2023 - 2025

COMMUNITY HEALTH IMPROVEMENT PLAN

Providence Little Company of Mary Medical Center San Pedro

Providence Little Company of Mary Medical Center Torrance

To provide feedback on this CHIP or obtain a printed copy free of charge, please email Justin Joe, Director of Community Health Investment at justin.joe@providence.org.

Providence

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EXECUTIVE SUMMARY

Providence continues its Mission of service in the South Bay service area of Los Angeles County through two ministries: Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance. Providence Little Company of Mary Medical Center Torrance is located at 4101 Torrance Boulevard, Torrance, CA, 90503. It is an acute care hospital with 327 licensed beds founded in 1960. Providence Little Company of Mary Medical Center San Pedro is located at 1300 West Seventh Street, San Pedro, CA, 90732. It is an acute care hospital with 231 licensed beds founded in 1925. These two Providence medical centers share the South Bay as a common service area because of their geographic proximity to each other, which is made up of a population of 884,116 people. The two hospitals share a defined community service area, employ a single department with shared staffing and resources to provide community benefit to the entire South Bay, and report to common governing body overseeing community benefit. Because of this approach to community benefit, Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance have adopted both a joint 2022 Community Health Needs Assessment as well as a joint Community Health Improvement Plan for 2023-2025. Therefore, the strategies described in this Community Health Improvement Plan are representative of efforts taken by both hospitals to address community needs.

Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance (PLCM) dedicate resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of people experiencing social inequities and health disparities. During 2022, Providence Little Company of Mary Medical Center San Pedro provided approximately $24 million and Providence Little Company of Mary Medical Center Torrance provided approximately $73 million in Community Benefit in response to unmet needs.

The Community Health Needs Assessment (CHNA) is an opportunity for PLCM to engage the community every three years with the goal of better understanding community strengths and needs. The results of the CHNA are used to guide and inform efforts to better address the needs of the community. Through a mixed-methods approach, using quantitative and qualitative data, the CHNA process relied on several sources of information: state and national public health data, qualitative data from interviews with community stakeholders and listening sessions with community members, and hospital utilization data.

Providence Little Company of Mary Medical Centers San Pedro and Torrance Community Health Improvement Plan Priorities

As a result of the findings of our 2022 CHNA and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, PLCM will focus on the following areas for its 2023-2025 Community Benefit efforts:

PRIORITY 1: ACCESS TO HEALTH CARE & PREVENTIVE CARE

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

PRIORITY 2: HOMELESSNESS & HOUSING INSTABILITY

Persons experiencing homelessness is defined as any individual or family who lacks a fixed, regular, and adequate nighttime residence; an individual or family who will imminently lose their primary nighttime residence; and any individual or family who is fleeing, or is attempting to flee, domestic violence, has no other residence, and lacks the resources or support networks to obtain other permanent housing. Health and homelessness are inextricably linked. Health problems can cause a person's homelessness as well as be exacerbated by the experience. Housing is key to addressing the health needs of people experiencing homelessness.

Housing instability encompasses several challenges such as having trouble paying rent, overcrowding, moving frequently, staying with relatives, or spending the bulk of household income on housing. Households are considered "cost burdened" if spending more than 30% of household income on housing, and "severely cost burdened" if spending more than 50% of household income on housing. Cost-burdened households have little left over each month to spend on other necessities such as food, clothing, utilities, and health care.

PRIORITY 3: BEHAVIORAL HEALTH (MENTAL HEALTH AND SUBSTANCE USE/MISUSE)

Mental health is an important part of overall health and well-being. Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we manage stress, relate to others, and make healthy choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood. Mental health programs include the prevention, screening, assessment, and treatment of mental disorders and behavioral conditions.

Substance use/misuse occurs when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and inability to meet major responsibilities at work, school, or home. Substance use/misuse includes the use of illegal drugs and the inappropriate use of legal substances, such as alcohol, prescription drugs and tobacco.

INTRODUCTION

Who We Are

Our Mission	As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.
Our Vision	Health for a Better World.
Our Values	Compassion — Dignity — Justice — Excellence — Integrity

Providence Little Company of Mary Medical Center Torrance is located at 4101 Torrance Boulevard, Torrance, CA, 90503. It is an acute care hospital with 327 licensed beds founded in 1960. Providence Little Company of Mary Medical Center San Pedro is located at 1300 West Seventh Street, San Pedro, CA, 90732. It is an acute care hospital with 231 licensed beds founded in 1925. These two Providence South Bay community medical centers share a common service area because of their proximity to each other.

Our Commitment to Community

Providence Little Company of Mary Medical Centers dedicate resources to improve the health and quality of life for the communities we serve. During 2022, Providence Little Company of Mary Medical Center San Pedro provided approximately $24 million and Providence Little Company of Mary Medical Center Torrance provided approximately $73 million Community Benefit[1] in response to unmet needs and to improve the health and well-being of those we serve in the South Bay community.

Health Equity

At Providence, we acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. Our Vision is "Health for a Better World," and to achieve that we believe we must address not only the clinical care factors that determine a person's length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes.

To ensure that equity is foundational to our CHIP, we have developed an equity framework that outlines the best practices that each of our hospital will implement when completing a CHIP. These practices include, but are not limited to the following:

[1] Per federal reporting and guidelines from the Catholic Health Association

Figure 1. Best Practices for Centering Equity in the CHIP

Community Benefit Governance

Providence Little Company of Mary Medical Centers demonstrate organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation and collaboration with community partners. The Director of Community Health Investment is responsible for coordinating implementation of State and Federal 501r requirements for both hospitals.

The Mission Community Health Committee of the Providence Little Company of Mary Community Ministry Board oversees and advises upon the PLCM commitment to serve and address our community's health needs. The Committee ensures that PLCM's Mission and Core Values are fulfilled and integrated through our service and investment in the community and that we pay special attention to poor and vulnerable populations in the South Bay. It is responsible for the oversight of the two ministries' community health needs assessment, the prioritization of the identified significant community needs, and advises PLCM on its community benefit programming and investment. The Committee is composed of PLCM leadership and community stakeholders (see appendix 1).

Because the two hospitals share a defined community service area and a common governing body overseeing community benefit, Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance have adopted both a joint 2022 Community Health Needs Assessment as well as a joint Community Health Improvement Plan for 2023-2025. Therefore, the strategies described in this Community Health Improvement Plan are representative of efforts taken by both hospitals to address community needs.

Planning for the Uninsured and Underinsured

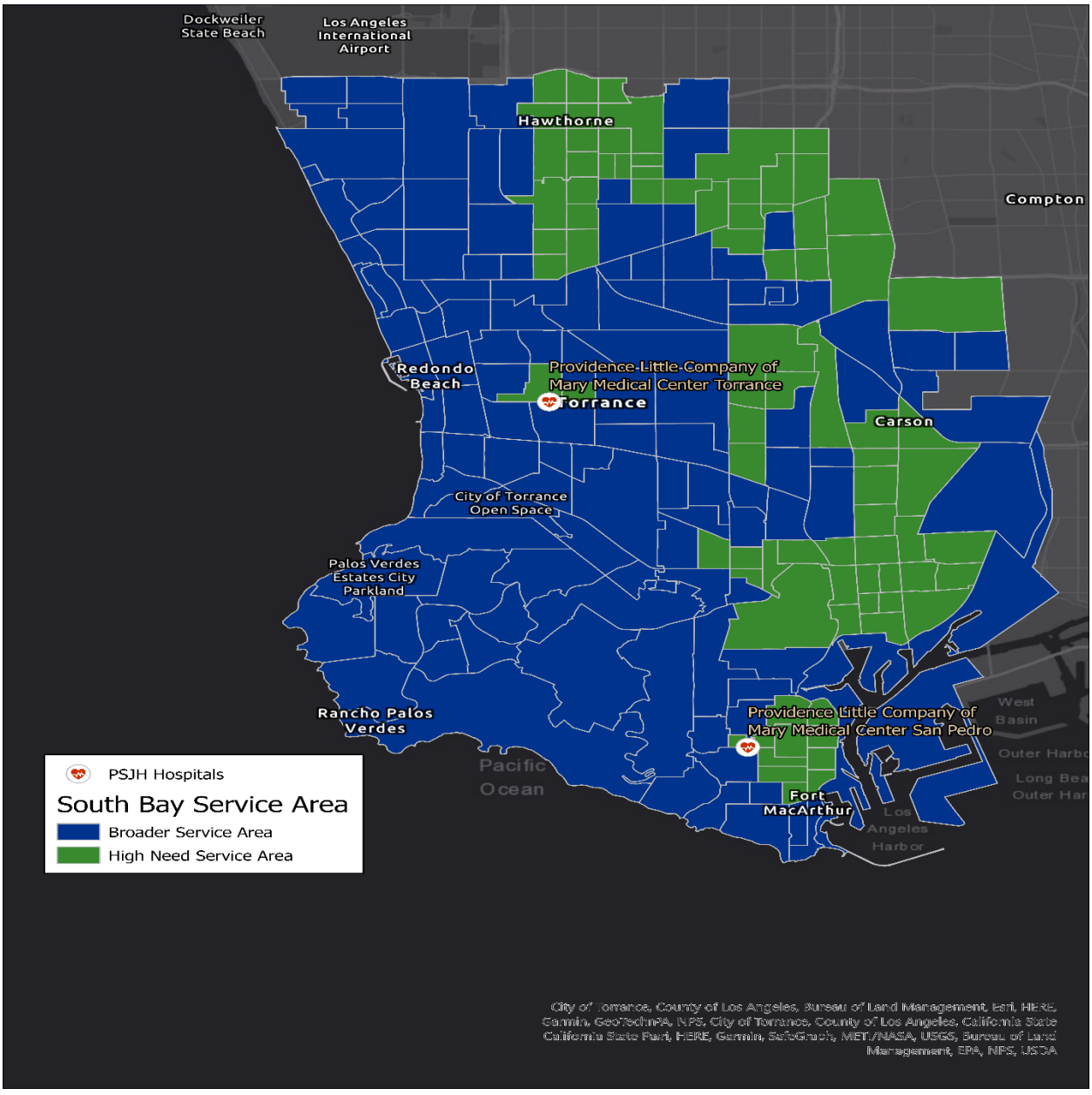
Our Mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why Providence Little Company of Mary Medical Centers have a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients.

One way PLCM informs the public of FAP is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third party insurers are offered an opportunity to complete the Patient Financial Assistance Application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible. For information on our Financial Assistance Program click https://www.providence.org/obp/ca.

OUR COMMUNITY

Description of Community Served

Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance share a common geographic service area because of their close proximity to each other. Based on the availability of data, geographic access to these facilities, and other hospitals in neighboring counties, the South Bay of Los Angeles County, as outlined in the map, serves as the boundary for the service area.



The South Bay service area is composed of 16 distinct municipalities and is a demographically and geographically diverse region stretching from El Segundo (North), to Carson (East), to the Port of Los Angeles (South), to the Pacific Ocean (West).

For the 2022 CHNA we identified a high need service area within the total South Bay service area, based on the social determinants of health specific to the inhabitants of the service area census tracts. Based on work done by the Public Health Alliance of Southern California and their Healthy Places Index (HPI) tool, the following variables were used to calculate a high need census tract:

- Population below 200% the Federal Poverty Level (American Community Survey, 2019)
- Percent of population with at least a high school education (American Community Survey, 2019)
- Percent of population, ages 5 Years and older in Limited English Households (American Community Survey, 2020)
- Life expectancy at birth (estimates based on CDC, 2010 – 2015 data)

Roughly 41% of the approximately 884,116 residents of the South Bay live in the "high need" area, defined by lower life expectancy at birth, lower high school graduation rates, and more households below 200% FPL compared to census tracts across the service area. For reference, in 2020, 200% FPL represents an annual household income of $52,400 or less for a family of four. These households are more likely to regularly make spending tradeoffs regarding utilities, rent, groceries, medicine, and other basic expenses.

Community Demographics

POPULATION AND AGE DEMOGRAPHICS

The age distribution of the high need service area skews younger compared to the total South Bay service area. Within the high need service area there is a larger percentage of children and youth in the high need area compared to the broader service area (27.3% vs 24.5%) and smaller percentage of population over the age of 50 (28.4% vs. 39.8%). Across the total South Bay service area 50.9% of the population is female compared to 49.1% male.

POPULATION BY RACE AND ETHNICITY

The majority of residents in the high need service area are Hispanic (60%) compared to only 20.8% of the broader service area. There are a larger percentage of White (55.1%) and Asian (22.8%) populations in the broader service area compared to the high need service area (37.4%) and (14.4%). The high need service area has a larger percentage of Black or African American population (13.6%) compared to broader service area (7.5%).

SOCIOECONOMIC INDICATORS

Table 1. Income Indicators for South Bay Service Area

Indicator	Broader Service Area	High Need Service Area	South Bay Service Area	Los Angeles County
Median Income Data Source: 2019 American Community Survey, 5-year estimate	$106,070	$56,484	$80,546	$67,817
Population Below 200% of the Federal Poverty Level Data Source: 2019 American Community Survey, 5-year estimate	15.0% (80,374 persons)	41.7% (149,408 persons)	25.9% (229,782 persons)	34.9% (3,458,721 persons)
Percent of Renter Households with Severe Housing Cost Burden Data Source: 2019 American Community Survey, 5-year estimate	20.1%	28.1%	23.4%	29.04%

Full demographic and socioeconomic information for the service area can be found in the 2022 CHNA for Providence Little Company of Mary Medical Centers.

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

The CHNA process is based on the understanding that health and wellness are influenced by factors within our communities, not only within medical facilities. In gathering information on the communities served by the hospitals, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors.

In addition, we recognize that there are often geographic areas where the conditions for supporting health are substantially poorer than nearby areas. Whenever possible and reliable, data are reported at the ZIP Code or census tract level. These smaller geographic areas allow us to better understand the neighborhood level needs of our communities and better address inequities within and across communities.

We reviewed quantitative data from the American Community Survey, Behavioral Risk Factor Surveillance System, and local public health authorities. In addition, we include hospital utilization data to identify disparities in utilization by income and insurance, geography, and race/ethnicity when reliably collected.

To actively engage the community, we conducted listening sessions with people who have chronic conditions, are from diverse communities, have low-incomes, and/or are medically underserved. We also conducted stakeholder interviews with representatives from organizations that serve these populations (including LA County Department of Public Health), specifically seeking to gain deeper understanding of community strengths and opportunities. Some key findings include the following:

- The pandemic exacerbated mental health needs, adding stress to a system already unable to meet the demand.
- Barriers to accessing health care included the complicated health care system, language, lack of culturally responsive providers, lack of childcare, and the cost of care.
- During the pandemic, some patients delayed accessing routine primary care and chronic disease management. As patients are returning for care, it takes months to get an appointment and, in many instances, there are not enough local providers.
- Oil refineries, multiple freeways, and the Port of Los Angeles negatively impact air quality and chronic diseases.
- The high cost of housing makes it difficult to be economically stable, resulting in overcrowded housing.

Significant Community Health Needs Prioritized

Through a collaborative process engaging local community members, external partners, and Providence leadership, the Mission Community Health Committee of the Providence Little Company of Mary Community Ministry Board identified three priority areas (listed in priority order):

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PRIORITY 2: HOMELESSNESS & HOUSING INSTABILITY

Persons experiencing homelessness is defined as any individual or family who lacks a fixed, regular, and adequate nighttime residence; an individual or family who will imminently lose their primary nighttime residence; and any individual or family who is fleeing, or is attempting to flee, domestic violence, has no other residence, and lacks the resources or support networks to obtain other permanent housing. Health and homelessness are inextricably linked. Health problems can cause a person's homelessness as well as be exacerbated by the experience. Housing is key to addressing the health needs of people experiencing homelessness.

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Needs Beyond the Hospital's Service Program

No hospital facility can address all of the health needs present in its community. We are committed to continuing our Mission through programs and grants addressing seven of the eight identified health needs from the 2022 Community Health Needs Assessment. However, identified health need of dental care will not be actively addressed and the explanations of our rationale are provided below:

- Dental Care is not as pressing as the other identified health needs and was prioritized as the lowest of the eight identified health needs in the 2022 Community Health Needs Assessment.
- Our hospital does not have expertise to effectively address dental care compared to other stakeholders who are better equipped to address this need.
- Dental care is being addressed by other stakeholders in the community, particularly multiple local Federally Qualified Health Centers who have been recently expanding this line of service in their clinics.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

The Community Health Improvement Plan was developed by leadership in Providence Little Company of Mary's Community Health Investment department. The CHIP considers 1) existing evidence-based hospital programs and investments, 2) new potential opportunities for additional growth, and 3) partnerships with local organizations committed to addressing the top three needs identified in the 2022 CHNA. The CHIP was presented to and reviewed by the Mission Community Health Committee on March 14, 2023 and was unanimously approved and adopted by the Committee on behalf of the Providence Little Company of Mary Community Ministry Board.

While the focus of the 2023-2025 CHIP primarily is centered around efforts to address the top three identified needs, PLCM recognizes there are numerous other programs that address other community needs that the hospitals will remain committed to continuing—particularly those with a long history and reputation of positive and effective impact (outlined in "Other Community Benefit Programs"). Furthermore, in light of the recent COVID-19 pandemic, we recognize that the needs of the community are a dynamically evolving situation, and we may need to adapt accordingly to be responsive to those needs. While our CHIP outlines our best intended efforts to meet the community's needs, we believe that it will be important to maintain a spirit of flexibility in our approach to community benefit throughout the course of this three-year period.

Addressing the Needs of the Community: 2023- 2025 Key Community Benefit Initiatives and Evaluation Plan

PLACES AND PEOPLE: TWO KEY APPROACHES TO ADDRESSING COMMUNITY HEALTH NEEDS

Providence Little Company of Mary's breadth of Community Health programs feature two key approaches to addressing the community's health needs: 1) opening Wellness Centers in under-resourced communities and 2) employing Community Health Workers to engage with our patients and neighbors.

Wellness and Activity Centers

For Providence, the operation of Wellness and Activity Centers in high-need communities highlights how a Medical Center can move outside its hospital walls to promote health equity in underserved communities. The Centers are concrete, visible reminders that accessible health promotion activities in the places where people live, work, study, and play contribute to lifelong health. The free programs offered by Providence, community volunteers, and community- and government-based organizations provide individuals with the tools they need to be healthy and reduce existing health disparities in the communities where the Centers are located.

In Wilmington, Providence Little Company of Mary worked with an affordable housing developer to open its first Wellness and Activity Center, in 2014. The Center is a 10,000 square foot complex that

includes a soccer field, outdoor basketball court, gymnasium, meeting space for large and small community meetings and offices for Providence staff who deliver services in the surrounding area. Thousands of Wilmington residents participate in skills-based programs and activities that promote healthy living. Programs include support groups, exercise classes, wellness classes, and enrollment assistance for health insurance and CalFresh. A weekly certified farmers' market provides local families with low-cost, fresh produce within walking distance of their homes. During the COVID-19 pandemic, the Center became a hub of resources for the local community; partnering with the County health department and community organizations the Center functioned as a COVID-19 testing site, COVID-19 vaccination site, provided weekly free food distributions, and was a trusted location for people to learn about resources to stay safe and healthy.

In 2023, Providence will open its second Wellness and Activity Center in Lawndale, CA. The Center, in partnership with the Lawndale Elementary School District, will be a new 1,600 square foot building on 5,512 square feet of community space transforming a previously vacant lot on the campus of William Anderson Elementary School. The project includes fencing with a lockable gate between the school and the new Center; and a new entrance between an adjacent public park and the Center allows the public to freely enter and exit the Center without having to go through the school. The venue will be surrounded by new landscaping, outdoor exercise space, shading, and a small bike path. As with the Wilmington site, this new Center will partner with volunteers and organizations to provide free programs to the surrounding community.

Community Health Workers

Since 2001, Providence has successfully hired, trained, and integrated Community Health Workers (CHWs) as valued members of the healthcare team in our hospital, clinic, and community settings. CHWs are front-line public health workers who share a common language and cultural experience with our patients and clients. They have faced the same barriers, stigmas and fears in accessing health care, so they have a greater understanding of the challenges faced by those we serve. Their roles within Providence include outreach, health and wellness education, medical care coordination, system navigation, advocacy, enrollment assistance for public benefit programs (health insurance and CalFresh), and they serve as liaisons between our medical centers and the community. They are a key ingredient for health care organizations to effectively care for their patient populations, especially in low-income neighborhoods. As part of the team, CHWs enrich the quality of care provided to patients. CHWs help patients navigate resources such as CalFresh, Covered CA, and Medi-Cal and improve access to preventive and medical care services, avoiding the use of costly emergency care in nonemergency situations.

In response to the growing demand from health care organizations across Los Angeles to employ trained CHWs in their settings, Providence partnered with Charles R. Drew University School of Medicine and Science in 2018, to develop an innovative and unique workforce development program called the Community Health Worker Academy (CHW Academy). The CHW Academy identifies, trains, and places CHWs within multiple healthcare systems to reach and serve children and adults in underserved, priority communities throughout the Los Angeles area.

COMMUNITY NEED ADDRESSED #1: ACCESS TO HEALTH CARE & PREVENTIVE CARE

Long-Term Goal(s)/ Vision

- To improve access to health care and preventive resources for people with low incomes and those uninsured by deploying programs to assist with navigating the health care system.
- To ease the way for people to access the appropriate level of care at the right time.
- To increase the percentage of people with insurance in the community.

Key Community Partners

Programmatic collaborators: Lawndale Elementary School District, Providence Medical Institute, Torrance Memorial

Co-located space sharing and/or referral partnerships: Harbor Community Health Center, Hawthorne School District, L.A. Care-Blue Shield Community Resource Center, Lawndale Elementary School District, Los Angeles Unified School District, Torrance Unified School District, Wilmington Community Clinic, Women Infants & Children Program (WIC), Venice Family Clinic, YMCA,

Funders of our programs: LA County Department of Public Health, First 5 LA, Covered California

Providence grantees: Behavioral Health Services, Harbor Community Health Center, To Help Everyone Clinic, Venice Family Clinic, Wilmington Community Clinic

Table 2. Strategies and Strategy Measures for Addressing Access to Health Care & Preventive Care

Strategy	Strategy Measure(s)	Anticipated Impact
Community Health Insurance Program: CHWs provide community-based outreach and enrollment assistance about affordable health insurance options including Medi-Cal and Covered California health plans	Number of insurance applications assisted Percentage of applications with enrollment confirmed	**Baseline (2022)** • 2,653 insurance applications assisted • 89.4% of applications assisted were confirmed enrolled **2023-2025 Objective** • 2,800 insurance applications assisted per year • 90% of applications assisted will have enrollment confirmed

Welcome Baby: a home-visitation program, led by RN and parent coaches providing pregnant and/or new parents with information and support to help them through the journey of pregnancy and early parenthood	Number of patients receiving home visitation services Percentage of Medi-Cal eligible infants insured by time of two- month home visit (total is the number of infants enrolled in Welcome Baby program)	**Baseline (2022)** • 1,248 patients received virtual home visitation services (from 2020-2022 home visitation pivoted to virtual visits due to COVID-19 pandemic) • 97% of Medi-Cal eligible infants insured **2023-2025 Objectives** • Reincorporate availability of in-person home visitation services • 1,200 patients receiving home visitation services per year (combined virtual or in-person) • 97% of Medi-Cal eligible infants insured
Partners for Healthy Kids: a mobile clinic offering childhood immunizations at elementary and middle schools; COVID-19 and flu immunizations for adults; and health insurance enrollment information and navigation assistance	Number of immunizations administered	**Baseline (2022)** • 2,646 childhood vaccines administered • 287 influenza vaccines administered • 1,100 COVID-19 vaccines administered **2023-2025 Objectives** • 4,400 childhood vaccines administered per year • 110 influenza vaccines administered per year • COVID-19 vaccine objective TBD based upon community need
CHW COVID-19 Outreach and Education: CHWs deliver grassroots outreach that promote information on COVID-19 prevention, testing, and vaccinations. The program focuses on local communities with low vaccination rates and high rates of COVID-19 transmission identified by LA County Department of Public Health	Number of outreach contacts made	**Baseline** • 96,249 outreach contacts made in 2022 (external grant funding by LA County Department of Public Health for this project reduced by 50% for 2023) **2023-2025 Objectives** • 50,000 outreach contacts/year • Expanded scope of work to include chronic disease prevention and early intervention outreach

Emergency Department Community Health Workers: CHWs who assist uninsured patients in the emergency department with affordable health care options, applications for enrollment in eligible health insurance programs and coordination of follow-up visits at a clinic in their community	Number of primary care referrals and appointments made Percentage of patient follow up primary care appointments kept	**Baseline** • 1,806 follow up primary care referrals and appointments made • 73% of patient follow up primary care appointments kept **2023-2025 Objectives** • 1,800 appointments made per year • 75% of follow up primary care appointments kept
Grantmaking: Financial support to local agencies that provide healthcare to underserved populations, including Federally Qualified Health Centers	Number of grants awarded Total $ value of grants awarded	**2023-2025 Objectives** • 2023: Identify organizations and award grants through PLCM local ministry grantmaking • 2024-2025: Nominate and advocate for local South Bay organizations for funding to Providence's South Division future grantmaking structure

Population Served

- Elementary and Middle School Students
- Low-Income Households
- New Mothers
- Providence Little Company of Mary Emergency Department Patients
- Residents of the identified High Need census tracts from 2022 CHNA
- Monolingual Spanish-Speaking Households
- Immigrants with Undocumented Status or Mixed-Status Families
- Uninsured/underinsured Community Members

Resource Commitment

- Staffing for multiple access to care programs
- Funding for agencies providing access to care services

Evidence Based Sources

Early childhood home visiting programs | County Health Rankings & Roadmaps

Community health workers | County Health Rankings & Roadmaps

Federally qualified health centers (FQHCs) | County Health Rankings & Roadmaps

Health insurance enrollment outreach & support | County Health Rankings & Roadmaps

Medical homes | County Health Rankings & Roadmaps

School-based health centers | County Health Rankings & Roadmaps

COMMUNITY NEED ADDRESSED #2: HOMELESSNESS & HOUSING INSTABILITY

Long-Term Goal(s)/ Vision

- A seamless connection between health care and homeless services, ensuring that people experiencing homelessness receive timely and appropriate linkage to community-based homeless services.
- Providence is a dedicated member of local coalitions to ensure coordination of homeless support services, including recuperative care, and that there are increased connections to supportive services for individuals experiencing homelessness.

Key Community Partners

Programmatic collaborators: Harbor Interfaith

Coordinating efforts and resources: Torrance Memorial, Harbor UCLA, Kaiser Permanente South Bay, LAHSA

Providence grantees: Harbor Community Health Center, Harbor Interfaith, City of Torrance, National Health Foundation, Golden State Recuperative Care, Healthcare in Action, Family Promise of the South Bay

Table 3. Strategies and Strategy Measures for Addressing Homelessness & Housing Instability

Strategy	Strategy Measure(s)	Anticipated Impact
CHW Homeless Care Navigators: CHWs placed within our emergency department to specifically care for patients experiencing homelessness. They act as liaisons between homeless service providers and our Medical Centers to reduce avoidable emergency department visits and link patients with permanent and interim housing.	Number of patients experiencing homelessness connected to shelter/housing	**Baseline (2022)** • 148 patients **2023-2025 Objective** • 200 patients connected to shelter/housing per year
Coalition Building: Strengthen collaboration between South Bay hospitals, homeless service providers, and FQHCs.	Participation and engagement in local/regional coalitions on homelessness New potential partnerships identified Number of cooperative and collaborative partnerships	**2023-2025 Objectives** • Increased participation and representation of Providence at two local coalitions on homelessness • Networking & Coordinating: Identify additional community-based organizations for potential partnerships • Collaborating: Strengthen existing partnerships to form collaborative relationships
Grantmaking: Financial support to local partners across the continuum of homeless services, including recuperative care, street medicine, and interim housing	Number of grants awarded Total $ value of grants awarded	**2023-2025 Objectives** • 2023: Identify organizations and award grants through PLCM local ministry grantmaking • 2024-2025: Nominate and advocate for local South Bay organizations for funding to Providence's South Division future grantmaking structure

Population Served

- People Experiencing Homelessness
- Providence Little Company of Mary Emergency Department Patients
- Staff at Local Nonprofit Homeless Service Providers

Resource Commitment

- Staffing for CHW Homeless Navigators
- Staff time for coalition building among hospitals, homeless service providers and FQHCs
- Grant funding for homeless service providers including recuperative care, street medicine and interim shelter

Evidence Based Sources

Community health workers | County Health Rankings & Roadmaps

COMMUNITY NEED ADDRESSED #3: BEHAVIORAL HEALTH (MENTAL HEALTH AND SUBSTANCE USE/MISUSE)

Long-Term Goal(s)/ Vision

- To ensure equitable access to high-quality, culturally responsive, and linguistically appropriate mental health services, especially for populations with low incomes.
- An improved workforce of mental health professionals that is representative of the community served and can effectively and compassionately respond to the community's mental health and substance use needs.

Key Community Partners

Programmatic collaborators: Richstone Family Center, Dignity Health California Hospital

Funders of our programs: California Community Foundation, Substance Abuse and Mental Health Services Administration (SAMHSA)

Providence grantees: Richstone Family Center, Our House Grief Support Center, Open Paths Counseling Center, Harbor Community Health Centers, Behavioral Health Services

Table 4. Strategies and Strategy Measures for Addressing Behavioral Health

Strategy	Strategy Measure(s)	Anticipated Impact
Mental Health First Aid: support prevention and early intervention by teaching the evidence-based MHFA curriculum. The skills-based course teaches participants how to identify, understand and respond to signs and symptoms of mental health and substance use challenges	Number of participants trained and certified in Mental Health First Aid	**Baseline (2022)** • New grant funding awarded to PLCM to support Mental Health First Aid program development **2023-2025 Objective** • By 2025, 650 participants trained and certified in MHFA per year

Behavioral Health Care Navigation: CHW links Providence Little Company of Mary Medical Center emergency department patients to follow up care with behavioral health treatment resources	Number of patients contacted Number of patients that consent to receive navigation assistance Number of patients that utilize behavioral health treatment resource	**Baseline (2022)** • 452 patients contacted • 79 patients consented to receive navigation assistance • 42 utilized behavioral health treatment resource **2023-2025 Objectives** • 500 patients contacted per year • 100 patients consent to receive navigation assistance per year • 60 patients utilize behavioral health treatment resource per year
Integrated Therapy Services within Primary Care: a partnership with Richstone Family Services to integrate mental health screenings and free short-term therapy services for patients at Providence's Vasek Polak Health Clinic (Hawthorne) and Butte Street Clinic (San Pedro)	Number of PHQ-9 and GAD-7 screenings completed Number of patients referred to therapy services Number of patients that utilize therapy services	**Baseline (2022)** • 1,193 mental health screenings completed (Vasek Polak) • 192 patients referred to therapy services (Vasek Polak) • 92 patients utilized therapy services (Vasek Polak) **2023-2025 Objective** <u>Vasek Polak</u> • 1,200 screenings completed per year • 180 patients referred to therapy services per year • 100 patients utilized therapy services per year Implementation of screening and therapy services at Butte Street Clinic

Grantmaking: Financial support for local non-profit mental health providers to increase access to services	Number of grants awarded Total $ value of grants awarded	**2023-2025 Objectives** • 2023: Identify organizations and award grants through PLCM local ministry grantmaking • 2024-2025: Nominate and advocate for local South Bay organizations for funding to Providence's South Division future grantmaking structure

Population Served

- Adults
- Adults working with youth or students
- Low-income households
- Providence Little Company of Mary Emergency Department Patients
- Seniors
- Spanish-speaking communities

Resource Commitment

- Staffing for preventive education classes on mental health
- Staffing for community health workers for patient navigation of behavioral health care
- Funding for agencies providing mental health and substance use treatment services

Evidence Based Sources

Community health workers | County Health Rankings & Roadmaps

Behavioral health primary care integration | County Health Rankings & Roadmaps

Other Community Benefit Programs

Table 3. Other Community Benefit Programs in Response to Community Needs

Program Name	Community Need Addressed	Description	Evidence Based Sources
Creating Opportunities for Physical Activity (COPA)	Overweight and Obesity	A peer coach training program for elementary school teachers that promotes independence in physical education instruction consistent with California grade level standards and creates a culture of physical activity throughout the school campus.	School-based physical education enhancements | County Health Rankings & Roadmaps Active recess | County Health Rankings & Roadmaps Multi-component school-based obesity prevention interventions | County Health Rankings & Roadmaps Physically active classrooms | County Health Rankings & Roadmaps
CalFresh Assistance	Food Insecurity	CHWs provide information and enrollment assistance about CalFresh—California's SNAP program	Social Determinants of Health Series: Food Insecurity and the Role of Hospitals | AHA
Community Health Worker Academy	Economic Insecurity	A workforce development and internship program that establishes a pipeline of academically trained community health workers (CHWs) for entry-level placement in healthcare employers throughout Los Angeles County	Community health workers | County Health Rankings & Roadmaps
Best Start Wilmington: Local Support Network	Economic Insecurity Food Insecurity	Provide support, capacity building, and strategic direction for the Best Start Wilmington initiative. Best Start Wilmington brings together local resident leaders and community-based organizations committed to establishing a healthy foundation for children in the community. It is driven by building neighborhood awareness and advocating for policy changes in the areas of Education, Safety, Health, Environment, and Immigration.	Intergenerational communities | County Health Rankings & Roadmaps

Health Education: • **Get Out and Live** • **FEAST** • **Choose2Change**	Chronic Diseases	Get Out And Live (GOAL): a Type 2 diabetes self-management program affording strategies for nutrition, exercise, and stress management to: empower more informed decisions about selfcare; lead a healthier lifestyle; and improve well-being. FEAST: a nutrition program offering healthy and affordable recipes to improve social, emotional, and physical wellness. Choose2Change: a year-long diabetes prevention program for people at-risk for Type-2 diabetes emphasizing the lifestyle changes needed to improve nutrition; help lose weight; promote exercise; and reduce stress.	Chronic disease self-management (CDSM) programs | County Health Rankings & Roadmaps Diabetes Prevention: Interventions Engaging Community Health Workers - Healthy People 2030 | health.gov About the National Diabetes Prevention Program | CDC
Wellness and Activity Centers	Economic Insecurity Food Insecurity Overweight and Obesity	Centers located in lower socioeconomic neighborhoods that give residents a physical space to participate in free programs, run by Providence, local volunteers and community partners, that promote social connections and help improve the health of the community.	Community centers | County Health Rankings & Roadmaps Shared use agreements | County Health Rankings & Roadmaps
Wilmington Farmer's Market	Food Insecurity Overweight and Obesity	The Wilmington Farmer's Market takes place every Tuesday from 10am – 2pm at our Wilmington Wellness and Activity Center. The Market provides the local community with accessible and affordable produce, eggs, and other local products. The Market accepts CalFresh, EBT, and offers the Market Match healthy food incentive program. The market also participates in the WIC and Senior Farmer's Market Nutrition Programs.	Farmers markets | County Health Rankings & Roadmaps Fruit & vegetable incentive programs | County Health Rankings & Roadmaps Electronic Benefit Transfer payment at farmers markets | County Health Rankings & Roadmaps WIC & Senior Farmers' Market Nutrition Programs | County Health Rankings & Roadmaps

2023- 2025 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the Mission Community Health Committee of the hospital on March 14, 2023. The final report was made widely available by May 15, 2023.

4/19/23

Garry Olney
Chief Executive
Providence Little Company of Mary Medical Centers San Pedro and Torrance

Date

Dean W. Nelson 4/19/23

Bishop Dean Nelson
Chair, Mission Community Health Committee
Community Ministry Board, Providence Little Company of Mary Medical Centers San Pedro and Torrance

Date

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4/24/2023

Kenya Beckmann
Chief Philanthropy and Health Equity Officer
South Division
Providence

Date

CHNA/CHIP Contact:

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

Appendix 1: Mission Community Health Committee

Mission Community Health Committee Members

Name	Title	Organization
Jordan Abushawish	Director, Public Affairs	Providence
Richard Afable, MD	Board Member	PLCM Community Ministry Board
Emily Blue	Community Member	
Randy Bowers	Board Member	PLCM Community Ministry Board
Jan Brandmeyer	Community Member	
Rev. Andrew Campbell	Chaplain	Providence
Scott Ciesielski	Chief Nursing Officer	Providence
Thomas Connaghan	Board Member	PLCM Community Ministry Board
Dr. Michele DelVicario	Board Member	PLCM Community Ministry Board
Ed Derenzis	Community Member	
Kathie Eckert	Chair	PLCM Foundation Board
Thelma Gonzalez	Director of Student Support Services	Lawndale School District
Suzi Gulcher	Board Member	PLCM Community Ministry Board
Jim Hartman	Community Member	
Justin Joe	Director, Community Health	Providence
Sr. Nancy Jurecki	Chief Mission Integration Officer	Providence
Glen Komatsu, MD	Chief Medical Officer	Trinity Care Hospice
Jerry Kouzmanoff	Board Chair	PLCM Community Ministry Board
Jennifer Kozakowski	Chief Mission Integration Officer South Bay	Providence
Phyllis Monroe, MD	Board Member	PLCM Community Ministry Board
Bishop Dean Nelson	Board Member	PLCM Community Ministry Board
Lori Nolan, RN	Philanthropy Officer	PLCM Foundation
Stephanie Nolan	Exec. Dir. Acute Care Svs.	Providence
Garry Olney	Chief Executive So. Bay	Providence
Jeff Parker	Community Member	Kaufman, Dolowich, Voluck, LLP
Mark Paullin	Treasurer	PLCM Foundation Board
Dr. Karen Pavic-Zabinski	Regional Ethicist	Providence
Amber Sheikh	Community Member	Sheikh Impact
Sr. JoAnn Showalter	Board Member	PLCM Community Ministry Board
Msgr. David Sork	Community Member	St. John Fisher Catholic Church
Jim Tehan	Regional Director, CHI	Providence
Mary Ann Walker	Vice-Chair	PLCM Foundation Board
Candice Washilewski	Exec. Dir. Acute Care Svs.	Providence
Paul White	Manager, Spiritual Care	Providence
Veronica Williams	Associate Marriage & Family Therapist	Richstone Family Center
Rabbi Gordon Zalman	Community Member	Jewish Community Ctr.