2023 - 2025

COMMUNITY HEALTH IMPROVEMENT PLAN

Providence Saint John's Health Center

Santa Monica, California

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

Providence

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EXECUTIVE SUMMARY

Providence continues its Mission of service in the Westside service area of Los Angeles County through Providence Saint John's Health Center (PSJHC). PSJHC is an acute-care hospital with 266 licensed beds, founded in 1942 and located in Santa Monica, California. The hospital's service area is the entirety of Service Planning Area 5 (Westside) of Los Angeles County, which is made up of a population of 650,563 people.

Providence Saint John's Health Center dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of people experiencing social inequities and health disparities. During 2022, the hospital provided approximately $45.8 million in Community Benefit in response to unmet needs.

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

Providence Saint John's Health Center 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, Providence Saint John's Health Center will focus on the following areas for its 2023-2025 Community Benefit efforts:

PRIORITY 1: HOMELESSNESS AND HOUSING INSTABILITY

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 2: 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.

PRIORITY 3: ACCESS TO HEALTH CARE AND 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.

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 Saint John's Health Center is a hospital founded in 1942 and located in Santa Monica, California. The hospital has 266 licensed beds, a staff of more than 1,200 employees, and professional relationships with more than 1,100 local physicians. Clinical programs and specialty services offered to the community include the following:

- Bariatric Surgery and Metabolic Weight Loss
- Margie Petersen Breast Center
- Cardiothoracic Surgery
- Lung and Thoracic
- Melanoma Program
- Pacific Neuroscience Institute
- Gastrointestinal Oncology Center
- Orthopedics
- Research through Saint John's Cancer Institute (one of largest tissue banks)
- Endocrine Tumor and Bone Disease Program
- Urologic Oncology

Our Commitment to Community

Providence Saint John's Health Center dedicates resources to improve the health and quality of life for the communities we serve. During 2022, the Providence Saint John's Health Center provided approximately $45.8 million in Community Benefit* in response to unmet needs and to improve the health and well-being of those we serve in the west Los Angeles 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

* Per federal reporting and guidelines from the Catholic Health Association.

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:

Figure 1. Best Practices for Centering Equity in the CHIP

Community Benefit Governance

Providence Saint John's Health Center demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation, and collaboration with community partners. The Director of Community Health Investment is responsible for coordinating compliance and community benefit reporting of State and Federal 501r requirements.

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 Saint John's Health Center has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients.

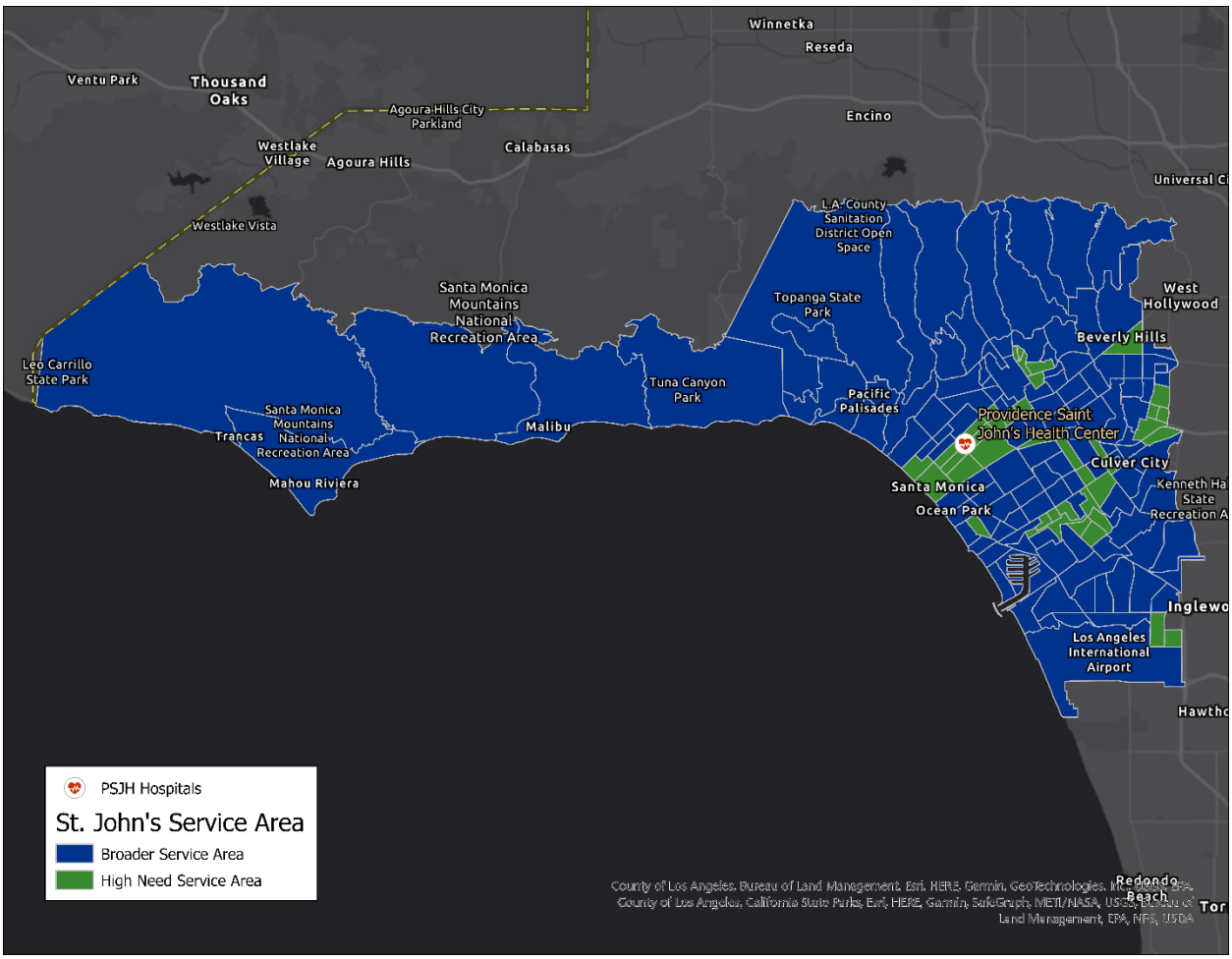
One way Providence Saint John's Health Center informs the public of FAP is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of

patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third party insurers are offered an opportunity to complete the Patient Financial Assistance Application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible. For information on our Financial Assistance Program click https://www.providence.org/obp/ca

OUR COMMUNITY

Description of Community Served

The service area defined for the Providence Saint John's Health Center (PSJHC) CHNA includes the neighborhoods located within Service Planning Area (SPA) 5 of Los Angeles County. The planning area includes the communities located on the west side of the county (referred to as "the Westside" locally, and in this report), and represents the area where a significant portion of the patients served by the hospital resides. SPA 5 was used as the target geographic area for this CHNA because 1) it closely matched where a majority of PSJHC's patients reside, 2) using the SPA definition aligned data collection to boundaries used by the L.A. County Department of Public Health and other government agencies and 3) it aligned with service areas of other hospitals whom we collaborated with in the needs assessment process. The area includes 20 distinct communities and 30 ZIP codes.



For the 2022 CHNA we identified a high need service area within the total Westside 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)

Of the over 650,000 permanent residents of the Westside, roughly 24% 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 county. 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 population in the Westside skews towards a larger proportion of younger adults (ages 20-39), most notably within the high need service area. Within the high need service area 45.4% of the population are between the ages of 20 to 39, compared to 30.8% in the broader service area. There are more children and youth in the broader service area with 20% of the population between the ages of 0-19 compared to 15.7% in the high need service area. Across the total Westside service area 51.2% of the population is female compared to 48.8% male.

Source: 2019 American Community Survey, 5-year estimates

POPULATION BY RACE AND ETHNICITY

The majority of residents in the service area are White (69.7%) with Asian populations being the second largest racial group (13.8%). There is a larger percentage of White (72.3%) populations in the broader service area compared to the high need service area (61.1%). The high need service area has a larger percentage of Black or African American population compared to broader service area (6.6% vs. 5.6%), Asian population (16.5% vs. 12.9%) and population that identify as "other" race (9.7% vs 3.0%). A larger population in the high need service area are Hispanic (28.0%) compared to only 12.3% of the broader service area.

Source: 2019 American Community Survey, 5-year estimates

SOCIOECONOMIC INDICATORS

Table 1. Income Indicators for Westside Service Area

Indicator	Broader Service Area	High Need Service Area	Westside Service Area	Los Angeles County
Median Income Data Source: 2019 American Community Survey, 5-year estimate	$118,295	$67,046	$98,059	$67,817
Population Below 200% of the Federal Poverty Level Data Source: 2019 American Community Survey, 5-year estimate	16.1% (73,856 persons)	34.8% (52,863 persons)	20.8% (126,719 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	22.3%	28.8%	25.1%	29.04%

Full demographic and socioeconomic information for the service area can be found in the 2022 CHNA for Providence Saint John's Health Center.

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

The Community Health Needs Assessment process was 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 hospital(s), we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. Additionally, we invited key stakeholders and community members (including LA County Department of Public Health) to provide additional context to the quantitative data through qualitative data in the form of interviews and listening sessions. Providence Saint John's Health Center partnered with Cedars-Sinai Medical Center, Cedars-Sinai Marina del Rey Hospital, Ronald Reagan UCLA Medical Center, UCLA Medical Center, Santa Monica, and Resnick Neuropsychiatric Hospital at UCLA, to conduct 33 stakeholder interviews with representatives from community-based organizations during October and November 2021. Additionally, Providence Saint John's Health Center conducted 3 listening sessions with 24 community members in June 2022.

We reviewed data from the American Community Survey and local public health authorities. In addition, we included hospital utilization data to identify disparities in utilization by income and insurance, geography, and race/ethnicity when reliably collected. As often as possible, equity was at the forefront of our presentation of the data, which often have biases based on collection methodology. We recognized that there are often geographic areas where the conditions for supporting health are substantially poorer than nearby areas. Whenever possible and reliable, data was 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.

Eight significant community health needs were identified for a prioritization process by the Community Health Needs Assessment Oversight Committee through a review of the secondary health data collected and based on qualitative data collected from interviews and listening sessions.

- Access to Health Care and Preventive Care
- Behavioral Health (Mental Health and Substance Use/Misuse)
- Chronic Diseases
- Community Safety
- COVID-19
- Economic Insecurity
- Food Insecurity
- Homelessness and Housing Instability

The Community Ministry Board of Directors for Providence Saint John's Health Center authorized an ad hoc Community Health Needs Assessment Oversight Committee to review the ministry's Community Health Needs assessment and the prioritize the identified significant community needs. The Committee was chaired by board member, Dr. Kathryn Jeffery, and composed of external stakeholders and Providence Saint John's leadership. The Committee met on November 4, 2022 to review key data findings and select the top three Priority Needs.

After a presentation of the key findings from the data on the eight identified significant needs by the Director of Community Health Investment, committee members took a vote on their top three needs for Saint John's to prioritize. The Committee was encouraged to take into consideration the following criteria when making their choices:

- Opportunity to Impact: Current PSJHC Community Health Programs/Services
- Opportunity to Impact: Current Community Benefit Investments (operations and grants)
- Partnerships
- Alignment with existing Providence Regional Strategies
- PSJHC service area rates in comparison to County/State/National Benchmarks
- Impact of the problem on vulnerable populations
- Key Stakeholder Survey Prioritization Score

Based on the vote, the Community Health Needs Assessment Oversight Committee identified three priority areas:

1) Homelessness and Housing Instability
2) Behavioral Health
3) Access to Health Care and Preventive Care

Significant Community Health Needs Prioritized

PRIORITY 1: HOMELESSNESS AND HOUSING INSTABILITY

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 2: 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.

PRIORITY 3: ACCESS TO HEALTH CARE AND 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.

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 six of the eight identified health needs from the 2022 Community Health Needs Assessment.

The following community health needs identified in the ministry CHNA will not be address and an explanation is provided below:

- COVID-19: This need ranked relatively low on the list of identified needs (7 out of 8) and many of the relevant interventions that would be implemented in addressing this need are already included within efforts to address Access to health Care and Preventive Care.
- Community Safety: This need ranked relatively low on the list of identified needs (8 out of 8). Our hospital does not have the expertise to effectively address community safety compared to other local stakeholders who are better equipped to address this need and have dedicated resources focused on addressing it as part of their organizational purpose and mission.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

The Community Health Improvement Plan was developed by leadership in Providence Saint John's Community Health Investment department. The plan was developed in collaboration with various departments within the organization including Mission, the Child and Family Development Center, Health Equity, and the Saint John's Health Center Foundation. 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 as well as. The CHIP was presented to and reviewed by the Executive Committee on April 26, 2023 and was unanimously approved and adopted by the Committee on behalf of the Providence Saint John's Health Center Community Ministry Board.

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

COMMUNITY NEED ADDRESSED #1: HOMELESSNESS AND HOUSING INSECURITY

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

United Way: Greater Los Angeles, LAHSA, Westside Coalition, City of Santa Monica, U.S. Vets*, The Landing at St. Robert's Center*, Pacific Palisades Task Force on Homelessness*, Safe Place for Youth*, The People Concern*, Venice Family Clinic*, and The Salvation Army*

* Providence Saint John's Health Center or Providence Saint John's Health Center Foundation Grantee

Table 2. Strategies and Strategy Measures for Addressing Homelessness and Housing Insecurity

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 approached and assessed Number of patients experiencing homelessness connected to shelter/housing Number of patients connected to LAHSA Hospital Liaison or Coordinated Entry System	**Baseline (2022)** • 282 patients approached • 20 patients connected to shelter/housing • 40 patients connected to LAHSA Hospital Liaison **2023-2025 Objectives** • 350 patients approached per year • 50 patients connected to shelter/housing per year • 75 patients connected to LAHSA Hospital Liaison or Coordinated Entry system per year
Coalition Building: Strengthen organizational partnerships to address homelessness and housing insecurity. Stakeholders include homeless service providers, FQHCs, affordable housing providers, and other hospitals.	PSJHC 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 Saint John's Health Center at two local coalitions on homelessness • Networking & Coordinating: Identify additional community-based organizations for potential partnerships • Collaborating: Strengthened 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	**Baseline (2022)** • Nine grants worth a total of $737,000 aimed at addressing homelessness and housing insecurity **2023-2025 Objectives** • Identify and award grants through PSJHC and PSJHC Foundation grantmaking • Nominate and advocate for local organizations for funding to Providence's South Division future grantmaking structure

Population Served

- People Experiencing Homelessness
- Providence Saint John's Health Center 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 #2: 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

Westside Family Health Center*, California WIC, DPSS, Santa Monica Public Library, Boys and Girls Clubs of Santa Monica*, Venice Family Clinic*, Well Baby Center, Open Paths, Mental Health First Aid from The National Council for Mental Wellbeing, Meals on Wheels West*, Love Dad, Harvest Home, Los Angeles County Department of Mental Health, Santa Monica Malibu Unified School District, LAUSD

Table 3. Strategies and Strategy Measures for Addressing Behavioral Health

Strategy	Strategy Measure	Anticipated Impact
Child and Family Development Center – Outpatient Therapy: Outpatient mental health services are available to children, teens, young adults and adults with developmental disabilities. Therapists offer targeted evidence-based treatment through a family focused lens that helps address problematic behaviors, thoughts and feelings with achievable goal-oriented strategies.	Number of patients who received therapy (Medi-Cal) Number of uninsured patients who received therapy	**Baseline (2022)** • 601 Medi-Cal patients served • 18 uninsured/indigent patients served **2023-2025 Objectives** • 601 patients served with Medi-Cal per year • 15 uninsured/indigent patients served per year

* Providence Saint John's Health Center or Providence Saint John's Health Center Foundation Grantee

Child and Family Development Center - Perinatal Wellness Program: Bilingual perinatal and infant mental health specialist visit families weekly in their homes to provide individual, dyadic, couple, and/or family therapy. Ongoing weekly perinatal support groups are offered to reduce isolation and promote social engagement.	Number of families served • Number of children • Number of adults Number of families served via the warm line referral service	**Baseline (2022)** • 35 families served • 65 children • 39 adults • 52 families served via warm line referral service **2023-2025 Objective** • 39 families per year • 70 children per year • 41 adults per year • 50 families served via warm line referral service
Child and Family Development Center – Child/Youth Development Project: is a school and community-based mental health program serving Santa Monica schools and community sites through direct mental health services, outreach, and school/community collaboration. Priority is given to children, youth and families who have been impacted by community violence, familial discord, poverty, substance abuse and trauma.	Number of children served in group therapy services Number of children served in individual/family therapy services Number of parent training groups/workshops conducted	**Baseline (2021-2022):** • 60 children/youth served in group therapy services • 38 children/youth served in individual therapy services. • Two parent training groups were provided, one in English and one in Spanish. **2023-2025 Objectives** • 50 children/youth served in group therapy services per year • 35 children/youth served in individual therapy services per year • Continue providing two parent training groups

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)** • 121 participants trained in Mental Health First Aid **2023-2025 Objective** • By 2025, average 200 participants trained and certified in MHFA per year
Grantmaking: Financial support to local non-profit mental health providers to increase access to services	Number of grants awarded Total $ value of grants awarded	**Baseline (2022)** • Five grants worth a total of $206,000 aimed at addressing behavioral health **2023-2025 Objectives** • Identify and award grants through PSJHC and PSJHC Foundation grantmaking • Nominate and advocate for local organizations for funding to Providence's South Division future grantmaking structure

Population Served

- Children and Youth
- Adults
- Low-income households
- Spanish-speaking communities
- Pregnant mothers and families with newborns
- Students at Santa Monica schools

Resource Commitment

- Staffing for the multiple programs operated by the Child and Family Development Center
- Staffing for preventive education classes on mental health
- Funding for agencies providing mental health and substance use treatment services

Evidence Based Sources

Community health workers | County Health Rankings & Roadmaps

Crisis lines | County Health Rankings & Roadmaps

Early childhood home visiting programs | County Health Rankings & Roadmaps

Mental health benefits legislation | County Health Rankings & Roadmaps

Mental Health First Aid | County Health Rankings & Roadmaps

Telemental health services | County Health Rankings & Roadmaps

COMMUNITY NEED ADDRESSED #3: ACCESS TO HEALTH CARE AND 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.

Key Community Partners

The Santa Monica Family YMCA*, Alcott Center, Westside Coalition, Virginia Avenue Park, Saint Anne School*, Wise and Healthy Aging*, Westside Family Health Center*, OPICA*, Boys and Girls Clubs of Santa Monica*, Vision to Learn*, Claris Health*, Cancer Support Community Los Angeles*, Venice Family Clinic*

* Providence Saint John's Health Center or Providence Saint John's Health Center Foundation Grantee

Table 4. Strategies and Strategy Measures for Addressing Access to Health Care and Preventive Care

Strategy	Strategy Measure	Anticipated Impact
Community Health Action Teams -- Improve Access to Colorectal Cancer Screening: deploy community health action teams (CHATs) to implement a locally designed and operated CRC screening campaign in Santa Monica (90404 zip code)	Number of individuals engaged Number of people screened Number of people referred to primary care or continued services (financial counseling, charity care, etc.)	**2023-2025 Objective** • 1,109 residents newly screened from Santa Monica 90404 zip code (achieving an 80% screening rate within the population)
Health Equity - Hypertension: Community Health Worker driven outreach and educational campaign to reduce hypertension in communities of color, focusing on at-risk Black and Latinx patient populations	Number of patients engaged Number of patients receiving blood pressure monitor	**Baseline (2022)** <u>Saint John's Physician Partners</u> • 57% of Black patients diagnosed with hypertension have blood pressure adequately controlled (<140/90 mmHG) • 63% of Latinx patients diagnosed with hypertension have blood pressure adequately controlled (<140/90 mmHG) **2023-2025 Objective** <u>Saint John's Physician Partners</u> • Improve blood pressure control in Black patients to 58% by end of 2023 • Improve blood pressure control in Latinx patients to 64% by end of 2023

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	**Baseline (2022)** • Nine grants worth a total of $460,000 aimed at addressing access to health care and preventive care **2023-2025 Objectives** • Identify and award grants through PSJHC and PSJHC Foundation grantmaking • Nominate and advocate for local organizations for funding to Providence's South Division future grantmaking structure

Population Served

- Low-Income Households
- Immigrants with Undocumented Status or Mixed-Status Families
- Uninsured/underinsured Community Members
- Black and Latinx patient populations
- Santa Monica Residents of the 90404 zip code

Resource Commitment

- Staffing for multiple access to care programs
- Funding for agencies providing access to care services
- In-kind lab and radiology services to local FQHCs

Evidence Based Sources

Community health workers | County Health Rankings & Roadmaps

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

Medical homes | County Health Rankings & Roadmaps

Other Community Benefit Programs

Table 5. Other Community Benefit Programs in Response to Community Needs

Program Name	Community Need Addressed	Description
Child and Family Development Center: Multidisciplinary Assessment Team	Behavioral Health	Mental health assessments for foster children
Child and Family Development Center: Therapeutic Preschool	Behavioral Health	Mental Health Day Treatment for preschoolers with severe behaviors from trauma/development
Child and Family Development Center: Helen Reid Parenting Program	Behavioral Health	Mental health groups for at risk very low income pregnant and postpartum women
Health Education FEAST classes (Food, Education, Access, Support, Together)	Food Insecurity, Economic Insecurity, Chronic Disease	Nutrition class that provides education on food topics, cooking demo with tasting, food stipend, and support social, emotional and physical wellness.

2023- 2025 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the Executive Committee of the Board of Directors of the hospital on April 26, 2023. The final report was made widely available by May 15, 2023.

DocuSigned by:
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4/27/2023

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Chief Executive
Providence Saint John's Health Center

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Donna Schweers — Date
Chairperson, Community Ministry Board of Directors
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To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Improvement Plans please email CHI@providence.org.