COMMUNITY HEALTH IMPROVEMENT PLAN

2020 - 2022

Providence
San Fernando Valley
Medical Centers

Providence

Holy Cross Medical Center

Mission Hills, California

Providence

Saint Joseph Medical Center

Burbank, California

Providence | Cedars Sinai

TARZANA MEDICAL CENTER

Tarzana, California

To provide feedback about this CHIP or obtain a printed copy free of charge, please email Ismael Aguila, Director, Community Health and Partnership at ismael.aguila@providence.org.

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Who We Are

Providence San Fernando Valley Medical Centers consist of three acute-care hospitals located in the San Fernando Valley region.

Providence Holy Cross Medical Center
Mission Hills, California

Providence Saint Joseph Medical Center
Burbank, California

Providence Cedars-Sinai Tarzana Medical Center
Tarzana, California

Collectively, the three Medical Centers have 1,072 licensed beds, a staff of more than 5,378 caregivers and professional relationships with more than 2,465 medical staff. Major programs and services offered to the community include cancer care, emergency and trauma services, heart and vascular care, maternity care, neuroscience, NICU, orthopedics and sports medicine, stroke care, and women and children's services.

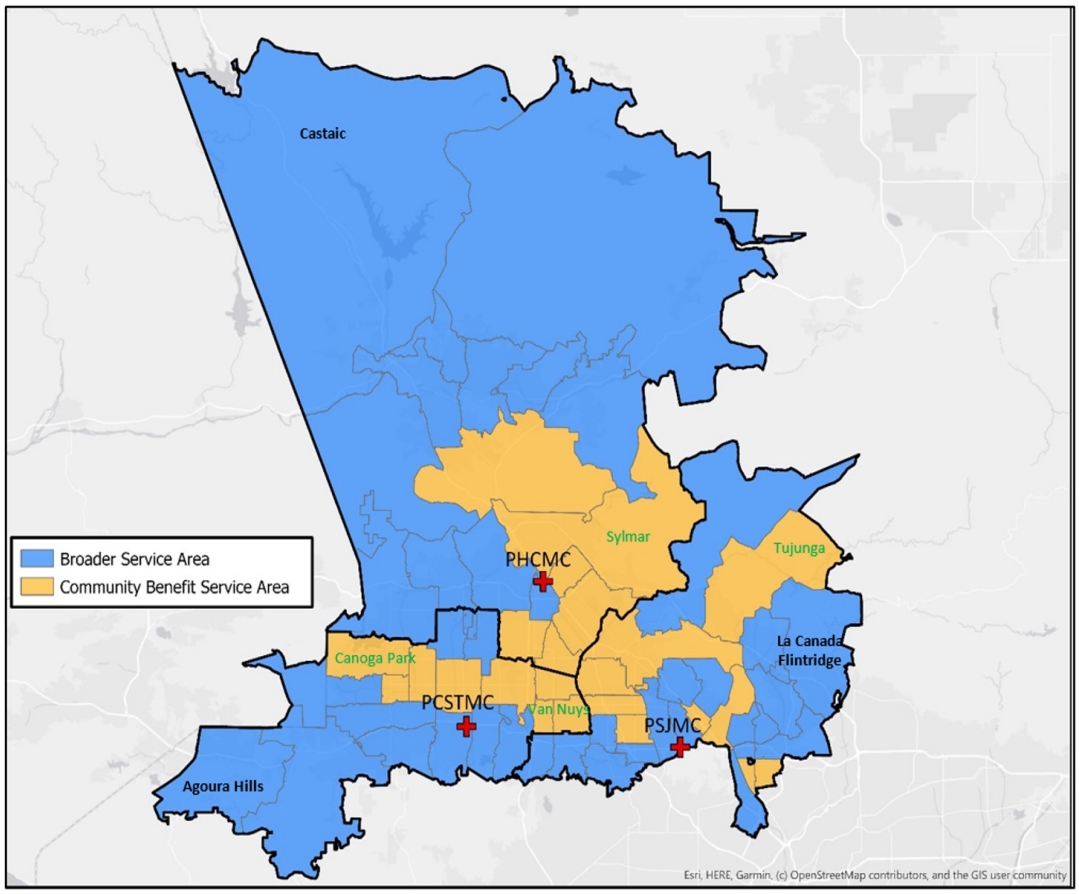
Our Commitment to Community

Providence San Fernando Valley Medical Centers dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. During 2019, our combined hospitals provided over $70 million in community benefit[1] in response to unmet needs and to improve the health and well being of those we serve in the San Fernando Valley region.

Every three years as required by state and federal regulations, the Providence Valley Service Area Community Ministry Board (Valley CMB) conducts a joint Community Health Needs Assessment (CHNA) to identify and prioritize the greatest health needs across the San Fernando Valley. In early 2019, the Providence Tarzana Medical Center entered into a joint venture with Cedars Sinai Health System, which resulted in a new governing board. The VSA CMB, composed of Providence Holy Cross Medical Center (Mission Hills) and Providence St. Joseph Medical Center (Burbank), along with 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.

[1] A community benefit is an initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives: a. Improves access to health services; b. Enhances public health; c. Advances increased general knowledge; and/or d. Relieves government burden to improve health.

For purposes of this CHNA, 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. With the exception of Initiative # 4, this Community Health Improvement Plan focuses programs and resources on the Community Benefit Service Area of the three Providence Medical Centers.



Health disparities within the Community Benefit Service Area (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.

Collaborating Organizations

Providence Holy Cross Medical Center, Providence St. Joseph Medical Center, and Providence Cedars-Sinai Tarzana Medical Center are three non profit acute care hospitals with two governing boards that operate within a complementary geography that covers the San Fernando Valley region of Los Angeles County. The Community Health Investment Team works on behalf of the three hospitals to conduct the triennial Community Health Needs Assessment and assemble primary data collected from Stakeholders throughout the SFV and secondary data sets provided by Los Angeles County Department of Public Health, as well as publicly available data sets and internal Providence data, provided by System Office analysts, that tracks community needs,. These primary and secondary data for each of the identified health needs are summarized and presented to the Community Benefit Oversight Committee,. The Oversight Committee, authorized by the governing boards and composed of an equal number of internal and external stakeholders, prioritizes the identified health needs which is recommended to each governing board. The adoption by the governing board informs and guides the development of this 2020-22 Community Health Improvement Plan (CHIP).

Providence San Fernando Valley Community Health Improvement Plan Initiatives

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:

INITATIVE 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.

Responding to the COVID-19 Pandemic

In addition to the aforementioned, priority areas, the 2020 community health improvement process was disrupted by the SARS-CoV-2 virus and COVID-19, which has impacted all of our communities. While we have focused on crisis response, it has required a significant re-direction of resources and reduced community engagement in the CHIP process.

This CHIP is currently designed to address the needs identified and prioritized through the 2019 CHNA, though COVID-19 will have substantial impacts on our community needs. These impacts are likely to exacerbate some of the needs identified, and cause others to rise in level of priority. While this is a dynamic situation, we recognize the greatest needs of our community will change in the coming months, and it is important that we adapt our efforts to respond accordingly. This CHIPs will be updated by March 2021 to better document the impact of and our response to COVID-19 in our community. We are committed to supporting, strengthening, and serving our community in ways that align with our Mission, engage our expertise, and leverage our Community Benefit dollars in the most impactful ways.

MISSION, VISION, AND VALUES

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

INTRODUCTION

Who We Are

Providence San Fernando Valley Medical Centers consist of three acute-care hospitals located in the San Fernando Valley area of Los Angeles County. Collectively, the Hospitals have 1,072 licensed beds, a staff of more than 5,378 caregivers and professional relationships with more than 2,465 medical staff. Major programs and services offered to the community include cancer care, emergency and trauma services, heart and vascular care, maternity care, neuroscience, NICU, orthopedics and sports medicine, stroke care, and women and children's services.

Our Commitment to Community

The Providence San Fernando Valley Service Area (SFV Service Area) is comprised of the complementary Service Areas of 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. Collectively, these Medical Centers seek to improve the health and quality of life for San Fernando Valley residents, with special emphasis on the needs of the economically poor and vulnerable. During 2019, our combined hospitals provided over $70 million in community benefits.

Community Benefit Governance and Management Structure

To ensure that the Providence Medical Centers in the San Fernando Valley comply with federal and state regulations on Community Health Needs Assessments, 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 with board member Sr. Nancy Jurecki appointed as the Oversight Committee Chair.

Planning for the Uninsured and Underinsured

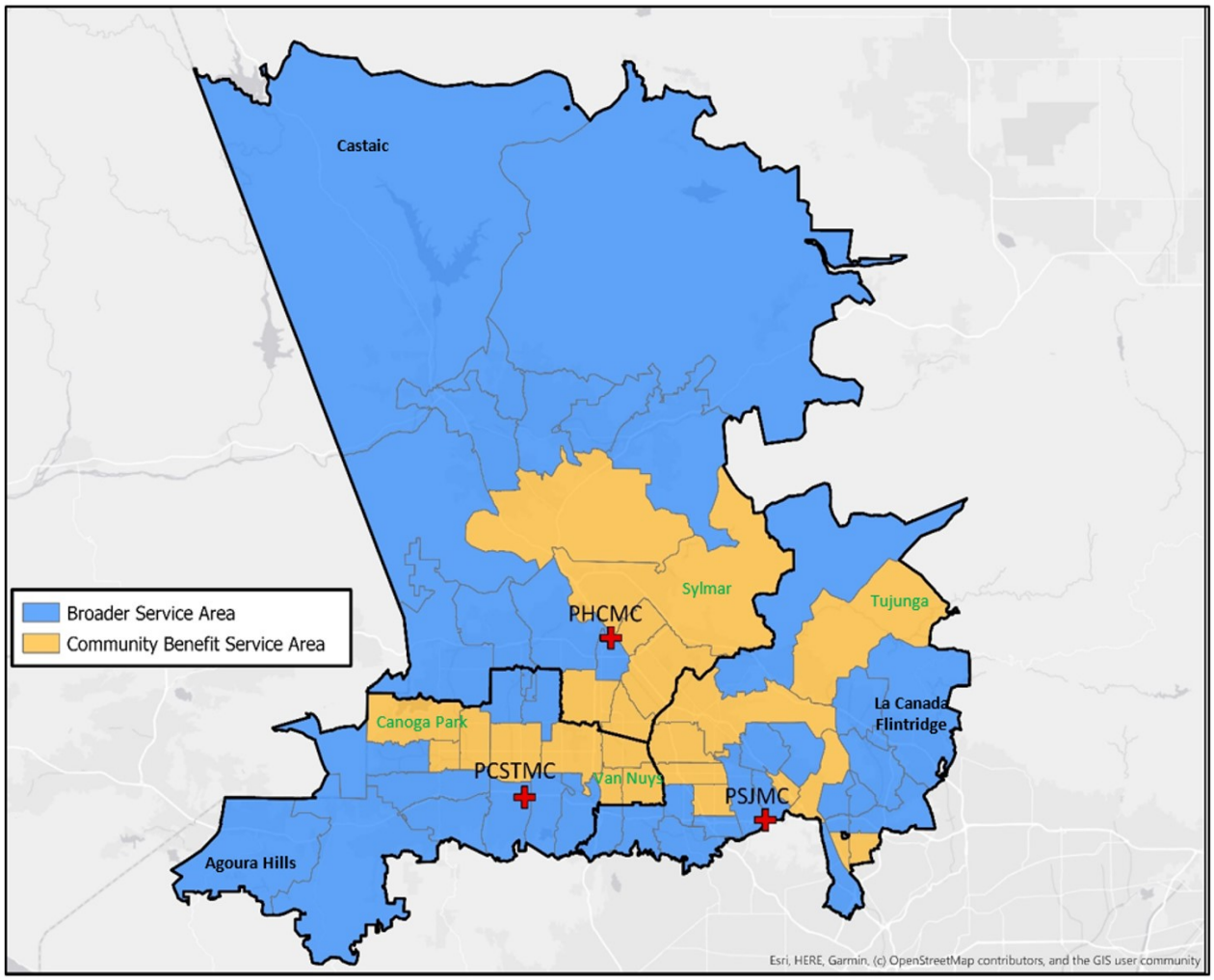
We provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why San Fernando Valley has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients. One way Providence San Fernando Valley Medical Center informs the public of FAP is by posting notices. Notices are posted in high volume inpatient and outpatient service areas, and 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. 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 www.providence.org/obp/ca/ca-la/financial-assistance.

OUR COMMUNITY

Description of Community Served

For purposes of this CHNA, 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. With the exception of Initiative # 4, this Community Health Improvement Plan focuses programs and resources on the Community Benefit Service Area of the three Providence Medical Centers.

Figure 1. San Fernando Valley Service Area



Much of the secondary data described below comes from Los Angeles County, Department of Public Health, and for purposes of highlighting the health disparities that exist between lower income communities and higher resourced communities, the data has been aggregated into two groups: 1) Community Benefit Service Area and 2) Broader Community. Each Medical Center has a Community Benefit Service Area (low income communities) and a Broader Community grouping (higher income communities) within its traditional Service Area boundaries. The data packages provided by Los Angeles County Department of Public Health allows for the comparison of Countywide results, along with the Community Benefit Service Area and Broader Communities for Providence.

The San Fernando Valley Community served by the three Providence Medical Centers is a 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.

Population and Age Demographics

The total population of the Providence San Fernando Valley (SFV) Service Area in 2019 is 2,225,425 people, which represents a 0.2% increase compared to the 2016 population, or approximately 5,000 additional residents living in the area. The total population of the SFV Community Benefit Service Area is just over 52% of the total service area population, with nearly 1.2 million people.

The majority of residents in the SFV Service Area are between 10 and 39 years old. Children under the age of 19 make up 28.2% of the population. This is notable and indicates a greater proportion of youth than elsewhere in the state, where children under the age of 18 make up 22.7% of the population. Adults 60 years of age and older make up 13.9% of the total service area population, compared to the State of California, where adults 65 and older make up 14.3% of the population. The SFV Service Area, therefore, is notably younger, on average, than the total population of the state of California.

Population by Race and Ethnicity

Among SFV Service Area residents, in 2019, 52.3% were White, 11.1% were Asian/Pacific Islander/ Hawaiian, 0.7% were Alaska Native or American Indian, 3.6% were African American or Black, and 5.0% were of two or more races. Approximately 59.0% of the residents identify as Latino.

Income Levels

In 2019, the median household income of the SFV Service Area varied significantly from a low of $41,053 for the community of Glendale, to $166,406 for the community of La Cañada Flintridge. The SFV Community Benefit Service Area, compared to Los Angeles County, is home to a higher concentration of low-income residents; approximately 45.4% of families have annual incomes below 200% of the Federal Poverty Level (FPL; $51,500 for a family of 4) compared to 39.6% in Los Angeles County as a whole.

Education Level

While many of the adults living in the SFV Community Benefit Service Area have at least a high school diploma (73.2%), there were several ZIP codes with a high concentration of adults who had not completed high school. These ZIP codes included Pacoima (91331; 44.8%), San Fernando (91340; 39.3%), Panorama City (91402; 36.4%) and Sun Valley (91352; 34.1%).

Economic Indicators

The percent unemployed in the SFV Community Benefit Service Area averages 5.4%. Nonetheless, 34.9% of the population is experiencing severe housing cost burden (greater than 50% of income goes to rent), and 11.3% of the population is enrolled in SNAP, or food assistance programs.

Language Proficiency

Within Los Angeles County, 56.6% of residents speak a language other than English at home. Far fewer households (an average of 30.1%) in the SFV Service Area speak a language other than English at home, and individuals speaking languages other than English at home are concentrated in Panorama City, Pacoima, Glendale, and San Fernando.

Summary of Community Needs Assessment Process and Results

To ensure the Providence San Fernando Valley Medical Centers continue to stay at the forefront of Community Benefit reporting and programs, the three hospitals in the SFV Service Area engaged in a joint Community Health Needs Assessment (CHNA). The 2019 joint CHNA furthers a commitment to develop regional impact strategies and increase collaboration on and recognition of shared challenges and solutions across the San Fernando Valley.

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.

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, and the disparities that exist among high need communities and neighborhoods, compared to the better-resourced, often higher income communities in the SFV Service Area.

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

Identification and Selection of Significant Health Needs

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. 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.

The group participated in two meetings to review the assembled primary and secondary data for each identified health need. The first meeting included discussions on how each issue affected the communities in the region, using the identified need of homelessness and housing instability to familiarize and prepare the participants for criteria that would be applied during the prioritization meeting. In the second meeting committee participants received a questionnaire at the start of the meeting and asked to rate the severity of each identified health need using three criteria: (1) the change over time, (2) the availability of community resources/assets to address the health need, and (3) the community readiness to implement/support programs to address the health need.

Committee participants were then asked to consider the three questions below and given three dots, or "votes" to assign to the identified topics resulting in a second set of priorities.

- 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?

Community Health Needs Prioritized

The two separate data point were combined into a single point score and prioritized health needs as follows:

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 Health Care and Resources
6 Senior Care
7 Immunization/School Health
8 Violence Prevention

Needs Beyond the Hospital's Service Program

No hospital facility can address all of the health needs present in its community. Our ability to address all of the identified health needs is linked to our Mission to pay special attention to the poor and vulnerable and by the strength of our partnerships with other organizations who can supplement or complement our annually budgeted resources. For example, Providence has provided a Tattoo Removal Program for many years for ex-gang members and offenders who have committed to turning their life around. Yet, we have learned that removing the tattoo is just part of the solution to supporting the individual who faces many barriers and stressors. So, we are committed to partnering with organizations that can provide the wrap around mental health, job training and other services that improve the chances of a successful re-entry back into the community. The Community Health Improvement Plan below presumes that additional organizational partner relationships will allow us to address all eight identified health needs. These organizations are public and private community partners that have expertise in addressing the identified community health needs at the local level.

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 change. For example, the COVID pandemic is likely to change the delivery of some program services or result in new unanticipated partnerships that will change the nature of how a program operated. 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. The following four initiatives is our best analysis of what can be accomplished over the next three years:

Addressing the Needs of the Community: 2020- 2022 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 *Hospital emergency department based Community Health Workers that assist homeless patients with discharge to shelter or homeless service providers*	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
	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 *Implement screening for risk of homelessness and identify public and private funded resources that focus on 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
	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	Confirm that 75% of those referred to homeless

			services providers do not become 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 *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 Establish consensus among Stakeholders as to the # of recuperative care beds in LA County 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 Develop standards that define spectrum of temporary housing options for individuals experiencing homelessness that lead to permanent supportive housing

Evidence Based Sources

Los Angeles County Homeless Initiative
https://homeless.lacounty.gov/the-action-plan

Resource Commitment

Homeless Care Navigators, Funding in Support of Recuperative Care/Temporary Housing Beds

Key Community Partners

Ascencia
Bridge to Home
Burbank Housing Authority
Hope of the Valley Rescue Mission
Los Angeles Family Housing
Los Angeles Housing Service Authority
Northeast Valley Healthcare Corporation
San Fernando Community Health Center
San Fernando Valley Rescue Mission
San Fernando Valley/Santa Clarita Valley Homeless Coalition

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 along side 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 Reach and Utilization of Community Based Wellness and Activity Centers

Van Nuys Wellness Center: A community-based partnership model that provides wellness programs and support services for adults and seniors, in partnerships with nonprofits and public agencies *Provide opportunities for community members in the Providence St. Joseph and Tarzana Cedars-Sinai Medical Center services areas to access mental health, food insecurity, and chronic disease management services, support groups and case management/linkage services*	**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

Evidence Based Sources

Collective Impact Model

www.councilofnonprofits.org/tools-resources/collective-impact

Resource Commitment

Staffing of Wellness Centers in Pacoima and Van Nuys

Leased space for both facilities

Core operating budget supplemented by grant writing resources to develop collaborative programs to support the Community Health Improvement Plan.

Key Community Partners

All-Inclusive Community Health Center
City of San Fernando Department of Recreation and Community Services
El Nido Family Centers
LA Care
Los Angeles County Department of Public Health
Los Angeles County Department of Social Services
Northeast Valley Healthcare Corporation
San Fernando Community Health Center
Tarzana Treatment Centers
Vaughn Next Century Learning Center
Valley Care Community Consortium
One Generation
VIC-Valley Inter Community Council - Sherman Oaks East Valley Adult Center

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 *A community based 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/residents 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 *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 *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 community health resources*	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
	Number of HPE enrolled	1381 HPE applications	1450 applications	10% increase
	HPE rate	78% HPE rate	78% HPE rate	78% HPE rate

Table 3. (Cont'd)--Strategies and Strategy Measures for Addressing Access to Healthcare and Resources

Diabetes Prevention Program *Year long CDC approved evidence-based lifestyle change program to prevent, delay, and reduce the risk for Type 2 Diabetes in at risk individuals*	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 *Eight lesson curriculum/ support group to help individuals learn about and adopt 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 *Eight hour class to train individuals and organizations about signs and symptoms of 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 20% increase
Latino Health Promoters Program *A team of bilingual (English/Spanish) Community Health Workers provide educational wellness workshops for adults in the community at nearby local schools and churches*	Number of classes Number of participants	336 classes 1203 served	356 classes 1323 served	15% increase 20% increase
Faith Community Partnerships *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%

Evidence Based Sources

Healthy People 2020
www.healthypeople.gov
CalFresh
www.getcalfresh.org
National Diabetes Prevention Program
www.cdc.gov/diabetes
Healthy Eating Active Living
http://www.publichealth.lacounty.gov/place/PLACE_Healthy_Eating_Active_Living_HEAL.htm
Mental Health First Aid
www.mentalhealthfirstaid.org

Resource Commitment

The Providence San Fernando Valley comprising of Providence Holy Cross Medical Center (Mission Hills), Providence St. Joseph Medical Center (Burbank) and Providence Cedars-Sinai Tarzana Medical Center will collaboratively commit funding, staffing, and equipment as needed to support the Community Health Improvement Plan.

Key Community Partners

Archdiocese of Los Angeles
Burbank Unified School District
City of San Fernando
Los Angeles County Department of Public Health
Los Angeles County Department of Public Social Services
Los Angeles Police Department
Los Angeles Unified School District
MEND Poverty
NAMI
Salvation Army
Vaughn Next Century Learning Center

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

Evidence Based Sources

COVID-19
www.cdc.gov/coronavirus/2019-ncov/index.html
CDC Immunization Guidance
www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html

Resource Commitment

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Key Community Partners

All-Inclusive Community Health Center
Archdiocese of Los Angeles
Burbank Unified School District
Los Angeles County Department of Public Health
Los Angeles Unified School District
Northeast Valley Healthcare Corporation
San Fernando Community Health Center
Vaughn Next Century Learning Center

2020- 2022 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted on April 16, 2020 by the Valley Service Area Community Ministry Board. The final report was made widely available by May 15, 2020.

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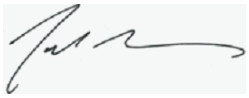

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To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Improvement Plans please email CommunityBenefit@providence.org.

APPENDICES

Appendix 1: Definition of Terms

Community Benefit: An initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives:

a. Improves access to health services;
b. Enhances public health;
c. Advances increased general knowledge; and/or
d. Relieves government burden to improve health.

Community benefit includes services to persons living in poverty, persons who are vulnerable, and the broader community.

To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following:

a. Community health needs assessment developed by the ministry or in partnership with other community organizations;
b. Documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; or
c. The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

Health Equity: Healthy People 2020 defines *health equity* as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."

Social Determinants of Health: Powerful, complex relationships exist between health and biology, genetics, and individual behavior, and between health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies. These factors, which influence an individual's or population's health, are known as *determinants of health*. *Social determinants of health* are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Initiative: An initiative is an umbrella category under which a ministry organizes its key priority efforts. Each effort should be entered as a program in CBISA Online (Lyon Software). Please be sure to report on all your Key Community Benefit initiatives. If a ministry reports at the initiative level, the goal (anticipated impact), outcome measure, strategy and strategy measure are reported at the initiative level. Be sure to list all the programs that are under the initiative. Note: All Community Benefit initiatives must submit financial and programmatic data in CBISA Online.

Program: A program is defined as a program or service provided to benefit the community (in alignment with guidelines) and entered in CBISA Online (Lyon Software). Please be sure to report on all community benefit programs. Note: All community benefit programs, defined as "programs", are required to include financial and programmatic data into CBISA Online.

Goal (Anticipated Impact): The goal is the desired ultimate result for the initiative's or program's efforts. This result may take years to achieve and may require other interventions as well as this program. (E.g. increase immunization rates; reduce obesity prevalence.).

Scope (Target Population): Definition of group being addressed in this initiative: specific description of group or population included (or not included, if relevant) for whom outcomes will be measured and work is focused. Identify if this initiative is primarily for persons living in poverty or primarily for the broader community.

Outcome measure: An outcome measure is a quantitative statement of the goal and should answer the following question: "How will you know if you're making progress on goal?" It should be quantitative, objective, meaningful, and not yet a "target" level.