COMMUNITY HEALTH IMPROVEMENT PLAN

2020 - 2022

Providence South Bay Community

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

PROVIDENCE
Little Company of Mary Medical Centers
San Pedro and Torrance

CONTENTS

EXECUTIVE SUMMARY

Who We Are

Providence Little Company of Mary Medical Centers San Pedro and Torrance provide the full spectrum of care from birth through end of life. While each medical center has its own unique character, both are known for providing the South Bay community with clinical excellence, sophisticated technology and care with a personal touch.

In addition to general medical, surgical and critical care services, the medical centers offer a number of specialty programs. Serving the community since 1960, PLCM Torrance offers minimally invasive surgical options using the advanced da Vinci® robotic surgery system and a cardiovascular center of excellence. It also houses a state-of-the-art maternity unit, complete with the county's first single-family level III neonatal intensive care unit to enhance parent-child bonding for even the most fragile of infants, as well as an on-site perinatal center that provides complete fetal diagnostic testing and genetic counseling.

For over 90 years, Providence Little Company of Mary Medical Center San Pedro has been a landmark, serving the community's needs with invaluable clinical services. In addition to establishing the South Bay's first Primary Stroke Center, the hospital offers specialty services such as chemical dependency and advanced rehabilitation therapy. The hospital's Sub Acute Care Center is one of California's largest sub-acute facilities, while the Center for Optimal Aging provides compassionate care for the elderly.

In addition to offering advanced services and technology, both medical centers have received several accolades and national recognition. PLCM Torrance was recognized by U.S. News & World Report as one of California's best hospitals and as a World's Best Hospital by Newsweek. The Leapfrog Group, a National Patient Safety advocacy group, acknowledged both San Pedro and Torrance medical centers with the highest ranking of an "A" for safety five rating periods in a row. Finally, we are proud to have been named the "Best Hospital" in the South Bay by the Daily Breeze.

Our Commitment to Community

As health care continues to evolve, the Providence South Bay Community is responding with dedication to its Mission and a desire to create healthier communities, together. Partnering with other non-profits that share our commitment to the poor and vulnerable, we conduct a formal Community Health Needs Assessment to learn about the greatest needs and assets in our community, especially considering members of medically underserved, low-income, and minority populations. This assessment helps us consider solutions to fulfill unmet needs while continuing to strengthen local resources. It guides our community benefit investments and supports many partners that look to PLCM as a leader in improving the health of our community.

During 2018, PLCM provided $63,824,873 in community benefit in response to unmet needs and to improve the health and well-being of those we serve in the South Bay.

Description of Community Served

The two Providence South Bay community medical centers, Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance (hereafter jointly referred to as the South Bay Community), share a common geography because of their close proximity to each other. The South Bay Community 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 purposes of this CHNA, the South Bay Community is divided into the "Community Benefit Service Area" and the "Broader South Bay Service Area." The Community Benefit Service Area was defined using the Community Need Index (CNI) mapping tool from Dignity Health and Truven Health Analytics. All communities with a score of 4 or greater on the scale were included. Communities identified as having higher need using the scale experience greater barriers to health care including income, cultural, educational, health insurance, and housing barriers. Areas identified as "Community Benefit Service Areas" include the neighborhoods and surrounding areas of Hawthorne, Lawndale, Gardena, Torrance (90501), Harbor City, San Pedro (90731), and Wilmington.

The Broader South Bay Service Area is the balance of communities within the Total Service Area with a CNI score below 4. These areas are more resource rich with a population on the higher end of the socioeconomic spectrum.

Providence Little Company of Mary 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 hospital strategic plan, Providence Little Company of Mary will focus on the following areas for its 2020-2022 Community Benefit efforts:

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

As hospitals that see a significant number of patients experiencing homelessness that come in through our emergency departments for care, we will partner with our local homeless service providers to strengthen the ability to connect these homeless patients to the rapidly changing environment of resources in LA County. In addition to facilitating better handoffs and coordination of care, we will focus on the gap of available recuperative care/interim shelter beds for homeless patients that are not sick enough to be admitted into a hospital but need a temporary place to heal that is safer than being discharged to their previous unhoused situation.

INITIATIVE 2: IMPROVE ACCESS TO HEALTH CARE SERVICES

We will continue to provide avenues of health care services for underserved and vulnerable populations. These target populations include uninsured, low-income households (Medi-Cal), victims of sexual assault, new immigrants, and children.

INITIATIVE 3: INVEST IN EXPANSION OF COMMUNITY-BASED WELLNESS AND ACTIVITY CENTERS

The Wellness and Activity Center gives children and adults in the Wilmington area a physical space to participate in free programs run by Providence, local volunteers and community partners that promote social connections among neighbors and help improve the health of the community. We plan to continue investing in the growth of this Wellness and Activity Center and replicate it in Lawndale, an additional identified undeserved neighborhood in our service area.

INITIATIVE 4: TRAIN AND DEPLOY A WORKFORCE OF COMMUNITY HEALTH WORKERS TO ADDRESS SOCIAL DETERMINANTS OF HEALTH IN UNDERSERVED POPULATIONS

Providence has a long history in employing Community Health Workers in a diverse breadth of roles in programs that address social determinants of health. These roles typically have fallen into three categories: case management, health education, and assistance with enrollment into public benefits (i.e. Medicaid/Medi-Cal and SNAP/CalFresh). These jobs create an entry point for people to work in the healthcare industry while allowing Providence to effectively provide culturally competent care within targeted underserved communities. In addition to continuing our own employment model of CHWs, we will partner with Charles Drew University to develop and implement a CHW Academy. This CHW Academy will provide formal training and facilitate paid internships for CHWs at Providence and other healthcare organizations who have an interest in incorporating a CHW workforce in their companies.

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 Little Company of Mary Medical Centers San Pedro and Torrance provide the full spectrum of care from birth through end of life. While each medical center has its own unique character, both are known for providing the South Bay community with clinical excellence, sophisticated technology and care with a personal touch.

In addition to general medical, surgical and critical care services, the medical centers offer a number of specialty programs. Serving the community since 1960, Providence Little Company of Mary Torrance offers minimally invasive surgical options using the advanced da Vinci® robotic surgery system and a cardiovascular center of excellence. It also houses a state-of-the-art maternity unit, complete with the county's first single-family level III neonatal intensive care unit to enhance parent-child bonding for even the most fragile of infants, as well as an on-site perinatal center that provides complete fetal diagnostic testing and genetic counseling.

For over 90 years, Providence Little Company of Mary Medical Center San Pedro has been a landmark, serving the community's needs with invaluable clinical services. In addition to establishing the South Bay's first Primary Stroke Center, the hospital offers specialty services such as chemical dependency and advanced rehabilitation therapy. The hospital's Sub Acute Care Center is one of California's largest sub-acute facilities, while the Center for Optimal Aging provides compassionate care for the elderly.

In addition to offering advanced services and technology, both medical centers have received several accolades and national recognition. PLCM Torrance was recognized by U.S. News & World Report as one of California's best hospitals and as a World's Best Hospital by Newsweek. The Leapfrog Group, a National Patient Safety advocacy group, acknowledged both San Pedro and Torrance medical centers with the highest ranking of an "A" for safety five rating periods in a row. Finally, we are proud to have been named the "Best Hospital" in the South Bay by the Daily Breeze.

Our Commitment to Community

As health care continues to evolve, Providence Little Company of Mary is responding with dedication to its Mission and a desire to create healthier communities, together. Partnering with other non-profits that share our commitment to the poor and vulnerable, we conduct a formal Community Health Needs Assessment to learn about the greatest needs and assets in our community, especially considering members of medically underserved, low-income, and minority populations. This assessment helps us consider solutions to fulfill unmet needs while continuing to strengthen local resources. It guides our community benefit investments and supports many partners that look to PLCM as a leader in improving the health of our community.

During 2018, PLCM provided $63,824,873 in community benefit in response to unmet needs and to improve the health and well-being of those we serve in the South Bay.

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 has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients.

One way Providence Little Company of Mary 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

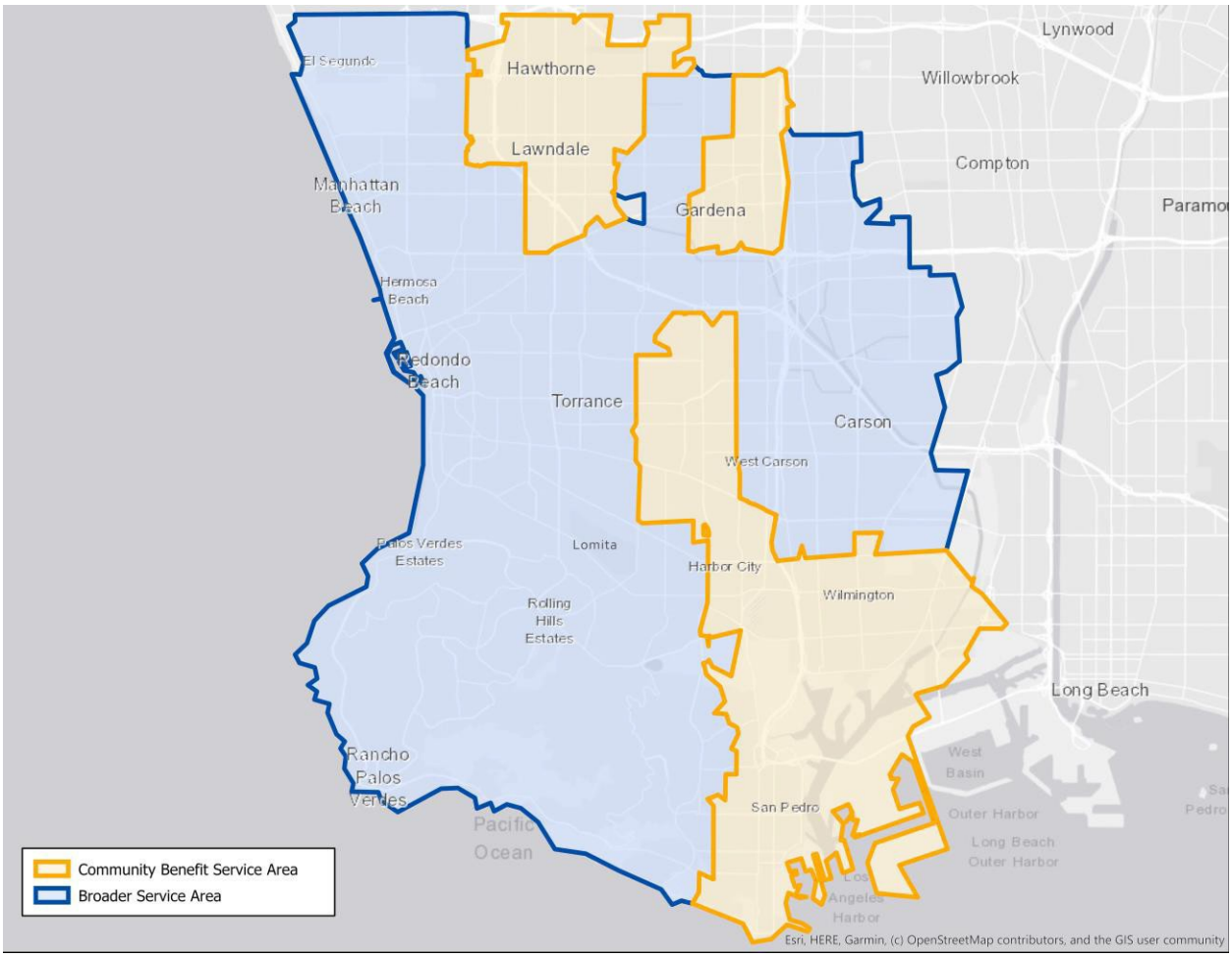
Description of Community Served

The two Providence South Bay community medical centers, Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance (hereafter jointly referred to as the South Bay Community), share a common geography because of their close proximity to each other. The South Bay Community 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 purposes of this CHNA, the South Bay Community is divided into the "Community Benefit Service Area" and the "Broader South Bay Service Area." The Community Benefit Service Area was defined using the Community Need Index (CNI) mapping tool from Dignity Health and Truven Health Analytics. All communities with a score of 4 or greater on the scale were included. Communities identified as having higher need using the scale experience greater barriers to health care including income, cultural, educational, health insurance, and housing barriers. Areas identified as "Community Benefit Service Areas" include the neighborhoods and surrounding areas of Hawthorne, Lawndale, Gardena, Torrance (90501), Harbor City, San Pedro (90731), and Wilmington.

The Broader South Bay Service Area is the balance of communities within the Total Service Area with a CNI score below 4. These areas are more resource rich with a population on the higher end of the socioeconomic spectrum.

Providence South Bay Community CHNA Service Area Map



COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

To ensure that the Providence Little Company of Mary Medical Centers (PLCM) comply with federal and state regulations on Community Health Needs Assessments, PLCM 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 2019 meeting, the CMB authorized this CHNA Oversight Committee with board member, Tim McOsker, appointed as the Oversight Committee Chair.

Gathering data for this CHNA involved systematic collection of both primary and secondary data relevant to the South Bay to identify the high priority needs and issues facing the community. For primary data, 8 organizational leaders provided input through structured phone interviews. In addition, a total of three listening sessions with 37 participants were conducted with the help of community-based organizations.

PLCM chose to conduct listening sessions at Vasek Polak Health Clinic and the Wellness & Activity Center because of their work to promote the health and wellness of all people living in the South Bay. The Vasek Polak Health Clinic in Hawthorne provides affordable primary care services to people who are uninsured or underinsured. It serves as a medical home for patients, supporting management of chronic diseases, referrals to other services in the South Bay and wellness classes. PLCM's Wellness and Activity Center, located in Wilmington, provides numerous wellness programs, assistance with applications for food and health benefits, referrals to resources, and space for community building.

Secondary data collection included the review of demographic, insurance, mortality, morbidity, mental health, economic and social determinant data from multiple sources. The secondary data sources included the following: the U.S. Census, Los Angeles Homeless Services Authority, Think Health L.A. Database, Community Commons Database, the Health Places Index, California Health Interview Survey Dataset, L.A. County Department of Public Health, and California Department of Public Health. Other quantitative data included primary data from PLCM's electronic health record system.

Identification and Selection of Significant Health Needs

Once the information and data were collected and analyzed by staff members, the following ten key areas were identified as community needs for the Community Health Needs Assessment Oversight Committee to prioritize, listed here in alphabetical order:

- Access to Health Care

- Behavioral Health
- Chronic Diseases
- Early Childhood Development
- Economic Insecurity and Workforce Development
- Food Insecurity
- Homelessness and Housing Instability
- Oral Health Care
- Services for Seniors
- Social Cohesion

Community Health Needs Prioritized

- Homelessness and Housing Instability
- Access to Health Care
- Behavioral Health
- Economic Insecurity and Workforce Development
- Food Insecurity
- Services for Seniors
- Chronic Diseases
- Early Childhood Development
- Social Cohesion

Needs Beyond the Hospital's Service Program

No hospital facility can address all of the health needs present in its community. The following community health needs identified in the ministry CHNA will not be addressed and an explanation is provided below:

- Oral Health: Our health facilities do not provide oral health care, and it is not our area of expertise within the Providence health system in the Los Angeles region. However, there are number of community partners including local Federally Qualified Health Clinics who are focusing on increasing access to oral health care—especially for the Medi-Cal population. For community members in need of these services we refer them to these providers of low-cost dental care.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

Based on the prioritized needs, Providence staff developed four strategic initiatives that address eight of the ten prioritized health needs. Taken into account were the existing programs and resources that Providence Little Company of Mary has in place to address these needs and the landscape of community partners to collaborate with together.

Providence Little Company of Mary anticipates that implementation strategies may change and therefore, a flexible approach is best suited for the development of its response to the CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by Providence Little Company of Mary in the enclosed CHIP.

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 Insecurity

Goal (Anticipated Impact)

Improve the ability to care for patients experiencing homelessness or at risk of becoming homeless

- Reduce the number of people experiencing homelessness

Scope (Target Population)

Patients experiencing homelessness or at risk of becoming homeless

Table 1. Strategies and Strategy Measures for Addressing Homelessness and Housing Insecurity

Strategies	Strategy Measure	Baseline	FY20 Target	FY22 Target
1. **CHW Homeless Navigators:** Hospital emergency department based Community Health Workers that assist	• Number of Patients Screened for Homelessness • Number of Patients linked to homeless services provider • Number of patients discharged to	No baseline. New program for 2020	• 200 patients screened for homelessness • 100 patients linked to homeless services provider	• 10% increase in patients screened for homelessness as compared to 2021 target • 10% increase in patients linked to homeless service

homeless patients with discharge to shelter or homeless service providers	temporary/permanent housing		• 25 patients discharged to temporary/permanent housing	provider as compared to 2021 target • 10% increase in number of patients discharged to temporary/permanent housing as compared to 2021 target
2. Coordinated Entry System Hospital Liaison: A collaborative workgroup of private non-profit hospitals in the South Bay have a direct single point of contact with the local lead homeless service agency to coordinate referrals and education hospital staff on changing resources	• Clients referred and served by Hospital Liaison • CHW/Social Worker attendance at Bi-monthly meetings of the South Bay Coalition to End Homelessness Hospital Subcommittee	• 120 clients referred and served by Hospital Liaison • CHW/Social Worker attendance not tracked in 2019	• 20% increase in clients referred and served by Hospital Liaison • 75% attendance at SBCEH Hospital Subcommittee meetings	• 10% increase in clients referred and served by Hospital Liaison as compared to 2021 target • 80% attendance at SBCEH Hospital Subcommittee meetings
3. Homeless Prevention: Implement screening for risk of homelessness and identify public and private funded resources that focus on prevention	• # of people screened at high risk of homelessness using PSJH housing insecurity algorithm • Increase the number of families/individuals with confirmed linkage to homeless prevention services	No baseline. New strategy for 2020-2022.	• Implement usage of housing insecurity algorithm in identifying patients who are housing insecure • Identify 5 organizations who provide homelessness prevention	• 10% increase of people screened at high risk of homelessness compared to 2021 target • 10% increase in the number of families/individuals linked to homeless prevention services as compared to 2021 target

	• Increase in the number of organization identified who provide prevention services in PLCM Service Area • Increase CHI/PLCM budget related to services/programs for those living with homelessness in PLCM Service Area, including crisis response and prevention		services in PLCM Service Area • $120,000 budgeted for PLCM services related to homelessness	• 50% increase in dollars budgeted related to services/programs for those experiencing homelessness as compared to 2021 target
4. Recuperative Care: Improve the infrastructure of available recuperative care/interim shelter for homeless patients that are not medically stable enough to be discharged back to the streets	• Identify target population, Interventions and partners to support LA Service Area housing initiative • Support policies to increase temporary housing as a pathway to permanent supportive housing	No baseline. New program 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 gaps/ improvements that would increase # recuperative care/ temporary housing beds for patients	• 2% baseline increase in # of temporary housing/recuperative care beds available to PSJH patients in LA Service Area • Develop standards that define spectrum of temporary housing options for individuals experiencing homelessness that lead to permanent supportive housing • Increase scope of covered Medi-Cal benefits to include recuperative care

			who are unsheltered • Partner with PSJH advocacy and other Stakeholders to support policy changes that reimburse recuperative care/ temporary housing services for homeless • Increase support for local policies that ease construction/remodeling regulations for temporary housing facilities, including case management/housing navigation services • Identify opportunities to leverage existing resources to support recuperative care/temporary housing priorities	• Increase number of recuperative care beds available to patients discharged from hospitals who do not have shelter • Partner with key stakeholders to increase # recuperative care beds and related support services including housing navigation and case management services

Evidence Based Sources

Approved Strategies to Combat Homelessness. *Los Angeles County Homeless Initiative. https://homeless.lacounty.gov/wp-content/uploads/2017/01/HI-Report-Approved2.pdf*

Resource Commitment

Homeless Care Navigators, Funding for Recuperative Care Beds

Key Community Partners

Harbor Interfaith Services, UniHealth Foundation, Los Angeles Homeless Services Authority

INITIATIVE #2: IMPROVE ACCESS TO HEALTH CARE SERVICES

Community Need Addressed

- Access to Care
- Behavioral Health

Goal (Anticipated Impact)

Improve access to quality health care services for vulnerable populations

- Reduce the utilization of Emergency Departments for "avoidable", non-emergency visits
- Reduce the rates of uninsured people in the community
- Increase the percentage of the population who receive flu shots

Scope (Target Population)

Uninsured and underinsured populations in low-income communities

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

Strategies	Strategy Measure	2019 Baseline	FY20 Target	FY22 Target
1. **Vasek Polak Health Clinic:** Vasek Polak Health Clinic is a clinic that provides an alternative to the emergency room for people who do not have insurance or have Medi-Cal. The clinic provides access to primary care and also acts as a walk-in clinic for treating uncomplicated minor illnesses. The clinic's goal is to care for the needs of the whole person. Patients receive free health education, referrals to low-cost	• Patient Visits • % patients screened for anxiety/depression • Patients enrolled in mental health therapy	• 2,751 medical visits • 86% patients screened for anxiety/depression • 88 patients enrolled in mental health therapy	• 3,500 medical visits • 85% patients screened for anxiety/depression • 100 patients enrolled in mental	• 10% increase in medical visits from 2021 baseline • 2% increase in patients screened from 2021 baseline • Maintain number of patients

	social services and on-site mental health support.			health therapy	enrolled in mental health therapy from 2021 baseline
2.	**Partners for Healthy Kids:** Partners for Healthy Kids is a mobile pediatric clinic that offers free weekly immunizations at elementary and middle schools as well as health insurance enrollment and navigation assistance. We also partner with underserved high schools to provide sports physicals.	Number of Immunizations Given	4,304 immunizations given	4,000 Immunizations	5% increase from 2021 baseline
3.	**Emergency Department Community Health Workers:** Community health workers assist uninsured patients in the emergency department, helping them 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.	Primary Care Appointments Made	1,940 primary care appointments made	2,000 appointments made	5% increase from 2021 baseline
4.	**Health Insurance Enrollment Assistance:** Our Community Health Insurance Program utilizes community health workers to provide education about affordable health care options and assistance with health insurance and CalFresh applications.	Total # of Unduplicated Insurance Applications Assisted	3,346 applications assisted	3,200 applications assisted	5% increase from 2021 baseline
5.	**Sexual Assault Response Team**: A multidisciplinary team providing victim centered response and high quality care to survivors of sexual assault. SART Teams are composed of representatives from agencies that serve victims of sexual assault such as Rape Crisis Centers, Victim Advocates, Law Enforcement, Children's	Total Exams Provided	171 Exams	180 Exams	Maintain number of exams from 2021

Advocacy Center, Hospitals, Sexual Assault Nurse Examiners and the District Attorney's office				

Resource Commitment

- Staffing for all programs
- Two rooms/facilities for Sexual Assault Response Team
- Multiple sources of external grant funding have been awarded to fund these programs.

Key Community Partners

LA Unified School District, Torrance Unified School District, Lawndale Elementary School District, Local Law Enforcement, Harbor Community Clinic, Wilmington Community Clinic, Richstone Family Services, Covered California

INITIATIVE #3: INVEST IN EXPANSION OF COMMUNITY-BASED WELLNESS AND ACTIVITY CENTERS

Community Need Addressed

- Behavioral Health
- Food Insecurity
- Services for Seniors
- Chronic Diseases
- Social Cohesion

Goal (Anticipated Impact)

Increase the number of Wellness and Activity Centers in the South Bay and expand breadth of programming at existing Wellness Center in Wilmington

- Reduction in the prevalence of chronic diseases
- Increase in community engagement
- Increase in the amount of people's daily physical activity

Scope (Target Population)

Residents in two identified higher need municipalities within the PLCM Service Area (Wilmington and Lawndale)

Table 3. Strategies and Strategy Measures for Developing Wellness and Activity Centers

Strategies	Strategy Measure	Baseline	FY20 Target	FY22 Target

1. Wilmington Wellness and Activity Center: The Wilmington Wellness and Activity Center gives children and adults in the Wilmington area a physical space to participate in free programs run by Providence, local volunteers and community partners that promote social connections among neighbors and help improve the health of the community.	• Average number of unduplicated monthly participants • Total number of events available during the year	• Visits by 54 unduplicated registered Wellness Center members/month • 1,000 events at the Wellness and Activity Center	• Increase average number of Wellness Center member visits by 10% • Increase number of events at the Wellness Center by 10% of baseline	• Average 100 visits by unduplicated registered Wellness Center members/month • Increase number of events at the Wellness Center by 25% of baseline
2. Lawndale Wellness and Activity Center: Providence and the Lawndale Elementary School District have been awarded a grant by the California Natural Resources Agency to build a Wellness Center on the campus of one of the Lawndale schools.	Completed construction and opening of Lawndale Wellness and Activity Center	N/A	Final design plans submitted to State	Completed construction and opening of Lawndale Wellness and Activity Center

Resource Commitment

Staffing at both Wellness Centers, Grant Funding from California Natural Resources Agency and California Community Foundation for construction of Lawndale site

Key Community Partners

Mercy Housing, Abode Communities, Lawndale Elementary School District, California Natural Resources Agency

INITIATIVE #4: TRAIN AND DEPLOY A WORKFORCE OF COMMUNITY HEALTH WORKERS TO ADDRESS SOCIAL DETERMINANTS OF HEALTH IN UNDERSERVED POPULATIONS

Community Need Addressed

- Economic Insecurity and Workforce Development
- Access to Care

- Behavioral Health
- Food Insecurity
- Chronic Diseases

Goal (Anticipated Impact)

Increase the number of Community Health Workers employed in health care settings in roles that address social determinants of health

- Reduction in the number of people who are uninsured
- Reduction the in the number of eligible but unenrolled in CalFresh/SNAP benefits

Scope (Target Population)

- Workforce development for employees without a college degree
- Services for residents of low-income neighborhoods, especially Spanish speaking communities

Table 4. Strategies and Strategy Measures for Training and Deploying Community Health Workers

Strategies	Strategy Measure	Baseline	FY20 Target	FY22 Target
1. **Create a CHW Academy:** In collaboration with Charles Drew University, develop an academy for Community Health Workers that focus on integration into health care organizations	# of CHW students who complete program	New program for 2020	20 CHW students enrolled in program	• 25% increase from 2021 in CHW students enrolled • Additional sustainable funding for CHW Academy identified and secured beyond pilot grant funding
2. **Health Insurance Enrollment Assistance:** Our Community Health Insurance Program utilizes community health workers to provide education about affordable health care options and assistance with health insurance and CalFresh applications	Total # of Unduplicated Insurance Applications Assisted	3,346 applications assisted	3,200 applications assisted	• 5% increase from 2021 baseline
3. **CalFresh Enrollment Assistance:** Our Community Health	# of CalFresh applications assisted	1,529 CalFresh applications assisted	1,600 CalFresh applications assisted	• 10% increase from 2021 baseline

	Insurance Program utilizes community health workers to provide education about affordable health care options and assistance with health insurance and CalFresh applications				
4	**Mental Health Education and Prevention:** Health Educators and CHWs paired together teach free community based courses in English and Spanish on mental health awareness and coping skills	• # of participants completing Mental Health First Aid (MHFA) • # of participants completing Creating Healthier Attitudes Today (CHAT)	• MHFA: No baseline, new program for 2020 • CHAT: 69 participants completed CHAT in 2019	• 500 participants complete MHFA certification • 200 participants complete CHAT	• 5% increase from 2021 baseline for Mental Heath First Aid • 10% increase from 2021 baseline for CHAT
5.	**Diabetes Self-Management Education and Prevention Programs:** Health Educators and CHWs paired together teach free community based courses in English and Spanish to patients who have been diagnosed with diabetes or prediabetes	• Diabetes Prevention Program (DPP): Number of Participants who complete year long program • Get Out and Live (GOAL): Number of participants who complete course	• DPP: In progress, 15 participants enrolled in program. • GOAL: 108 participants completed course	• DPP: 10 participants complete year long program • GOAL: 120 participants complete course	• DPP: 10% increase from 2021 baseline in number of participants • GOAL: 5% increase from 2021 baseline in number of participants

Evidence Based Sources

- Center for Disease Control and Prevention: Community Health Worker Toolkit https://www.cdc.gov/dhdsp/pubs/toolkits/chw-toolkit.htm

- Center for Disease Control and Prevention: National Diabetes Prevention Program https://www.cdc.gov/diabetes/prevention/research-behind-ndpp.htm

- Center for Disease Control and Prevention: Self-Management Education https://www.cdc.gov/learnmorefeelbetter/programs/diabetes.htm

- LA Department of Public Health: Food Insecurity in Los Angeles County http://www.publichealth.lacounty.gov/ha/docs/2015LACHS/LA_HEALTH_BRIEFS_2017/LA%20Health_FoodInsecurity_finalB_09282017.pdf

- Mental Health First Aid Research Summary https://www.mentalhealthfirstaid.org/cs/wp-content/uploads/2013/10/2018-MHFA-Research-Summary.pdf

Resource Commitment

- Awarded California Community Reinvestment Grant funding by the Governor's Office of Business and Economic Development to create CHW Academy.
- Awarded multiple grants to support CHW positions in outreach and enrollment for Covered CA, Medi-Cal, and CalFresh.
- Awarded grant funding from the Well-Being Trust for mental health education programs.

Key Community Partners

Charles Drew University, Kaiser Permanente, Cedars-Sinai, Harbor Community Clinic. Other LA County healthcare providers

Other Community Benefit Programs and Evaluation Plan

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

Initiative (Community Need Addressed)	Program Name	Description	Target Population (Low Income, Vulnerable or Broader Community)
1. Social Cohesion	Building Stronger Communities	Training of adults as community leaders who then plan events, activities and classes that reduce social isolation for families with children up to age 5.	Low Income
2. Social Cohesion	Best Start Community Partnership-Wilmington Local Support Network	Best Start Community Partnerships provide the opportunity for parents, residents, organizations, non-	Low Income

		profits, elected officials and other stakeholders to collaboratively improve neighborhoods so that young children can thrive and enter kindergarten ready to succeed in school and life. Providence provides operational support and guidance for the Wilmington Community Partnership.	
3. Chronic Diseases	Creating Opportunities for Physical Activity	COPA is a peer coach physical education training program for elementary school teachers that promotes independence in instruction, consistent with California grade level standards. COPA also organizes and implements school-wide health promotion events and sponsors activity camps at our Wellness and Activity Center.	Low Income
4. Early Childhood Development	Welcome Baby	Welcome Baby is a home visitation program that provides pregnant women and new moms with information, support and a trusted partner to help them through the journey of pregnancy and early parenthood.	Low Income

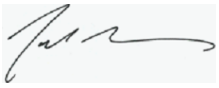
2020- 2020 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the Providence Little Company of Mary Community Ministry Board on March 24th, 2020.

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

DocuSigned by:
Suzi Gulcher
AFD8633D507648A...

Suzi Gulcher
Chair, Providence Little Company of Mary Community Ministry Board



Joel Gilbertson
Senior Vice President, Community Partnerships
Providence St. Joseph Health

CHNA/CHIP Contact:

Justin Joe, MPH
Director, Community Health Investment
2601 Airport Drive, Suite 220
Torrance, CA 90505
justin.joe@providence.org

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.