

2026-  
2028

# COMMUNITY HEALTH IMPROVEMENT PLAN



## Providence Saint Joseph Medical Center

Burbank, California

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## EXECUTIVE SUMMARY

Providence continues its Mission of service in Los Angeles County – Valley Service Area through Providence Saint Joseph Medical Center, Providence Holy Cross Medical Center, and Providence Cedars Sinai Tarzana Medical Center. The following Community Health Improvement Plan (CHIP) outlines our strategic response to addressing the prioritized needs from the 2025 Community Health Needs Assessment (CHNA).

This is a joint Community Health Improvement Plan, including Providence Saint Joseph Medical Center, Providence Holy Cross Medical Center, and Providence Cedars Sinai Tarzana Medical Center in response to a joint 2025 CHNA. The strategies included in this plan are representative of efforts taken by all hospitals to address the identified community needs.

Providence Saint Joseph Medical Center, Providence Holy Cross Medical Center, and Providence Cedars Sinai Tarzana Medical 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. The Community Health Needs Assessment (CHNA) is an opportunity for Providence Saint Joseph Medical Center, Providence Holy Cross Medical Center, and Providence Cedars Sinai Tarzana Medical 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, hospital utilization data, and more.

Our commitment to improving the health of our community extends beyond patient care. Through community health improvement and strategic partnerships, health professions education and research, free, discounted and subsidized care, and other means of outreach, we commit to caring for those we serve through high-impact community benefit programs and investments.

### Providence Saint Joseph Medical Center Community Health Improvement Plan Priorities

As a result of the findings of our [2025 CHNA](#) and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, Providence Saint Joseph Medical Center, Providence Holy Cross Medical Center, and Providence Cedars Sinai Tarzana Medical Center will focus on the following areas for its 2026-2028 Community Benefit efforts:

#### ACCESS TO CARE AND PREVENTIVE RESOURCES

Access to care and preventive resources is a top priority and concerns include difficulty accessing primary care providers and specialists, affordability, and reduced coverage for vulnerable populations

## BEHAVIORAL HEALTH INCLUDING MENTAL HEALTH AND SUBSTANCE USE/MISUSE

Behavioral health, mental health, and substance use/misuse continues to be a major concern for individuals experiencing trauma, domestic violence, and social isolation among children, adults, and seniors

## CHRONIC DISEASE

Chronic diseases like cancer, diabetes, dementia, hypertension, and other chronic diseases disproportionately affect communities of color and vulnerable populations that lack screenings and preventive resources

# 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 San Fernando Valley Medical Centers include Providence Holy Cross Medical Center, Providence Saint Joseph Medical Center, and Providence Cedars-Sinai Tarzana Medical Center are acute care hospitals located in the San Fernando Valley within Los Angeles, 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 and people we serve. For more information, refer to the [Annual Report to our Communities](#) and [Community Health Needs Assessments/Community Health Improvement Plans](#).

## Joint CHIP Report

This is a “joint CHIP report,” within the meaning of Treas. Reg. § 1.501(r)-3(b)(6)(v), by and for Providence including Providence Saint Joseph Medical Center, Providence Holy Cross Medical Center and Providence Cedars Sinai Tarzana Medical Center. These hospitals completed a joint 2025 CHNA report. A joint approach to addressing the needs identified in the joint CHNA will be most effective given that the hospitals share a CHNA service area and community served, staffing, leadership teams, and resources. The strategies included in this plan are representative of efforts taken by all hospitals to address the identified community needs. The hospitals have a shared governance structure and share one Mission Community Health Committee that adopts the CHIP for all hospitals.

## Equity Practices in the CHIP

At Providence, we are committed to addressing the underlying and root causes of health disparities and inequities in the communities we serve. We work to address not only the clinical factors that determine a person’s length and quality of life, but also the social and economic dimensions, physical environment, and other factors that play a role in determining health outcomes. Addressing these factors includes leveraging community strengths and utilizing evidence-based, leading practices.

Through literature and our community partners, we recognize that long-standing systemic inequities exist and that they can lead to health disparities. We routinely evaluate health disparities in the communities we serve and use qualitative and quantitative data to inform how we enhance access to high-quality, evidence-based care. The purpose of the CHIP is to respond to and address the needs identified by our communities. The CHIP strategies are based on the CHNA data to meet the highest level of need, which is ultimately in service to all our community members.

## Financial Assistance Program

Our mission is to improve the health and well-being of each person we serve, regardless of ability to pay. We believe no one should delay seeking needed medical care because they lack health insurance. Providence has a [Financial Assistance Program \(FAP\)](#) that provides free or discounted services to eligible patients.

# COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS AND RESULTS

## Our Community and the Community Health Needs Assessment Process and Results

Providence Saint Joseph Medical Center conducted a 2025 Community Health Needs Assessment (CHNA) in partnership with Providence Holy Cross Medical Center and Providence Cedars Sinai Tarzana Medical Center. The CHNA service area is the entirety of Los Angeles County – Service Planning Area 1,2, and 4.

The CHNA is an opportunity for Providence hospitals to engage the community every three years with the goal of better understanding strengths and needs. Through a mixed-methods approach, using quantitative and qualitative data, the CHNA process relies on several sources of information: state and national public health data, qualitative data from key informant interviews and community listening sessions, hospital utilization data, and more. An oversight committee reviews all the data from the CHNA and identifies priority needs to address in the 2026-2028 Community Health Improvement Plan (CHIP).

More information on the CHNA process and findings can be found in the [2025 Providence Saint Joseph Medical Center CHNA](#).

## Significant Community Health Needs Prioritized

Providence San Fernando Valley Medical Centers include Providence Saint Joseph Medical Center, Providence Holy Cross Medical Center, and Providence Cedars-Sinai Tarzana Medical Center will focus on the following priority areas identified in the 2025 CHNA to best leverage their capacity, expertise, and resources for greatest impact:

### ACCESS TO CARE AND PREVENTIVE RESOURCES

Access to care and preventive resources is a top priority and concerns include difficulty accessing primary care providers and specialists, affordability, and reduced coverage for vulnerable populations

### BEHAVIORAL HEALTH INCLUDING MENTAL HEALTH AND SUBSTANCE USE/MISUSE

Behavioral health, mental health, and substance use/misuse continues to be a major concern for individuals experiencing trauma, domestic violence, and social isolation among children, adults, and seniors

### CHRONIC DISEASE

Chronic diseases like cancer, diabetes, dementia, hypertension, and other chronic diseases disproportionately affect communities of color and vulnerable populations that lack screenings and preventive resources

# COMMUNITY HEALTH IMPROVEMENT PLAN

## Summary of Community Health Improvement Planning Process

The 2025 CHNA completed for Providence San Fernando Valley Medical Centers, including Providence Saint Joseph Medical Center, Providence Holy Cross Medical Center, and Providence Cedars-Sinai Tarzana Medical Center, was the basis for the 2026-2028 CHIP. The assessment, which was completed as part of the Providence San Fernando Valley Medical Center, identified community needs, assets, resources, and strategies to improve health for Los Angeles County residents.

The Mission Community Health Committee evaluated the needs and supporting data identified in the 2025 CHNA and selected areas of focus for Providence Holy Cross Medical Center, Providence Saint Joseph Medical Center, and Providence Cedars-Sinai Tarzana Medical Center: Access to Care and Preventative Resources, Behavioral Health Including Mental Health and Substance Use/Misuse and Chronic Disease. Prioritizing these needs allows the hospitals to focus on leveraging their strengths, expertise, and resources for greatest impact.

A multi-disciplinary team spanning clinical care, community health, business development, etc. was convened as part of the 2026-2028 CHIP Committee to identify strategies, programs, and initiatives that respond to the prioritized needs. Individuals on the committee bring their deep knowledge of the prioritized needs, clinical and community based best practices, and Los Angeles County communities.

Through a series of dialogue and feedback sessions with members of the committee and other internal subject matter experts, a set of core CHIP strategies were presented to Mission Community Health Committee, senior leaders, and the Valley Service Area Community Ministry Board for additional review, feedback, and alignment.

In April 2026, the Valley Service Area Community Ministry Board adopted the 2026-2028 CHIP, including the following strategies for addressing the priority community needs.

## Addressing the Needs of the Community: 2026 - 2028 Key Community Benefit Initiatives and Evaluation Plan

The following strategies for addressing priority needs consider how communities change over time, as well as their existing strengths and capacity. They were intentionally selected with the understanding that some community health needs may evolve during the duration of the CHIP, and that subsequent implementation strategies may require adjustment based on resources and to best meet the needs of our communities. While our response to community need must remain flexible to changing dynamics, our commitment to improving the health of our communities is unwavering.

## COMMUNITY NEED ADDRESSED #1: ACCESS TO CARE AND PREVENTIVE RESOURCES

### Population Served

In line with our mission, we are focused on underserved populations, including those with low incomes, uninsured, and underinsured. Within these populations, we aim to serve low-income adults, seniors and older adults.

### Long-Term Goal(s)/ Vision

To improve access to care for people with low incomes and those uninsured by deploying programs to assist with navigating the health care system

Table 1. Strategies and Measures for Addressing Access to Care and Preventive Services

| Identified need: Access to Care and Preventive Services   |   |   |   |   |
|---|---|---|---|---|
| Strategy  | Population Served   | Strategy Measure(s)   | Baseline  | 2028 Target   |
| <b>Community Health Insurance Program -</b><br>CHWs provide community-based outreach and enrollment assistance about affordable health insurance options including Medi-Cal and Covered California health plans   | Underserved, low-income populations who are uninsured or underinsured needing insurance coverage              | Number of insurance applications assisted and troubleshooting cases   | 200 individuals   | 200 individuals   |
| <b>Social Drivers of Health Screenings:</b><br>Each hospital ministry screens patients for social needs like housing, food insecurity, transportation, utilities, and interpersonal safety. Patients are then linked to community resources and support services. | Underserved, low-income populations, including members of BIPOC, refugee, immigrant, and LGBTQIA+ communities | Percentage of patients screened for SDOH<br><br>Percentage of positively screened patients linked to community resources and services | 90% of patients screened for SDOH<br><br>30% of patients linked to resources and services | Maintain the screening rate<br><br>Improve the linkage rate by 5% each year |

|   |   |   |                         |   |
|---|---|---|-------------------------|---|
| <p><b>Senior Support Services and Screenings:</b> programs that support seniors with healthy and active living activities along with screenings for preventive services</p>   | <p>Low-income seniors and older adults</p>  | <p>Number of participants completed program(s)</p> <p>Number of patients screened for needs</p> | <p>No baseline data</p> | <p>Increase the number of completed participants by 5% YOY</p> <p>Increase the number of individuals screened by 5% YOY</p> |
| <p><b>Partnerships with Community Clinics and Federally Qualified Health Centers:</b> Community Health Workers assist Medi-CAL patients if they are without a PCP or medical home and assist in connecting them with local primary care provider or medical home.</p> | <p>Low-income patients with limited healthcare coverage needed assistance with navigating the healthcare system</p> | <p>Number of patients referred to a local community clinic</p>                                  | <p>No baseline data</p> | <p>Refer a minimum of 200 patients</p>  |
| <p><b>Mother Joseph Fund Grant Program:</b> a grantmaking program that funds projects and programs addressing needs in the community.</p>   | <p>Underserved individuals and families needing various types of social and health related services</p>             | <p>Number of projects addressing access to care</p>   | <p>No baseline data</p> | <p>Maintain the number of projects supported each year</p>  |

*Community and Research Informed Resources*

Health Insurance

Health Insurance Enrollment Outreach and Support

Preventing Tooth Decay

*Resource Commitment*

Providence Saint Joseph Medical Center will commit staff time, supplies and equipment, grants and in-kind donations to support these strategies.

*Key Community Partners*

All-Inclusive Community Health Center

ALZ of Greater Los Angeles

Catholic Charities – Guadalupe Center

Charles Drew University

City of Burbank Joslyn Center

Comprehensive Community Health Centers

Convalescent Aid Society

El Proyecto del Barrio

Kids Community Dental Clinic

LA Care

MEND

Northeast Valley Health Care Corporation

ONEGeneration

San Fernando Community Health Center

Tarzana Treatment Centers

YMCA of Greater Metropolitan Los Angeles

## COMMUNITY NEED ADDRESSED #2: BEHAVIORAL HEALTH INCLUDING MENTAL HEALTH AND SUBSTANCE USE/MISUSE

### Population Served

In line with our mission, we are focused on underserved populations, including those with low incomes, uninsured, and underinsured. Within these populations, we aim to serve people experiencing behavioral health issues including mental illness and substance use disorders.

### 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.

**Table 2. Strategies and Measures for Addressing Behavioral Health including mental health and substance use/misuse**

| Identified need: Behavioral health including mental health and substance use/misuse   |   |  |                  |  |
|---|---|--|------------------|--|
| Strategy  | Population Served   | Strategy Measure(s)  | Baseline         | 2028 Target  |
| <b>Mental Health Awareness, Prevention, and Coping Skills Trainings:</b> support prevention and early intervention by teaching <a href="#">Mental Health First Aid</a> , <a href="#">Mind Matters</a> , and Overdose Prevention curricula in community-based settings | People with mental health illness                               | Number of participants trained   | 210 participants | Maintain the number of participants trained per year |
| <b>Behavioral, Substance Use, Mental Health Care Navigation:</b> CHW links Providence Valley Service Area emergency department patients to follow up care with mental and behavioral health treatment resources   | People with substance use disorders and behavioral health needs | Number of referrals made for behavioral health and mental health needs | 200 referrals    | Maintain the number of participants per year         |

|  |  |  |                         |   |
|--|--|--|-------------------------|---|
| <p><b>ALZ Educational Workshops:</b> Community health workers provide education and awareness on Alzheimer’s and dementia topics</p>   | <p>Senior and older adults experiencing dementia and older mental illness</p>                    | <p>Number of participants completing workshops</p>           | <p>85 participants</p>  | <p>Increase the number of participants by 10%</p>                         |
| <p><b>Opioid Use Disorder Narcan Distribution:</b> Narcan (naloxone) is a form of overdose response program that to help the communities fight against opioid epidemic. Narcans are available for free at the Emergency Department and distributed in community health education programs.</p> | <p>Community members and patients at-risk of opioid overdose</p>                                 | <p>Number of Narcan kits distributed per year</p>            | <p>No baseline data</p> | <p>Increase the number of Narcan kits distributed per year by 5%</p>      |
| <p><b>Mother Joseph Fund Grant Program:</b> a grantmaking program that funds projects and programs addressing needs in the community.</p>  | <p>Community members and patients experiencing behavioral health and mental health disorders</p> | <p>Number of projects addressing behavioral health needs</p> | <p>No baseline data</p> | <p>Maintain the number of projects addressing behavioral health needs</p> |

*Community and Research Informed Resources*

[Evidence-Based Strategies for Preventing Opioid Overdose: What’s Working in the United States](#)

[Meeting the Challenge of Caring for Persons Living with Dementia and their Care Partners and Caregivers](#)

[Mental Health First Aid](#)

[Naloxone education and distribution programs](#)

*Resource Commitment*

Providence Saint Joseph Medical Center will commit staff time, supplies and equipment, grants and in-kind donations to support these strategies.

### *Key Community Partners*

ALZ of Greater Los Angeles

Child Development Institute

City of Burbank

Didi Hirsch Mental Health Center

Leeza's Care Connection

Mental Health

National Council for Mental Wellbeing

Providence High School

Tarzana Treatment Centers

The Village Family Services

Valley Family Center

West Coast University

## COMMUNITY NEED ADDRESSED #3: CHRONIC DISEASE

### *Population Served*

In line with our mission, we are focused on underserved populations, including those with low incomes, uninsured, and underinsured. Within these populations, we aim to serve individuals experiencing chronic diseases like cancer, diabetes, heart disease, and neurological diseases.

### *Long-Term Goal(s)/ Vision*

Reduce the prevalence and impact of chronic diseases in the community by expanding access to preventive care, promoting healthy lifestyle behaviors, and improving the social and environmental conditions that influence health.

**Table 3. Strategies and Measures for Addressing Chronic Disease**

| Identified need: Chronic Disease   |  |   |                  |  |
|--|--|---|------------------|--|
| Strategy   | Population Served  | Strategy Measure(s)   | Baseline         | 2028 Target  |
| <b>Healthy Eating and Active Living:</b> A community health worker helps community members learn how to eat healthier, more nutritious meals while increasing their weekly physical activity levels  | Underserved, low-income populations experiencing obesity, chronic food insecurity, and those lacking physical activity | Number of participants  | 120 participants | Increase the number of participants by 10%   |
| <b>Diabetes Prevention Program (DPP) and Diabetes Empowerment Education Program (DEEP):</b> Health educators implement the year long Diabetes Prevention Program lifestyle change program to help individuals that are prediabetic and at-risk for Type 2 diabetes and Diabetes Empowerment Education Program helps patients with diabetes control their disease and its risk factors in 10-week sessions. | Individuals and patients affected by diabetes  | Number of participants completing the program   | 24 participants  | Increase the number of participants by 10% per year  |
| <b>Hypertension and stroke education and screening:</b> Hospital conducts annual stroke education programs for patients and community members about the risk for hypertension and stroke. Community Health conducts blood pressure screenings at community events and provides education.  | Individuals and patients affected by hypertension and at-risk for stroke or heart disease                              | Number of events conducted each year<br><br>Number of individuals screened for hypertension | No baseline data | Increase the number of events per year by 50%<br><br>Increase the number of individuals screened by 5% |
| <b>Cancer education:</b> Hospital conducts annual cancer education programs for patients and community members about the risk for cancer.  | Individuals affected by cancer including lung, breast, colorectal, etc.  | Number of education events conducted  | No baseline data | Increase number of education events per year by 50%  |

*Community and Research Informed Resources*

[Breast Cancer Screening](#)

[Colorectal Cancer: Screening](#)

[Diabetes Prevention: Interventions Engaging Community Health Workers](#)

[Diabetes Management: Interventions Engaging Community Health Workers](#)

[Diabetes Management: Intensive Lifestyle Interventions for Patients with Type 2 Diabetes](#)

[High Blood Pressure in Adults: Screening](#)

[Implementation of Lung Cancer Screening](#)

[Physical Activity Evidence-Based Programs](#)

*Resource Commitment*

Providence Saint Joseph Medical Center will commit staff time, supplies and equipment, grants and in-kind donations to support these strategies.

*Key Community Partners*

American Cancer Society

American Heart Association

American Lung Association

Boys and Girls Club of Pacoima

Boys and Girls Club of Burbank

Charles Drew University

City of Burbank Recreation Department

City of Hope

City of San Fernando Recreation Department

Disney Family Cancer Center

Facey Medical Group

FEAST

Los Angeles County Department of Public Health

Skinny Gene Project

YMCA of Greater Metropolitan Los Angeles

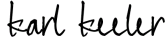
# Other Community Benefit Programs

**Table 4. Other Community Benefit Programs in Response to Community Needs**


| Initiative (Community Need Addressed)   | Program Name                         | Description   | Population Served (Low Income, Vulnerable or Broader Community) |
|---|--------------------------------------|---|---|
| 1. Food Insecurity                      | CalFresh Application Assistance      | CHWs assist community members to enroll in food assistance programs.            | Low Income, Vulnerable, Broader                                 |
| 2. Homelessness and Housing Instability | CHW Care Navigators for the Homeless | Navigators assist unhoused patients with resources in the Emergency Department. | Low Income, Vulnerable  |
| 3. Senior Support                       | Leeza’s Care Connection              | Support for caregivers and families members affected by dementia.               | Vulnerable, Broader   |

## 2026 - 2028 CHIP GOVERNANCE APPROVAL

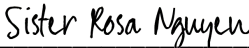
This Community Health Improvement Plan was adopted by the Valley Service Area Community Ministry Board of the hospital on April 16, 2026. The final report was made widely available by May 15, 2026.

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