

**COMMUNITY HEALTH IMPROVEMENT PLAN**  
**2020 - 2022**

# Providence Saint John's Health Center



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To provide feedback about this CHIP or obtain a printed copy free of charge, please email [justin.joe@providence.org](mailto:justin.joe@providence.org)

**Saint John's  
Health Center**  
 **PROVIDENCE** Health & Services

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# EXECUTIVE SUMMARY

## Who We Are

Providence Saint John's Health Center (PSJHC) serves Santa Monica and Los Angeles (L.A.) County's Westside communities and has earned a reputation for clinical excellence and award-winning care in a compassionate and tranquil healing environment. Founded by the Sisters of Charity of Leavenworth in 1942, who in 2014 passed its sponsorship to Providence Health & Services, PSJHC is rooted in the Catholic health care tradition, which is devoted to providing leading-edge medicine with unwavering compassion and personalized care. Providence St. John's seeks to create healthier communities by investing in community benefit programs, with an emphasis on the poor and vulnerable.

Today, PSJHC is a nationally recognized 266-bed hospital with physicians, nurses, volunteers and support staff who work as a team to provide the best possible medical care to its patients and the community. PSJHC offers a comprehensive array of medical services (both inpatient and outpatient) to meet the health care needs of the Westside area. These services include cardiac/cardiovascular, neurosciences, orthopedics, obstetrics and women's health, general medicine/surgery, and a comprehensive cancer program and research center offered at the John Wayne Cancer Institute.

## Our Commitment to Community

As health care continues to evolve, PSJHC 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 economically poor and vulnerable, we conduct a formal community health needs assessment (CHNA) 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, not only for our own programs but also for many partners that look to PSJHC to improve the health of entire populations.

PSJHC has a strong commitment to directly addressing the health needs in the community with special concern for the poor and vulnerable. The Providence Saint John's Child and Family Development Center offers comprehensive outpatient mental health services to low-income children and their families. In 2015, PSJHC started the Homeless Care Navigation Program to assist patients experiencing homelessness who utilize the emergency department by linking them with shelter/housing and other resources.

During 2019, PSJHC provided over \$39 million in community benefit in response to unmet needs and to improve the health and well-being of those it serves on L.A. County's Westside.

## Description of Community Served

The service area defined for PSJHC includes the ZIP codes located within Service Planning Area (SPA) 5 of L.A. County. The planning area includes the communities located on the west side of the county (referred to as “the Westside” locally, and in this report), and represents the area where a significant portion (over 70%) of the patients served by the hospital reside. SPA 5 was used as the target geographic area for the 2019 CHNA since it closely matches where a majority of PSJHC’s patients reside. Using the SPA definition also helped with the collection of data from the L.A. County Department of Public Health and other government agencies that use these boundaries when conducting studies. The area includes 20 distinct communities and 30 ZIP codes.

For purposes of the 2019 CHNA, in alignment with our Mission to pay special attention to the poor and vulnerable, we utilized the California Healthy Places Index developed by the Public Health Alliance of Southern California to identify 18 specific “high need” census tracts within SPA 5. These 18 census tracts scored lower than other California census tracts across a composite of 25 community conditions that predict life expectancy. The identification of these “high need” census tracts will allow us to prioritize where to strategically place community benefit resources as PSJHC implements the Community Health Improvement Plan (CHIP).

## Providence Saint John’s Health Center 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 Saint John’s Health Center 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 a hospital that sees 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 patients experiencing homelessness 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 patients experiencing homelessness 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 financial and in-kind support to community clinics and nonprofit organizations that improve health care access to underserved and vulnerable populations. These populations include people experiencing homelessness, those who are uninsured, and low-income households (Medi-Cal). Furthermore, in light of the recent Coronavirus Disease 2019 (COVID-19) pandemic, we will also place an emphasis on alleviating the strain on local healthcare resources from infectious diseases such as flu and COVID-19 by increasing the availability of testing and immunizations in the community.

### INITIATIVE 3: IMPROVE ACCESS TO BEHAVIORAL HEALTH AND REDUCE STIGMA

PSJHC has had a longstanding commitment to improving access to behavioral health through the Child and Family Development Center (CFDC). CFDC has been providing on-site and community-based treatment services for children, adolescents and their families since 1952 and we will continue to improve access to behavioral health by providing these programs. In addition to providing treatment and early intervention services, CFDC will focus on capacity building for local organizations with trainings on trauma-informed care. To promote awareness of mental health and reduce stigma about mental illness, PSJHC will also provide mental health education and prevention trainings directly to community members.

### 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 (CHWs) 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 health care industry while allowing Providence to effectively provide culturally competent care within specific 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 PSJHC and other health care organizations who have an interest in incorporating a CHW workforce in their organizations.

## Responding to the COVID-19 Pandemic

The 2020 Community Health Improvement Planning (CHIP) 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. Additionally, the data projections included were crafted based on data collection and project forecasting done prior to the COVID-19 pandemic, so may be modified as we understand adjusted resources and priorities within our communities in the aftermath of the pandemic.

# MISSION, VISION, AND VALUES

<i>Our Mission</i>	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.
<i>Our Vision</i>	Health for a Better World.
<i>Our Values</i>	Compassion — Dignity — Justice — Excellence — Integrity

# INTRODUCTION

## Who We Are

Providence Saint John’s Health Center (PSJHC) serves Santa Monica and Los Angeles (L.A.) County’s Westside communities and has earned a reputation for clinical excellence and award-winning care in a compassionate and tranquil healing environment. Founded by the Sisters of Charity of Leavenworth in 1942, who in 2014 passed its sponsorship to Providence Health & Services, PSJHC is rooted in the Catholic health care tradition, which is devoted to providing leading-edge medicine with unwavering compassion and personalized care. PSJHC seeks to create healthier communities by investing in community benefit programs, with an emphasis on the poor and vulnerable.

Today, PSJHC is a nationally recognized 266-bed hospital with physicians, nurses, volunteers and support staff who work as a team to provide the best possible medical care to its patients and the community. PSJHC offers a comprehensive array of medical services (both inpatient and outpatient) to meet the health care needs of the Westside area. These services include cardiac/cardiovascular, neurosciences, orthopedics, obstetrics and women’s health, general medicine/surgery, and a comprehensive cancer program and research center offered at the John Wayne Cancer Institute.

## Our Commitment to Community

PSJHC 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 ministry provided over \$39 million in community benefit<sup>1</sup> in response to unmet needs and to improve the health and well-being of those we serve on LA County’s Westside.

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

One way PSJHC 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

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<sup>1</sup> 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. Note: Community benefit includes both services to the economically poor and 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: 1) community health needs assessment developed by the ministry or in partnership with other community organizations; 2) 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; 3) or the involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.



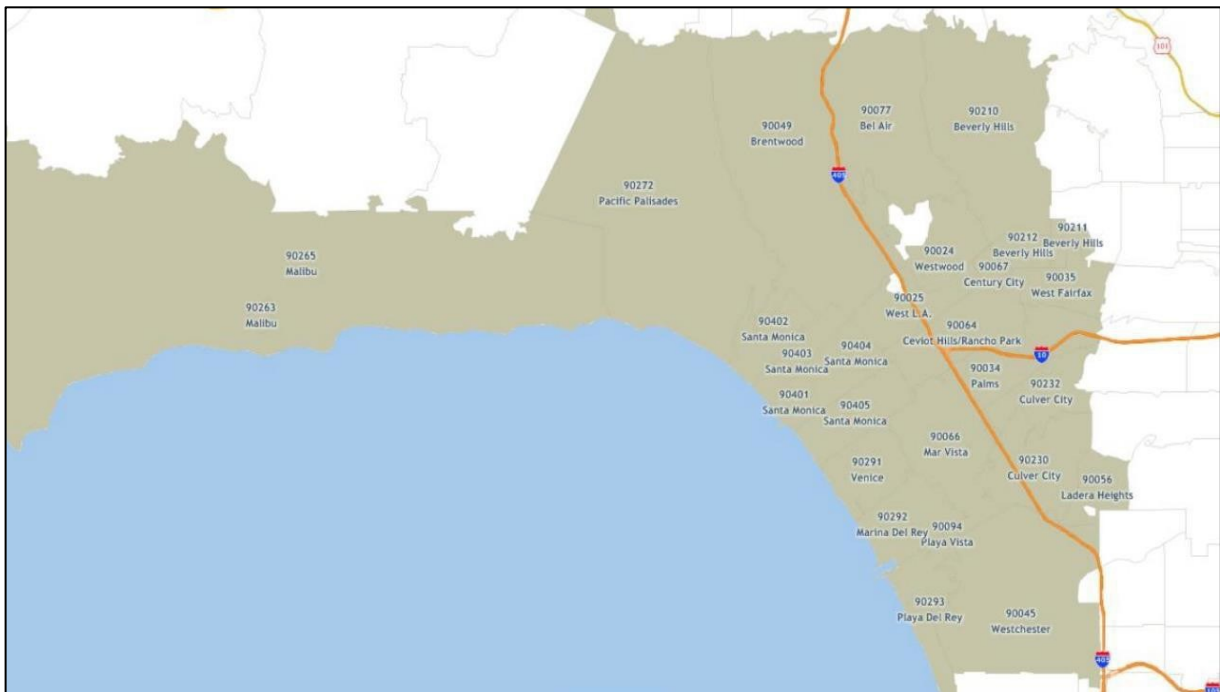
assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third party insurers are offered 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 please visit <https://www.providence.org/obp/ca>

# OUR COMMUNITY

## Description of Community Served

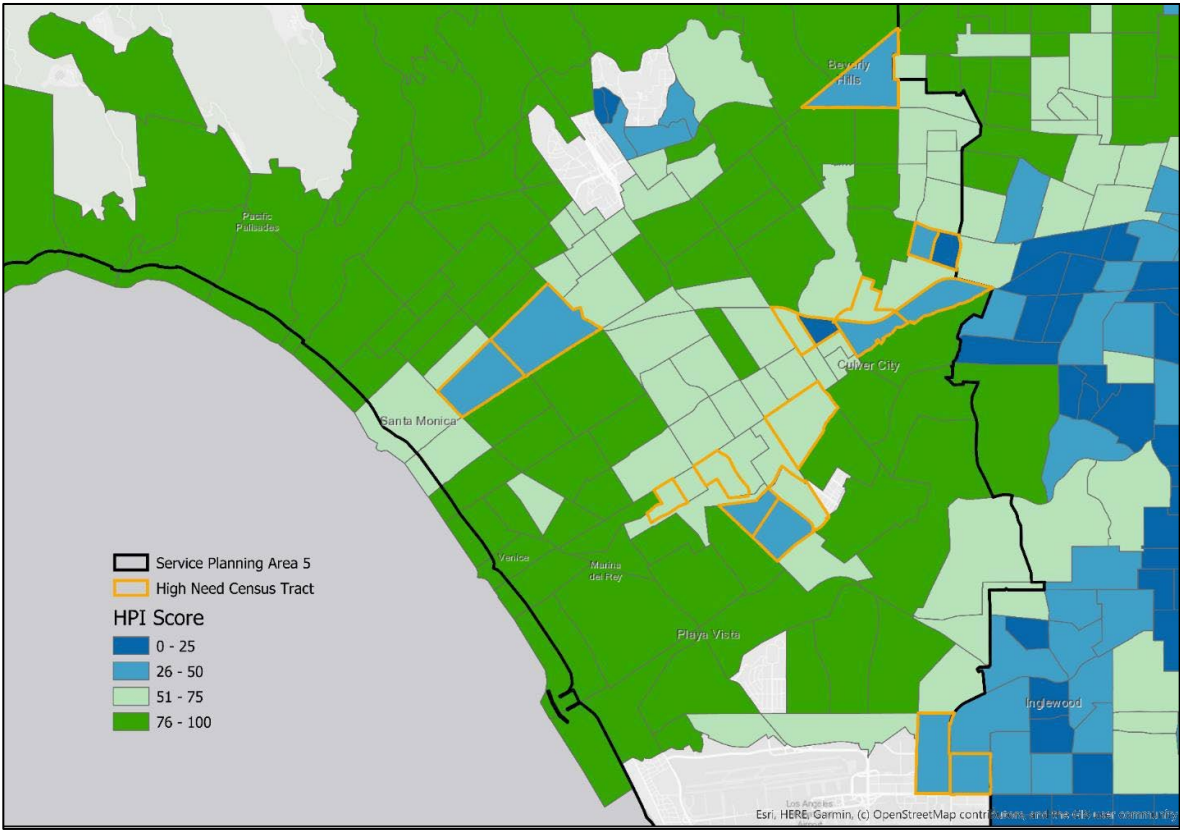
The service area defined for the PSJHC Community Health Needs Assessment (CHNA) includes the ZIP codes located within Service Planning Area (SPA) 5 of L.A. County. The planning area includes the communities located on the west side of the county (referred to as “the Westside” locally, and in this report), and represents the area where a significant portion (over 70%) of the patients served by the hospital reside. SPA 5 was used as the target geographic area for this CHNA since it closely matches where a majority of PSJHC’s patients reside. Using the SPA definition also helped with the collection of data from the L.A. County Department of Public Health and other government agencies that use these boundaries when conducting studies. The area includes 20 distinct communities and 30 ZIP codes.

*Figure 1. Providence Saint John's Health Center CHNA Service Area Map (SPA 5)*



For purposes of the 2019 CHNA, in alignment with our Mission to pay special attention to the poor and vulnerable, we utilized the California Healthy Places Index developed by the Public Health Alliance of Southern California to identify 18 specific “high need” census tracts within SPA 5. These 18 census tracts, outlined in yellow in Figure 2, scored lower than other California census tracts across a composite of 25 community conditions that predict life expectancy. The identification of these “high need” census tracts will allow us to prioritize where to strategically place community benefit resources as PSJHC implements the Community Health Improvement Plan (CHIP).

Figure 2. Healthy Places Index Map: High Need Census Tracts in SPA 5



# COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

## Summary of Community Needs Assessment Process and Results

The CHNA process involved systematic collection of both primary and secondary data relevant to the Westside to identify the high priority needs and issues facing the community. For primary data, input was sought from 30 community leaders and residents using both phone and written surveys. Part of this primary data collection involved a collaborative relationship between PSJHC, UCLA Health System, Cedars-Sinai Medical Center, and Kaiser Permanente Medical Center West L.A. to conduct the interviews with community leaders and service providers. In addition, PSJHC conducted two listening sessions with local community members at Virginia Avenue Park and Venice Family Clinic.

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, California Health Interview Survey Dataset, L.A. County Department of Public Health, and California Department of Public Health. Truven Analytics/ Dignity Health provided Community Need Index data, the Public Health Alliance of Southern California provided Healthy Places Index data, and the City of Santa Monica provided community specific data.

## Identification and Selection of Significant Health Needs

Once the information and data were collected and analyzed by staff members, the following nine 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
- Food Insecurity
- Homelessness and Housing Instability
- Oral Health Care
- Services for Seniors

## Community Health Needs Prioritized

The significant health needs were ranked based on score of severity, change over time, resources in the community and PSJHC's ability to respond. Results were as follows:

1. Homelessness and Housing Instability
2. Behavioral Health
3. Economic Insecurity
4. Access to Health Care
5. Services for Seniors
6. Early Childhood Development
7. Food Insecurity
8. Chronic Diseases
9. Oral Health

## 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 CHNA will not be address and an explanation is provided below:

- Oral Health: This was identified as the lowest priority need in the 2019 CHNA. Furthermore, 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 a 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 nine prioritized health needs. Considered were the existing programs and resources that PSJHC has in place to address these needs and the landscape of community partners to collaborate with together.

PSJHC 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 Saint John's Health Center 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 Instability
- Economic 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
<p><b>1. CHW Homeless Navigators:</b> Hospital emergency department-based Community Health Workers that assist patients experiencing homelessness with discharge to shelter or homeless service providers</p>	<ul style="list-style-type: none"> <li>• Number of patients screened for homelessness</li> <li>• Number of Patients linked to homeless services provider</li> <li>• Number of patients discharged to temporary/permanent housing</li> </ul>	<ul style="list-style-type: none"> <li>• 660 patients screened for homelessness</li> <li>• 65 patients linked to homeless services provider</li> <li>• 105 patients discharged to temporary/permanent housing</li> </ul>	<ul style="list-style-type: none"> <li>• 700 patients screened for homelessness</li> <li>• 150 patients linked to homeless services provider</li> <li>• 100 patients discharged to temporary/permanent housing</li> </ul>	<ul style="list-style-type: none"> <li>• 10% increase in patients screened for homelessness as compared to 2021 target</li> <li>• 10% increase in patients linked to homeless service provider as compared to 2021 target</li> <li>• 10% increase in number of patients discharged to temporary/permanent housing as compared to 2021 target</li> </ul>
<p><b>2. Provide or facilitate funding to homeless service providers:</b> Bring financial support to local organizations either through directly awarding grants or by facilitating grant awards from external funders</p>	<ul style="list-style-type: none"> <li>• Funding directed towards local homeless service providers</li> </ul>	<ul style="list-style-type: none"> <li>• Total of \$200,000 awarded to two local homeless services organizations</li> </ul>	<ul style="list-style-type: none"> <li>• Maintain sources of sustainable funding for homeless service providers</li> </ul>	<ul style="list-style-type: none"> <li>• Maintain sources of sustainable funding for homeless service providers</li> <li>• Identify at least one collaborative funding opportunity from external funder</li> </ul>

<p><b>3. Recuperative Care:</b> Improve the infrastructure of available recuperative care/interim shelter for patients experiencing homelessness that are not medically stable enough to be discharged back to the streets</p>	<ul style="list-style-type: none"> <li>• Identify target population, Interventions and partners to support L.A. Service Area housing initiative</li> <li>• Support policies to increase temporary housing as a pathway to permanent supportive housing</li> </ul>	<p>No baseline. New program for 2020</p>	<ul style="list-style-type: none"> <li>• Partner with Stakeholders to complete landscape analysis related to recuperative care</li> <li>• Establish consensus among stakeholders as to the # of recuperative care beds in L.A. County</li> <li>• Identify gaps/improvements that would increase # recuperative care/ temporary housing beds for patients who are unsheltered</li> <li>• Partner with PSJH advocacy and other stakeholders to support policy changes that reimburse recuperative care/ temporary housing services for homeless</li> <li>• Increase support for local policies that ease construction/</li> </ul>	<ul style="list-style-type: none"> <li>• 2% baseline increase in # of temporary housing/ recuperative care beds available to PSJH patients in L.A. Service Area</li> <li>• Develop standards that define spectrum of temporary housing options for individuals experiencing homelessness that lead to permanent supportive housing</li> <li>• Increase scope of covered Medi-Cal benefits to include recuperative care</li> <li>• Increase number of recuperative care beds available to patients discharged from hospitals who do not have shelter</li> <li>• Partner with key stakeholders to</li> </ul>
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			remodeling regulations for temporary housing facilities, including case management/housing navigation services <ul style="list-style-type: none"> <li>Identify opportunities to leverage existing resources to support recuperative care/ temporary housing priorities</li> </ul>	increase # of recuperative care beds and related support services including housing navigation and case management services
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*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, Grant funding to homeless service providers

*Key Community Partners*

- The People Concern
- Saint Joseph Center
- Westside Coalition
- Safe Place for Youth
- City of Santa Monica
- Venice Family Clinic
- UniHealth Foundation
- Los Angeles Homeless Services Authority

## INITIATIVE #2: IMPROVE ACCESS TO HEALTH CARE SERVICES

### *Community Need Addressed*

- Access to Health Care
- Homelessness and Housing Instability
- Economic Insecurity

### *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 Health Care Services**

Strategies	Strategy Measure	Baseline	FY20 Target	FY22 Target
<b>1. Provide/facilitate funding and in-kind support for access to care to local community agencies</b>	<ul style="list-style-type: none"> <li>• Funding directed towards access to health care programs</li> </ul>	<ul style="list-style-type: none"> <li>• \$375,000 in grants to local organizations awarded for access to care in 2019</li> </ul>	<ul style="list-style-type: none"> <li>• Maintain sources of sustainable funding for access to care</li> </ul>	<ul style="list-style-type: none"> <li>• Maintain sources of sustainable funding for access to care</li> <li>• Identify at least one collaborative funding opportunity from external funder</li> </ul>
<b>2. Increase availability of testing and vaccinations for COVID-19 and Flu</b>	<ul style="list-style-type: none"> <li>• Number of flu shots provided</li> <li>• Number of COVID-19 testing locations established</li> </ul>	<ul style="list-style-type: none"> <li>• No baseline, new program for 2020</li> </ul>	<ul style="list-style-type: none"> <li>• Identify collaborative partnership with other health systems to increase access to COVID-19 testing and/or flu shots</li> </ul>	<ul style="list-style-type: none"> <li>• Target benchmarks to be determined based on identified collaborative project in 2020.</li> </ul>

### *Evidence Based Sources*

Benefits of Influenza Vaccination: Selected Publications <https://www.cdc.gov/flu/prevent/benefit-publications.htm>

### *Resource Commitment*

Grant funding to local organizations, in-kind labs and diagnostics to FQHCs

### *Key Community Partners*

- Venice Family Clinic
- Westside Family Health Center
- Saint Anne's School

## **INITIATIVE #3: IMPROVE ACCESS TO BEHAVIORAL HEALTH AND REDUCE STIGMA**

### *Community Need Addressed*

- Behavioral Health
- Early Childhood Development

### *Goal (Anticipated Impact)*

- Increased access to quality mental health services, especially for low income populations
- Increased awareness of trauma informed care
- Increased availability of maternal mental health programs and child abuse prevention programs

### *Scope (Target Population)*

The target population for direct services will be children and families who are underinsured or uninsured and have difficulty accessing quality mental health services. Our services will be targeting families who depend on public assistance and state funded medical insurance. Our Community Outreach Services will also include community partners such as local schools who work with the children from this marginalized population.

**Table 3. Strategies and Strategy Measures for Addressing Behavioral Health**

Strategies	Strategy Measure	Baseline	FY20 Target	FY22 Target
<p><b>1. Child and Family Development</b>  <b>Center:</b> Address Birth Trauma</p>	<ul style="list-style-type: none"> <li>• Number of clients referred to Post-Partum Support Groups</li> <li>• Number of clients referred to the Perinatal Support Meetings</li> <li>• Number of clients referred to Bringing Baby Home group</li> </ul>	<ul style="list-style-type: none"> <li>• 10 clients participating in a post-partum support group</li> </ul>	<ul style="list-style-type: none"> <li>• Establish the Bringing Home Baby Group</li> <li>• Establish the Peri-Natal Support meeting</li> </ul>	<ul style="list-style-type: none"> <li>• Have at least 10 clients in each of the three groups</li> </ul>
<p><b>2. Child and Family Development</b>  <b>Center:</b> Capacity building for local organizations through trauma informed trainings</p>	<ul style="list-style-type: none"> <li>• Number of in-service trainings provided to schools</li> <li>• Number of in-service trainings provided to after school care facilities</li> </ul>	<ul style="list-style-type: none"> <li>• 10 in-service trainings provided at schools</li> <li>• No baseline for after school care facilities. New for 2020.</li> </ul>	<ul style="list-style-type: none"> <li>• 12 in-service trainings at various schools</li> <li>• 2 in-service trainings at after school childcare facilities</li> </ul>	<ul style="list-style-type: none"> <li>• 16 in-service trainings at various schools</li> <li>• 4 in service trainings at after school childcare facilities</li> </ul>
<p><b>3. Child and Family Development</b>  <b>Center:</b> Provide programs that support the social emotional functioning of young children</p>	<ul style="list-style-type: none"> <li>• Conduct a trauma informed parenting group</li> <li>• Provide mental health education at local libraries</li> <li>• Provide Infant Massage groups in the community</li> </ul>	<ul style="list-style-type: none"> <li>• 1 mental health education sessions</li> <li>• Infant Massage in one on one setting only with clients</li> </ul>	<ul style="list-style-type: none"> <li>• Provide at least 1 trauma informed parenting groups</li> <li>• Provide at least 2 mental health education sessions in the community</li> <li>• Provide at least 1 Infant Massage group in the community</li> </ul>	<ul style="list-style-type: none"> <li>• Provide at least 2 trauma informed parenting groups</li> <li>• Provide at least 4 mental health education sessions in the community</li> <li>• Provide at least 2 Infant Massage groups in the community</li> </ul>

<p><b>4. Mental Health Education and Prevention:</b> Health Educators and CHWs paired together teach free community-based courses in English and Spanish on mental health awareness and coping skills</p>	<ul style="list-style-type: none"> <li>• Number of participants completing Mental Health First Aid (MHFA)</li> <li>• Number of participants completing Creating Healthier Attitudes Today (CHAT)</li> </ul>	<ul style="list-style-type: none"> <li>• No baseline, new program for 2020</li> </ul>	<ul style="list-style-type: none"> <li>• 140 people trained in Mental Health First Aid*</li> <li>• 50 people participate in Creating Healthier Attitudes Today*</li> </ul>	<ul style="list-style-type: none"> <li>• 10% increase in people trained in MHFA from 2021 baseline</li> <li>• 10% increase in CHAT participants from 2021 baseline</li> </ul>
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***\*Targets for FY20 were set prior to COVID-19 pandemic. The ability to achieve these objectives will be significantly impacted by COVID-19 and will need modification in 2021.***

*Evidence Based Sources*

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

*Resource Commitment*

- Operating support of Child and Family Development Center
- Awarded grant funding from the Well-Being Trust for mental health education programs

*Key Community Partners*

- Los Angeles County Department of Mental Health
- Los Angeles County Department of Children and Family Services
- Los Angeles County Home Visiting Consortium
- Santa Monica Malibu Unified School District
- Los Angeles Unified School District
- City of Santa Monica
- Santa Monica Public Library
- Well Baby Center
- Open Paths
- Joy in Birthing Foundation
- Allies for Every Child
- Maternal Mental Health Now

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

### *Community Need Addressed*

- Behavioral Health
- Economic Insecurity
- Food Insecurity
- Chronic Diseases
- Services for Seniors

### *Goal (Anticipated Impact)*

- Increase the number of Community Health Workers employed in health care settings in roles that address social determinants of health
- Reduce food insecurity
- Reduce the number of people that are 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
<p><b>1. CalFresh Enrollment Assistance :</b> CHWs provide outreach and one-on-one application assistance with CalFresh applications</p>	<p>Number of people enrolled in CalFresh</p>	<p>No baseline, new program for 2020.</p>	<p>100 people enrolled in CalFresh</p>	<p>20% increase from 2021 baseline in people enrolled in CalFresh</p>
<p><b>2. Health Education and Prevention Classes:</b> Health Educators and CHWs paired together teach free community based courses in English and Spanish on nutrition, mental health awareness, and coping skills</p>	<ul style="list-style-type: none"> <li>• Number of participants in FEAST</li> <li>• Number of people trained in Mental Health First Aid (MHFA)</li> <li>• Number of participants in Creating Healthier Attitudes Today</li> </ul>	<ul style="list-style-type: none"> <li>• 61 people participated in FEAST in 2019</li> <li>• No baseline for MHFA, new program for 2020</li> <li>• No baseline for CHAT, new program for 2020.</li> </ul>	<ul style="list-style-type: none"> <li>• 80 people will participate in the FEAST* program</li> <li>• 140 people trained in Mental Health First Aid*</li> <li>• 50 people participate in Creating Healthier Attitudes Today*</li> </ul>	<ul style="list-style-type: none"> <li>• 25% increase from 2021 baseline in FEAST participants</li> <li>• 10% increase from 2021 baseline in MHFA participants</li> <li>• 10% increase from 2021 baseline in CHAT participants</li> </ul>
<p><b>3. CHW Academy:</b> In collaboration with Charles Drew University, develop an academy for Community Health Workers that focus on integration into health care organizations</p>	<p>Number of CHW students who complete program</p>	<p>New program for 2020</p>	<ul style="list-style-type: none"> <li>• 20 CHW students enrolled in program</li> </ul>	<ul style="list-style-type: none"> <li>• 25% increase from 2021 in CHW students enrolled</li> <li>• Additional sustainable funding for CHW Academy identified and secured beyond pilot grant funding</li> </ul>

**\*Targets for FY20 were set prior to COVID-19 pandemic. The ability to achieve these objectives will be significantly impacted by COVID-19 and will need modification in 2021.**

#### *Evidence Based Sources*

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

- Funding for Providence employed Community Health Workers and supervisory staff
- Awarded grant funding from the Well-Being Trust for mental health education programs
- Awarded California Community Reinvestment Grant funding by the Governor’s Office of Business and Economic Development to create CHW Academy.

#### *Key Community Partners*

- Charles Drew University
- City of Santa Monica (Virginia Avenue Park)
- WISE & Healthy Aging
- Venice Family Clinic
- Mar Vista Family Center
- Santa Monica Boys and Girls Club



## 2020-2022 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted on April 29th, 2020 by the Saint John's Health Center Community Ministry Board.

DocuSigned by:



Michael Ricks

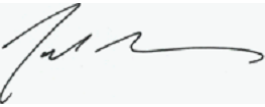
Chief Executive  
Providence Saint John's Health Center

DocuSigned by:



James H. Forryce

Chair, Community Ministry Board  
Providence Saint John's Health Center



Joel Gilbertson  
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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](mailto: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.