



# **Providence Saint Joseph Medical Center Community Benefit and Implementation Plan**



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## **Executive Summary**

In December 2013, Providence Saint Joseph Medical Center (PSJMC) 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 Saint Joseph Medical Center CAMIS.

The area studied for the needs assessment included over 702,000 residents living in the eastern and central portions of the San Fernando Valley. Twelve 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:

- Affordable and expanded services for a growing senior population.
- Access to affordable primary and specialty care.
- Expanded primary care capacity especially with more people obtaining coverage.
- Access to affordable mental health services.
- Coordination of existing programs and services.
- Heart disease, cancer, hypertension, and diabetes screening and prevention programs.

## **Overview of the Organization**

Providence Saint Joseph Medical Center (PSJMC) was founded in 1943 by the Sisters of Providence to serve a growing population in the San Fernando Valley. Starting from a small 100-bed facility, the Medical Center has grown over the years to become a major health care facility serving the residents of Northern Los Angeles County. The Medical Center is part of a non-profit 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.

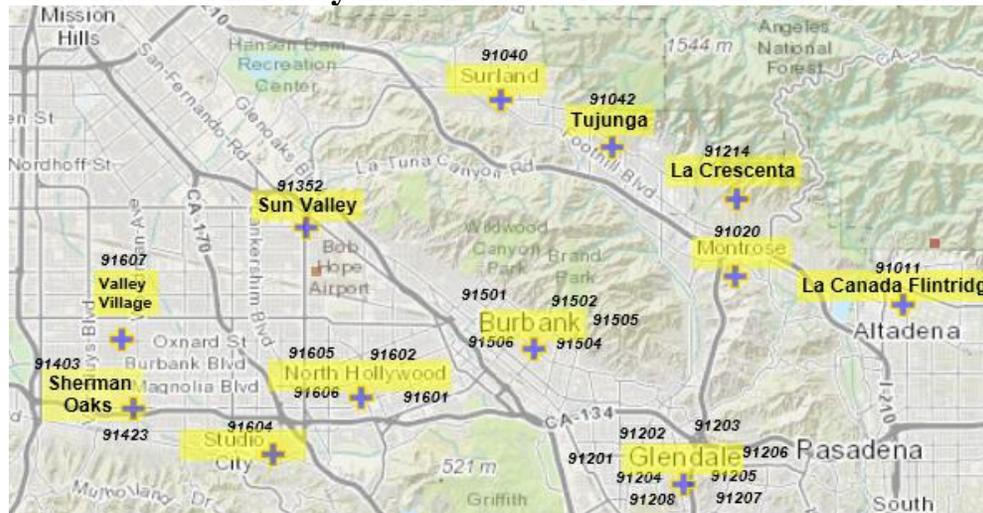
Providence Saint Joseph Medical Center has expanded over the years to become a 446-bed licensed acute care facility. The Medical Center offers a full continuum of health care, from inpatient and outpatient services to home health care, health education and community outreach programs which are focused on caring for the under-served in the community. PSJMC is known for its state-of-the-art technology and high quality, compassionate care.

## Definition of the Community

The community defined for the Providence Saint Joseph Medical Center Community Needs Assessment included twenty-seven zip codes and twelve communities. There are 702,328 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:

- 91011 La Canada Flintridge
- 91020 Montrose
- 91040 Sunland
- 91042 Tujunga
- 91201 Glendale
- 91202 Glendale
- 91203 Glendale
- 91204 Glendale
- 91205 Glendale
- 91206 Glendale
- 91207 Glendale
- 91208 Glendale
- 91214 La Crescenta
- 91352 Sun Valley
- 91403 Sherman Oaks
- 91423 Sherman Oaks
- 91501 Burbank
- 91502 Burbank
- 91504 Burbank
- 91505 Burbank
- 91506 Burbank
- 91604 Studio City
- 91601 North Hollywood
- 91602 North Hollywood
- 91605 North Hollywood
- 91606 North Hollywood
- 91607 Valley Village

### PSJMC 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 PSJMC service area studied for the community needs assessment.

- Males make up 49.2% and females comprise 50.8% of the total population.
- A breakdown of the population of the area by age shows that 17.8% are between the ages of 0-14, 12.3% are 15-24 years, 30.6% are 25-44 years, 27.1% are 45-64 years, 10.3% are 65-84 years, and 1.9% are 85 and over.
- Within the area targeted for this needs assessment there were 7,758 births.
- The education level of the population 25 years and above showed that 16% of the residents did not graduate from high school and 37% have a four year college degree or graduate degree.
- A breakdown of the population of the area by race shows that 53.8% are Caucasian, 29.1% are Hispanic, 11.5% are Asian, 2.7% are African American, and 2.9% are other races.
- Approximately 55.9% of the population of the area noted that they speak a language other than English and 26.7% 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 57% were rented and 43% were owned.
- Approximately 21.9% 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 27.9% in the Glendale Health District reported no regular source of medical care.
- Approximately 23.9% of adults 18+ years in the East Valley Health District and 15.9% in the Glendale 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 25.5% in the Glendale Health District.
- Children ages 3-17 years that were unable to afford dental care were 10.8% in the East Valley Health District and 6.9% in the Glendale Health District.
- The percent of adults 18+ years unable to afford dental care were 35.2% in the East Valley Health District and 33.0% in the Glendale Health District.
- The areas with the highest unemployment rate in the zip codes targeted for this study included 91204 (Glendale) at 15.7%, 91605 (North Hollywood) at 14.6% and 91606 (North Hollywood) at 14.3%.
- The zip codes included in this study that had the highest percentage of children living in poverty included 91204 (Glendale) at 32.6%, 91203 (Glendale) at 26.9%, and 91205 (Glendale) at 26.4%.

- The areas studied for this assessment that had the highest percentage of seniors (65+) living in poverty included 91205 (Glendale) at 38.4%, 91204 (Glendale) at 27.8%, and 91505 (Burbank) at 21.8%.
- 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.
- Within the area 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 91606 (North Hollywood) 4.8, 91605 (North Hollywood) 4.6, 91352 (Sun Valley) 4.6, 91204 (Glendale) 4.6, and 91502 (Burbank) 4.4.
- The major illnesses/diseases present within the area defined for the PSJMC needs assessment included:
  - Hypertension
  - Low Back Pain
  - Arthritis
  - Sinusitis
  - Depression and Anxiety
- The leading causes of death in the PSJMC community health needs assessment service area included:
  - Heart Disease (29.1%)
  - Cancer (24.8%)
  - Other Causes (15.3%)
  - Stroke/CVA (5.9%)
  - Chronic Lower Respiratory Disease (5.1%)
  - Alzheimer's Disease (5.0%)
- Approximately 54.7% of adults (18+) in the East Valley Health District and 56.1% of adults in the Glendale Health District are obese or overweight.
- Only 38.8% of children (age 6-17 years) in the East Valley Health District and 29.8% of children in the Glendale 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 39.6% in the Glendale 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 36.7% in the Glendale 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 13.5% in the Glendale 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/violence reduction
- 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
- Affordable and expanded services for a growing senior population
- Free and low cost health education programs
- Culturally and language appropriate health services
- Affordable screening and treatment for those with hearing problems
- 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
- Parenting resources for new parents and grandparents raising grandchildren
- Coordination of existing programs and services
- Underutilized services in the community
- Expanded primary care capacity
- Dementia/Alzheimer's screening and education

## Status of 2013 Community Benefit Strategies and Metrics

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

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

## 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 Saint Joseph 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. PSJMC 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):

- Affordable and expanded services for a growing senior population.
- Access to affordable primary and specialty care.
- Expanded primary care capacity.
- Access to affordable mental health services.
- Coordination of existing programs and services that are culturally and language appropriate.
- Heart disease, hypertension, diabetes, and cancer screening and prevention programs.

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

**Providence Saint Joseph Medical Center  
Community Benefit Implementation Strategies and Metrics**

Priority Needs	Implementation Strategy	Measurable Metrics
Affordable and expanded services for a growing senior population.	-Increase the number of volunteers in the Senior Peer Counseling and Volunteers for Seniors Program.	- In the next twelve months add ten new volunteers to the Volunteers for Seniors Program. -In the next twelve months recruit and train eight new volunteers to the Senior Peer Counseling Program.
Access to affordable primary and specialty care.	-Implement the Providence Mobile Chronic Disease Clinic. -Expand the number of physician specialists collaborating with the Providence Access to Care Program.	-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 PSJMC service area. - Add two new specialists to the Providence Access to Care referral network from the PSJMC medical staff.
Expanded primary care capacity.	-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 Calif.	- Link six hundred uninsured patients utilizing the PSJMC E.D. with primary medical homes and/or insurance coverage over the next twelve months.
Access to affordable 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 PSJMC to provide targeted mental health interventions over the next twelve months.
Coordination of existing programs and services that are culture/language appropriate.	-Implement a healthy community planning committee within Burbank.	- By Fall 2014 form a healthy community committee with key stakeholders and city representatives focused on health and wellness issues within the Burbank area.

Priority Needs	Implementation Strategy	Measurable Metrics
Heart disease, diabetes, hypertension, and cancer screening and prevention programs.	-Implement the Nutrition Education and Obesity Project in partnership with the Valley Care Community Consortium and local faith communities.	-Implement NEOP at two churches within the PSJMC service area over the next twelve months.

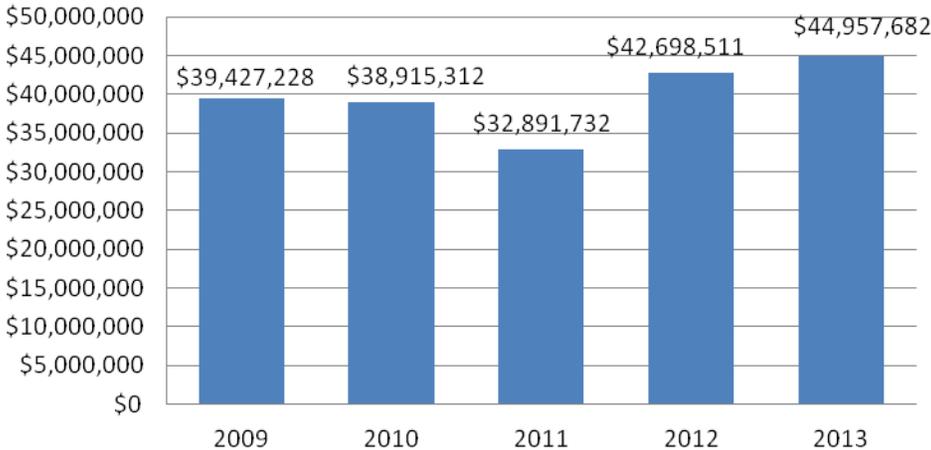
## **Inventory and Economic Value of Community Benefit Programs/Services for 2013**

The table on the following pages provides an accounting of all the community benefit programs, activities and services provided by Providence Saint Joseph Medical Center in 2013. Combined the facility provided unsponsored community benefits totaling over \$44.9 million in 2013 which served 50,706 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 and School Nurse Outreach Program. The programs serve all ages within the community from children to seniors.

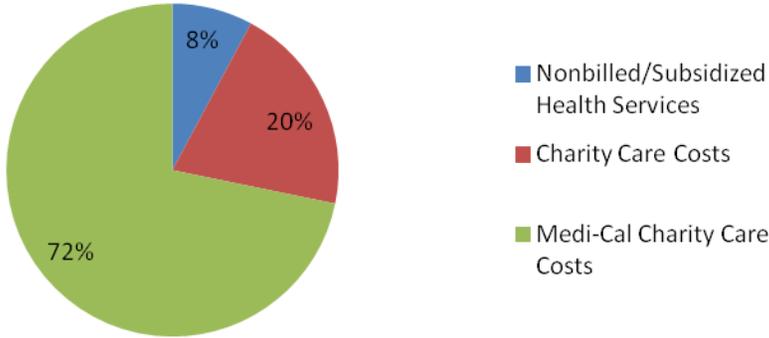
Through these different programs, Providence Saint Joseph Medical Center seeks feedback from those being served (i.e. client satisfaction surveys, customer questionnaires, interviews, etc.) to ensure that we are addressing the health care needs of importance to the community. This feedback from clients 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 Saint Joseph Medical Center in 2013 shows that 72% was from the unpaid costs of Medi-Cal, 20% from the unpaid costs of charity care, and 8% from non-billed/free and subsidized health programs.

**Providence Saint Joseph Medical Center  
Total Community Benefit Expenditures**



**Providence Saint Joseph Medical Center  
Community Benefit by Category  
2013**



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

<b>Community Benefit Activity/Program</b>	<b>Type of Benefit</b>	<b># Served</b>	<b>Economic Value</b>	<b>Calculation of the Economic Value</b>
Charity Care Cost	Medical Care Services	4,346	\$9,164,645	Unpaid cost of providing care based on ratio of costs to charges calculation
Medi-Cal/Medicaid Charity Cost	Medical Care Services	21,571	32,271,797	Unpaid cost of providing care based on ratio of costs to charges calculation
Center for Community Health Improvement	Other Benefits for the Broader Community	12	195,938	Salary cost and other operating expenses
Home Health Services to Low Income and Uninsured Patients	Medical Care Services	213	373,761	Salary and supply expenses
Clinical Pastoral Education Program	Other Quantifiable Benefits	3	107,313	Salary cost of staff
Christmas Meal Donation	Other Quantifiable Benefits	55	571	Salary and supply expenses
Provide Discharge Medication for Uninsured Patients	Medical Care Services	467	91,173	Salary and supply expenses
Faith Community Health Partnership	Other Benefits for the Broader Community	3,870	159,962	Other operating expenses
Health Resource Center	Other Quantifiable Benefits	371	46,705	Salary cost of staff
Latino Health Promoter Program Expenses	Other Benefits for the Broader Community	2,508	97,162	Salary cost of staff
Maternal Child Outreach and Education	Other Quantifiable Benefits	392	150,771	Salary cost of staff
Medical Library	Other Quantifiable Benefits	90	32,256	Salary cost of staff
Distribution of Dinner and Comfort Kits at Homeless Shelter	Other Quantifiable Benefits	40	1,552	In-Kind Donation
Mission Fund for Community Benefit and Access to Care	Other Benefits for the Broader Community	8	165,640	Monetary donation
Donation of Lunches and Food Items	Other Quantifiable	2	1,276	In-Kind Donation

<b>Community Benefit Activity/Program</b>	<b>Type of Benefit</b>	<b># Served</b>	<b>Economic Value</b>	<b>Calculation of the Economic Value</b>
to Community Organizations	Benefits			
Paramedic Base Station	Medical Care Services	9,033	350,864	Salary and supply expenses
Beyond 50 Program	Other Benefits for the Broader Community	436	1,505	Salary and other operating expenses
Samuel Dixon Clinic Partnership for Laboratory Services	Medical Care Services	3,447	20,259	Salary and other operating expenses
Patient Transportation Program	Other Benefits for the Broader Community	706	89,682	Other operating expenses
Senior Outreach Program	Other Benefits for the Broader Community	384	133,112	Salary and supply expenses
Student Nurse Preceptorship and Mentoring	Other Quantifiable Benefits	101	859,464	Salary cost of staff
Support of Community Events and Fundraisers	Other Quantifiable Benefits	34	42,770	Monetary donation
School Nurse Outreach Program	Other Benefits for the Broader Community	880	77,263	Salary and other operating expenses
Unreimbursed Psychiatric Care	Medical Care Services	118	337,150	Unpaid costs of providing care
Supervision and Preceptor Dietetic Interns	Other Quantifiable Benefits	3	33,843	Salary cost of staff
Speech Therapy Lecture to Community Groups	Other Benefits for the Broader Community	130	1,248	Salary cost of staff
Support for Leeza's Care Connection	Other Benefits for the Broader Community	1,486	150,000	Monetary and In-Kind Donation
<b>Total PSJMC Community Benefit</b>		<b>50,706</b>	<b>\$44,957,682</b>	
Unpaid Costs of Medicare			\$27,104,540	Unpaid costs of providing care based on ratio of costs to charges calculation
Total PSJMC Community Benefit with Medicare			\$72,062,222	