is the notion that diversity of language and culture is an asset and that disparities can be reduced through collaboration, advocacy among stakeholders and resources targeted to communities with the greatest need. The 2019 needs assessment describes the continuing process for determining which communities have the greatest need, bringing together primary and secondary data sources to identify specific disparities, and in collaboration with community partners, develop a three-year plan that describes our priorities. Through this process, the communities of each Medical Center, which are determined to have the greatest need and which we prioritize community benefit resources to, are defined in the CHNA as the Community Benefit Service Area.

The Community Benefit Service Area for each Medical Center was defined using the Community Need Index (CNI) mapping tool from Dignity Health and Truven Health Analytics. All communities with a score of 4 or greater on the scale were included. Communities identified as having higher need using the scale experience greater barriers to health care, including income, cultural, educational, health insurance, and housing barriers. The communities defined as "Broader Service Areas" are the remaining communities within each Medical Center's Service

Area. These areas are more resource rich with a population on the higher end of the socioeconomic spectrum. While our Community Benefit Services are available throughout the San Fernando Valley, the program infrastructure is directed to the Community Benefit Service Area. Additionally, while our Mission commands special attention to the poor and vulnerable, the CHNA Implementation Strategy includes programs that benefit the broader community. The three Providence Medical Centers in the San Fernando Valley track community benefit expenses throughout the year as part of their operating commitments.

### C. Strengthening Communities through Prevention & Collaboration

Too often, hospitals limit community outreach programs to acute health care problems. The inevitable result is that underlying unhealthy behaviors never get the attention needed to create a positive change in the health of communities. When the intervention is limited to "fixing" a medical problem, the opportunity to prevent unhealthy behaviors is lost.

The San Fernando Valley Community Health Department seeks to balance the clear need for community outreach related to access to medical care services with the need for skills-based prevention services that create health improvements in underserved communities. The challenge is to design a program with stakeholder input, implement a successful intervention, sustain it, achieve measurable results and, as new resources are found, expand to as many high need communities as resources will permit. Our ability to accomplish this result is directly linked to successful results.

As we establish program effectiveness, we seek out funding partnerships with key stakeholders, public and private, to give further reach and impact to this work. Currently, there are 28 Providence Community Health Department employees who provide community outreach programs and services in the San Fernando Valley.

## IV. 2019 Needs Assessment

To ensure that the Providence Medical Centers in the San Fernando Valley comply with SB697, the Community Health staff requested the Community Ministry Board (CMB) authorize the creation of an ad hoc CHNA Oversight Committee made up of an equal number of Providence representatives and external Stakeholders to prioritize the identified health needs. At its March 25, 2019 meeting, the CMB authorized this CHNA Oversight Committee. The goals of this CHNA assessment are the following:

- Involve public health and community stakeholders including low-income, minority, and other underserved populations, in describing the assets and health needs of the community.
- Assess and understand the community's health issues and needs.
- Understand the health behaviors, risk factors and social determinants that impact health.
- Identify community resources and collaborate with community partners.
- Use CHNA findings and priorities to develop and implement a 2020-2022 implementation plan.

The CHNA Oversight Committee, met twice in the fall of 2019 to prioritize and recommend the top identified health needs to be addressed over the next three years. The external representatives included the perspective of a pediatrician, an FQHC, mental health services provider, an affordable housing organization, senior services provider and the Area Health Officer for the San Fernando Valley from the Department of Public Health. Internal Providence representatives were from all three Medical Centers and represented Hospital Administration, Social Work, Nursing, Emergency Department and the philanthropic foundation. The Chief Mission Integration Officer for the Southern California Region facilitated both meetings, on behalf of the governing board.

## A. Process and Methods.

Community Input: Qualitative Data

Providence San Fernando Valley recognizes the value of input from community members and local stakeholders during the Community Health Needs Assessment (CHNA) process. As the people who live and work in the San Fernando Valley, they have first-hand knowledge of the needs and strengths of their community and their opinions help to shape our future direction. For primary data, input was collected from 18 key community leaders via phone interviews. In addition, input was collected from 51 residents during six listening sessions at Vaughn Early Learning Center, San Fernando Elementary School, Blythe Street Elementary School, and Guardian Angel Catholic School. Qualitative data, or data in the form of words instead of numbers, provide additional context and depth to the CHNA that may not be fully captured by quantitative data alone. Key takeaways gathered through organizational leader interviews and community resident listening sessions are included in this report, organized by relevant health need.

Solicited CHNA Comments from the Public

The 2016 San Fernando Valley Joint Community Health Needs Assessment is publicly available on each of the three hospital's websites, with a point of contact listed in the report. No written comments on the 2016 Community Health Needs Assessment and Implementation Strategy report were received from the public to be considered for the 2019 Community Health Needs Assessment.

Collaborative Partners

As part of the primary data collection process, Providence staff worked in collaboration with community partners to collect and analyze information and:

- Develop a list of key community stakeholders/leaders to be included in the telephone interviews.
- Compile a list of questions to be used in the telephone interviews to identify the key community needs and contributing factors. Providence staff collaborated with hospitals participating in the LA Partnership, a collection of nonprofit hospital systems and stand-alone hospitals, to develop a common set of interview questions for Stakeholder interviews.
- Share secondary data sources regarding key information available on the targeted area.

In the future the Providence hospitals intend to continue efforts that promote additional Community Benefit collaboration in the conduct of needs assessment and programs that can be implemented across a broader geography.

Quantitative Data

Secondary data collection included socio-economic indicators and mortality and morbidity rates from multiple sources. These sources included the U.S. Census American Community Survey, the California Health Interview Survey (UCLA), the L.A. County Department of Public Health, the State of California Department of Public Health, and the Los Angeles Homeless Services Authority.

Additionally, primary quantitative data were collected from the Providence electronic health record system provided Emergency Department and inpatient utilization

Data Limitations and Information Gaps

The secondary data allow for an examination of the broad health needs within a community. However, these data have limitations, as is true with any secondary data:

- Data were not always available at the ZIP code level, so Los Angeles County level data as well as Service Planning Area level data were utilized.
- Disaggregated data for age, ethnicity, race, and gender are not available for all data indicators, which limited the examination of disparities of health issues within the community.
- At times, a stakeholder-identified health issue may not have been reflected by the secondary data indicators.
- Data are not always collected on an annual basis, meaning that some data are several years old.

Identified Health Needs

Once the information and data were collected and analyzed by staff members, the following eight key areas were identified as community needs for the Community Health Needs Assessment Oversight Committee to prioritize. Issue briefs that encompassed both primary and secondary data were prepared for each identified health need, listed here in alphabetical order:

- Access to Healthcare and Resources
- Behavioral Health, Including Mental Health and Substance Use
- Food Insecurity
- Homelessness and Housing Instability
- Immunization/School Health
- Prevention and Management of Chronic Diseases
- Senior Care
- Violence Prevention

Prioritization Process and Criteria

The CHNA Oversight Committee met in September 2019 to conduct its work with a clear statement of its role: to recommend to the Community Ministry Board the top identified health needs to be prioritized and addressed over the next three years. At the first meeting, on September 10, 2019, the CHNA Oversight Committee considered the CHNA Framework, the definition of the community and the high need areas within the SFV Service Area. The group participated in two panel discussions related to homelessness and food insecurity and utilized some of the secondary data from the high need areas to sharpen the discussion. This approach was taken to familiarize the group with the identified health needs to be presented in the second meeting and to practice a structured discussion format that would be followed in the second panel session.

In advance of the second meeting, Oversight Committee Members received a summary of primary and secondary data collected for nine identified health needs. The second meeting began with each member of the committee submitting a complete email survey of their input for the nine specific identified health needs, based upon the collection of primary and secondary data by Providence staff. For each identified health need, committee participants were asked to rate (1) the severity of the identified health need, (2) the change over time, (3) the availability of community resources/assets to address the health need, and (4) the community readiness to implement/support programs to address the health need. These criteria formed the initial impressions of committee members. This survey was then followed by a review of the data assembled for each identified health need. Half of the meeting time was then set aside to break the Oversight Committee into three groups to address the following questions for each identified need:

- How does this need impact the work of your organization and the clients you serve?
- What other service gaps currently exist?
- What role can Providence play in addressing this need?

After each group rotated through the nine topics, a facilitator for each topic reported out the points of consensus that emerged from the committee members. As a final summary of the discussion, each of the participants was given three dots, or “votes” to assign to the identified topics resulting in the prioritization of the nine health needs identified by the primary and secondary data collected.

Two separate data points were combined into a single point score to prioritize the health needs. This was achieved by combining the results of both the email survey that was distributed before the second meeting and dot count votes taken during the end of the second meeting to calculate the relative priority rank of each of the health needs.

***A.*** 2019 Prioritized Health Needs

The top five prioritized health needs are as follows:

**Table 2. Health-Related Needs in Order of Priority**

| Rank | Health-Related Need |
|---|---|
| 1 | Homelessness and Housing Instability |
| 2 | Behavioral Health, including Mental Health and Substance Use |
| 3 | Food Insecurity |
| 4 | Prevention and Management of Chronic Diseases |
| 5 | Access to Healthcare and Resources |
| 6 | Senior Care |
| 7 | Immunizations/School Health |
| 8 | Violence Prevention |

## Description of Significant Community Health Needs

### Homelessness and Housing Instability

Primary Data— Service Provider and Community Resident Input

Stakeholders shared that having a safe, stable place to live is foundational to a person's wellbeing. Therefore, addressing homelessness and housing instability is an urgent need. Stakeholders shared the following factors that contribute to homelessness and housing instability:

- Siloed services due to funding streams
- Lack of safety net supports to offset high cost of living
- Lack of affordable housing options and presence of "NIMBYism" (Not in My Backyard)
- Lack of sufficient homelessness services to meet the demand
- Economic insecurity and a lack of living wage jobs
- Lack of funding for grassroots homelessness service providers
- Lack of full stakeholder engagement in addressing homelessness

Stakeholders named two groups as particularly affected by homelessness/housing instability and lacking support services:

- Young people
- Older adults

Effective strategies to address homelessness and housing instability shared by stakeholders include the following:

- Family reconciliation and homeless diversion (helping people identify immediate

- alternate housing arrangements and connecting them with financial and housing assistance programs)
- Relationship building and improved integration of services
- Community outreach and health education to people experiencing homelessness
- A continuum of housing and supportive services, from transitional to permanent housing

Secondary Data

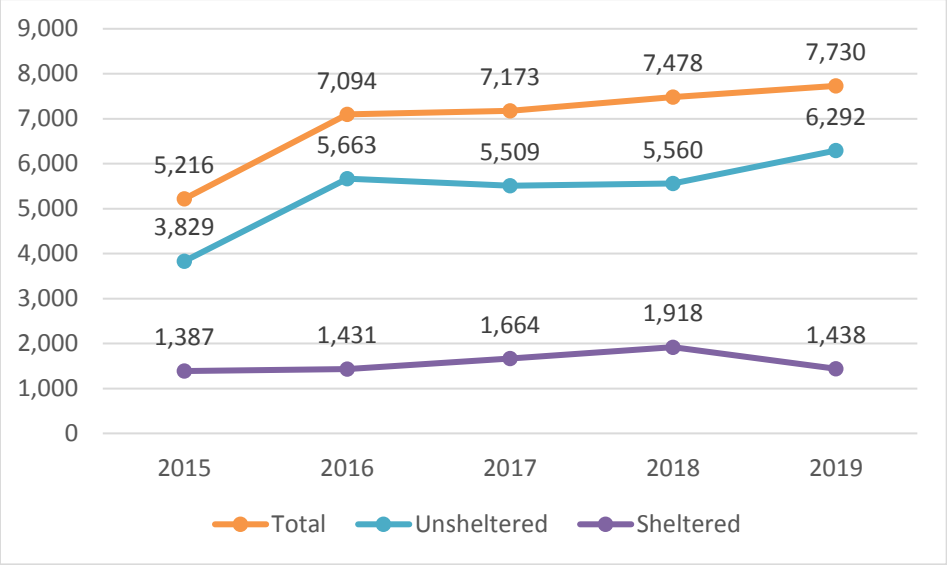
The Los Angeles Homeless Services Authority (LAHSA) conducts a yearly point-in-time count called the Greater Los Angeles Homeless Count. Moderated by the U.S. Department of Housing and Urban Development, LAHSA conducts the nation's largest homeless census count with the help of volunteers over the course of three days and nights. Results are published on LAHSA's website and are available here: [https://www.lahsa.org/documents.](https://www.lahsa.org/documents.)

The table on the next page displays the results of the 2019 Greater Los Angeles Homeless Count with a focused look at the results of Service Planning Area (SPA) 2.

**Table 3. 2019 Point-In-Time Homeless Count**

| Geographic Area | Sheltered | Unsheltered | Total | Percent Change 2018 - 2019 |
|---|---|---|---|---|
| Los Angeles County | 14,722 | 44,214 | 58,.936 | +12% |
| SPA 2 | 1,438 | 6,292 | 7,730 | +3% |

**Figure 1. Total Number of People Experiencing Homelessness, Sheltered and Unsheltered, in SPA 2, 2015-2019**



The total number of individuals experiencing homelessness in SPA 2 has continued to increase since 2015 according to the 2019 Greater Los Angeles Homeless Count. From 2018 to 2019, the number of sheltered individuals experiencing homelessness in SPA 2 has decreased, while the number of unsheltered individuals experiencing homelessness has increased.

**Behavioral Health, Including Mental Health and Substance Use**

Primary Data— Service Provider and Community Resident Input

Mental Health

Stakeholders shared they are seeing increased incidences of mental health challenges in the community, with increased depression, anxiety, and suicidal ideation, especially in young people. Many stakeholders identified mental health challenges as an urgent issue in the community. Stakeholders named a variety of contributing factors to the community's mental health challenges:

- Poverty and a lack of opportunities
- Trauma and violence
- Fear and racism related to immigration status
- Lack of access to culturally and linguistically appropriate mental health services in the community and schools

Stakeholders identified several populations that are most affected by behavioral health challenges:

- Young people
- Older adults
- Immigrants, particularly undocumented immigrants

Common themes for effective strategies to address behavioral health challenges include the following:

- Improve access to counseling and mental health services
- Integrate mental health care and primary care
- Utilize health education classes and workshops
- Provide mentorship to young people
- Increase mental health awareness and reduce stigma using social media

Substance Use

Stakeholders were concerned about the increase of substance use, particularly among young people, in the San Fernando Valley. They identified opioids and marijuana as the two substances they are most concerned about, but also identified vaping, methamphetamines, and alcohol as issues. Therefore, addressing substance use is an urgent need. Stakeholders shared the following factors that contribute to substance use:

- Poverty and a lack of opportunities
- Lack of education about risks of substance use
- Increased accessibility of marijuana

- Mental health challenges and use of marijuana as a coping mechanism
- Lack of access to substance use treatment

Stakeholders were concerned about substance use in two populations in particular: young people and people experiencing homelessness. For young people, they were particularly concerned about marijuana use and vaping.

Effective strategies to address substance use shared by stakeholders include:

- Provide health education in local organizations and schools related to substance use risks
- Hub and spoke model of Medication-Assisted Treatment

Secondary Data

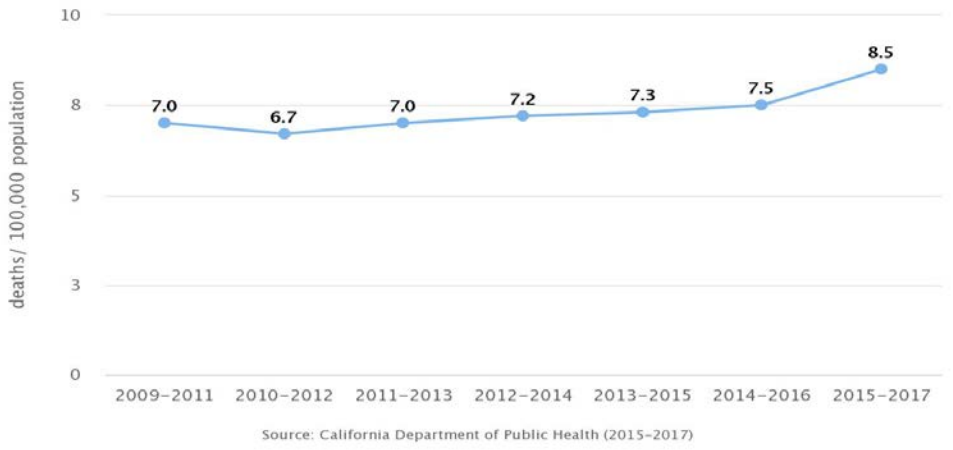
The percent of adults who reported binge drinking in the past 30 days is greater in the Community Benefit Service Area as compared to the Broader Service Area or Los Angeles County. Similarly, the percent of adults who smoke cigarettes is also greatest in the Community Benefit Service Area.

**Table 4. Mental Health and Substance Use Data by Geographic Area**

| Mental Health and Substance Use | Community Benefit Service Area | Broader Service Area | Los Angeles County |
|---|---|---|---|
| Percent of adults at risk for major depression | 11.4% | 9.3% | 11.8% |
| Alzheimer's disease-specific death rate (per 100,000 population) | 33.2 | 38.8 | 38.7 |
| Premature death rate due to suicide in total Years of Potential Life Lost (YPLL) per 100,000 population | 215.5 | 238.7 | 209.0 |
| Percent of adults reporting their health to be fair or poor | 23.1% | 13.0% | 21.5% |
| Average number of days in past month adults reported regular daily activities were limited due to poor physical/mental health | 2.3 | 2.7 | 2.3 |
| Percent of children ages 0-17 years who have special health care needs | 12.1% | 20.0% | 14.5% |
| Percent of adults who binge drink (men who had 5 or more alcoholic drinks, women 4 or more, on at least one occasion in the past 30 days) | 16.1% | 12.4% | 15.9% |
| Percent of adults who smoke cigarettes | 15.2% | 10.8% | 13.3% |
| Rate (per 10,000 population) of adult opioid use-related hospitalizations | 1.9 | 2.7 | 1.9 |
| Premature death rate due to drug overdose in total Years of Potential Life Lost (YPLL) per 100,000 population | 196.3 | 238.2 | 220.3 |

There has been an increase in the age-adjusted death rate per 100,000 population due to drug use for Los Angeles County since 2010.

Figure 2. Age-Adjusted Death Rate due to Drug Use in LA County




## Food Insecurity

Primary Data—Service Provider and Community Resident Input

Stakeholders discussed how food insecurity is linked to other health-related needs, such as economic insecurity, and contributes to chronic diseases. They shared the following contributing factors to food insecurity:

- Higher cost of nutritious, fresh foods compared to processed foods
- Insufficient SNAP benefits to cover a family's food expenses
- Lack of access to healthy food options and grocery stores

During a listening session on food insecurity, community members identified the barriers they experience to accessing nutritious, high-quality food:

- Poor quality of nutritious, fresh foods in the local grocery stores
- Higher cost of nutritious, fresh foods compared to processed foods,
- Time and stress
- Transportation
- Family influence

Community members shared the following strategies to improve access to nutritious, good quality food:

- Increased information on nutrition from hospitals through health education and resource fairs
- Increased number of government programs to help with grocery expenses or increased financial support from CalFresh

- Lower cost of groceries or increased food specials in stores
- Better signage and information about how to use WIC and CalFresh benefits
- More good-quality grocery stores in food deserts and areas with high amounts of fast food restaurants (food swamps)
- More outreach to students and seniors to share resources and discounts
- More affordable housing options
- Assistance paying for utilities to improve family's financial stability

Secondary Data

CalFresh/ Food Assistance Enrollment

**Table 5. Household Government Assistance by Area**

| Variable | Community Benefit Service Area | Broader Service Area | Los Angeles County |
|---|---|---|---|
| 2013-2017 ACS Households Receiving Food Stamps/SNAP (%) | 39,562 (11.19%) | 13,245 (3.39%) | 294,372 (8.93%) |

In 2017, the SFV Community Benefit Service Area had a higher participation rate than Los Angeles County in CalFresh/Food Stamp benefits in 2017.

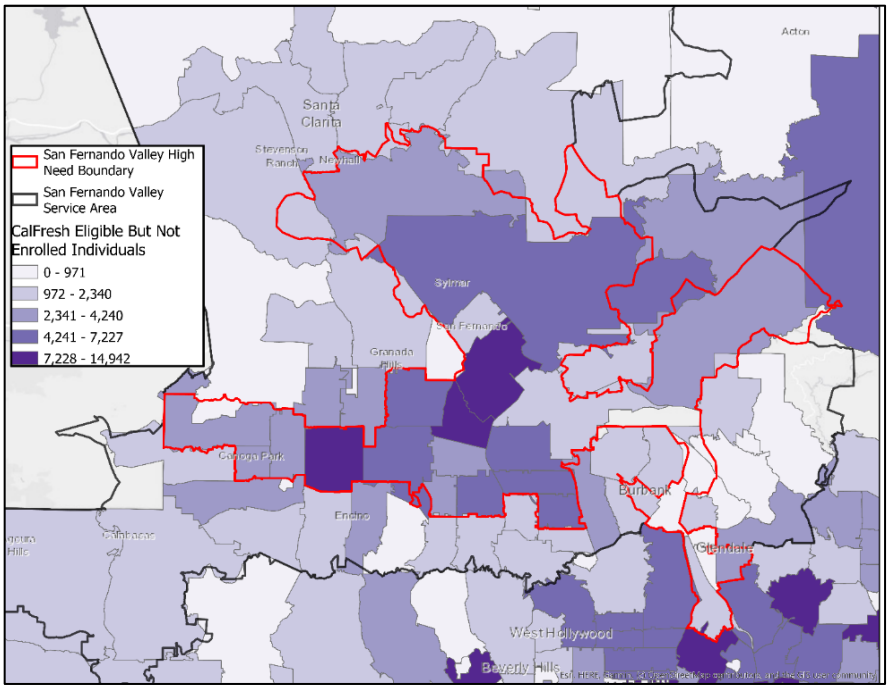



**Figure 3. CalFresh Enrollment in the San Fernando Valley Service Area**

According to the Los Angeles Department of Public Social Services, in June of 2018 there were a high concentration of individuals eligible but not enrolled in CalFresh in ZIP codes within the Community Benefit Service Area.

## Chronic Diseases

Primary Data—Service Provider and Community Resident Input

Stakeholders shared their concerns about the high numbers of people they serve with chronic diseases, in particular diabetes, obesity, and hypertension. Stakeholders particularly focused on the connection between obesity and diabetes and healthy habits.

Stakeholders named a variety of contributing factors to the community's chronic disease challenges:

- Inactive lifestyles
- Food insecurity causing poor nutrition
- Lack of health literacy and knowledge
- Lack of affordable, fresh, good quality foods in many low-income communities

Stakeholders identified the following populations as most affected by chronic diseases:

- Latinos
- Immigrants, particularly new and undocumented immigrants

Stakeholders shared the following strategies for addressing chronic diseases:

- Increase health education and system navigation using patient navigators and closed loop referrals
- Increase screening for chronic diseases and the social determinants of health
- Increase safe and affordable locations for people to be physically active

Secondary Data

Los Angeles County Indicators

**Table 6. Chronic disease Indicators by Geographic Area**

| Health Outcomes | Community Benefit Service Area | Broader Service Area | Los Angeles County |
|---|---|---|---|
| ***Obesity*** | | | |
| Percent of adults who are obese (BMI≥30.0) | 22.5% | 17.3% | 23.5% |
| ***Diabetes*** | | | |

| | | | |
|---|---|---|---|
| Percent of adults ever diagnosed with diabetes | 9.0% | 7.4% | 9.8% |
| Diabetes-related hospital admissions (per 10,000 population) | 13.69 | 8.35 | 15.74 |
| Diabetes-specific death rate (per 100,000 population) | 22.06 | 14.38 | 24.21 |
| ***Cardiovascular Disease*** | | | |
| Hypertension-related hospital admissions (per 10,000 population) | 5.68 | 3.24 | 5.10 |
| Percent of adults ever diagnosed with hypertension | 23.3% | 24.8% | 23.5% |
| Coronary heart disease-specific death rate (per 100,000 population population) | 120.69 | 105.48 | 108.10 |
| Stroke-specific death rate (per 100,000 population) | 32.86 | 28.69 | 36.20 |

According the California Health Interview Survey (CHIS), the prevalence of diabetes in Los Angeles County has jumped from 6.9% in 2003 to 12.1% in 2017. Adults who have ever been told they have pre-diabetes has risen over 10% since 2009. As of 2017, the CHIS reveals that 17.4% of the adult population in Los Angeles has been told they have pre-diabetes.

## Access to Health Care

Primary Data—Service Provider and Community Resident Input

Stakeholders identified improved access to health care as high a need in the San Fernando Valley. Stakeholders emphasized that addressing access to care should involve ensuring care is culturally responsive. Stakeholders named a variety of contributing factors to the community's access to health care challenges:

- Lack of necessary knowledge to navigate the complexities of the health care system
- High cost of care and lack of knowledge about support resources
- Fear related to immigration status and cultural/language barriers
- Long wait times and not enough providers
- Lack of coordination in the health care system

While different populations may experience different barriers to accessing the health care services they need, stakeholders identified a few populations that may especially face challenges with access to care:

- Immigrants, particularly undocumented immigrants, and people who do not speak English

Stakeholders shared the following strategies for addressing access to health care challenges:

- Utilize housing navigators in the Emergency Department
- Improve access to counseling and mental health services by hiring more mental health providers
- Integrate mental health care and primary care
- Increase health education and system navigation using patient navigators and closed loop referrals
- Increase screening for mental health, chronic diseases and the social determinants of health.
- Develop respite care for patients

Secondary Data

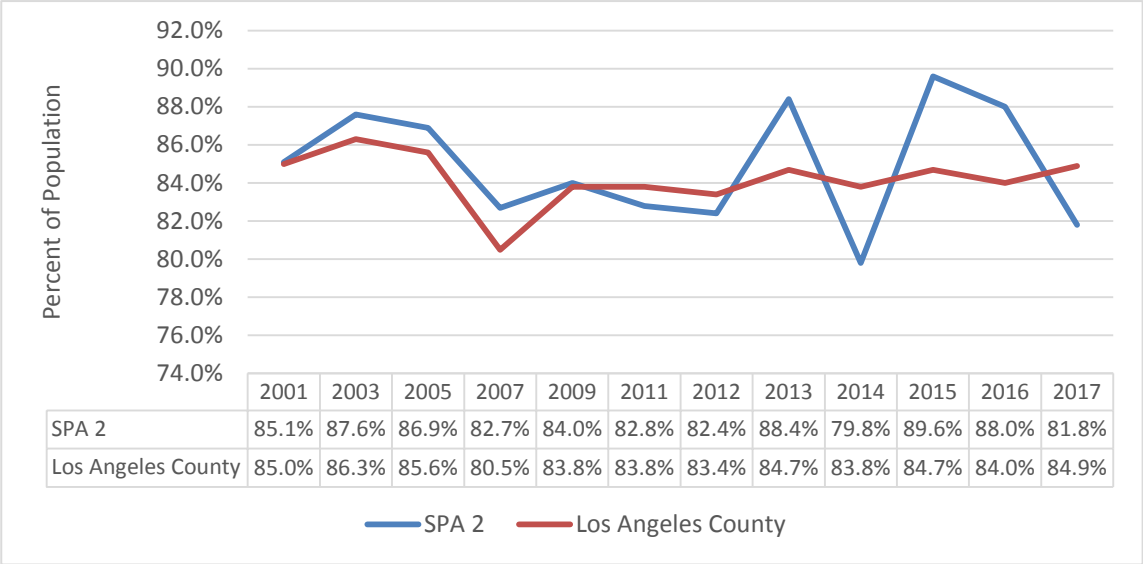
Overall, the Community Benefit Service Area performs less favorably than LA County on a series of access to care indicators, with the exception of the number of adults and children that are not receiving dental care because they could not afford it.

**Table 7. Access to Care Data**

| Indicator | Community Benefit Service Area | Broader Service Area | Los Angeles County |
|---|---|---|---|
| Percent of children ages 0-17 years who are insured | 95.6% | 99.5% | 96.6% |
| Percent of adults ages 18-64 years who are insured | 82.0% | 93.9% | 88.3% |
| Percent of children ages 0-17 years with a regular source of health care | 93.0% | 97.0% | 94.3% |
| Percent of adults 18-64 years with a regular source of health care | 77.5% | 82.0% | 77.7% |
| Percent of adults who did not see a dentist or go to a dental clinic in the past year | 44.8% | 26.3% | 40.7% |
| Percent of children ages 3-17 years who did not obtain dental care (including check-ups) in the past year because they could not afford it | 12.2% | 8.6% | 11.5% |

Source: 2015 Los Angeles County Health Survey

Figure 4. Population with Usual Source of Care, 2001-2017, SPA 2 and Los Angeles County




| | 2001 | 2003 | 2005 | 2007 | 2009 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SPA 2 | 85.1% | 87.6% | 86.9% | 82.7% | 84.0% | 82.8% | 82.4% | 88.4% | 79.8% | 89.6% | 88.0% | 81.8% |
| Los Angeles County | 85.0% | 86.3% | 85.6% | 80.5% | 83.8% | 83.8% | 83.4% | 84.7% | 83.8% | 84.7% | 84.0% | 84.9% |

Since 2009 Los Angeles County has had an increasing trend in respondents who have a usual source of care. SPA 2 has seen wide fluctuations in those who have a usual source of a care with a recent downward trend beginning in 2015.

## Senior Care

Primary Data—Service Provider and Community Resident Input

Stakeholders were concerned about older adults being unable to afford to live in the San Fernando Valley due to increasing housing costs and financial insecurity. Stakeholders shared that the number of seniors in the service area experiencing economic insecurity has increased over the past ten years. Stakeholders identified time, transportation, lack of interest or motivation, literacy/language, awareness of resources, and qualification standards as barriers to accessing resources in the community. Additionally stakeholders were concerned that social isolation among older adults which can contribute to depression.

Secondary Data

Senior Population in Service Planning Area 5

- Both the Community Benefit Service Area and the Broader Service Area have growing 55+ and 65+ age group populations.
- By 2024, the age group 55+ will make up about 25% of the population in the Community Benefit Service Area and over 30% of the population in the Broader Service Area.

**Table 8. Older Adult Population by Age in Community Benefit Service Area**

| Community Benefit Service Area | Census 2019 | | Census 2024 (projection) | |
|---|---|---|---|---|
| **Population by Age** | Number | Percent | Number | Percent |
| 55 - 64 | 128,584 | 11.0% | 132,506 | 11.1% |
| 65 - 74 | 83,576 | 7.2% | 95,995 | 8.0% |
| 75 - 84 | 39,894 | 3.4% | 49,693 | 4.2% |
| 85+ | 17,867 | 1.5% | 19,191 | 1.6% |
| 55+ | 269,921 | 23.2% | 297,385 | 24.9% |
| 65+ | 141,337 | 12.1% | 164,879 | 13.8% |

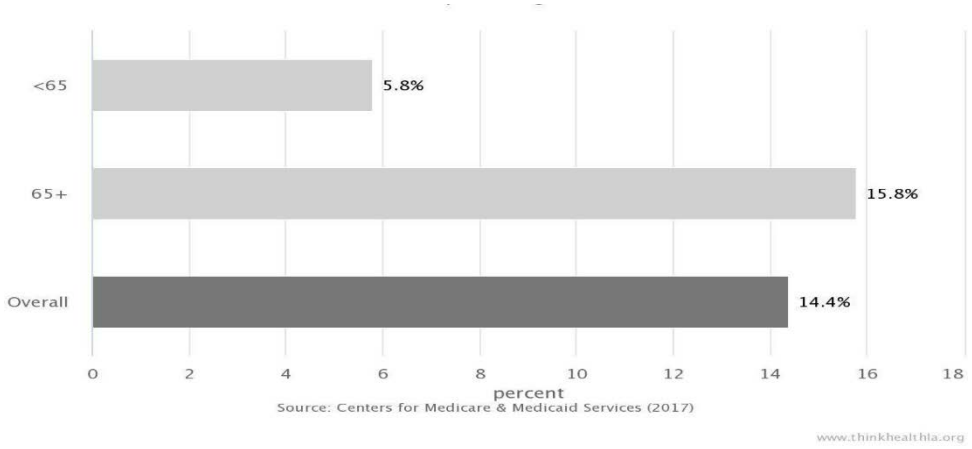
**Table 9. Older Adult Population by Age in Broader Service Area**

| Broader Service Area | Census 2019 | | Census 2024 (projection) | |
|---|---|---|---|---|
| **Population by Age** | Number | Percent | Number | Percent |
| 55 - 64 | 151,966 | 14.0% | 148,617 | 13.4% |
| 65 - 74 | 103,841 | 9.6% | 117,316 | 10.6% |
| 75 - 84 | 52,285 | 4.8% | 64,163 | 5.8% |
| 85+ | 23,783 | 2.2% | 25,108 | 2.3% |
| 55+ | 331,875 | 30.6% | 355,204 | 32.0% |
| 65+ | 179,909 | 16.6% | 206,587 | 18.6% |

## Alzheimer's and dementia

The Centers for Medicare and Medicaid Services show that the percentage of Medicare beneficiaries who were treated for Alzheimer's disease or dementia has seen an increasing trend in Los Angeles County with the largest spike between the years 2015 and 2016, with a 2.3% increase.

**Figure 5. Alzheimer's Disease or Dementia in the Medicare Population by Age in LA County**



Falls

The percent of adults (ages 65+) who have fallen in the past year is substantially higher in the Community Benefit Service Area than in the Broader Service Area and Los Angeles County.

**Table 10. Falls in Adults Ages 65+ by Geographic Area**

| Indicator | Community Benefit Service Area | Broader Service Area | Los Angeles County |
|---|---|---|---|
| Percent of adults ages 65+ years who have fallen in the past year | 35.7% | 28.2% | 27.1% |

## Violence Prevention

Primary Data— Service Provider and Community Resident Input

Community members identified public safety, including violence, safety in parks, and inadequate street lighting as one of the biggest health and social issues in their community. Therefore, addressing violence prevention is an urgent need.

Effective violence prevention creates a healthy community:

- A community free of violence and gangs
- A clean community, free of trash on the streets and in the parks

Secondary Data

**Table 11. Violence Data by Geographic Area**

| Violence | Community Benefit Service Area | Broader Service Area | Los Angeles County |
|---|---|---|---|
| Percent of adults who believe their neighborhood is safe from crime | 91.8% | 97.8% | 84.0% |
| Premature death rate due to homicide in total Years of Potential Life Lost (YPLL) per 100,000 population | 180.0 | 43.4 | 240.3 |
| Percent of adults who have ever experienced physical (hit, slapped, pushed, kicked, etc.) or sexual (unwanted sex) violence by an intimate partner | 14.0% | 15.7% | 13.4% |

The percent of adults who believe their neighborhood is safe from crime is higher in both the Community Benefit and Broader Service Areas than in Los Angeles County. This comparison is the same for the percent of adults who have ever experienced violence from an intimate partner.

The premature death rate due to homicide (measured in total years of potential life lost) is over four times greater in the Community Benefit Service Area than in the Broader Service Area.

## Immunizations and School Health

Primary Data—Service Provider and Community Resident Input

Stakeholders shared that addressing immunization and interrelated school health challenges is an urgent need. Stakeholders shared the following factors that contribute to why people may choose not to vaccinate or barriers to child immunization:

- Lack of understanding and misinformation
- Fear of side effects
- Perceived benefits versus risks
- HPV vaccine confusion

Effective strategies to address immunizations and school health by stakeholders include the following:

- Free flu shots
- Free health checks
- Community clinics with affordable care
- Mobile health care clinics

Secondary Data

## Immunization/Community Health

**Table 12. Child Vaccination Data by Geographic Area**

| Immunization/School Health | Community Benefit Service Area | Broader Service Area | Los Angeles County |
|---|---|---|---|
| Percent of children ages 6 months - 17 years vaccinated for influenza | 50.7% | 58.2% | 55.2% |

The percent of children (ages 6 months to 17 years) who have received the flu vaccination less in the Community Benefit Service Area when compared to the Broader Service Area and to Los Angeles County.

**Table 13. Adolescent Vaccination Data by Geographic Area**

| Immunization/School Health | SPA 2 | Los Angeles County | HP 2020 Target |
|---|---|---|---|
| Percent of teen girls (13-17 years) vaccinated for HPV | 43.2% | 44.6% | 80.0% |

The percent of girls vaccinated for HPY in SPA 2 1.4% less than the County average. However, 46.8% off from Healthy People 2020 target.

Available Resources to Address Identified Needs - Understanding the potential resources to address significant health needs is fundamental to determining current state capacity and gaps. Resources potentially available to address these needs are vast in the San Fernando Valley Community. There are numerous health care providers, social service non-profit agencies, faith-based organizations, private and public-school systems that contribute resources to address these identified needs. For a list of potentially available resources available to address significant health needs go to Appendix 4.

## V. Measurable Objectives 2020-22

As a result of the findings of our 2019 Community Health Needs Assessment (CHNA) and through a prioritization process aligned with our Mission, resources, and Medical Center strategic plans, the four initiatives below will become the focus of the 2020-22 Community Health Improvement Plan for Providence Holy Cross, Providence Saint Joseph and Providence Cedars-Sinai Tarzana Medical Centers:

### A. Summary of Community Health Improvement Planning Process

Based on the prioritized needs, Providence staff developed four strategic initiatives that address the eight prioritized health needs. Taken into account were the existing programs and resources that Providence San Fernando Valley Medical Centers have in place to address these needs and the landscape of community partners to collaborate with together. At the same time, the organization is committed to provide new resources to address the top identified need, homelessness and housing instability.

In light of the COVID pandemic, the Providence San Fernando Valley Medical Centers anticipate that some implementation strategies may not be possible to achieve and/or need to be revised in light of social distancing protocols. . While we have made every attempt in the Initiatives below to identify specific metrics designed to document improvement in program serves, it is likely that some may need to be revised or restated on an annual basis.

## B. Key Community Benefit Initiatives and Evaluation Plan

### INITIATIVE #1: STRENGTHEN INFRASTRUCTURE OF CONTINUUM OF CARE FOR PATIENTS EXPERIENCING HOMELESSNESS

**Community Need Addressed:** Homelessness and Housing Instability.

**Goal (Anticipated Impact):** To provide additional support to patients experiencing homelessness and housing instability through efforts to strengthen infrastructure of continuum of care. These efforts include navigators, prevention of homelessness, and advocating for additional recuperative care beds in the region.

**Scope (Target Population):** Patients experiencing homelessness and housing instability.

***Table 1. Strategies and Strategy Measures for Addressing Homelessness and Housing Instability***

| Strategies | Strategy Measure | Baseline | FY20 Target | FY22 Target |
|---|---|---|---|---|
| CHW Homeless Navigator | Number of patients identified as homeless and assigned to CHW | No baseline for 2020 | 200 patients identified as homeless and assigned to CHW | 10% increase in patients screened for homelessness as compared to 2021 baseline |
| ***Hospital emergency department based Community Health Workers that assist homeless patients with discharge to shelter or homeless service providers*** | Number of patients linked to homeless services provider | No baseline for 2020 | 100 patients linked to homeless services provider | 10% increase in patients linked to homeless service providers as compared to 2021 baseline |
| | Number of patients discharged to temporary/permanent housing | No baseline for 2020 | 25 patients with confirmed temporary/permanent housing | 10% increase in number of patients with temporary/permanent housing as compared to 2021 baseline |
| Homeless Prevention | Using PSJH housing instability algorithm, # of people screened for housing instability | No baseline for 2020 | Implement housing instability algorithm to identify 200 patients who are housing insecure | 20% increase of people identified at high risk of homelessness compared to 2020 baseline |
| ***Implement screening for risk of homelessness and identify public and private funded resources that focus on prevention*** | CHW outreach to those at high risk of homelessness to facilitate linkages | No baseline for 2020 | Refer 100 individuals to homeless prevention services providers | 20% increase in outreach compared to 2020 baseline. |
| | Confirmed linkage to homeless prevention services providers | No baseline for 2020 | Confirm that 70% of those referred to homeless prevention services providers do not become homeless | Confirm that 75% of those referred to homeless prevention services providers do not become homeless |

| | | | | |
|---|---|---|---|---|
| | Seek new resources related that support those at high risk of homelessness in SFV | No baseline for 2020 | $180,000 budgeted for SFV services related to homelessness | 50% increase in resources that support those at high risk of homelessness in SFV |
| Temporary/ Recuperative Care<br><br>***Improve the infrastructure of available recuperative care/temporary shelter for homeless patients that are not medically stable enough to be discharged back to the streets.*** | Identify interventions and partners to support LA Service Area housing initiative | No baseline for 2020 | Partner with Stakeholders to complete landscape analysis related to recuperative care<br><br>Establish consensus among Stakeholders as to the # of recuperative care beds in LA County<br><br>Identify improvements that would increase # recuperative care/ temporary housing beds for unsheltered patients | 2% baseline increase in # of temporary housing/ recuperative care beds available to SFV patients<br><br>Develop standards that define spectrum of temporary housing options for individuals experiencing homelessness that lead to permanent supportive housing |

## INITIATIVE #2: INCREASE REACH AND UTILIZATION OF COMMUNITY BASED WELLNESS AND ACTIVITY CENTERS

**Community Needs Addressed:** Behavioral health including mental health and substance use disorder; food insecurity; and senior care.

**Goal (Anticipated Impact):** To increase the reach and utilization of Providence community based wellness and activity centers by expanding the scope of health and wellness services available to local residents, strengthening the infrastructure of wellness services in underserved communities and engaging public and private partners to work alongside us in the implementation of program services.

***Scope (Target Population):*** Residents who are students, parents, seniors, food insecure, have a chronic disease and at-risk or diagnosed with mental health illnesses, including social isolation and substance use disorders.

Table 2. Strategies and Strategy Measures for Addressing Behavioral Health and Food Insecurity

| Strategies | Strategy Measure | Baseline | FY20 Target | FY22 Target |
|---|---|---|---|---|
| Pacoima Wellness Center: **As part of a school-base partnership model with Vaughn Next Century Learning Center, increase number of participants and number of** | Number of unduplicated participants | 1203 participants | Increase by 12% to 1348 participants | 15% increase |
| | Number of classes implemented | 336 classes | Increase by 10% to 370 classes | 15% increase |

| | | | | |
|---|---|---|---|---|
| **classes; align programs with CHNA needs**<br><br>***Provide opportunities for parents and students in the Providence Holy Cross Medical Center Service Area community to access substance use disorder, chronic disease management and food insecurity programs and services.*** | Alignment of classes to identified CHNA needs | No baseline for 2020 | 25% of classes will be aligned with identified CHNA needs | 50% of classes will be aligned with identified CHNA needs |
| | Number of SUD prevention cohort | No baseline for 2020 | 1 cohort for students | 50% increase |
| | Number of students participated in SUD cohort | No baseline for 2020 | 30 students | 50% increase |
| | COVID-19 student awareness project | No baseline for 2020 | Develop strategic plan | 3-4 grade specific projects completed |
| Van Nuys Wellness Center**: As part of a community-based partnership model, implement programs and secure partnerships, and provide adult and senior support services**<br><br>***Provide opportunities for community members (including the senior population) in the Providence St. Joseph and Tarzana Cedars-Sinai Medical Center services areas access to mental health, food insecurity, and chronic disease management services and programs*** | Establish portfolio: classes and programs | No baseline for 2020 | 5 programs implemented | 10 total programs implemented |
| | Public/private community partners | No baseline for 2020 | 3 partnerships secured | 10 partnerships secured |
| | Number of seniors: short-term counseling | 118 senior participants | 124 senior participants | 15% increase |
| | Number of participants (support groups addressing anxiety, social isolation, and depression) | 138 senior participants | 145 senior participants | 15% increase |

**INITIATIVE #3: IMPROVE ACCESS TO HEALTHCARE SERVICES AND PREVENTIVE RESOURCES**

**Community Need Addressed:** Access to Healthcare and Resources; Prevention and Management of Chronic Diseases; Violence Prevention.

**Goal (Anticipated Impact):** To improve access to health care and preventive resources to the most vulnerable communities of the region especially the poor and underserved by deploying

programs to assist in the navigation of the health care system, provide education, and enrollment assistance.

**Scope (Target Population):** Patients with limited access to health care services and preventive resources including those that face socioeconomic, linguistic and cultural barriers.

***Table 3. Strategies and Strategy Measures for Addressing Access to Healthcare and Resources***

| Strategies | Strategy Measure | Baseline | FY20 Target | FY22 Target |
|---|---|---|---|---|
| Community Health Insurance Project<br><br>***A team of bilingual (English/Spanish) Community Health Workers that provide outreach, education, and application assistance to hard-to-reach populations for Medi-Cal and Covered California resources*** | Number of patients assisted | 776 applications | 815 applications | 10% increase |
| | Number of patients enrolled | 510 enrolled | 536 enrolled | 15% increase |
| | Percent enrolled | 66% enrollment rate | 71% enrollment rate | 5% increase |
| CalFresh<br><br>***A team of bilingual (English/Spanish) Community Health Workers that assist families to enroll in California's nutrition program (CalFresh) to help them buy healthy foods*** | Number of applications | 415 applications | 436 applications | 10% increase |
| | Number enrolled | 270 enrolled | 283 enrolled | 5% increase |
| | Percent enrolled | 65% enrollment rate | 70% enrollment rate | 5% increase |
| Emergency Department Community Health Workers<br><br>***Community Health Workers assigned in the ED assist patients with applying for immediate medical health insurance, make and keep follow up primary care appointments after visiting the ED, and navigating*** | Primary care appointment made/kept | 621/467 | 652/491 | • 10% increase in appts made |
| | Appointment rate | 75% appointment rate | 75% | 5% increase |
| | Number of HPE applications | 1765 HPE applications | 1853 applications | 10% increase |

| | | | | |
|---|---|---|---|---|
| ***community health resources*** | | | | |
| | Number of HPE enrolled | 1381 HPE applications | 1450 applications | 10% increase |
| | HPE rate | 78% HPE rate | 78% HPE rate | 78% HPE rate |

*Table 3. Strategies and Strategy Measures for Addressing Access to Healthcare and Resources Cont.*

| | | | | |
|---|---|---|---|---|
| Diabetes Prevention Program<br>***CDC approved evidence-based lifestyle change program to prevent, delay, and reduce the risk for Type 2 Diabetes*** | Number of registered participants | 16 registered participants | 18 registered participants | 20% increase |
| | Number of completed participants; | 10 completed participants | 11 completed participants | 5% increase |
| | Percent of completed participants | 63% completion rate | 68% completion rate | 5% increase |
| FEAST<br>***Helps individuals to learn about healthier eating and active lifestyles*** | Number of registered participants | No baseline for 2020 | 24 participants | 25% increase |
| | Number of completed participants | No baseline for 2020 | 24 participants | Maintain a 90% completion rate |
| | Percent increase in fruit/vegetable consumption | No baseline for 2020 | 90% increase in fruit/vegetable consumption | Maintain a 90% increase in fruit/vegetable consumption |
| Mental Health First Aid<br>***Trains individuals and organizations about mental health and substance use issues and how to help those affected*** | Number of individuals trained | No baseline for 2020 | 180 individuals | 15% increase |
| | Number of agencies and orgs trained | No baseline for 2020 | 5 agencies and orgs. | 30% increase<br>20% increase |
| Latino Health Promoters Program<br>***A team of bilingual (English/Spanish)*** | Number of classes | 336 classes | 356 classes | 15% increase |
| | | 1203 served | 1323 served | 20% increase |

| | | | | |
|---|---|---|---|---|
| ***Community Health Workers provide educational wellness workshops for adults in the community at nearby local schools and churches*** | Number of participants | | | |
| Faith and Community Partnerships<br><br>***Improve the wellbeing of the faith-based community by providing technical assistance, health education, referrals, linkage to services, and support groups.*** | Number of referrals provided (including resources to shelter, food banks, mental health services, and COVID-19 health services) | No baseline for 2020 | 50 | 100% |
| | Number of health education workshops and support groups | No baseline for 2020 | 2 | 100% |

## INITIATIVE #4: SUPPORT COLLABORATIVE PARTNERSHIPS FOR BETTER HEALTH

**Community Need Addressed:** Immunizations/School Health.

**Goal (Anticipated Impact):** Build collaborative partnerships with nonprofit organizations, community clinics, public and private schools in the San Fernando Valley to address the needs of children, families, adults and seniors to become up to date on age appropriate immunizations and vaccinations.

**Scope (Target Population):** Children, adults, and seniors with limited access to immunizations.

***Table 4. Strategies and Strategy Measures for Addressing Access to Healthcare and Resources***

| Strategies | Strategy Measure | Baseline | FY20 Target | FY22 Target |
|---|---|---|---|---|
| Immunizations Flu Shots – Community Based<br><br>***Facilitates the immunization of individuals in the community through community outreach and education efforts throughout the SFV Service Area*** | Number of immunizations | No baseline for 2020 | To be determined | To be determined |
| | Number of patients receiving vaccines | No baseline for 2020 | To be determined | To be determined |
| | Number of sites | No baseline for 2020 | To be determined | To be determined |
| Immunizations – School Based Pediatric | Number of immunizations | No baseline for 2020 | 24 | 25% increase |

| | | | | |
|---|---|---|---|---|
| ***Facilitates the immunizations of children in school settings*** | Number of students immunized | No baseline for 2020 | 12 | 25% increase |
| | Number of schools inspected (immunization) | No baseline for 2020 | 1 | 100% increase |
| COVID 19 – Vaccinations based on CDC or LA County Guidelines | Number of patients receiving vaccines | No baseline for 2020 | To be determined | To be determined |
| ***Assist in the forthcoming efforts to protect the community against COVID 19 via vaccinations*** | Number of vaccination sites | No baseline for 2020 | To be determined | To be determined |

## VI. Annual Update to 2016 CHNA & 2017-19 Measurable Objectives

### A. Progress towards Three-Year Benchmarks

The Providence Community Health (CHI) Department believes that health care happens both inside and outside hospital walls. Every day we care for and teach people how to be healthy so that children, adults, and families throughout the San Fernando Valley – especially in low-income neighborhoods – are inspired to live the healthiest lives possible. We do this, alongside our community partners, because everyone should have the opportunity to live a healthy life, regardless of their income or where they live.

The CHI Department operates eight direct service programs related to healthcare access, managing chronic disease conditions, skilled-based health education, and violence prevention. Collectively, the programs reach approximately 9,000 people each year. All of our programs are conducted in partnership with community groups, nonprofits, business, and local residents with the goal of improving health – outside of our Medical Centers' walls. Through these strong partnerships, we are able to reach thousands of children and adults throughout the San Fernando Valley.

The goal of the Community Health Improvement Plan was to measurably improve the health of individuals and families living in the areas served by the three Providence Medical Centers: PHCMC, PSJMC, and PCSTMC. The 2017-2019 plan was the first Joint CHNA describing the San Fernando Valley Service (SFV) as the community of focus. The plan's target population includes the community as a whole with particular attention to the communities with the greatest need, which generally include low income populations and minority groups. The measurable objective included strategies related to:

- Access to Healthcare and Community resources
- Prevention and Management of Chronic Disease
- Senior Care and Resources
- Mental Health Services (including Substance Abuse)
- Poverty and Food Insecurity

There were two key strategies that were the foundation to the 2017-19 implementation strategy. The first was the value of "strong" partnerships. The partnerships that we developed were designed to address social determinants of health, which is vital to address health disparities. As a hospital, the Community Health Department has limited resources in the community. It was key to create collaborative partnerships in underserved communities and turn them into longstanding practices and relationships that can extend beyond the length of a single project. One of the key strong relationships developed was with Vaughn Next Century Learning Center, which is a public independent K-12 charter school located in Pacoima, California. The Community Health Department collaborated with Vaughn to open a 1,500 square foot Wellness and Activity Center. The goal of the Center is to create a place in the community that gives children and adults access to a clean and safe place to play, learn, and come together with their neighbors to improve their own health. Additional strong partners in the SFV include the Kinesiology Department at California State University, Northridge, include Meet Each Need with Dignity (MEND), San Fernando Community Health Center, All Inclusive Community Health Center, Los Angeles Unified School District, City of San Fernando, City of Los Angeles, Tarzana Treatment Center, and Valley Care Community Consortium.

The second strategy was the value of workforce engagement. The importance of employee engagement can't be overstated in public health and when working in trying to improve the health of underserved populations. Underserved populations often face significant barriers to healthcare because of poverty, discrimination, violence, low health literacy and other factors thus it requires staffing that can understand these barriers and are well trained in addressing the social determinants of health. One of the key strategies developed was providing mental health 101 training to all staff so that they have a better understanding of one of the rising issues community health is dealing with today. In addition, the Community Health Department utilized three levels of Community Health Workers that each have different levels of skills sets and training designed to provide services in both the community and Emergency Room setting. In particular, the Community Health Workers are trained and certified as enrollment counselors to assist clients and families with MediCal and CalFresh applications for health insurance and food stamp public benefits.

**B. Summary of Measurable Benchmarks 2017-19**

(Refer to 2017-19 Implementation Strategy Matrix for progress details)

- **Strategy 1: Improving Access to Healthcare and Resources**
  - Action Plan: ***Health Insurance***
    - Tactic: ***Community Health Insurance Program***: Community Health Workers (CHW) - bilingual in English and Spanish – assisted a total of 1,562 clients with completing applications for Medi-Cal and Covered California in the span of three years. In addition, the CHW provided information and skills to newly insured adults on how to effectively utilize the health insurance benefits. There was a significant increase of 82% more applications assisted in 2019 as compared to 2018. This was due to the wellness centers that were established in 2018 and 2919 in Pacoima and Van Nuys locations. In addition, the approval efficiency for insurance applications increased from 49% in 2017 to 79% in 2019.

- Action Plan: ***Primary Care***
  - Tactic: ***Emergency Dept. Community Health Workers****:* Community Health Workers in the Emergency Department at both Providence Holy Cross Medical Center and Providence St. Joseph Medical Center linked uninsured emergency department patients to local community clinics for follow up care. A local community clinic to serve as their medical home for future primary care visits. Since 2017, CHW's scheduled a total of 1,924 appointments with a 78% show up rate.

- Action Plan: ***Primary Car*e**
  - Tactic: ***Increase Number of Clinics/FQHC's who participate in Access to Care Program****:* Community Health Department Staff strengthened partnerships with various health clinics/federal qualifying health centers to improve access to care for patients. There are a total of 4 clinics participating in the Access to Care program, which include Meet Each Need with Dignity (MEND), All-Inclusive Community Health Center, San Fernando Community Health Center, and El Proyecto del Barrio. This collaboration allows for ER patients from Providence Holy Cross Medical Center or Providence St. Joseph Medical Center to have a follow-up appointment with their primary physicians as their being discharged. The goal is to ensure the highest quality of post ER healthcare as possible.

- Action Plan: ***Primary Car*e**
  - Tactic: ***Facilitate follow-up appointments to a medical home for health fair participants who receive out-of-range POCT test results****:* Community Health Department Staff have developed a toolkit and resource guide to assist faith-based partners in planning, coordinating, and implementing a health-fair. We have also facilitated connections between faith-based partners and FQHC's/Medical Providers to provide health screenings and follow-up appointments or follow-up care. FQHC's/Medical Providers include All-Inclusive, San Fernando Community Health Center, Henry Mayo Hospital, and Alamar Diabetes Center. Since 2017, a total of 1,115 people have received follow-up calls after blood pressure clinics and health fairs to ensure they made an appointment at a clinic or their primary care provider for follow-up care.

- Action Plan: ***Immunizations***
  - Tactic: ***Start-up immunization clinic, establish schedules of participating schools and document immunizations provided****:* The Providence Community Health team did partner with Facey Medical Group and was planning on providing immunization services to various LAUSD schools, independent charters, and private faith-based schools However, the Mobile Immunization Clinic faced many challenges. An initial application was submitted in the summer of 2018 to the LA County "Vaccination for Children Program" to provide free vaccines.

However, the application was put hold due to various reasons, which included securing a medical director, access to EPIC, and completing the formalities of competing the LA County application process. There were two barriers that ultimately prevented the Community Health Department from completing this tactic. The first was that the refrigerating system in the mobile unit not meeting the LA County guidelines. After researching options, it was learned that it would involve significant retrofitting of the interior of the mobile to install a refrigerating system that would meet LA County requirements. In 2019, the Community Health Department was able to acquire a larger mobile unit that was previously certified by LA County for the "Vaccination for Children Program." Our efforts came to an end when the California Department of Motor Vehicles informed staff that the mobile unit had a maximum limit of 1,000 miles per year to drive due to the age and type of engine. This limitation made the mobile unit incapable of being used for this program as the San Fernando Valley of made up of over 450 square miles.

- **Strategy 2: Implement Prevention Interventions to Reduce the Prevalence or Progression of Chronic Disease**
    - Action Plan: ***Increase Physical Activity***
        - Tactic: ***Initiate Creating Opportunities: for Physical Activity (COPA) in schools, churches and/or community centers***: Cardio Carnivals (CC) are physical activity field days that provide kids an opportunity to have fun while exercising. In 2018, there were a total 400 (K-5th grade) students that participated in cardio carnivals at four different schools. There were no CC's implemented in 2019. Community Health Staff are currently evaluating the effectiveness and sustainability of the model.

    - Action Plan*:* ***Increase Physical Activity***
        - Tactic: ***Conduct wellness visits as part of the Faith Community Health Partnership and CSUN/3WIN Programs***: One of the strongest partnerships within the Community Health Department has been with the Kinesiology Department at California State University, Northridge. The student intern model has been able to produce a community fitness program in collaboration with local Park and Recreation Departments in the City of San Fernando, City of Los Angeles and churches including Guardian Angel Church (Pacoima, CA) and Lanark Park (Canoga Park, CA). Since 2017, a total of 238 individuals (unduplicated) participated in the exercise program.

    - Action Plan: ***Increase Access to Healthier Foods***
        - Tactics: **Host "Fit Food Fairs," which teach local residents how to cook healthy foods**: There were limited Fit Food Fairs/Cardio Carnivals were conducted at three faith-based schools including St. Patrick's, Guardian Angel, and St. Didacus to highlight nutrition education, physical

activity, and wellness promotion that targeted approximately 400 individuals.

- Action Plan: ***Increase Access to Healthier Foods***
  - Tactics: **Pilot Groceryships—a non-profit nutrition education and support group program**: One cohort of FEAST ("Food, Education, Access and Support, Together" - formerly known as Groceryships) was completed at Guardian Angel. The FEAST program includes a 10-week nutrition support group, including nutrition education, cooking demonstrations, and food scholarships.
    - 10 adults completed the course.
    - At the beginning of the program, 58% of participants drank soda once a week or more. By the end of the program 91% of participants either drank no soda or only 1 soda a week. (33% change)
    - At the beginning of the program 58% of participants were cooking meals at home once a day. By the end of the program, 75% of participants were cooking meals at home at least once a day (17% change)

- Action Plan: ***Diabetes Self-Management Education***
  - Tactic: ***Adopt an Evidence-based Curriculum for Pre-diabetic Adults***: Community Health Staff developed and implemented a Diabetes Prevention Program (DPP) called Attention to Prevention. Using a Center for Disease Control and Prevention (CDC) curriculum for diabetes prevention, the program will consist of 4 certified Lifestyle Coaches who teach participants how to make lifestyle changes to prevent Type 2 diabetes. The goal of the program will be for participants to lose 5-7% of their bodyweight and experience a lower incidence of type 2 diabetes compared to those who do not participate. The Diabetes Prevention program cohort was initiated and completed in 2019 at the Providence Wellness Center at Vaughn Learning Academy in Pacoima, California. The DPP program graduated 10 participants who completed the 12 month program in December 2019. The average weight loss for participants was 9.34 lbs. for a total of 92.4 lbs. lost between all 10 participants. 7 participants lost 2% of their initial weight and 6 participants lost 5% of their initial weight.

- Action Plan: ***Increase Access to Healthier Foods***
  - Tactics: **Increase CalFresh enrollment through application assistance in community settings**: Community Health Workers assisted 1,069 individuals with applications for the CalFresh program since 2017. All department programs supported the CalFresh program by referring participants that were in need of food assistance. Referrals were linked directly to the CHIP team and clients are assisted with Cal Fresh

application. A great deal of success goes to the partners established and the wellness centers.

- Action Plan: ***Increase Access to Healthier Foods***
  - Tactics: **Work with local farmers markets to accept CalFresh as a form of payment**: CHIP team collaborated with Valley Care Community Consortium to promote and distribute Cal Fresh information, benefits, and enrollments to both Farmer Market operators and participants of our Community Health Programs. Although we did not get any farmer market vendor to commit to accept CalFresh as a form of payment, we were able to get the City of San Fernando to commit to implement a Farmers market in their downtown area for 2020.

- Action Plan: ***Strengthen Senior Outreach Program***
  - Tactics: **Partner with San Fernando Valley senior services agencies to improve continuum of services, including seeking funding to fill identified gaps**: Community Health Staff partnered with local senior agencies, such as One Generation and the Joslyn center, to improve continuum of services, including seeking funding to fill identified gaps. In 2019, Community Health Department and PCSTMC Emergency Room Department collaborated with One Generation on a "Transitional Older Adult" project funded by the Mother Joseph Grant for the amount of $25,000. The project allowed for adults between the ages of 55-59 who are frequent visitors of PCSTMC ED to receive in home support including meal delivery services, home safety equipment purchase and installation, access to ONEgeneration Senior Enrichment Center services and programs, all at no cost. In an effort to provide preventative support and linkages to community based services that are typically offered to those over the age of 60, the goal of the Transitional Older Adult project connected over 100 individuals between the age of 55-59 to community based services that ultimately reducing or preventing avoidable ED visits and/or hospitalization admissions.

- Action Plan: ***Strengthen Senior Outreach Program***
  - Tactics: **Improve documentation on sources of referrals to program, scope of referrals, and confirmation of partner services provided**: Community Health Staff have reviewed and improved the documentation on sources of referrals to program scope of referrals, and confirmation of partner services provided. In particular, new referral resources were created specific for the SAFE program and Burbank area to address seniors near the new wellness center we opened in 2019.

- Action Plan: ***Strengthen Senior Outreach Program***
  - Tactics: **Plan, design and implement a physical activity program for seniors**: As part of our partnership with the Kinesiology Department with California State University, Northridge, 238 seniors participated in a

physical activity program in the span of the 2017-19 through 3WINS Exercise Program for seniors.

- Action Plan: ***Diabetes Self-Management Education***
  - Tactics: **Adopt an evidence-based curriculum for Pre-diabetic adults**: One Diabetes Prevention program cohort was initiated and completed in 2019. The DPP program graduated 10 participants who completed the 12 month program in December 2019. The average weight loss for participants was 9.34 lbs. for a total of 92.4 lbs. lost between all 10 participants. 7 participants lost 2% of their initial weight and 6 participants lost 5% of their initial weight.

- Action Plan: ***Diabetes Self-Management Education***
  - Tactics: **Work with hospital or community partners to strengthen the infrastructure of classes for adults through the Latino Health Promoter program**: The Community Health staff have worked with several partners to help with Latino Health Promoter Program. In 2017-19, the Latino Health Promoter Program partnered with Tarzana Treatment Center to provide health education, information, and referrals at no costs to families in underserved communities. In addition, staff worked with Los Angeles County Department of Public Health to provide technical assistance and health education training classes for the promoters.

- **Strategy 3: Strengthen Community Based Mental Health Infrastructure to Better Align with Hospital-Based Mental Health Services**

  - Action Plan: ***Improve Access***
    - Tactic: ***Coordinate Linkage of Participants in Health Promoter Classes to Mental Health Providers****:* Health Promoters offer health education workshops at various school parent centers and churches in the community. Topics include mental health awareness and how to prevent mental health illnesses. Health Promoters also provided participants with information on how to access mental health services when needed. Participants who have private health insurance or Medi-Cal HMO coverage were taught how to access mental health services via their insurance, while uninsured participants and those whose Medi-Cal plan is fee-for-service were referred mental health resources, including Tarzana Treatment Center and as appropriate. Between 2017 and 2019, community health workers referred 108 clients directly to Tarzana Treatment Center for mental health services.

- Action Plan: ***Prevention***
  - Tactic: ***Teach coping skills and resiliency classes for adults in community settings, such as local churches***: NO COPA program was implemented within the 2017-19 due to lack of resources, including staffing and funding.

- Action Plan: ***Prevention***
  - Tactic: ***Pilot Adolescent Coping Education Series (ACES) for middle school students***: Staff identified three different schools to conduct ACES which impacted a total of 271 students. One of the most successful pilots was in the spring 2017 at Sepulveda Middle School. The curriculum was facilitated during the 7th grade health education class of 111 students and was facilitated once a week for eight weeks. Results were as follows:
    - 98% of students found the curriculum to be helpful.
    - 96% of students stated the topics covered in the curriculum were new to them.
    - 64% of students stated "deep breathing" to be a tool they utilized outside of the classroom.

- Action Plan: ***Prevention***
  - Tactic: ***Provide educational outreach presentations in community settings to reduce the stigma associated with mental health services***: A to total of 2,439 individuals participated in mental health workshops over the course of three years conducted by Community Health Workers at local Parent Centers in various LAUSD schools in the SFV as well as Vaughn Next Century Learning Center Charter School.

- Action Plan: ***Treatment***
  - Tactic: ***Implement Mental Health First Aid Training***: In partnership with the National Council for Behavioral Health, our new Wellness Center at Vaughn Next Century Learning Center conducted a mental health first aid training workshop for 25 Providence Community Health Employees. Mental Health First Aid is a guide to providing social support and comfort, and helping to reduce distress related to stressful situations, trauma, and crisis. The training provided useful information on how to assist a person who has a history of a mental disorder or longer term mental health problems.

- Action Plan: ***Treatment***
  - Tactic: ***Explore the Feasibility of a Wellness and Activity Center***: A 1,500 sq. ft. Wellness and Activity Center was opened in March of 2018 on the property of Vaughn Next Century Charter School in the City of Pacoima. This location allows for the Community Health Department to enhance its footprint in the Northeast San Fernando Valley. The location is being used to conduct community health navigation and educational services, including Promotora mental health classes. In 2018, Community

Health Staff provided daily exercise programs: Zumba®, aerobics and walking groups, assistance with applications: Medi-Cal, Covered California and CalFresh, referrals to other local resources and ongoing health and wellness classes. In August 2019, the Wellness Center in Van Nuys which is approximately 3,200 square feet to focus on more adult programming such as public application assistance, senior services, and exercise programs. In addition, a smaller wellness center was opened in Burbank, Ca in partnership with Burbank Housing to offer similar services on a smaller scale.

- **Strategy 4: Align Community Benefit Programs with San Fernando Medical Centers**

  - Action Plan: ***Providence Holy Cross & Saint Joseph Medical Centers***
    - Tactic: ***Develop a network of private sub-specialty physicians who provide consults to patients referred by PHCMC & PSJMC to local clinics***. In the period between 2017 and 2019, the Access to Care specialty program has had 7 physicians participating in the Access to Care program and have specialized in the field of orthopedics, cardiovascular health, urology, ophthalmology, dermatology, gastroenterology, podiatry, and otolaryngology (ENT). There were a total of 1,079 patients referred by participating clinics for specialty care consultation services.

  - Action Plan: ***Providence Saint Joseph Medical Center***
    - Tactic: ***Support "Live Well" program operations and expand to high need communities in Saint Joseph Medical Center's service area****:* The Live Well Program is a partnership between Providence St. Joseph Medical Center, Providence Community Health and various organizations in the Burbank Community, including the YMCA. The 4-month evidence-based program is free to seniors and combines exercise, nutritional counseling and disease prevention & management education to help at-risk people improve their quality of life. In 2018, Community Health Dept. Staff assisted in providing pre and post screening for 53 participants.

  - Action Plan: ***Providence Holy Cross Medical Center***
    - Tactic: ***Develop a pilot program that addresses mental health/resiliency skills for middle school students***: Staff identified three different schools to conduct ACES which impacted a total of 271 students. One of the most successful pilots was in the spring 2017 at Sepulveda Middle School. The curriculum was facilitated during the 7th grade health education class of 111 students and was facilitated once a week for eight weeks. Results were as follows:
      - 98% of students found the curriculum to be helpful.
      - 96% of students stated the topics covered in the curriculum were new to them.

- 64% of students stated "deep breathing" to be a tool they utilized outside of the classroom.

- Action Plan: ***Providence Tarzana Medical Center***
  - Tactic: ***Develop a pilot program for seniors at risk for social isolation at time of hospital discharge***: Community Health Staff implemented a program in the Emergency Department at PCSTMC in March of 2019 called SAFE (Specialized Assistance for the Elderly). The goal of SAFE is to reduce the likelihood of readmission for discharged senior patients. Utilizing a team of social worker and a Community Health Worker, the intervention includes a patient assessment, patient education, navigation/linkage to services. In 2019, the SAFE program served 348 patients.

- Action Plan: ***Providence Tarzana Medical Center***
  - Tactic: ***Implement peer coach training related to physical education for elementary classroom teachers and/or community based youth organizations***: NO COPA program was implemented within the 2017-19 due to lack of resources.

## C. Community Benefit Expenditures during 2019

Providence Holy Cross, Providence St. Joseph, and Providence Cedars-Sinai Tarzana Medical Centers' Community Benefit activities are classified into three broad expenditure categories consistent with standards established by the Catholic Health Association: 1) Charity Care, 2) Community Benefit Services and 3) Unpaid Costs of Medi-Cal. The overall expense in 2019 was $70,341,128, which represents a 17% decrease from 2018 and a total of 37% since 2017. This was primarily due to reductions in the combined Medi-Cal shortfall for the three Medical Centers. For OSHPD reporting purposes, we also identify the unpaid costs of Medicare.[1] Table 1.1 below summarizes all community benefit expense for 2019:

**Table 1.1 - Summary of 2019 SFV Community Benefit Expenses**

| Expense | Holy Cross | St. Joseph | Tarzana | Valley |
|---|---|---|---|---|
| Charity Care | $9,610,675 | $4,962,722 | $3,087,646 | $17,661,043 |
| Community Benefits Services | $5,614,259 | $5,771,233 | $2,981,671 | $14,367,163 |
| Medi-Cal Shortfall | $0 | $16,297,615 | $22,015,307 | $38,312,922 |
| **TOTAL** | **$15,224,934** | **$27,031,570** | **$28,084,624** | **$70,341,128** |
| Medicare Shortfall | $27,198,416 | $52,045,415 | $52,554,517 | $131,798,347 |

**Charity Care**. Charity care decreased by 4% from 2018 to 2019.

**Unpaid Costs of Medi-Cal.** Overall, Medi-Cal shortfall, the difference between the cost of providing care and the amount to receive from Medi-Cal for the Medical Centers – San Fernando

2. OSHPD issued guidance in 2006, notifying hospitals to report Medicare shortfall. Medicare shortfall id not publicly reported as a community benefit expense.

Valley, decreased by 29% from 2018 to 2019 due to application of the provider tax covering a four-year period. Providence St. Joseph decreased of 29% from 2018 to 2019 and Providence Cedars-Sinai Tarzana Medical decreased by 28%. Providence Holy Cross Medical Center received provider tax benefits, resulting in no Medi-Cal Shortfall. Table 1.1 summarizes the Medi-Cal Shortfalls for 2019.

**Community Benefit Services.**

Community Benefit Services for 2019 compared to 2018 increased by 16%. This is primarily due to an increase in three of the five broad areas that make up Community Benefit Services. Community Health Improvement Services was $6,342,728 for 2019, which was an increase of 23% from 2018; Subsidized Health Services was $2,231,659, which was an increase of 50% from 2018, and Community Benefit Operations was $850,728, which was an increase of 87% from 2018. Expenses of all five categories are broken out in the Detailed Listing of Community Benefit Services provided in the four appendices of this report. The first page in the detailed listing combines expenses for all three Medical Centers, which collectively total $14,367,163. The second, third and fourth pages are the breakout of expenses for each Medical Center.

**D. Number of Individual Impacted by SFV Community Benefits Program**

There was a 5% increase in the number of people impacted by the CBP from 31,466 in 2018 to 33,075 in 2019.

**Table 1.2 - Number of Individuals Impacted, by Community Benefit Categories**

| Expense | Holy Cross | St. Joseph | Tarzana | Valley |
|---|---|---|---|---|
| Charity Care | 1,844 | 832 | 482 | 3,158 |
| Community Benefits Services | 15,609 | 13,466 | 4,000 | 33,075 |
| Medi-Cal Shortfall | 27,647 | 13,031 | 8,465 | 49,143 |
| **TOTAL** | **45,100** | **27,329** | **12,947** | **85,376** |

**E. Strategic Mission Priorities**

Consistent with the Providence St. Joseph Health's Mission Statement and the Ethical and Religious Directives for Catholic Healthcare Services, our Community Benefit Plan places a priority on community-based outreach to the poor and vulnerable. We carefully track the number of individuals impacted by programs and services provided in underserved communities and seek to leverage Providence San Fernando Valley Service Area resources with private and governmental support.

**Table 1.3 - Individuals Impacted by 2019 SFV Community Benefit Programs**

Overall, the total number of people impacted by the Community Benefit programs in Table 1.3 increased by 5%, from 8,697 in 2018 to 9,096 in 2019. There was a significant increase in the number of individuals assisted in the Community Health Insurance Program as there was a 41% increase from 2018. This is due to the establishment of the wellness center in the Pacoima location in partnership with Vaughn Next Century Learning Center. The wellness centers provide Providence staff access to underserved population that qualifies for MediCal health insurance programs. There was also a 46% increase in individuals assisted in the senior program. This program, implemented in March of 2019, is designed to reduce the likelihood of readmission for discharged senior patients from the ER at Providence Tarzana. The intervention

helps identify other potential obstacles that could decrease their quality of life and/or lead to a relapse in health. The tattoo removal program experienced a significant decrease of 75% less individuals impacted in 2019 as compared to 2018. This is due to a program structure change that provides clients more wrap around services, including resume writing assistance, application assistance for public programs such as MediCal and CalFresh, health education, GRE programs, and partnering with community partners to facilitate mental health, job training and other support services. This new model provides clients with a variety of resources to support gang intervention. However, the model does limit the amount of clients that can be seen in a given year.

| **Outreach to Poor/Underserved Programs** | **PHCMC** | **PSJMC** | **PCSTMC** | **2019** |
|---|---|---|---|---|
| Access to Care | 1,036 | 1,003 | 573 | 2,612 |
| Community Health Insurance Program (CHIP) | 649 | 97 | 183 | 929 |
| Faith Community Health Partnership | 158 | 267 | 213 | 638 |
| Latino Health Promoter Program/Mental Health Outreach | 608 | 256 | 246 | 1,110 |
| Mental Health Assessment Team (started 11/19) | 5 | 5 | 5 | 15 |
| School Nurse Outreach Program | 1,000 | 1,000 | 1,000 | 3,000 |
| Senior Outreach Program | 54 | 75 | 414 | 543 |
| Tattoo Removal Program | 32 | 48 | 34 | 114 |
| UCLA/Providence Health Study | 29 | 28 | 28 | 85 |
| **TOTAL** | **3,568** | **2,696** | **2,696** | **9,046** |

| | | 2017-19 Implementation Strategy - 2019 Progress Matrix | | | APPENDIX 1 |
|---|---|---|---|---|---|
| **Strategy 1: Improve Access to Health Care Services** | | | | | |
| **Measurable Objectives:** | **Action Plan** | **Tactics** | **Progress in 2017** | **Progress 2018** | **Progress 2019** |
| **1) Increase enrollment in and utilization of health insurance**<br><br>**2) Increase the number of people with a primary care provider**<br><br>**3) Increase the number of children who receive the recommended immunizations** | **Increase enrollment in and utilization of health insurance** | **Community Health Insurance Program:** utilize community health workers -bilingual in English and Spanish - to provide outreach and education about affordable health insurance options to hard-to-reach populations. Community health workers assist clients with completing applications for Medi-Cal and Covered California. | **364** individuals assisted with health insurance applications.<br><br>**180** individuals successfully enrolled into health insurance. | **422** individuals assisted with health insurance applications.<br><br>**343** individuals successfully enrolled into health insurance. | **776** individuals assisted with health insurance applications.<br><br>**510** individuals successfully enrolled into health insurance. |
| | | Provide information and skills to newly insured adults on how to effectively utilize health insurance benefits. | | | Follow up calls to all clients completed 3 months after assistance to answer any questions and confirm utilization of services. |
| | | **Emergency Room Promotoras:** screen uninsured patients in the emergency departments of our medical centers for Medi-Cal and assist them with applying for Medi-Cal coverage. | **23** of applications assisted with Hospital Presumptive Eligibility Medi-Cal for ER Patients. | **865** applications assisted with Hospital Presumptive Eligibility Medi-Cal for ER Patients.<br>**649** individuals successfully enrolled into Hospital Presumptive Eligibility Medi-Ca | **1,765** applications assisted with Hospital Presumptive Eligibility Medi-Cal for ER Patients.<br><br>**1,381** individuals successfully enrolled into Hospital Presumptive Eligibility Medi-Cal |
| | | | | | |
| | **Increase the number of people with a primary care provider** | **Increase the number of clinics/FQHC's who participate in the Access to Care program** and improve access to specialists who provide consults for clinic/FQHC patients. | Partnering with **5** clinics/FQHC's within the San Fernando Valley Sevice Area, including All Inclusive, Valley Community Health Center, Sam Dixon, San Fernando Community Health Center, and MEND.<br><br>**710** ER patients linked to primary care provider appointment schedule. **554** of the **710** primary care appointments were kept.<br><br>FCHP: **348** people received follow-up calls after health fairs to ensure they made an appointment at a clinic for follow-up care. Of the **348** people called, **189** made an appointment. | Partnering with **5** clinics/FQHC's within the San Fernando Valley Sevice Area, including All Inclusive, Valley Community Health Center, San Fernando Community Health Center, MEND, and El Proyecto del Barrio.<br><br>**593** ER patients linked by ER Community Health Workers to a medical home via scheduled appointment. **396** of the **593** appointments were kept. (**67%** kept appointments). | Partnering with **5** clinics/FQHC's within the San Fernando Valley Sevice Area, including All Inclusive, Valley Community Health Center, San Fernando Community Health Center, MEND, and El Proyecto del Barrio.<br>**621** ER patients linked by ER Community Health Workers to a medical home via scheduled appointment.<br>**467** of the **621** primary care appointments were kept. (75% kept appointments). |
| | | **Emergency Room Promotoras:** link uninsured emergency department patients with a local community clinic to serve as their medical home for future primary care visits. | | | |
| | | **Facilitate follow-up appointments to a medical home for health fair participants who received out-of-range screening test results** (ie, blood pressure, A1C, cholseterol, etc). | | FCHP: **382** people received follow-up calls after blood pressure clinics and health fairs to ensure they made an appointment at a clinic for follow-up care. Of the 382 individuals called, **257** were reached and made an appointment or stated they would make an appointment. | 2019 FCHP: 389 people received follow-up calls after blood pressure clinics and health fairs to ensure they made an appointment at a clinic or their primary care provider for follow-up care. Of the 389 individuals called, 279 were reached and made an appointment or stated they would make an appointment. |
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|---|---|---|---|---|---|
| | **Increase the number of children who receive the recommended immunizations** | **Start-up immunization clinic:** Establish schedules of participating schools and document immunizations provided. | Identified a mobile unit with the capacity to meet LA County Vacination for Children Program specifications.<br><br>Identified immunization needs of **13** schools in the SFV.<br><br>Identified **3** schools to conduct immunizations for children, including Reseda Elementary, Vaughn Next Century Learning Center, and Guardian Angel Catholic School. | A Community Health team will begin immunization services, using a mobile clinic, at various LAUSD schools, independent charter schools, and private faith-based schools (Fall 2019). | Community Health team completed the mandated EZIZ certification that is provided through LA county. The program partnered with the pharmacy department at Saint Joseph's Medical Center to receive and house vaccines. Vaccinations were not conducted in Fall 2019. Unforseen hurdles arised through the process of getting certified through LA county. |
| | | **Promote HPV and meningococcal immunizations:** With local pediatricians and family practice physicians to encourage parents to have their children receive the cancer prevention vaccinations. | | | Promotional material as offered to San Fernando Community Health Center. However, were told they had plenty of promotional material already. |

## 2017-19 Implementation Strategy - 2019 Progress Matrix

### Strategy 2: Implement Prevention Interventions to Reduce the Prevalence or Progression of Chronic Disease

| Measurable Objectives: | Action Plan | Tactic | Progress in 2017 | Progress 2018 | Progress 2019 | Comments for 2019 |
|---|---|---|---|---|---|---|
| *1) Increase physical activity for children by partnering with elementary schools and community-based youth services providers*<br><br>*2) Initiate physical activity for adults by partnering with clinics, churches and CBO's*<br><br>*3) Increase access to healthier foods, nutrition events & start follow-up classes*<br><br>*4) Increase scope of services and partners to strengthen Senior outreach program*<br><br>*5) Implement a diabetes prevention program for an at-risk adult population* | Increase Physical Activity | Initiate Creating Opportunities: for Physical Activity (COPA) in schools, churches and/or community centers. | No COPA programs were implemented in 2017.<br><br>Idenditfied 4 churches to implement wellness visit programming, which include St. Patrick's Catholic Church, St. Didacus Catholic Church, Our Lady of Peace Catholic Church, Guardian Angel Catholic Church. | **4** cardio carnival an aspect of COPA was onducted at four Catholic Schools targeting 400 students. | No physical activity or cardio carnivals were conducted in 2019 primarily due to the retiement of school nurse at the beginning of 2019. | Tactic impacted by retirement of school nurse the beginning of 2019. |
| | | Conduct Wellness visits: as part of the Faith Community Health Partnership and CSUN/3 Wins programs. | 136 participants received exercise programming and wellness visits. | Adult exercise program at 4 sites:<br>Robert Gonzales Park/Guardian Angel (Pacoima).<br>St. Patrick Church (North Hollywood).<br>Recreation Park (City of San Fernando)<br>Lanark Park (Canoga Park).<br>Providence staff developed individualized fitness plan with clients.<br>(262 adults completed pre post wellness visits). | **141** participants received exercise programming and **62** received a wellness visit.<br>Number of sites decreased to Guardian Angel Church (David Gonzalez Park) and Our Lady of the Valley Church (Canoga Park). New leadership at Our Lady of Peace Church in North Hills, CA removed the health ministry and subsequently 3WINs physical activity program. In addition, 3WINs could not recruit enough student interns to continue programming at St. Patrick's Church in North Hollywood. In addition, due to program sites being outdoors, participation and recruitment was impacted by the fires in the west valley. | Due to program sites being outdoors, participation and recruitment was impacted by the fires in the west valley for Canoga Park, and rain impacted programming at both Canoga Park and David Gonzales Park. Both sites had to cancel programming for several days as a result of inclement weather.<br>In Addition, St. Patrick's Catholic Church in North Hills, changed clergy and in that process removed the 3WINs program from church services. |
| | | | | | | |
| | Increase Access to Healthier Foods | Pilot Groceryships: a non-profit nutrition education and support group program. | 1 cohort conducted at Guardian Angel Catholic school. 10 people participated and completed the course. | Due to program revamp of Groceryships. No cohorts where conducted for 2018. | **1** FEAST cohort was conducted at our Pacoima Wellness Center. **9** people participated and completed the course. | FEAST was formerly known as Groceryships. |
| | | Pilot Groceryships—a non-profit nutrition education and support group program—at the Wellness and Activity Center. Expand into additional community settings throughout the South Bay Community based on lessons learned in pilot phase. | | Plan to implement a cohort in fall of 2019. | **3** additional Community Health Department staff members were certifies to provide FEAST (formerly known as Groceryships). Funding was secured vua the Wellbeing Trust. | Funding was secured from Well Being Trust to provide FEAST in the SFV. |
| | | Increase CalFresh enrollment: through application assistance in community settings. | 220 individuals enrolled in CalFresh. | **434** individuals were assisted with their application for CalFesh Enrollment. 250 individuals were enrolled in Cal Fresh Services. | **415** individuals were assisted with their applications for Cal Fresh Enrollment. A total of **270** individuals were enrolled in Cal Fresh Services. | All department programs supported the CalFresh program by referring participants that were in need of food assistance. Referrals are linked directly to the CHIP team and clients are assisted with Cal Fresh application. |
| | | Work with local farmers markets to accept CalFresh as a form of payment. | Have not worked with any local farmers in 2017. | Have not worked with any local farmers in 2018. CHIP staff referred clients to food programs which accepted Cal Fresh. | CHIP team provided a list of local farmers markets to all clients that applied for Cal Fresh. CHIP staff also referred clients to local food banks and food programs which accepted Cal Fresh. | CHIP team collaborated with Valley Care Community Consortium to provide Cal Fresh information, Benefits, and enrollments to both Farmer Market operators and participants of our Community Health Programs. Although we did not get any vendor to commit to accept CalFresh as a form of payment, we were able to get the City of San Fernando to commit to implement a Farmers market in their downtown area in 2020. |
| | | | | | | |
| | Strengthen Senior Outreach Program: Tactics | Partner with San Fernando Valley senior services agencies: to improve continuum of services, including seeking funding to fill identified gaps. | We are providing service to approximately 457 unduplicated clients. | **239** individuals were assisted with senior peer counseling and Volunteer for Seniors with transportation to doctor appointments and grocery shopping. SAFE (Specialized Assistance for the Elderly) was not implemented. | Partnering with **3 senior service agencies** within the San Fernando Valley Sevice Area, including One Generation, Helping Hands Senior Foundation, and VIC (Valley Intercommunity Council) for home delivered meals.<br>**467** individuals were assisted with senior peer counseling and case management. | The number of seniors were higher for 2019 due to having several community partners to assist with food insecurity, durable medical equipment, and providing case management. |
| | | Improve documentation on sources of referrals: to program, scope of referrals, and confirmation of partner services provided. | Revised data collection process for referals.<br><br>82 seniors are involved in a physical activity program through the 3WINS program as reported in Strategy 2, "Increase PA Section." | Collaboration with senior community partners was initiated to review and evaluate protocols and revisions were started. | Senior Outreach collaboarted with ONE Generation to ensure intake process was revised. | Senior Outreach improved data collection by revising the intake process, and keeping track of the patients on a 6 month bases. Community Health Staff have reviewed and improved the documentation on sources of referrals to program scope of referrals, and confirmation of partner services provided. In particular, new referral resources were created specific for the SAFE program and to include resources in the Burbank area to address seniors near the new wellness center we opened in 2019. |
| | | Plan, design and implement a physical activity program for seniors. | | **231** seniors have been involved in a physical activity program through 3WINS as reported in Strategy 2 "Increase PA" | Only **32** Seniors are participating in a physical activity program through the 3WINs program as reported in Strategy 2 "Increase PA Section". | As reported in Strategy 2 "Increase PA", due to program sites being outdoors, participation and recruitment was impacted by the fires in the west valley for Canoga Park, and rain impacted programming at both Canoga Park and David Gonzales Park. Both sites had to cancel programming for several days as a result of inclement weather. |

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| | Diabetes Self-Management Education | Adopt an evidence-based curriculum: which teach local residents how to cook healthy foods. | No Diabetes Prevention cohorts have been hosted s of yet. In process of training staff for DPP certification in collabortation with LACDPH. | Four staff members have completed the certification course.<br>Application to CDC to start diabetes prevention program (DPP) submitted in August 2018<br>Outreach efforts, screenings and session zero was conducted in December of 2018. DPP program is currently on going.<br>First cohort began January 2019 at Vaughn Next Century Learning Center. | **1** Diabetes Prevention progrma cohort was initiated and complted in 2019. The DPP program graduated **10** participants who completed the 12 month program in December 2019. The a**verage weight loss** for participants was **9.34 lbs**. for a **total of 92.4 lbs**. lost between all 10 participants. 7 participants lost 2% of their initial weight and 6 participants lost 5% of their initial weight. | Participants were all taught how to cook healthier meals and make healthier meal choices. |
| | | Work with hospital or community partners: a non-profit nutrition education and support group program. | No progress for 2017. | In discussions with Project Alto, which is operated by SF Community Health Clinic in regards to collaboration for 2019. | The Community Health staff have worked with several partners to help with Latino Health Promoter Program. For the past three years, the Latino Health Promoter Program has partnered with Tarzana Treatment Center to provide health education, information, and referrals at no costs families in underserved communities. In addition, staff have worked with Los Angeles County Department of Public Health to provide technical assistance and health education training classes for the promoters throughout the years. | The Community Health staff have worked with several partners to help with Latino Health Promoter Program. For the past three years, the Latino Health Promoter Program has partnered with Tarzana Treatment Center to provide health education, information, and referrals at no costs families in underserved communities. In addition, staff have worked with Los Angeles County Department of Public Health to provide technical assistance and health education training classes for the promoters throughout the years. |

| | | 2017-19 Implementation Strategy - 2019 Progress Matrix | | | | |
|---|---|---|---|---|---|---|
| **Strategy 3: Strengthen Community Based Mental Health Infrastructure to Better Align with Hospital-Based Mental Health Services** | | | | | | |
| **Measurable Objectives:** | **Action Plan** | **Tactic** | **Progress in 2017** | **Progress 2018** | **Progress 2019** | **Comments 2019** |
| ***1) Improve access to mental health services in school and community settings<br>2) Build resilience in children, teens, families and seniors<br>3) Reduce the stigma of mental illness*** | **Improve Access** | **Coordinate linkage of participants in Health Promoter classes to mental health providers**. | 27 of adults who participate in Health Promoter classes and request assistance in finding a mental health safety net clinic.<br><br>Zero of community residents trained on mental health first aid. | **33** Clients were referred directly to Tarzana Treatment Center for Mental Health Services. | **48** Clients were referred directly to Tarzana Treatment Center for Mental Health Services. | Our Latino Health Promoter Program provided **336** wellness classes to **1,203** adults in 2019. The classes ranged from Women's Health to Getting a Healthy Life. All curriculums included a mental health component. |
| | | | | Mental health first aid was conducted in Vaughn Charter School and North Hollywood. **25** Providence Community Health Employees attended the training | 2 Community Health staff members were certified to provide Mental Health First Aid Classes to community members. | Funding was secured thru the WBT to certify staff members to provide MHFA classes. |
| | | | | | | |
| | | | | | | |
| | **Prevention** | **Teach coping skills and resiliency classes for adults in community settings, such as local churches.** | Zero of adults completed a coping skills curriculum.<br><br>111 youth completed ACES curriculum. | | 121 Youth Completed ACES Curriculum at James Monroe High School. | School very satified with program. Will return next year to continue program. |
| | | **Pilot Adolescent Coping Education Series (ACES):** for middle school students. | | We are working on identifying a middle school to conduct ACES classes. However, a resliency workshop was conducted for 6, 7, amd 8 graders at the Health and Wellness Fair at four Catholic school in SFV. There was about 150 students that compeleted the workshop. | ACES was taught at Sepulveda middle school. The curriculum was faciliated to 7th and 8th graders for 6 weeks. | |
| | | **Provide educational outreach presentations**: in community settings to reduce the stigma associated with mental health services. | The Latino Health Promotor Program provides a wide variety of presentations targeting underserved population. | **1,236** individuals participated in mental health workshops conducted by Community Health Workers at local Parent's Centers in various schools in SFV, including Vaughn Next Century Learning Center. | **1,203** individuals participated in mental health workshops conducted by Community Health Workers at local Parent Centers in various LAUSD schools in the SFV as well as Vaughn Next Century Learning Center Charter School. | Contract has been renewed for new fiscal year. Relationship with TTC and partnering schools is very synergesitic. |
| | **Treatment** | **Implement mental health first aid training in partnership with the National Council for Behavioral Health.** | Have not implemented Program in 2017. | Partnered with the National Council for Behavior Health to provide **25** employees a Mental Health First Aid workshop. | 2 Community Health staff members were certified by the National Council for Behavioral Health to provide Mental Health First Aid Classes to community members. | Funding was secured thru the WBT to certify staff members to provide MHFA classes. |
| | | **Explore the feasibility of a Wellness and Activity Center.** | | We opened a 1,500 sq. ft. wellness center in the City of Pacoima in April of 2018 that is located on the property of Vaughn Next Century Charter School. This location allows for us to enhance our footprint in the Northeast San Fernando Valley. The location will be utilized to conduct community health navigation and educational services, including Promotora mental health classes. | Our Pacoima Wellness Center in the City of Pacoima located on the property of Vaughn Next Century Learning Center serviced **817** Vaughn parents and community members from the surrounding communities. This location allowed us to enhance our footprint in the Northeast San Fernando Valley. The location was utilized to conduct community health navigation and educational services, including Promotora mental health classes as well as health promotion and physical activity classes. Promotoras offered direct referrals to Tarzana Treatment Center for mental health services and Community health workers provided access to Medical insurance and Cal Fresh enrollments and education about utilizing services. Linkage to needed services were provided to all those visiting the Wellness Center. | March of 2018 on the property of Vaughn Next Century Charter School in the City of Pacoima. This location allows for the Community Health Department to enhance its footprint in the Northeast San Fernando Valley. The location is being used to conduct community health navigation and educational services, including Promotora mental health classes. In 2018, Community Health Staff provided daily exercise programs: Zumba®, aerobics and walking groups, assistance with applications: Medi-Cal, Covered California and CalFresh, referrals to other local resources and ongoing health and wellness classes. In August 2019, the Wellness Center in Van Nuys which is approximately 3,200 square feet to focus on more adult |

| | | 2017-19 Implementation Strategy - 2019 Progress Matrix | | | | |
|---|---|---|---|---|---|---|
| **Strategy 4: Align Community Benefit Programs with San Fernando Medical Centers** | | | | | | |
| **Measurable Objectives:** | **Action Plan** | **Tactic** | **Progress in 2017** | **Progress 2018** | **Progress 2019** | **Comments for 2019** |
| **1.) Align Community Benefit Programs with San Fernando Medical Centers** | **Holy Cross Medical Center Tactics** | **Develop a network of private sub-specialty physicians who provide consults to patients referred by FQHC's PHCMC to local clinics.** | **8** specialty physicians by medical center, participating in Access to Care Program.<br><br>**37** of patients were referred by clinics for specialty consult. | **7** specialty physicians by medical center, participating in Access to Care Program.<br><br>**127** of patients were referred by clinics for specialty consult. | **6** specialty physicians by medical center, participating in Access to Care Program. **82** of patients were referred by clinics for specialty consult. | In 2019, we continued our focus of the Access to Care program to faciliate linkage to a medical home for patients seen in the ER for conditions that are better seen in a primary care setting. We work closely with ER staff to faciliate followup appointments at local FQHCs and clinics that are accessible and convenient for the patient. In collaboration with local clinic partners, the program was able to assist individuals with thier specialty healthcare needs and decrease visits to the emergency department. |
| | | **Develop a pilot program that addresses mental health/resiliency skills for middle school students.** | | | **121** Youth Completed ACES Curriculum at James Monroe High School. | |
| | | | | | | |
| | **Saint Joseph Medical Center Tactics** | **Strengthen the network of private sub-specialty physician consults for patients referred to by ER to community clinics.** | **8** specialty physicians by medical center, participating in Access to Care Program.<br><br>**162** patients were referred by a clinic for specialty consult.<br><br>Assisted St. Joseph with **263** participants for Live Well Program. | **7** specialty physicians by medical center, participating in Access to Care Program.<br><br>**341** of patients were referred by clinics for specialty consult. | **6** specialty physicians by medical center, participating in Access to Care Program.<br>**270** of patients were referred by clinics for specialty consult. | In 2019, we continued our focus of the Access to Care program to faciliate linkage to a medical home for patients seen in the ER for conditions that are better seen in a primary care setting. We work closely with ER staff to faciliate followup appointments at local FQHCs and clinics that are accessible and convenient for the patient. In collaboration with local clinic partners, the program was able to assist individuals with thier specialty healthcare needs and decrease visits to the emergency department |
| | | **Support "Live Well" program operations and expand the high need communities in Saint Joseph Medical Center service area.** | | | | |
| | | | | Assisted St. Joseph with **263** participants for Live Well Program. | Assisted St. Joseph with **53** participants for Live Well Program. | |
| | | | | | | |
| | **Tarzana Medical Center** | **Develop a pilot program for seniors at risk for social isolation at time of hospital discharge.** | **13** seniors participated in pilot program.<br><br>No COPA program has been implemented at this time. | In discussions with ER staff to bring back piloted senior program. Plan to start in March 2019. | **493** senior patients were approached. | The overall goal of the SAFE (Specialized Assistance for the Elderly) program is to reduce the likelihood of readmission for discharged senior patients. The intervention will include patient assessment, patient education, navigation/linkage to services. The goal is to help patients understand and follow through with discharge plan. |
| | | **Implement peer coaching training related to physician education for elementary classroom teachers and/or community based youth organizations.** | | No COPA program has been implemented at this time. | **348** senior patients were served with linkage to services and referrals to the community. | The significant increase in patient referrals was contributed to having a FTE in the ER screening patients as there being discharged. |

**Providence Medical Centers - San Fernando Valley**
**Detailed Listing of Community Benefit Services**
**Reporting Period: January 1, 2019 - December 31, 2019**

| Category | Total Expense | Net Revenue | Net Expense | Persons Served |
|---|---|---|---|---|
| **A. Community Health Improvement Services** | | | | |
| Access to Care | 416,338 | - | 416,338 | 2,612 |
| Community Health Insurance Program (CHIP) | 58,316 | 40,133 | 18,183 | 929 |
| Community High School Athletic Training Program | 711,842 | - | 711,842 | 2,724 |
| Faith Community Health Partnership | 545,347 | - | 545,347 | 638 |
| Latino Health Promoter Program/Mental Health Outreach | 534,619 | 56,382 | 478,237 | 1,110 |
| Leeza's Care Connection | 55,511 | - | 55,511 | 382 |
| Live Well Program | 95,401 | 62,107 | 33,294 | 130 |
| Maternal Child Outreach and Education | 420,710 | 128,752 | 291,958 | - |
| Maternal Child Outreach and Education/Welcome Baby | 2,111,660 | 1,477,367 | 634,293 | 1,368 |
| Mental Health Assessment Team | 28,167 | 17,079 | 11,088 | 15 |
| Mental Health Promotion | 27,618 | 16,183 | 11,435 | - |
| Paramedic Base Station | 1,044,978 | 11,250 | 1,033,728 | 15,443 |
| Post-Discharge for Medically Indigent (including Psych Patients) | 1,255,495 | - | 1,255,495 | 765 |
| School Nurse Outreach Program | 291,808 | - | 291,808 | 3,000 |
| Senior Outreach Program | 311,466 | - | 311,466 | 543 |
| Tattoo Removal Program | 191,713 | - | 191,713 | 114 |
| UCLA/Providence Health Study | 122,287 | 71,295 | 50,992 | 85 |
| **Total A** | **8,223,276** | **1,880,548** | **6,342,728** | **29,858** |
| **B. Health Professions Education** | | | | |
| Preceptorships | 5,252,355 | 311,202 | 4,941,153 | 1,296 |
| **Total B** | **5,252,355** | **311,202** | **4,941,153** | **1,296** |
| **C. Subsidized Health Services** | | | | |
| Palliative Care | 3,228,500 | 996,841 | 2,231,659 | 366 |
| Trauma Center | - | - | - | 1,259 |
| **Total C** | **3,228,500** | **996,841** | **2,231,659** | **1,625** |
| **E. Cash and In-Kind Contributions** | | | | |
| Donation of Food | 895 | - | 895 | 296 |
| **Total E** | **895** | **-** | **895** | **296** |
| **G. Community Benefit Operations** | | | | |
| Community Outreach Administration | 850,728 | - | 850,728 | - |
| **Total G** | **850,728** | **-** | **850,728** | **-** |
| **Total Community Benefit** | **17,555,754** | **3,188,591** | **14,367,163** | **33,075** |

# Providence Saint Joseph Medical Center
## Detailed Listing of Community Benefit Services
## Reporting Period: January 1, 2019 - December 31, 2019

| Category | Total Expense | Net Revenue | Net Expense | Persons Served |
|---|---|---|---|---|
| **A. Community Health Improvement Services** | | | | |
| Access to Care | 159,873 | - | 159,873 | 1,003 |
| Community Health Insurance Program (CHIP) | 6,086 | 4,190 | 1,896 | 97 |
| Community High School Athletic Training Program | 237,288 | - | 237,288 | 908 |
| Faith Community Health Partnership | 228,228 | - | 228,228 | 267 |
| Latino Health Promoter Program/Mental Health Outreach | 123,297 | 13,003 | 110,294 | 256 |
| Leeza's Care Connection | 55,511 | - | 55,511 | 382 |
| Live Well Program | 95,401 | 62,107 | 33,294 | 130 |
| Maternal Child Outreach and Education | 420,710 | 128,752 | 291,958 | - |
| Mental Health Assessment Team | 9,389 | 5,693 | 3,696 | 5 |
| Mental Health Promotion | 9,206 | 5,395 | 3,811 | - |
| Paramedic Base Station | 621,914 | - | 621,914 | 7,979 |
| Post-Discharge for Medically Indigent (including Psych Patients) | 488,221 | - | 488,221 | 159 |
| School Nurse Outreach Program | 97,270 | - | 97,270 | 1,000 |
| Senior Outreach Program | 44,834 | - | 44,834 | 75 |
| Tattoo Removal Program | 80,727 | - | 80,727 | 48 |
| UCLA/Providence Health Study | 40,763 | 23,764 | 16,999 | 28 |
| **Total A** | **2,718,718** | **242,904** | **2,475,814** | **12,337** |
| **B. Health Professions Education** | | | | |
| Preceptorships | 2,620,082 | 76,452 | 2,543,630 | 756 |
| **Total B** | **2,620,082** | **76,452** | **2,543,630** | **756** |
| **C. Subsidized Health Services** | | | | |
| Palliative Care | 676,060 | 208,742 | 467,318 | 77 |
| **Total C** | **676,060** | **208,742** | **467,318** | **77** |
| **E. Cash and In-Kind Contributions** | | | | |
| Donation of Food | 895 | - | 895 | 296 |
| **Total E** | **895** | **-** | **895** | **296** |
| **G. Community Benefit Operations** | | | | |
| Community Outreach Administration | 283,576 | - | 283,576 | - |
| **Total G** | **283,576** | **-** | **283,576** | **-** |
| **Total Community Benefit** | **6,299,331** | **528,098** | **5,771,233** | **13,466** |

# Providence Holy Cross Medical Center
## Detailed Listing of Community Benefit Services
## Reporting Period: January 1, 2019 - December 31, 2019

| Category | Total Expense | Net Revenue | Net Expense | Persons Served |
|---|---|---|---|---|
| **A. Community Health Improvement Services** | | | | |
| Access to Care | 165,134 | - | 165,134 | 1,036 |
| Community Health Insurance Program (CHIP) | 40,745 | 28,038 | 12,707 | 649 |
| Community High School Athletic Training Program | 237,266 | - | 237,266 | 908 |
| Faith Community Health Partnership | 135,051 | - | 135,051 | 158 |
| Latino Health Promoter Program/Mental Health Outreach | 292,841 | 30,884 | 261,957 | 608 |
| Maternal Child Outreach and Education/Welcome Baby | 2,111,660 | 1,477,367 | 634,293 | 1,368 |
| Mental Health Assessment Team | 9,389 | 5,693 | 3,696 | 5 |
| Mental Health Promotion | 9,206 | 5,394 | 3,812 | - |
| Paramedic Base Station | 423,064 | 11,250 | 411,814 | 7,464 |
| Post-Discharge for Medically Indigent (including Psych Patients) | 513,286 | - | 513,286 | 528 |
| School Nurse Outreach Program | 97,271 | - | 97,271 | 1,000 |
| Senior Outreach Program | 32,276 | - | 32,276 | 54 |
| Tattoo Removal Program | 53,810 | - | 53,810 | 32 |
| UCLA/Providence Health Study | 40,763 | 23,766 | 16,997 | 29 |
| **Total A** | **4,161,762** | **1,582,392** | **2,579,370** | **13,839** |
| **B. Health Professions Education** | | | | |
| Preceptorships | 1,470,452 | 58,868 | 1,411,584 | 291 |
| **Total B** | **1,470,452** | **58,868** | **1,411,584** | **291** |
| **C. Subsidized Health Services** | | | | |
| Palliative Care | 1,938,161 | 598,432 | 1,339,729 | 220 |
| Trauma Center | - | - | - | 1,259 |
| **Total C** | **1,938,161** | **598,432** | **1,339,729** | **1,479** |
| **G. Community Benefit Operations** | | | | |
| Community Outreach Administration | 283,576 | - | 283,576 | - |
| **Total G** | **283,576** | **-** | **283,576** | **-** |
| **Total Community Benefit** | **7,853,951** | **2,239,692** | **5,614,259** | **15,609** |

**Providence Cedars-Sinai Tarzana Medical Center**
**Detailed Listing of Community Benefit Services**
**Reporting Period: January 1, 2019 - December 31, 2019**

| Category | Total Expense | Net Revenue | Net Expense | Persons Served |
|---|---|---|---|---|
| **A. Community Health Improvement Services** | | | | |
| Access to Care | 91,331 | - | 91,331 | 573 |
| Community Health Insurance Program (CHIP) | 11,485 | 7,905 | 3,580 | 183 |
| Community High School Athletic Training Program | 237,288 | - | 237,288 | 908 |
| Faith Community Health Partnership | 182,068 | - | 182,068 | 213 |
| Latino Health Promoter Program/Mental Health Outreach | 118,481 | 12,495 | 105,986 | 246 |
| Mental Health Assessment Team | 9,389 | 5,693 | 3,696 | 5 |
| Mental Health Promotion | 9,206 | 5,394 | 3,812 | - |
| Post-Discharge for Medically Indigent (including Psych Patients) | 253,988 | - | 253,988 | 78 |
| School Nurse Outreach Program | 97,267 | - | 97,267 | 1,000 |
| Senior Outreach Program | 234,356 | - | 234,356 | 414 |
| Tattoo Removal Program | 57,176 | - | 57,176 | 34 |
| UCLA/Providence Health Study | 40,761 | 23,765 | 16,996 | 28 |
| **Total A** | **1,342,796** | **55,252** | **1,287,544** | **3,682** |
| **B. Health Professions Education** | | | | |
| Preceptorships | 1,161,821 | 175,882 | 985,939 | 249 |
| **Total B** | **1,161,821** | **175,882** | **985,939** | **249** |
| **C. Subsidized Health Services** | | | | |
| Palliative Care | 614,279 | 189,667 | 424,612 | 69 |
| **Total C** | **614,279** | **189,667** | **424,612** | **69** |
| **G. Community Benefit Operations** | | | | |
| Community Outreach Administration | 283,576 | - | 283,576 | - |
| **Total G** | **283,576** | **-** | **283,576** | **-** |
| **Total Community Benefit** | **3,402,472** | **420,801** | **2,981,671** | **4,000** |