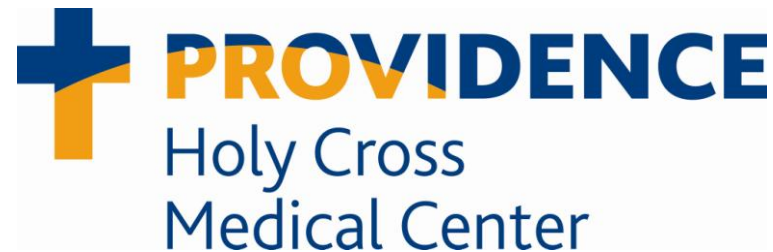




Providence Holy Cross Medical Center Community Benefit and Implementation Plan



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Executive Summary

In December 2013, Providence Holy Cross Medical Center (PHCMC) completed a comprehensive community health needs assessment of its service area. This assessment process was initiated back in November, 2012 and included a review of both primary and secondary data. Key informant interviews and focus groups were conducted along with surveys distributed to community stakeholders and residents. In addition, several community forums were conducted at faith-based institutions and schools in which surveys were done using an electronic automatic response system. Secondary data included information collected from the L.A. County Department of Public Health, Truven Analytics, U.S. Bureau of the Census, State of California, Department of Public Health, Local Police and Sheriff Crime Statistics, and Providence Holy Cross Medical Center CAMIS.

The area studied for the needs assessment included over 830,000 residents living in the central and northern portions of the San Fernando Valley and the Santa Clarita Valley. Sixteen communities were included in the assessment area.

While an extensive list of needs and issues were identified from the assessment, a prioritization process was developed that involved local community leaders to help identify the top issues. The priority needs/issues include:

- Expanded primary care capacity.
- Obesity prevention programs, including more community based nutrition and physical activity programs.
- Free, low-cost and culturally/language appropriate health education programs.
- Diabetes, heart disease and hypertension prevention and management programs.
- Affordable and accessible mental health services.

Overview of the Organization

Providence Holy Cross Medical Center (PHCMC) was founded in 1961 by the Sisters of the Holy Cross to serve a growing population in the northern San Fernando Valley. In 1996 the Medical Center was purchased by Providence Health and Services. The Medical Center is part of a nonprofit integrated health care system which operates six hospitals, post-acute care, outpatient services, a medical foundation, skilled nursing, and sub-acute care services to residents of Los Angeles County. Providence Health and Services has been serving the health care needs of the residents of the San Fernando Valley since 1943.

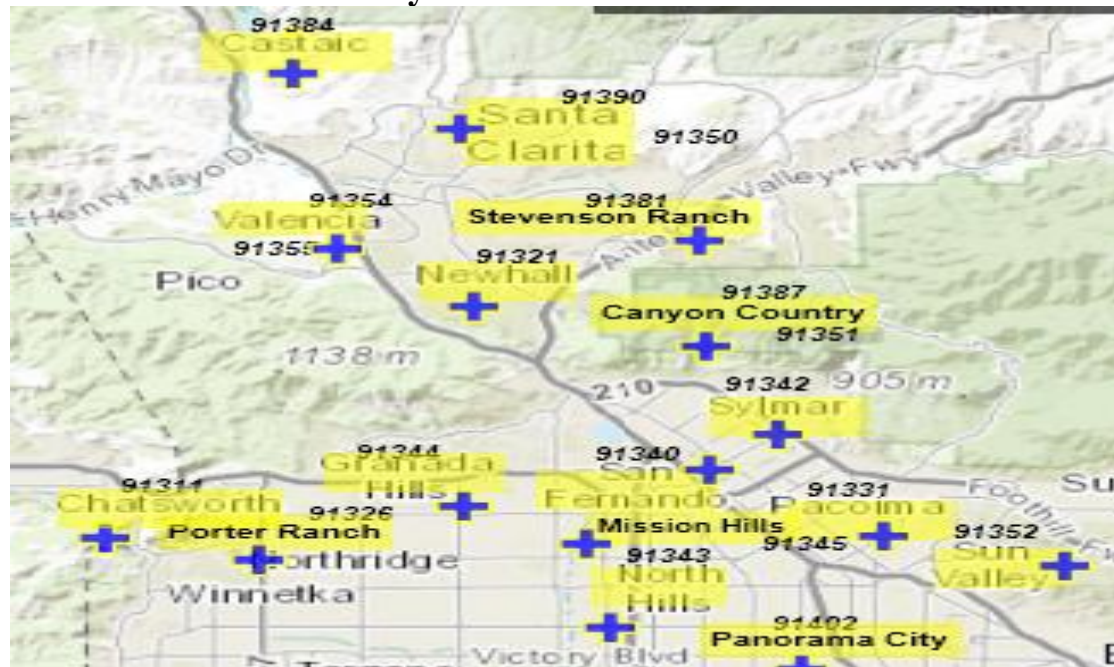
Providence Holy Cross Medical Center has expanded to a 377-bed hospital serving the health care needs of residents of the San Fernando, Santa Clarita, and Simi Valleys. The Medical Center offers a full continuum of health care, from inpatient and outpatient services to sub-acute care, health education, and community outreach programs which are focused on caring for the underserved in the community. PHCMC offers a state-of-the-art Cancer Center, a Heart Center, Orthopedics, Neurosciences, Rehabilitation Services, Women's and Children's Services, as well as providing the area with a Level II Trauma Center.

Definition of the Community

The area defined for the Providence Holy Cross Medical Center Community Needs Assessment included nineteen zip codes and sixteen communities. There are 830,822 persons who reside in the area and include both wealthy communities and areas with high levels of poverty and need. The communities studied for the community needs assessment included:

- | | |
|----------------------|------------------------|
| -91311 Chatsworth | -91350 Santa Clarita |
| -91321 Newhall | -91387 Canyon Country |
| -91326 Porter Ranch | -91351 Canyon Country |
| -91331 Pacoima | -91352 Sun Valley |
| -91340 San Fernando | -91354 Valencia |
| -91342 Sylmar | -91355 Valencia |
| -91343 North Hills | -91381 Stevenson Ranch |
| -91344 Granada Hills | -91384 Castaic |
| -91345 Mission Hills | -91402 Panorama City |
| -91390 Santa Clarita | |

PHCMC Community Health Needs Assessment Service Area



Key Findings From CHNA

Based on a review of both primary and secondary data, this section summarizes some of the key information on the PHCMC service area collected for the community needs assessment.

- Males make up 49.98% and females comprise 50.01% of the total population.
- A breakdown of the population of the area by age shows that 22.5% are between the ages of 0-14, 15.1% are 15-24 years, 29.1% are 25-44 years, 23.7% are 45-64 years, 8.2% are 65-84 years, and 1.4% are 85 and over.
- Within the area targeted for this needs assessment there were 11,300 births.
- The education level of the population 25 years and above showed that 25% of the residents did not graduate from high school and 25% have a four year college degree or graduate degree.
- A breakdown of the population of the area by race shows that 30.4% are Caucasian, 53.2% are Hispanic, 10.7% are Asian, 3.4% are African American, and 2.3% are other races.
- Approximately 56.2% of the population of the area noted that they speak a language other than English and 24.7% of the population noted that they speak English less than very well.
- Of the occupied housing units in the area studied for the needs assessment approximately 35% were rented and 65% were owned.
- Approximately 15.5% of the population of the area was uninsured.
- Of the two health districts that comprise the area studied for the needs assessment, 24.3% of adults 18+ years in the East Valley Health District and 13.9% in the San Fernando Health District reported no regular source of medical care.
- Approximately 23.9% of adults 18+ years in the East Valley Health District and 14.1% in the San Fernando Health District reported having poor/fair health status.
- Adults 18+ years who reported that they could not afford to see a doctor were 19.9% in the East Valley Health District and 9.4% in the San Fernando Health District.
- Children ages 3-17 years that were unable to afford dental care were 10.8% in the East Valley Health District and 12.8% in the San Fernando Health District.
- The percent of adults 18+ years unable to afford dental care were 35.2% in the East Valley Health District and 21.1% in the San Fernando Health District.
- The areas with the highest unemployment rate in the zip codes targeted for this study included 91340 (San Fernando) at 14.5%, 91402 (Panorama City) at 12.8% and 91331 (Pacoima) at 12.6%.
- The zip codes included in this study that had the highest percentage of children living in poverty included 91402 (Panorama City) at 26.7%, 91343 (North Hills) at 25.0%, and 91331 (Pacoima) at 22.8%.

- The areas studied for this assessment that had the highest percentage of seniors (65+) living in poverty included 91402 (Panorama City) at 15.2%, 91343 (North Hills) at 13.9%, and 91331 (Pacoima) at 13.6%.
- The East Valley Health District had 7.7% of the population 18+ years who are below 300% of the federal poverty level were homeless or living in a transitional living situation. In the San Fernando Health District the statistic was 10.1%.
- Within the are studied for this needs assessment there were five zip codes that had a Community Needs Index Score of 4.4 or greater (CNI scores close to 5 indicate areas with high needs). These zip codes included 91343 (North Hills) 4.8, 91402 (Panorama City) 4.6, 91331 (Pacoima) 4.6, 91352 (Sun Valley) 4.6, and 91340 (San Fernando) 4.4.
- The major illnesses/diseases present within the area defined for the PHCMC needs assessment included:
 - Hypertension
 - Low Back Pain
 - Arthritis
 - Sinusitis
 - Asthma
 - Depression and Anxiety
- The leading causes of death in the PHCMC community health needs assessment service area included:
 - Heart Disease (29.0%)
 - Cancer (25.3%)
 - Other Causes (15.4%)
 - Stroke/CVA (5.1%)
 - Alzheimer’s Disease (4.8%)
- Approximately 54.7% of adults (18+) in the East Valley Health District and 60.0% of adults in the San Fernando Health District are obese or overweight.
- Only 38.8% of children (age 6-17 years) in the East Valley Health District and 25.6% of children in the San Fernando Health District participate in at least one hour of physical activity seven days per week.
- The percent of children (age 0-17 years) who eat fast food at least once per week is 44.2 % in the East Valley Health District and 47.3% in the San Fernando Health District.
- The percent of adults (18+ years) who eat fast food at least once per week is 36.5% in the East Valley Health District and 34.6% in the San Fernando Health District.
- The percent of adults (18+ years) who eat at least five or more servings of fruits and vegetables per day is only 18.8% in the East Valley Health District and 16.8% in the San Fernando Health District.

Community Needs

Following are the major needs and issues identified through the collection of secondary data and primary data collection including surveys and interviews with community stakeholders and residents.

- Access to affordable primary and specialty care
- Access to affordable dental care
- Access to affordable mental health services
- Obesity prevention
- Safe neighborhoods
- Accessible physical activity programs
- Nutrition education and affordable healthy food options
- Affordable health insurance for adults
- Community case management and resource referral
- Heart disease screening and prevention
- Cancer screening and prevention
- Diabetes prevention and management
- Hypertension prevention and management
- Asthma prevention and management
- Affordable housing and transitional housing
- Substance abuse treatment programs
- Affordable services for a growing senior population
- Free and low cost health education programs
- Teen pregnancy prevention
- Sexually Transmitted Disease prevention
- Stress management programs
- Caregiver resources and support
- Free/low cost health screening services (e.g. mammograms, colonoscopies, etc.)
- Back injury prevention
- Affordable child care and adult day care
- Parenting resources for new parents and grandparents raising grandchildren
- Coordination of existing programs and services
- Expanded primary care capacity
- Culturally and language appropriate health services

Status of 2013 Community Benefit Strategies and Metrics

Providence Holy Cross Medical Center works collaboratively with other organizations and community stakeholders to address the unmet health needs in the area. The Medical Center has identified specific multi-year community benefit strategies to direct its resources and the following table provides an update on progress made over the past year in meeting them.

Community Benefit Strategy	Measurable Metrics	Status Update
<p>Improve access to health and mental health services and coverage to those who are uninsured or underinsured in the community.</p>	<ul style="list-style-type: none"> -Increase the number of uninsured patients linked to medical homes and insurance. -Expand access to counseling services. -Expand specialty care network in the Access to Care Program. 	<ul style="list-style-type: none"> -In 2013 there were 4,596 persons assisted in getting linked with a medical provider. -The Latino Health Promoter Program assisted 47 persons in getting enrolled in insurance coverage. -The Latino Health Promoter Program assisted 1,414 persons in getting linked with mental health resources in the community. -Added five new specialists to the Providence Access to Care referral network.
<p>Expand number of education topics and classes in the community to assist people in changing behaviors and living healthier lifestyles.</p>	<ul style="list-style-type: none"> -Increase health education topics and class locations. -Complete training of outreach staff in the new insurance options with the ACA. -Train more Senior Peer Counselors. -Increase internship opportunities. 	<ul style="list-style-type: none"> -Added two new school sites to provide health education workshops through the parent centers. -Eleven staff completed training for Covered California. -Completed training with 13 new Senior Peer Counselors. -Internship opportunities provided to 41 nursing, health administration and allied health students.
<p>Improve disease management outreach efforts especially targeted towards diabetes, hypertension, and obesity.</p>	<ul style="list-style-type: none"> -Increase community based support groups. -Increase diabetes and hypertension outreach efforts. 	<ul style="list-style-type: none"> -Added a new church site to provide a diabetes support group. -Provided 4,725 glucose screenings in the community. -Latino Health Promoters provided blood pressure screenings to 738 persons.

Community Benefit Strategy	Measurable Metrics	Status Update
<p>Expand the number of disease prevention and health promotion programs/activities in the community.</p>	<ul style="list-style-type: none"> -Partner with Providence Medical Institute/Facey to expand the number served at health fairs and screenings. -Expand catchment area and resources provided to Tattoo Removal clients. -Expand outreach to at risk seniors needing supportive services. -Develop partnerships to promote healthy eating in the community. -Improve activity and better nutrition among at risk youth and their families. 	<ul style="list-style-type: none"> -Partnered with Facey to provide a community health fair in October in which over 500 people participated. -Expanded Tattoo Removal Program catchment area to all of L.A. County. -Tattoo Removal staff member completed Gang Intervention Specialist Training. -Received 385 new client intakes in the Volunteers for Seniors Program. -Received NEOP grant to work with 18 churches in the area on better nutrition. -Added two new schools to the School Nurse Outreach Program, serving 410 additional students. -Supported a Physical Education Specialist at three elementary schools serving low income families.

Priority Needs

Based on a review of the primary and secondary data collected as part of the community needs assessment process, a group of community stakeholders (both within and outside the organization) were invited to review these needs to help the medical center identify the priority issues. Although Providence Holy Cross Medical Center is not able to address all the needs identified in this assessment process, the organization is focused on those needs/issues where it can bring its expertise and resources to make the best impact on serving the community. PHCMC partners with other organizations in the community and provides financial and in-kind resources to address community needs that are not included on the list of priorities.

The key needs/issues identified through the assessment and prioritization process include the following (listed in priority order):

- Expanded primary care capacity.
- Obesity prevention programs, including more community based nutrition and physical activity programs.
- Free, low-cost and culturally/language appropriate health education programs.
- Diabetes, heart disease and hypertension prevention and management programs.
- Affordable and accessible mental health services.

The table on the next page identifies the key strategies and measurable metrics that will be targeted to address these needs/issues within the PHCMC community.

**Providence Holy Cross Medical Center
Community Benefit Implementation Strategies and Metrics**

Priority Needs	Implementation Strategy	Measurable Metrics
Expanded primary care capacity	<ul style="list-style-type: none"> -Implement the Providence Mobile Chronic Disease Clinic. -Expand the number of physician specialists collaborating with the Providence Access to Care Program. -Work with area FQHC and other clinics to provide primary care medical homes to uninsured patients in the community. -Link uninsured in the community with expanded Medi-Cal and Covered California coverage. 	<ul style="list-style-type: none"> -Purchase mobile vehicle and hire mobile outreach clinic staff within the first six months. -Provide 250 clinic visits in the first twelve months the mobile unit is treating patients within in the PHCMC service area. - Add two new specialists to the Providence Access to Care referral network from the PHCMC medical staff. - Link six hundred uninsured patients utilizing the PHCMC E.D. with primary medical homes and/or insurance coverage over the next twelve months.
Obesity prevention programs including more community based nutrition and physical activity programs	<ul style="list-style-type: none"> -Implement the Nutrition Education and Obesity Project in partnership with the Valley Care Community Consortium and local faith communities. 	<ul style="list-style-type: none"> -Implement NEOP at six churches within the PHCMC service area over the next twelve months.
Free, low-cost and culturally/language appropriate health education programs	<ul style="list-style-type: none"> -Recruit and train additional volunteer health promoters from the community. -Take leadership in continuing the Santa Clarita Valley Healthy Community Coalition to identify health program and service gaps in area. 	<ul style="list-style-type: none"> -Schedule a health promoter training with the target of having 15 new health promoters trained by the end of 2014. -Schedule first meeting of the SCV Healthy Community Coalition by the end of Spring 2014.
Diabetes, heart disease and hypertension prevention and management programs	<ul style="list-style-type: none"> -Implement community based support groups and disease prevention classes at six new locations within the PHCMC service area. 	<ul style="list-style-type: none"> -Have a minimum of 250 people participating in the support groups and classes within 12 months from implementation.

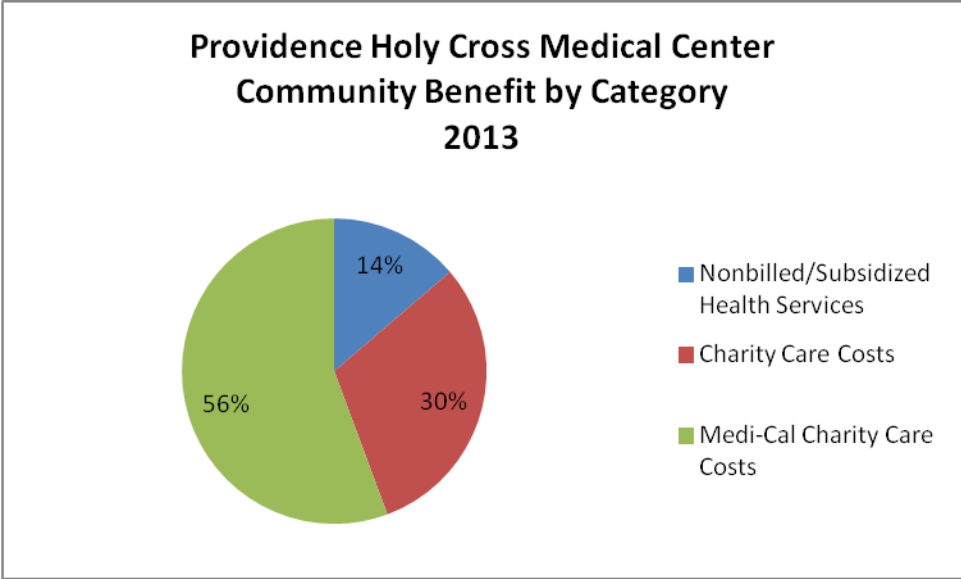
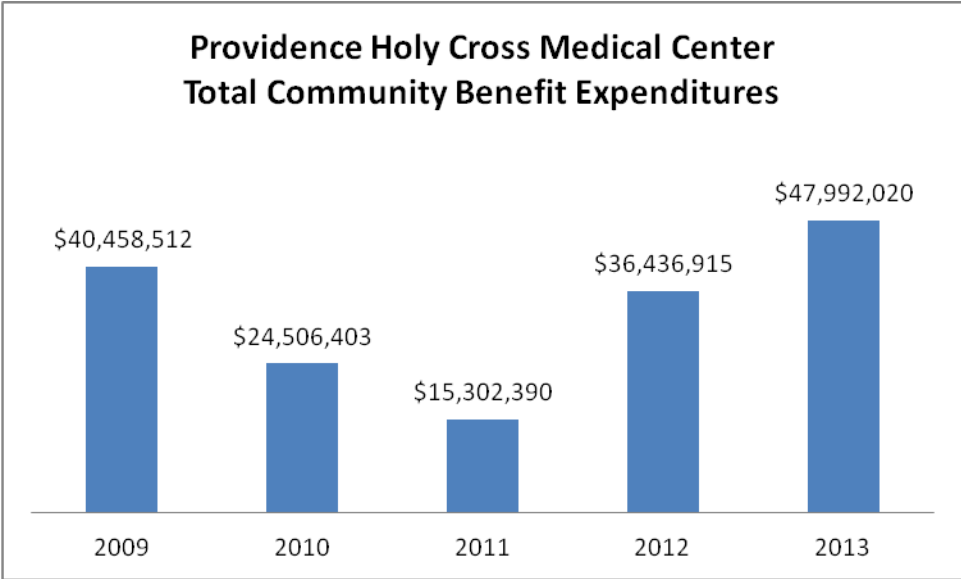
Priority Needs	Implementation Strategy	Measurable Metrics
Affordable and accessible mental health services.	-Continue to focus on the mental health outreach project with Tarzana Treatment Centers. - Work with the South Bay and Valley Medical Centers to implement a project to reduce the utilization of the E.D. by patients with psychiatric issues.	-Link 2,250 individuals with mental health resources and education over the next 12 months. -Pilot project with 20 high E.D. utilization patients from PHCMC to provide targeted mental health interventions over the next twelve months.

Inventory and Economic Value of Community Benefit Programs/Services for 2013

The table on the following pages provides an accounting of all the community benefit programs, activities and services provided by Providence Holy Cross Medical Center in 2013. Combined the facility provided unsponsored community benefits totaling over \$47.9 million in 2013 which served 84,470 people. As the graph shows on the following page, the dollars expended on community benefit by the Medical Center have represented a significant contribution over the last five years. The focus of these community benefit programs includes services provided for the general community such as health screenings, educational lectures, support groups, information/referral, and health fairs. Services are also targeted to the poor and vulnerable populations including the Senior Outreach Program, Mary Potter Program for Human Dignity (charity care), Latino Health Promoter Program, Faith Community Health Partnership Program, Access to Care Program, Tattoo Removal Program, and School Nurse Outreach Program. The programs serve all ages within the community from children to seniors.

Through these different programs, Providence Holy Cross Medical Center seeks feedback from those being served (i.e. client satisfaction surveys, customer questionnaires, interviews, etc.) to ensure that we are addressing the health care needs of importance to the community. This feedback from clients is used to help us improve the programs and services that we offer the community. In addition, the impact that these programs are making on the populations being served is also monitored to ensure that the organization's outreach efforts are having a positive impact on the health of our community. The complete listing of all of the programs and services provided to the community by the Medical Center in 2013 is included on the following pages.

A breakdown of the community benefit dollars provided by Providence Holy Cross Medical Center in 2013 shows that 56% was from the unpaid costs of Medi-Cal, 30% from the unpaid costs of charity care, and 14% from non-billed/free and subsidized health programs.



**Providence Holy Cross Medical Center
Community Benefit Program and Services
For period from 1/1/2013 through 12/31/2013**

Community Benefit Activity/Program	Type of Benefit	# Served	Economic Value	Calculation of the Economic Value
Charity Care	Medical Care Services	5,366	\$14,678,985	Unpaid costs of providing care based on a ratio of costs to charges calculation
Medi-Cal/Medicaid Charity Costs	Medical Care Services	49,556	26,718,784	Unpaid costs of providing care based on a ratio of costs to charges calculation
Physical Therapy Participation in Community Events	Other Quantifiable Benefits	20	346	Salary cost of staff
Tattoo Removal Program	Other Benefits for Vulnerable Populations	1,029	185,972	Salary and other operating expenses
Pharmacy Outreach for Uninsured Patients	Medical Care Services	33	5,163	Salary and supply expenses
Latino Health Promoters	Other Benefits for the Broader Community	5,022	382,178	Salary and other operating expenses
Student Nursing Preceptors and Training	Other Quantifiable Benefits	74	818,519	Salary cost of staff
Parish Nurse Partnership	Other Benefits for the Broader Community	7,740	204,695	Salary and other operating expenses
Health Resource Center	Other Benefits for the Broader Community	144	57,940	Salary and other operating expenses
MEND Public Relations Committee	Other Quantifiable Benefits	1	6,321	Salary cost of staff
Clinical Pastoral Education Program	Other Quantifiable Benefits	2	130,330	Salary and other operating expenses
Paramedic Base Station	Medical Care Services	8,048	475,431	Salary and other operating expenses
Medical Library Services for the Community	Other Benefits for the Broader Community	113	16,016	Salary cost of staff
School Nurse Outreach Program	Other Benefits for the Broader Community	1,768	100,192	Salary and other operating expenses
Unreimbursed Psychiatric Care	Medical Care Svcs.	45	129,550	Unpaid costs of providing care

Community Benefit Activity/Program	Type of Benefit	# Served	Economic Value	Calculation of the Economic Value
Training for Physical Therapy Students	Other Benefits for the Broader Community	4	99,108	Salary cost of staff
Physical Therapy Facilitation of Support Groups	Other Quantifiable Benefits	10	329	Salary cost of staff
Donations to Community Organizations, Fundraisers and Events	Other Benefits for the Broader Community	39	50,720	Monetary Donation
Occupational Therapy Support Groups	Other Benefits for the Broader Community	40	1,401	Salary cost of staff
Mission Fund for Community Benefit and Access to Care	Other Benefits for the Broader Community	7	142,946	Monetary Donation
Maternal Child Outreach and Education Maternal Child Education	Other Quantifiable Benefits	179	167,537	Salary cost of staff
Speech Therapy Participation & Facilitation of Support Groups	Other Quantifiable Benefits	61	507	Salary cost of staff
Center for Community health Improvement	Other Benefits for the Broader Community	12	201,544	Salary and other operating expenses
Senior Outreach Program	Other Benefits for the Broader Community	192	67,043	Salary and other operating expenses
Providence Access to Care	Other Quantifiable Benefits	4,596	240,825	Salary and operating expenses
Preceptoring Moorpark College Imaging Students Clinical Education	Other Quantifiable Benefits	7	12,264	Salary cost of staff
Trauma Program Physician Fees Emergency Dept	Medical Care Services	362	3,097,374	Other operating expenses
Total PHCMC Community Benefit		84,470	\$47,992,020	
Unpaid Costs of Medicare			\$17,809,895	Unpaid costs of providing care based on a ratio of costs to charges calculation
Total PHCMC Community Benefit with Medicare			\$65,801,915	