California Hospital Medical Center

2019 Community Health Implementation Strategy

Adopted October 2019

Dignity Health.
California Hospital
Medical Center

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At-a-Glance Summary

Community Served

CHMC is located in a federally designated Medically Underserved Area and serves a Medically Underserved Population (MUA/P ID #04011) (Census tract 2240.10). While CHMC is located in Service Planning Area (SPA) 4 or Metro Los Angeles, its service area also includes parts of SPA 6 (South), SPA 7 (East) and SPA 8 (South Bay). CHMC serves 1,576,013 racially diverse residents with a median income of $40,705. 8% of adults in the hospital's service area are homeless; the service area includes Skid Row that has the largest concentration of homeless in LA County.

Significant Community Health Needs Being Addressed

The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are:

1. Housing & homelessness
2. Access to health care
3. Mental health
4. Chronic diseases
5. Economic insecurity
6. Substance use and misuse
7. Food insecurity
8. Education
9. Preventive practices
10. Birth indicators

Strategies and Programs to Address Needs

The hospital intends to take several actions and to dedicate resources to these needs, including:

- Programming offered through the Hope Street Margolis Family Center including Early Head Start Program (EHS), EHS-Childcare Partnership, four licensed early care and education centers, the Family Childcare Network, the Hope Street Youth Center, Youth Fitness Program, Family Literacy Program, Pico Union Family Preservation Program, Wraparound Services Program, Early Intervention Program, and CA Behavioral Health Clinic
- LA Best Babies Network's perinatal and early childhood home visitation programs including Welcome Baby, Healthy Families America and Parents as Teachers and the LA Perinatal and Early Childhood Home Visitation Consortium
- *Para Su Salud*, health insurance enrollment and outreach program
- Health Ministry screening and health education programs
  - Chronic Disease Self-Management Program
  - Diabetes Empowerment Education Program
  - Healthy Eating and Lifestyle Program (H.E.L.P.)
  - Heart HELP
- Coordinated Care Initiative
- Transition to Wellness Project for Homeless Patients with Behavioral Health Issues
- Family Medicine Residency Program
- The COPE Health Scholars Program
- UniHealth Cultural Trauma and Mental Health Resiliency Project

	• CA Bridge Program in ED • Dignity Health Community Grant-funded projects, including 10th Decile Project, Zahn Memorial Center and Lily's Place for Homeless Families, and Mental Health Support for Women with Histories of Homelessness at Downtown Women's Center.
Anticipated Impact 	• Increased access to permanent affordable or supportive housing for homeless individuals and families • Increased access to physical and behavioral health, and dental care and other social services, i.e., WIC, CalFresh, etc. • Increased community awareness of how to identify children, youth, and adults in mental distress and get them the help they need; increased access to mental health services; early identification and treatment of women with perinatal mood and anxiety disorders thereby improving the developmental trajectory of their infants/toddlers and older children; youth and adults will learn healthy coping skills • Early identification and treatment of risk factors for cardiovascular disease thereby decreasing the rate of heart disease and stroke; early identification and treatment of obesity/overweight in children ages 5-12 yr; early identification and treatment of pre-diabetes thereby preventing or postponing the onset of diabetes; increased knowledge about the importance of healthy cooking and eating and maintaining a healthy lifestyle; better understanding of their chronic disease and how to manage it in order to prevent complications • Increased access to quality childcare thereby enabling parents to further their education or work • Increased access to MAT in our ED; decreased risk of opioid overdose by providing free Naloxone to friends and family of those with opioid use disorder; increased access to drug treatment • Improved school readiness; improved success in elementary, middle, and high school; improved college readiness; greater likelihood of pursuing higher education; improved health literacy
Planned Collaboration 	The Hope Street Margolis Family Center has over 30 community partners. LA Best Babies Network works with 14 hospitals and over 38 community partners The Health Ministry Program works with over 30 schools, churches, and other community sites. Coordinated Care Initiative has 8 project partners. UniHealth Cultural Trauma and Mental Health Resiliency Project involves the 6 Dignity Health hospitals in Southern CA and their community partners. CHMC is also involved in the following community-wide collaboratives: • LA County Community Health Assessment and Action Partnership • Women's Health Policy Council for the LA County Office of Women's Health • LA County Diabetes Prevention Community Advisory Board

This document is publicly available online at www.chmcla.org.

Written comments on this report can be submitted to the CHMC's COMMUNITY HEALTH OFFICE, 1401 S. Grand Ave., Los Angeles, CA 90015 or by e-mail to m.l.yonekura@dignityhealth.org.

Our Hospital and the Community Served

About California Hospital Medical Center

California Hospital Medical Center is a member of Dignity Health, which is a part of CommonSpirit Health.

California Hospital Medical Center (CHMC), founded in 1887, is located at 1401 S. Grand Avenue, Los Angeles, CA 90015. It became a member of Dignity Health in 2004. The facility has 318 licensed beds, and began construction on a new patient tower in early 2019. CHMC has a staff of more than 1800 and professional relationships with more than 400 local physicians. Major programs and services include: emergency and trauma services, women's health, obstetrics, neonatal intensive care, pediatrics, medical/surgical services, cardiac care, stroke care, critical care, orthopedics, and cancer care.

Our Mission

We are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

- Delivering compassionate, high-quality, affordable health services;
- Serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community to improve the quality of life.

Financial Assistance for Medically Necessary Care

California Hospital Medical Center delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services. The financial assistance policy and a plain language summary and other materials are on the hospital's web site.

Description of the Community Served

California Hospital Medical Center (CHMC) is located in a federally designated Medically Underserved Area and serves a Medically Underserved Population (MUA/P ID #04011) (Census tract 2240.10). CHMC serves 28 ZIP codes in Los Angeles City Council District 14. The service area is comprised of portions of Los Angeles Service Planning Areas (SPAs) 4, 6, 7, and 8. The hospital service area was determined from the ZIP Codes that reflect a majority of patient admissions from the local geographic are. A summary description of the community is below. Additional details can be found in the CHNA report online.

- CHMC serves the most densely populated area of Los Angeles County, second only to Manhattan, containing the oldest housing stock and with only 0.95 park acres of green space/1000 persons (compared to 8.0 countywide). CHMC's service area is home to a largely Central American and Mexican immigrant population as well as a Korean immigrant population (5.6%). Spanish is spoken in the home among 55.3% of the population, English in 35.1%, an Asian language in 5.6%, and an Indo-European language in 2.6%. In CHMC's service area there are 476,121 households and 501,827 housing units. Over the last five years, households grew by 4.0%, housing units grew at a lower rate (2.3%) and vacant units decreased by 12%. Owner-occupied housing increased by 1.8% and renter-occupied units increased by 6.1%. 58.6% of owner and renter-occupied households in the service area spend 30% or more of their income on housing (compared to 48.0% countywide). Among residents in CHMC's service area, 29.9% live in households which have incomes <100% of the Federal Poverty Level. 45.4% of children in SPAs 4 and 6 and 29.9% of children in SPA 7 live below the poverty level. In SPA 4, 46.4% of adults below 200% FPL can't afford food and 25.5% utilize CalFresh. In SPA 6, 49.3% of residents below 200% FPL can't afford food and 29% utilize CalFresh. In SPA 7, 49.7% of residents below 200% FPL can't afford food and 24.6% utilize CalFresh. Among children in SPA 4, 53.6% access WIC benefits, 69.9% in SPA 6 access WIC benefits and in SPA 7 49.7% access WIC benefits. Among SPA 6 resident, 15.8% are TANF/CalWorks recipients, 10.7% of SPA 4 residents and 11% of SPA 7 residents are TANF/CalWorks recipients.

- In CHMC's service area 8% of adults reported being homeless or not having their own place to live or sleep in the past five years (compared to the county rate of 4.8%). In SPA 4, 89.7% of the homeless are individual adults and 9.9% are families. In SPA 6, 70.1% of the homeless are single adults and 25.8% are families. In SPA 7, 85.2% of the homeless are single adults and 19.5% are families. Among the homeless population, 30.2% in SPA 4, 20.7% in SPA 6, and 18.7% in SPA 7 are

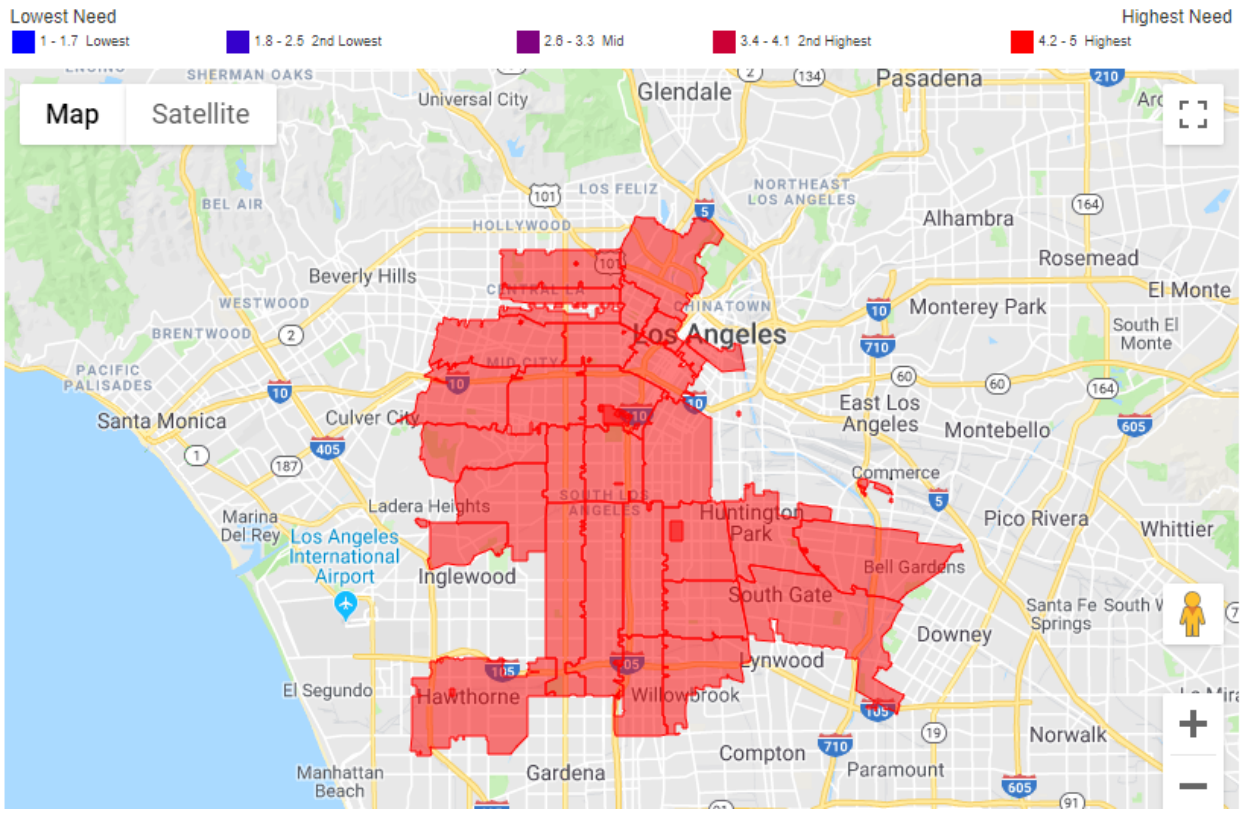
chronically homeless. The rates of chronic homelessness among individuals in SPA 4 have increased from 2015 to 2018 and decreased in SPAs 6 and 7. Rates of serious mental illness among the homeless have also gone down in SPAs 6 and 7 but remain unchanged at 29.4% in SPA 4. From 2015 to 2018, there has been an increase in the homeless population with domestic violence experience in SPAs 4 and 6. Substance abuse rates among the homeless have decreased across the service area SPAs from 2015 to 2018.

- Demographic Profile of People Living in CHMC's Service Area
    - Total Population: 1,576,013
    - Hispanic or Latino: 62.0%
    - Race: 22.2% Black/African American, 6.8% White, 6.8% Asian, and the remaining 2.1% American Indian/Alaskan Native, Native Hawaiian/Pacific Islander, or multiple races
    - Median income: $35,956
    - Uninsured: 17.7% of adults and 2.3% of children
    - Unemployment: 6.3%
    - No HS diploma: 37.4%
    - CNI Score: 4.8
    - Medicaid Population: 32.7% in SPA 4, 48.7% in SPA 6, and 25.2% in SPA 7
    - Other Area Hospitals: 6
    - Medically Underserved Areas or Populations: Yes

Community Need Index

One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and IBM Watson Health. The CNI analyzes data at the zip code level on five factors known to contribute or be barriers to health care access: income, culture/language, education, housing status, and insurance coverage.

Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zip code in the community. Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores.


Lowest Need
1 - 1.7 Lowest
1.8 - 2.5 2nd Lowest
2.6 - 3.3 Mid
3.4 - 4.1 2nd Highest
4.2 - 5 Highest
Highest Need
Map
Satellite
Universal City
Glendale
Pasadena
SHERMAN OAKS
BEL AIR
LOS FELIZ
NORTHEAST LOS ANGELES
HOLLYWOOD
Alhambra
Rosemead
Beverly Hills
WESTWOOD
BRENTWOOD
Monterey Park
El Monte
South El Monte
Los Angeles
PACIFIC PALISADES
Santa Monica
Culver City
East Los Angeles
Montebello
Commerce
Marina Del Rey
Ladera Heights
Los Angeles International Airport
Inglewood
Huntington Park
Pico Rivera
Whittier
Bell Gardens
South Gate
Santa Fe Springs
Downey
El Segundo
Hawthorne
Willowbrook
Norwalk
Compton
Paramount
Manhattan Beach
Gardena

Community Assessment and Significant Needs

The hospital engages in multiple activities to conduct its community health improvement planning process. These include, but are not limited, to conducting a Community Health Needs Assessment with community input at least every three years, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

Community Health Needs Assessment

The health issues that form the basis of the hospital's community health implementation strategy and programs were identified in the most recent CHNA report, which was adopted in April 2019. The CHNA contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods;
- Presentation of data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at www.chmcla.org or upon request at the hospital's Community Health office.

Significant Health Needs

The community health needs assessment identified the following significant community health needs:

1. Housing and homelessness: 8% of adults in CHMC's service area reported being homeless or not having their own place to live or sleep in the past five years (compared to the county rate of 4.8%). 58.6% of service area owner and renter-occupied households spend 30% or more of their income on housing (compared to 48% countywide). Many families who spend a high percent of their income on housing live in crowded housing conditions and poor housing and that contributes to adverse health outcomes.
2. Access the health care – 17.7% of adults and 2.3% of children in CHMC's service area are uninsured. In the service area, 97.7% of children and 73% of adults have a regular source of health care.
3. Mental health – In the hospital service area, 9.1% of SPA 4 adults, 7.2% of adults in SPA 6, and 9.3% of adults in SPA 7 had experienced serious psychological distress in the past year. Stakeholders noted that for many ethnic communities, there is stigma around needing mental health services.
4. Chronic diseases - Heart disease, cancer and stroke are the top three causes of death in the service area. Diabetes is the fourth leading cause of death and Chronic Lower Respiratory Disease is the fifth leading cause of death in the service area.
5. Economic insecurity- Among the residents in CHMC's service area, 29.9% live in households with incomes less than 100% FPL. A high poverty rate is both a cause and a consequence of poor

economic conditions. Stakeholders noted there are not enough jobs, which results in increased numbers of low-income people.

6. Substance use and misuse-Prescription drug misuse and its related problems are among society's most pervasive health and social concerns. In SPA 4, 20% of the population had misused prescription drugs. 18% of SPA 6 and 16% of SPA 7 residents had misused prescription drugs.
7. Food insecurity-38.1% of service area households with incomes equal to or less than 300% FPL are food insecure. This percent is higher than the county rate of 29.2%.
8. Education – 37.4% of the adult population in the service area had less than a high school education (compared to 27.4% in the county). The HS graduation rate for Los Angeles Unified School District (76.1%) is lower than the Healthy People 2020 objective of 87%.
9. Preventive practices – In the service area, 56.3% of children, 6 months to 17 years, and 32.3% of adults have been vaccinated for influenza. The Healthy People 2020 objective is to have 70% of the population receive a flu shot. In the service area, 80.3% of women had a mammogram in the past two years compared to the Healthy People 2020 objective of 81.1%.
10. Birth indicators- The service area rate of low birth weight babies is 7.9% (78.8/1000 live births) which is higher than the county rate of 7.1%. Breastfeeding rates at CHMC indicate 91.0% of new mother use some breastfeeding and 63.8% use breastfeeding exclusively.

There are additional needs identified by the CHNA that were not deemed to be significant compared to the other needs, but we do have programming addressing most of them and will describe it later in this report.

Significant Needs the Hospital Does Not Intend to Address

The hospital intends to take actions to address all of the prioritized significant health needs in the CHNA report, both through its own programs and services and with community partners. Lists and descriptions of those planned actions are included in this report.

2019 Implementation Strategy

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years. It summarizes planned activities with statements on anticipated impacts and planned collaboration. Program Digests provide additional detail on select programs.

This report specifies planned activities consistent with the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community

health needs or in community assets and resources directed to those needs may merit refocusing the hospital's limited resources to best serve the community.

The anticipated impacts of the hospital's activities on significant health needs are summarized below, and for select program initiatives are stated in Program Digests. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to needed and beneficial care; and help create conditions that support good health. The hospital works to evaluate impact and sets priorities for its community health programs in triennial Community Health Needs Assessments.

Creating the Implementation Strategy

California Hospital Medical Center is dedicated to improving community health and delivering community benefit with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

The Community Benefit Planning Workgroup comprised of key community stakeholders and *promotoras* residing in CHMC's service area uses a process that focuses on two levels of decision making to determine how identified health issues will be addressed:

- Content areas
    - Size of the problem
    - Severity of the problem
    - Economic feasibility
    - Available expertise
    - Necessary time commitment
    - External salience
- Project activities
    - Target population
    - Number of people (i.e., How many people will be helped by this intervention?)
    - Estimated effectiveness/ efficiency
    - Existing efforts (i.e., who else is working on this? What is our role? How can we best complement/enhance an existing effort?)

We also considered:

- Existing programs with evidence of success/impact
- Expanding or adapting a successful program run by another health system (e.g., UniHealth Cultural Trauma and Mental Health Resiliency Project)
- Access to appropriate skills or resources
- Problems linked to high utilization rates at CHMC
- Prevention Requirements of Level II Trauma Center
- Requirements for Stroke Program
- *Dignity Health Community Health Strategy Blueprint 2019-2023*
- *Dignity Health Diabetes System Strategy Assessment*, June 2019
- *Plan for a Healthy Los Angeles: A Health and Wellness Element of the General Plan of Los Angeles City*, 2014
- *Homelessness Los Angeles, CA*, Urban Land Institute Advisory Services Panel Report, December 2017

Strategy by Health Need

The tables below present strategies and program activities the hospital intends to deliver to help address significant health needs identified in the CHNA report.

They are organized by health need and include statements of the strategies' anticipated impact and any planned collaboration with other organizations in our community.

Health Need 1: Housing & Homelessness

Strategy or Program Name	Summary Description
10th Decile Project	• This Dignity Health Community Grant-funded project connects the top 10% highest cost, highest need chronically homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical and behavioral health care services through a collaboration of Corporation for Supportive Housing, JWCH Institute, and Housing Works.
Transition to Wellness Project	• This project is a partnership with Jewish Family Services designed to provide service navigation to homeless patients with mental illness seen in ED or hospital to connect them with housing resources and treatment interventions to improve their overall health and social well-being, reduce ED utilization and hospital readmissions.
Zahn Memorial Center & Lily's Place for Homeless Families	• This Dignity Health Community Grant will fund a Housing Specialist who will assist 30 families in residence at Zahn Memorial Center & Lily's Place in locating and securing permanent housing more quickly.
Mental Health Support for Women with Histories of Homelessness	• The Downtown Women's Health Center is the only gender-specific health clinic in Skid Row and provides specialized, trauma-informed primary care, patient navigation, medical case management, behavioral health care, women's specialty health and holistic wellness services.
HSFC's Early Head Start Program	• Homeless pregnant women and/or parenting women with child ages 0-3 yr are a priority group for program enrollment based on HSFC's last EHS Community Needs Assessment. • EHS staff outreach to these families in shelters and work to help them access permanent affordable housing.

Anticipated Impact: Increased access to permanent supportive housing for chronically homeless individuals with complex needs; increased access to permanent affordable housing for homeless families; increased access to female-centric, trauma-informed mental health services for homeless women; decreased ED utilization and hospital readmissions and improved health and wellbeing.

Planned Collaboration: Each of these programs involves collaboration with multiple agencies serving the homeless including hospital navigators, physical and behavioral health providers, housing navigators, homeless shelters, etc.
CHMC will also collaborate with Dignity Health's Homeless Health Initiative.

Health Need 2: Access to Health Care

Strategy or Program Name	Summary Description
Para Su Salud	• Enrollers assist individuals and families sign up for health and dental health insurance benefits • Recertification is required every 6 mo.
Health Ministry Program	• Parish Nurse screens for common chronic conditions at a variety of community sites • Refers those with abnormal results and those without a medical home to local FQHCs
Charity Care based on financial need	• See CHMC's financial assistance policy
Clinical experience for medical professional students	• CHMC provides clinical experience to: our own Family Medicine residents, USC and UCLA residents, Cedars-Sinai residents, Ross University School of Medicine students, and nursing students from a variety of schools
COPE Health Scholars Program	• Program participants are ≥ 18 yr, accepted to, enrolled in, or graduated from an accredited college or university, pursuing a career in health care and basic CPR certified • They enroll in an 8-unit certification course through UC Riverside Extension delivered on site at CHMC; serve a minimum of 4-6 hr/wk; accumulate ≥280 hr in order to formally graduate from the program and receive certification of completion. • They work alongside nurses, physicians, and allied health professionals in clinical and administrative settings at CHMC • They receive training to assist in basic patient-care tasks such as bathing, changing and feeding patients as they rotate among the different departments of the hospital
10th Decile Project	• This Dignity Health Community Grant-funded project connects the top 10% highest cost, highest need homeless individuals seen at CHMC to intensive case management, supportive housing, and

	appropriate physical, mental, and behavioral health care services through a collaboration of Corporation for Supportive Housing, Housing Works, and JWCHI, Inc.
Transition to Wellness	• This project is a partnership with Jewish Family Services designed to provide service navigation to homeless patients with mental illness treated in ED and inpatient hospital units to connect them with community resources and treatment interventions to improve their overall health and social well-being, reduce ED utilization and hospital readmissions
HSFC's Early Head Start Program	• Assists families in accessing health and dental health insurance coverage • Assists families in establishing a medical home for each family member • Encourages attendance at all prenatal and/or well-child visits
LA Best Babies Network's perinatal and early childhood home visiting programs	• Assists families in accessing health and dental health insurance coverage • Assists families in establishing a medical home for each family member • Encourages attendance at all prenatal and/or well-child visits
Navigating the Health Care System	• A four-unit health literacy curriculum designed by Nemours Children's Health System for use with high school students in classroom or community setting • It is designed to prepare students to be responsible for managing their own health care as they transition into adulthood • The hospital partners with various schools`

Anticipated Impact: Gains in public or private health care coverage; increased knowledge about how to access and navigate the health care system; increased primary care "medical homes" among those reached by navigators; workforce development in a safety net hospital

Planned Collaboration: The hospital will partner with many local schools, churches and community sites to provide enrollment assistance for uninsured individuals and families and/or make referrals to FQHCs of the Southside Coalition of Community Health Centers. The hospital also collaborates with a variety of medical professional education programs to provide clinical experience for their students. HSFC has over 30 community partners. LABBN works with 14 hospitals and over 38 community partners, First 5 LA, LACDPH, and PAC/LAC. LABBN oversees the training of all new home visitors and together with PAC/LAC and MCHA provides technical assistance to all home visiting agencies and maintains their common database.

Health Need 3: Mental Health

Strategy or Program Name	Summary Description

HSFC Early Head Start Program	• Parents will be screened for depression/anxiety and intimate partner violence (IPV) • Parents and/or children 0-3 needing treatment will be referred to community resources
Pico Union Family Preservation Network	• Parents will be screened for depression/anxiety and IPV. • Children with be screened for adverse childhood experiences (ACEs) and mental health or behavioral issues • Parents and/or children needing treatment for mental health concerns will be referred to community resources • Offers support group for women who have experienced IPV • Offers anger management psychoeducational group • Offers a parenting psychoeducational group
Wraparound Services Program	• Parents will be screened for depression/anxiety and IPV • Wraparound Program provides community-based support and individualized planning for children, including those with severe emotional and behavioral disorders and their families • The Wraparound Team creates an intensive family preservation plan that supports keeping the child at home with their family. • Parents and/or children needing treatment for mental health issues are referred to community resources.
HSFC Early Care and Education Centers	• Children will be screened for mental health and behavioral issues • Those needing treatment will be referred to community resources
Hope Street Youth Center	• Youth needing treatment for mental health issues will be referred to community resources • Youth are encouraged to participate in Youth Fitness Program • Youth learn how to manage stress through yoga
CA Behavioral Health Clinic	• Children aged 0-21 with Medi-Cal receive mental health services • Women suffering from PMADs receive dyadic care with their infant/toddler
Transition to Wellness Project	• This project is a partnership with Jewish Family Services designed to provide service navigation to homeless patients with mental illness treated in ED and inpatient hospital units to connect them with community resources and treatment interventions to improve their overall health and social well-being, reduce ED utilization and hospital readmissions. • Navigators can follow patients for up to 90 days after discharge providing transportation to appointments and warm hand-offs.
LABBN's perinatal and early childhood home visitation programs	• Home visitors routinely screen for PMADs and IPV and refer individuals needing treatment to community resources
10th Decile Project	• This Dignity Health Community Grant-funded project connects the top 10% highest cost, highest need homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services

	through a collaboration of Corporation for Supportive Housing, Housing Works, and JWCHI, Inc.
Mental Health Support for Women with Histories of Homelessness	• The Downtown Women's Health Center is the only gender-specific health clinic in Skid Row and provides specialized, trauma-informed primary care, patient navigation, medical case management, behavioral health care, women's specialty health and holistic wellness services • This is a Dignity Health Grant-funded program
UniHealth Cultural Trauma and Mental Health Resiliency Project	• Joint effort of the six Dignity Health hospitals in Southern California working in tandem to increase the capacity of local community organizations, community members and hospitals to identify mental distress and/or suicidality among at risk youth, and to respond appropriately • Improve access to prevention and early intervention mental health and SUD services, thereby decreasing health disparities, especially for those affected by poverty, racism, adverse childhood experiences, and violence. • This project is jointly funded by UniHealth Foundation and the Dignity Health Foundation.

Anticipated Impact: The hospital's initiatives to address mental health issues are anticipated to result in: early identification and treatment of women with depression/anxiety or PMADs thereby improving the developmental trajectory of their infants/toddlers and older children; increased access to needed mental health services for children and adults; youth and adults will learn healthy coping skills; by providing navigation services to high risk individuals with mental illness, increased likelihood of their accessing treatment services; increased ability of those interacting with vulnerable youth to identify mental distress and/or suicidality and respond appropriately; decreased mental health stigma and increased help seeking among those with clinical need.

Planned Collaboration: Each of the programs involves collaboration with multiple community partners. CHMC is also an active member of the Immigrant Integration Task Force hosted by CCF in order to stay abreast of all the politically motivated attacks on the immigrant community striking fear, confusion, isolation, depression/anxiety, and a sense of hopelessness.

Health Need 4: Chronic Diseases

Strategy or Program Name	Summary Description
Health Ministry Program	• Parish Nurse screens for common chronic diseases including overweight/obesity • Refers those with abnormal results to local FQHCs if they do not already have a medical home

	• Pre-diabetics are referred to National Diabetes Prevention Program and/or Diabetes Empowerment Education Program (DEEP) • Individuals with elevated cholesterol or hypertension are referred to Heart HELP Program • If interested in smoking cessation, refers them to DPH Smoking Cessation assistance program and/or 1-800-NO-BUTTS
Heart HELP Program	• Participants learn how to minimize their risk for cardiovascular disease (CVD) by healthy eating and cooking and maintaining an active lifestyle and addressing risk factors like obesity/overweight, hypertension, cholesterol, and pre-diabetes/diabetes.
Diabetes Empowerment Education Program	• Participants with pre-diabetes learn how to prevent diabetes • Participants with diabetes learn how to manage their disease and improve their health in order to prevent complications • Participants learn that diabetes is a major risk factor for CVD and are encouraged to attend Heart HELP after completing DEEP
Chronic Disease Self-Management Program	• In 6 weekly workshops participants with chronic conditions learn how to manage and improve their health • Topics include: pain management, nutrition, exercise, medication use, emotions, and communicating with doctors
Emotional Well-Being Support Group	• Patient and community support group for people with chronic diseases to improve their emotional well-being through mutual support, coping strategies, and psychoeducation
Breast Cancer Support Group	• In partnership with Celebrate Life Cancer Ministry, the hospital offers a Breast Cancer Support Group to help recovery through mutual support, coping strategies and psychoeducation
CHMC's Women's Health Center	• Uninsured women are referred to Women's Health Center for free mammography and cervical cancer screening
Coordinated Care Initiative	• Patients with chronic diseases who have their medical home at FQHCs belonging to the Southside Coalition of Community Health Centers and are inpatients at CHMC are eligible for this program • Deploys HIE*Lite for patient identification and management • Patient navigators develop care plans for enrolled patients and coordinate their post-discharge care • Decreases ED revisits and 30-day readmissions
10th Decile Project	• This Dignity Health Community Grant-funded project connects the top 10% highest cost, highest need homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services through a collaboration of Corporation for Supportive Housing, Housing Works, and JWCHI, Inc. • A majority of these patients have chronic diseases such as hypertension, diabetes, or CVD.
Healthy Eating and Lifestyle Program	• Overweight/obese children aged 5-12 yr are referred to this program by their primary care provider

	• The children and their parents learn to decrease screen time, consumption of fast food, sugar-sweetened beverages, and calorie-dense, nutrient poor food and to increase their physical activity and consumption of fresh fruits and vegetables and water • By decreasing children's overweight/obesity, the program will decrease their risk for diabetes and hypertension.
HSFC Early Head Start Program	• Pregnant and parenting women with children aged 0-3 yr learn about the importance of: exclusive breastfeeding for the first 6 mo of life with continued breastfeeding for as long as feasible; the consumption of fresh fruits and vegetable as well as water; the avoidance of fast food, sugar sweetened beverages, and calorie-dense nutrient poor foods; and maintaining an active lifestyle in order to prevent obesity/overweight
HSFC Early Care and Education Centers	• Pregnant and parenting women with children aged 0-3 yr learn about the importance of: exclusive breastfeeding for the first 6 mo of life with continued breastfeeding for as long as feasible; the consumption of fresh fruits and vegetable as well as water; the avoidance of fast food, sugar sweetened beverages, and calorie-dense nutrient poor foods; and maintaining an active lifestyle in order to prevent obesity/overweight • Menus of licensed childcare centers conform with nutrition guidelines for EHS/HS
HSFC Family Childcare Network	• Pregnant and parenting women with children aged 0-3 yr learn about the importance of: exclusive breastfeeding for the first 6 mo of life with continued breastfeeding for as long as feasible; the consumption of fresh fruits and vegetable as well as water; the avoidance of fast food, sugar sweetened beverages, and calorie-dense nutrient poor foods; and maintaining an active lifestyle in order to prevent obesity/overweight • Menus of licensed childcare centers conform with nutrition guidelines for EHS/HS
Hope Street Youth Center	• Children and Youth aged 7-18 yr learn about healthy eating, healthy cooking, portion control, the importance of maintaining an active lifestyle and healthy coping strategies for life's stressors • They are encouraged to participate in the Youth Fitness Program
LABBN's Perinatal and Early Childhood Home Visitation Programs	• Home visiting staff learn about: the importance of, and how to support, exclusive breastfeeding for the first 6 mo of life and as long as feasible thereafter; how to introduce solid food to infants, portion control, the importance of fresh fruits and vegetable, drinking water and maintaining an active lifestyle; and the importance of limiting fast food, sugar-sweetened beverages, and screen time

Anticipated Impact: CHMC's initiatives related to chronic diseases are designed to: prevent early childhood overweight/obesity; prevent adolescent obesity by early identification and treatment of overweight/obesity in children aged 5-12 yr; prevent diabetes by early identification and treatment of pre-diabetes; prevent complications of diabetes by teaching people with diabetes how to better manage their disease; prevent complications of CVD by teaching people with hypertension, high cholesterol

and/or heart disease how to better manage their disease; help people cope with living with a chronic diseases
Planned Collaboration: LA County Community Health Assessment and Action Partnership (LA Partnership) is made up of community health directors of non-profit hospitals and health systems of LA County who have agreed to collaborate on their CHNA with the support of LACDPH and engage in population health improvement strategies. It will invest in upstream prevention strategies to maximize population impact ("making the healthy choice the easy choice"). It will promote a coordinated set of strategies in selected high need communities to achieve measurable gains. The LA County DPH-led National Diabetes Prevention Program Community Advisory Board aims to spread NDPP throughout LA County, increase access to the program through commercial and public health plans including Medicare and Medi-Cal thereby increasing access for high-risk, low income community members with pre-diabetes.

Health Need 5: Economic Insecurity

Strategy or Program Name	Summary Description
HSFC Family Literacy Program	• Family literacy program helps parents improve both their parenting and literacy skills while providing young children with early childhood education to support their emerging literacy skills • Parents learn ESL and the importance of child-led play • Parents also learn financial literacy
HSFC Early Head Start Program	• Promotes economic self-sufficiency for parents • Beginning with expectant families, healthy, loving relationships between parents and children will lead to success in school and life • EHS promotes school readiness in a variety of ways including encouraging parents to talk, read, and sing to their infants, toddlers, and young children
HSFC Early Care and Education Centers	• Access to full-day licensed childcare enables parents to continue their education or work • Children 0-5 learn school readiness skills at these centers that meet the rigorous EHS/HS standards
HSFC Family Childcare Network	• Access to licensed childcare during evenings, nights and week-ends enables parents to continue their education or work • Children 0-5 learn school readiness skills at these centers that meet the rigorous EHS/HS standards
Hope Street Youth Center	• Youth aged 7-18 can access homework assistance, a computer learning lab, and the Youth Fitness Program at this afterschool program • College students provide mentoring and learning opportunities • High school students and their parents participate in College Prep training and local college tours

	• During the summer, a special STEMI Program is offer in collaboration with the Museum of Science and Industry
LABBN's Perinatal & Early Childhood Home Visitation Programs	• Home visitors encourage parents to talk, read, and sing to their infants, toddlers, and young children.

Anticipated Impact: CHMC's initiatives to improve literacy in general and more specifically health and financial literacy are anticipated to result in: improved school readiness; improved success in elementary, middle, and high school; improved college readiness; greater likelihood of pursuing higher education; improved financial earning power as well as better health is associated with increased educational attainment. Providing high quality, all-day childcare for infants, toddlers and young children as well as family childcare during evening, nights, and week-ends enables parents to continue their education or work.

Planned Collaboration: All of these programs involve community partnerships/collaborations.

Health Need 6: Substance Use and Misuse

Strategy or Program Name	Summary Description
CA Bridge Program in ED	• Initiate buprenorphine for patient with Opioid Use Disorder in withdrawal • Teach family and friends of patient with OUD how to use naloxone in case of opioid overdose • Substance Use Navigator (SUN) will arrange discharge plan with local MAT provider • If patient with OUD is homeless, he/she may qualify for Bridge Housing for 90 day. The MAT provider must make that request.
Pico Union Family Preservation Program	• Family Preservation services are short-term, family-focused services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. • Families may be referred to this program by DCFS because of parental SUD and/or child abuse or neglect • Parent with SUD will be referred to appropriate treatment program • If child has mental health or behavioral concerns as result of child abuse or neglect, he/she will be referred to appropriate community resource.
Wraparound Services Program	• Wraparound Program provides community-based support and individualized planning for children, including those with severe emotional and behavioral disorders and their families • The Wraparound Team creates an intensive family preservation plan that supports keeping the child at home with his/her family • By preventing ACEs, one can decrease the likelihood that the child will become an alcoholic or drug addict in the future.

HSFC Early Head Start Program	• EHS is a Federal initiative providing child development and parent support services to low-income pregnant women and families with children birth-3 yr. • Children who participate have lower rates of child abuse and neglect, thereby decreasing the likelihood that they will become an alcoholic or drug addict in the future
HSFC's Early Care and Education Centers	• Parents learn the importance of responsive caregiving and keeping their children safe. • Early education and parent support services are provided to low-income families with children birth to 5 yr. • By preventing ACEs, one can decrease the likelihood that the child will become an alcoholic or drug addict in the future
HSFC's Family Childcare Network	• Parents learn the importance of responsive caregiving and keeping their children safe. • Early education and parent support services are provided to low-income families with children birth to 5 yr. • By preventing ACEs, one can decrease the likelihood that the child will become an alcoholic or drug addict in the future
CA Behavioral Health Clinic	• Children aged 0-21 yr with Medi-Cal will receive mental health services • By diagnosing and addressing children's mental health needs, there is a decreased likelihood that they will become an alcoholic or drug addict in the future.
HSFC's Early Intervention Program	• Families with infants or toddlers who have a developmental delay or disability or with an established risk condition likely to result in a delay are eligible for services • Specialists evaluate and assess infants and toddlers and provide EI and family support services for young children birth – 3 yr. • Families who understand the nature of their child's delay or disability are less likely to abuse the child • By preventing adverse childhood experiences (ACEs), one can decrease the likelihood that the child will become an alcoholic or drug addict in the future
LABBN's Perinatal & Early Childhood Home Visitation Programs	• Home visitors teach the families about milestones of child development • Families receiving family support services through home visits are significantly less likely to abuse or neglect their children • By preventing adverse childhood experiences (ACEs), one can decrease the likelihood that the child will become an alcoholic or drug addict in the future
Transition to Wellness Project	• This project is a partnership with Jewish Family Services designed to provide service navigation to homeless patients with mental illness treated in ED and inpatient hospital units to connect them with community resources and treatment interventions to improve their

	overall health and social well-being, reduce ED utilization and hospital readmissions • Some of these patients have co-morbidity of alcoholism or SUD (substance use disorder) and will be referred for treatment
10th Decile Project	• This Dignity Health Community Grant-funded project connects the top 10% highest cost, highest need homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services through a collaboration of CSH, Housing Works, and John Wesley Community Health Institute, Inc.
UniHealth Cultural Trauma and Mental Health Resiliency Project	• Joint effort of the six Dignity Health hospitals in Southern California working in tandem to increase the capacity of local community organizations, community members and hospitals to identify mental distress and/or suicidality among at risk youth, and to respond appropriately • Improve access to prevention and early intervention mental health and SUD services, thereby decreasing health disparities, especially for those affected by poverty, racism, adverse childhood experiences, and violence.

Anticipated Impact: CHMC's initiatives to prevent child abuse or neglect are anticipated to prevent children from suffering from ACEs which are known to impose neurobiological and psychosocial effects that often results in health risk behaviors (smoking, drinking, substance use) in adolescence which, in turn, result in long-term consequences such as alcoholism, SUD, chronic disease, mental illness, unemployment, criminal behavior, and homelessness. CHMC's initiatives to address child abuse and neglect are anticipated to ameliorate the long-term consequences of ACEs. CHMC's initiatives to address mental illness and homelessness are anticipated to increase access to SUD treatment services to those in need. CHMC's CTMHR Project will result in: increased ability of those interacting with vulnerable youth to identify mental distress and/or suicidality and respond appropriately; decreased mental health stigma and increased help seeking among those with clinical need.

Planned Collaboration: All of these programs involve community collaborations. The CTMHR Project involves collaboration between all six Dignity Health hospitals in Southern CA and their community partners; moreover, each County has its own Community Advisory Committee.

Health Need 7: Food Insecurity

Strategy or Program Name	Summary Description
Para Su Salud	• Health insurance enrollers are encouraged to offer enrollment in food assistance programs that the individual/families may qualify for, i.e., WIC or CalFresh.

	• Seniors are now eligible for CalFresh • Can now enroll in CalFresh online, instead of going into DPSS office
Diabetes Empowerment Education Program	• As many as 15% of individuals who are food insecure have diabetes and 27.7% are obese; therefore, it is important to screen all participants for food insecurity using a short screening tool called the Hunger Vital Sign. • Those who are food insecure should be referred to CalFresh, WIC. and other food assistance programs for which they qualify • Nutrition education should teach individuals to maximize their family budget while preparing healthy diabetic meals.
Heart HELP	• 27.7% of individuals who are food insecure are obese and 30% have hypertension, 29.6% have high cholesterol, and 15% have diabetes; therefore, it is important to screen all participants for food insecurity using a short screening tool called the Hunger Vital Sign. • Those who are food insecure should be referred to CalFresh, WIC. and other food assistance programs for which they qualify • Nutrition education should teach individuals to maximize their family budget while preparing heart healthy meals.
Chronic Disease Self-Management Program	• In 6 weekly workshops participants with chronic conditions learn how to manage and improve their health • Topics include: pain management, nutrition, exercise, medication use, emotions, and communicating with doctors • All participants should be screened for food insecurity using a short screening tool called the Hunger Vital Sign • Those who are food insecure should be referred to CalFresh, WIC. and other food assistance programs for which they qualify
Healthy Eating and Lifestyle Program	• Overweight/obese children aged 5-12 yr are referred to this program by their primary care provider • Parents should be screened for food insecurity using a short screening tool called the Hunger Vital Sign • Those who are food insecure should be referred to CalFresh, WIC. and other food assistance programs for which they qualify • The children and their parents learn to decrease screen time, consumption of fast food, sugar-sweetened beverages, and calorie-dense, nutrient poor food and to increase their physical activity and consumption of fresh fruits and vegetables and water
HSFC Early Head Start Program	• All families are screened for food insecurity • Those who are food insecure are referred to WIC, CalFresh, and other food assistance programs for which they qualify
LABBN's Perinatal and Early Childhood Home Visitation Programs	• All families are screened for food insecurity • Those who are food insecure are referred to WIC, CalFresh, and other food assistance programs for which they qualify
CHMC's Food Recovery Initiative	• Food produced for cafeteria consumption that is not consumed is appropriately cooled and set aside for pick-up by Food Finders

	• Food Finders picks up the food and immediately transports it to a local partner that can use it, i.e., a homeless shelter, a sober living home, etc.

Anticipated Impact: CHMC's initiatives to address food insecurity are anticipated to assist individuals and families in accessing affordable, nutritious food.

Planned Collaboration: LA County Community Health Assessment and Action Partnership (LA Partnership) is made up of community health directors of non-profit hospitals and health systems of LA County who have agreed to collaborate on their CHNA with the support of LACDPH and engage in population health improvement strategies. It will invest in upstream prevention strategies to maximize population impact ("making the healthy choice the easy choice"). It will promote a coordinated set of strategies in selected high need communities to achieve measurable gains. One of the workgroups is focused on addressing food insecurity by:1) increasing CalFresh enrollment; and 2) increasing the participation of more hospitals in the Food Recovery Initiative.

Health Need 8: Education

Strategy or Program Name	Summary Description
HSFC Family Literacy Program	• Family literacy program helps parents improve both their parenting and literacy skills while providing young children with early childhood education to support their emerging literacy skills • Parents learn ESL and the importance of child-led play • Parents also learn financial literacy
HSFC Early Head Start Program	• Beginning with expectant families, healthy, loving relationships between parents and children will lead to success in school and life • EHS promotes school readiness in a variety of ways including encouraging parents to talk, read, and sing to their infants, toddlers, and young children
HSFC's Early Care and Education Centers	• Access to full-day licensed childcare enables parents to continue their education or work • Children 0-5 learn school readiness skills at these centers that meet the rigorous EHS/HS standards
HSFC Family Child Care Network	• Access to licensed childcare during evenings, nights and week-ends enables parents to continue their education or work • Children 0-5 learn school readiness skills at these centers that meet the rigorous EHS/HS standards
Hope Street Youth Center	• Youth aged 7-18 can access homework assistance, a computer learning lab, and the Youth Fitness Program at this afterschool program • College students provide mentoring and learning opportunities

	• High school students and their parents participate in College Prep training and local college tours • During the summer, a special STEMI Program is offer in collaboration with the Museum of Science and Industry
LABBN's Perinatal and Early Childhood Home Visitation Programs	• Home visitors encourage parents to talk, read, and sing to their infants, toddlers, and young children.
UniHealth Cultural Trauma and Mental Health Resiliency Project	• Joint effort of the six Dignity Health hospitals in Southern California working in tandem to increase the capacity of local community organizations, community members and hospitals to identify mental distress and/or suicidality among at risk youth, and to respond appropriately • Improve access to prevention and early intervention mental health and SUD services, thereby decreasing health disparities, especially for those affected by poverty, racism, adverse childhood experiences, and violence • Improving the mental health of youth will result in decreased conduct problems, aggressive behavior, hyperactivity/attention problems, risky sexual behavior, substance abuse, social deviance and anxiety/depression and increased empathy, well-being, quality relationships, prosocial behavior, satisfaction with school, leadership skills, and academic achievement.

Anticipated Impact: CHMC's initiatives to improve literacy in general and more specifically health literacy are anticipated to result in: improved school readiness; improved success in elementary, middle, and high school; improved college readiness; greater likelihood of pursuing higher education; improved financial earning power as well as better health is associated with increased educational attainment. Although not everyone needs to go to college, everyone needs skills and knowledge for which others are willing to pay a living wage. Providing high quality, all-day childcare for infants, toddlers and young children as well as family childcare during evening, nights, and week-ends enables parents to continue their education or work.

Planned Collaboration: All of these programs involve community collaborations. The CTMHR Project involves collaboration between all six Dignity Health hospitals in Southern CA and their community partners; moreover, each County has its own Community Advisory Committee.

Health Need 9: Preventive Practices

Strategy or Program Name	Summary Description
HSFC Early Head Start Program	• EHS is a Federal initiative providing child development and parent support services to low-income pregnant women and families with children birth-3 yr.

	• All pregnant women and infants and toddlers from birth to age 3 are strongly encouraged to keep all of their scheduled appointments in order to receive all necessary preventive services. • Influenza vaccination is strongly encouraged annually for children 6 months old and above and for all adults
LABBN's Perinatal and Early Childhood Home Visitation Programs	• All pregnant women and infants, toddlers and young children from birth to age 5 are strongly encouraged to keep all of their scheduled appointments in order to receive all necessary preventive services. • Influenza vaccination is strongly encouraged annually for children 6 months old and above and for all adults
CHMC's Women's Health Center	• Uninsured women are referred to Women's Health Center for free mammography and cervical cancer screening
HSFC's Early Care and Education Centers	• Vaccine records of all participating children must be kept up to date including an annual influenza vaccine after 6 months of age.
HSFC Family Child Care Network	• Vaccine records of all participating children must be kept up to date including an annual influenza vaccine after 6 months of age.
Para Su Salud	• Enrollers assist individuals and families sign up for health insurance and dental health insurance benefits. • Recertification is required every 6 mo. • Once individuals and families have physical and dental health insurance, they can establish a medical home where they can readily access necessary preventive services.

Anticipated Impact: CHMC's initiatives to increase compliance with recommended preventive services are anticipated to result in improved vaccination rates among participating infants, toddlers, and young children; however, busy parents who may be working multiple jobs often do not prioritize their own preventive care.

Planned Collaboration: All of these programs involve community collaborations.

Health Need 10: Birth Indicators

Strategy or Program Name	Summary Description
LABBN's perinatal and early childhood home visitation programs	• Home visiting services that start prenatally can improve birth outcomes by decreasing prematurity and low birth weight • Programs are offered by *14* hospitals and their community partners throughout LA County including at CHMC • Patients experiencing their first pregnancy are enrolled in Nurse Family Partnership which is run by LA County DPH.

	• LACDPH-funded community partners now cover areas of LA County previously uncovered by First 5 LA-funded sites.
HSFC's Early Head Start Program	• Pregnant women can enroll in home-based EHS services • Home visiting services starting prenatally can improve birth outcomes by decreasing prematurity and LBW
Improving birth outcomes for African American babies in LA County	• CHMC was invited to participate in this initiative led by LA County DPH because of our high proportion of African American births • This initiative aims to decrease black infant mortality by decreasing prematurity, LBW, and SIDS.
Decreasing preterm birth of African American babies in CA	• CHMC was invited to participate in this initiative led by CDPH • This initiative aims to decrease the rate of preterm birth among African American babies in CA by implementing the March of Dimes strategies to prevent prematurity.
LA County Perinatal and Early Childhood Home Visitation Consortium	• Membership includes the majority of organizations providing home visiting services in LA County. • In FY18 developed a plan to expand home visiting services to reach more new families as per the request from the LA County Board of Supervisors • In FY19 implemented plan to expand PAT and HFA in Los Angeles County. Services to be offered by certified PAT and HFA providers who will hire additional staff with funding from LACDMH

Anticipated Impact: : CHMC's initiatives to improve birth outcomes are anticipated to result in: decreased prematurity and LBW by providing intensive case management, health education, and improved access to needed resources through perinatal and early childhood home visiting programs; decreased disparities in birth outcomes among African American women compared to other racial/ethnic groups in our county and state.

Planned Collaboration: LABBN's perinatal and early childhood home visitation programs .is a collaborative involving 14 hospitals and over 38 community partners, First 5 LA, LACDPH, and PAC/LAC. LABBN oversees the training of all new home visitors and together with PAC/LAC and MCHA provides technical assistance to all home visiting agencies and maintains their common database.

LA County Perinatal and Early Childhood Home Visitation Consortium is a network of approximately 50 perinatal and early childhood home visitation programs, maternal and child health organizations, advocacy groups, and stakeholders. Together, they work to support Los Angeles County's home visitation programs by sharing training and educational resources, researching best practice standards, supporting enhanced referral systems between programs, conducting research and collecting data on home visiting outcomes, and advocating for systems and policies that recognize the tremendous value of home visitation services.

CDPH Community Birth Plan is a collaborative effort to reduce African American preterm births. The Maternal, Child and Adolescent Health Division has partnered with key organizations across California to develop, pilot and implement a Community Birth Plan uniting the Black community, hospitals, perinatal healthcare providers and other statewide and community organizations. Our objective is to educate the community about Black preterm birth rates and implement evidence-based health

improvement activities that improve birth outcomes, ultimately resulting in a reduction in Black preterm births.
The African American Infant and Maternal Mortality Steering Committee guides the implementation of the LA County Department of Public Health's 5-Year Action plan to address African American and infant mortality as well as informs the development and implementation of strategies to compliment the plan. This group also comes together to advance advocacy, awareness and policy change.

The strategies and programs on pages 27 – 35 address other needs identified in the CHNA report that were deemed not significant, in relation to those above.

Health Need: Overweight and Obesity

Strategy or Program Name	Summary Description
Health Ministry Program	• Parish Nurse will screen adults for obesity/overweight • Parish Nurse will refer obese/overweight adults to CHMC's programs that address physical activity and healthy eating
Diabetes Empowerment Education Program	• Pre-diabetics will learn how to prevent type 2 diabetes by addressing obesity/overweight through increasing their physical activity and healthy eating • Participants will be screened for food insecurity using a short screening tool called the Hunger Vital Sign • Those who are food insecure should be referred to CalFresh, WIC. and other food assistance programs for which they qualify
Healthy Eating and Lifestyle Program	• Overweight/obese children aged 5-12 yr will be referred to this program by their pediatrician/family physician • The children and their parents will learn to decrease screen time, consumption of fast food, sugar-sweetened beverages, and calorie-dense, nutrient poor foods and to increase their physical activity and consumption of fresh fruits and vegetables and water. • Parents will be screened for food insecurity using a short screening tool called the Hunger Vital Sign • Those who are food insecure should be referred to CalFresh, WIC. and other food assistance programs for which they qualify
HSFC Early Head Start Program	• Pregnant and parenting women with children aged 0-3 yr will learn about the importance of: exclusive breastfeeding for the first 6 months of life with continued breastfeeding for as long as feasible; the consumption of fresh fruits and vegetables as well as water; the avoidance of fast food, sugar-sweetened beverages, and calorie-dense, nutrient poor foods; and maintaining an active lifestyle in order to prevent obesity/overweight • Menus of licensed childcare centers will conform with nutrition guidelines for Early Head Start/Head Start (EHS/HS)

	• Parents will be screened for food insecurity using a short screening tool called the Hunger Vital Sign • Those who are food insecure should be referred to CalFresh, WIC. and other food assistance programs for which they qualify
HSFC's licensed early care and education centers	• Parenting women with children aged 0-5 yr will learn about the importance of: exclusive breastfeeding for the first 6 months of life with continued breastfeeding for as long as feasible; the consumption of fresh fruits and vegetables as well as water; the avoidance of fast food, sugar-sweetened beverages, and calorie-dense, nutrient poor foods; and maintaining an active lifestyle in order to prevent obesity/overweight. • Menus of licensed childcare centers will conform with nutrition guidelines for EHS/HS • Parents will be screened for food insecurity using a short screening tool called the Hunger Vital Sign • Those who are food insecure should be referred to CalFresh, WIC. and other food assistance programs for which they qualify
HSFC's Family Childcare Network	• Parenting women with children aged 0-3 yr will learn about the importance of: exclusive breastfeeding for the first 6 months of life with continued breastfeeding for as long as feasible; the consumption of fresh fruits and vegetables as well as water; the avoidance of fast food, sugar-sweetened beverages, and calorie-dense, nutrient poor foods; and maintaining an active lifestyle in order to prevent obesity/overweight • Menus will conform with nutrition guidelines for EHS/HS
Hope Street Youth Center	• Children aged 7-18 yr will learn about healthy eating, healthy cooking, portion control, the importance of maintaining an active lifestyle and healthy coping strategies for life's stressors
LABBN's perinatal and early childhood home visitation programs	• Home visiting staff will learn about: the importance of, and how to support, exclusive breastfeeding for the first 6 mo of life and as long as feasible thereafter; how to introduce solid foods to infants, portion control, the importance of fresh fruits & vegetables, drinking water and maintaining an active lifestyle; and the importance of limiting sugar-sweetened beverages, fast food, and screen time. • Home visitors will impart this information to families during home visits • Parents will be screened for food insecurity using a short screening tool called the Hunger Vital Sign • Those who are food insecure should be referred to CalFresh, WIC. and other food assistance programs for which they qualify
CHMC's Welcome Baby Program	• Home visitors teach families about: the importance of, and how to support, exclusive breastfeeding for the first 6 mo of life and as long as feasible thereafter; how to introduce solid foods to infants, portion control, the importance of fresh fruits & vegetables, drinking water and maintaining an active lifestyle; and the importance of limiting sugar-sweetened beverages, fast food, and screen time. This program

	is in collaboration with Maternal Child Health Access whose staff do the home visits. • Parents will be screened for food insecurity using a short screening tool called the Hunger Vital Sign • Those who are food insecure should be referred to CalFresh, WIC. and other food assistance programs for which they qualify
CHMC's Food Recovery Initiative	• Food produced for cafeteria consumption that is not consumed is appropriately cooled and set aside for pick-up by Food Finders • Food Finders picks up the food and immediately transports it to a local partner that can use it, i.e., a homeless shelter, a sober living home, etc.

Anticipated Impact: : The hospital's initiatives to address obesity/overweight are anticipated to result in: prevention of childhood obesity/overweight; early identification and treatment of obesity/overweight in children aged 5-12 yr.; increased knowledge about the importance of healthy eating and maintaining an active lifestyle; less food insecurity by assisting families to access WIC and CalFresh benefits and local food banks; increased healthy eating, healthy cooking, and physical activity among participating adults.

Planned Collaboration: All of these programs involve planned collaborations.
LA County Community Health Assessment and Action Partnership (LA Partnership) is made up of community health directors of non-profit hospitals and health systems of LA County who have agreed to collaborate on their CHNA with the support of LACDPH and engage in population health improvement strategies. It will invest in upstream prevention strategies to maximize population impact ("making the healthy choice the easy choice"). It will promote a coordinated set of strategies in selected high need communities to achieve measurable gains. One of the workgroups is focused on thr prevention of overweight and obesity by addressing food insecurity by:1) increasing CalFresh enrollment; and 2) increasing the participation of more hospitals in the Food Recovery Initiative.

Health Need: Dental Care

Strategy or Program Name	Summary Description
Health Ministry Program	• Parish Nurse will identify individuals needing oral health services and will refer to local FQHCs with dental clinics
Diabetes Empowerment Education Program	• Patients with medication-dependent diabetes are at high risk for periodontal disease • Patients with medication-dependent diabetes are referred for an evaluation at Eisner Health's Periodontal Clinic
Para Su Salud	• Enrollers assist individuals and families sign up for health and dental health insurance benefits • Recertification is required every 6 months

10th Decile Project	• This Dignity Health Community Grant-funded project connects the top 10% highest cost, highest need homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services through a collaboration of CSH, Housing Works, and John Wesley Community Health Institute, Inc. • Homeless patients often have periodontal disease and require extensive oral health services
Transition to Wellness Project	• This project is a partnership with Jewish Family Services designed to provide service navigation to homeless patients with mental illness treated in ED and inpatient hospital units to connect them with community resources and treatment interventions to improve their overall health and social well-being, reduce ED utilization and hospital readmissions • Homeless patients often have periodontal disease and require extensive oral health services
LABBN's Perinatal and Early Childhood Home Visitation Programs	• Home visitors teach mothers how to prevent early childhood caries by: o Cleaning baby's gums with a soft toothbrush or cloth and water starting at birth. Once their first tooth erupts, use a soft toothbrush twice a day. Use a "smear" of toothpaste if child is under two years of age and a "pea-size" amount if they are between two and five years of age. o Not dipping pacifiers in any sweetened liquid. o Not putting baby to bed with bottle filled with milk, formula, juice or other sweet liquids. o Teaching child to start drinking from a cup as early as possible, preferably before they turn one year of age. By drinking from a cup, the liquid is less likely to pool around the front teeth. o Taking child to a pediatric dentist for an early evaluation by their first birthday
HSFC's Early Head Start Program	• Home visitors teach mothers how to prevent early childhood caries (as seen above) • USC Pediatric Dental Residents provide annual evaluations of all participants. • Children with caries are referred to a local pediatric dental provider for care and f/u.

Anticipated Impact: CHMC's initiatives to address oral health are anticipated to result in: increased access to oral health services; prevention of early childhood caries; increased access to periodontal treatment services to medication-dependent diabetics and homeless individuals.

Planned Collaboration: All of these programs involve planned collaborations.

Health Need: Violence and Injury Prevention

Strategy or Program Name	Summary Description
Hope Street Youth Center	• Youth aged 7-18 can access homework assistance, a computer learning lab, and the Youth Fitness Program at this afterschool program • Youth develop relationships with caring adults
HSFC's Youth Fitness Program	• Youth aged 7-18 can participate in a variety of physical activity programs • Youth learn healthy coping skills through yoga
CA Behavioral Health Clinic	• Children aged 0-21 yr with Medi-Cal will receive mental health services • If children have been victims of child abuse or neglect, it is important to address their resulting mental health needs as promptly as possible in order to prevent long-term consequences of ACEs • Some children suffer from PTSD as a result of witnessing IPV involving their parents • By diagnosing and addressing children's mental health needs there is a decreased likelihood that they will join a gang
LABBN's perinatal and early childhood home visitation programs	• Home visitors teach the families about milestones of child development • Parents learn the importance of responsive caregiving and keeping their children safe • Families receiving family support services through home visits are significantly less likely to abuse or neglect their children • Participants are routinely screened for IPV and referred for counseling and support as needed • Participating families receive First 5 LA *Kit for New Parents* that discusses car seat safety and making your home safe for an infant/toddler • Home visitors also discuss these topics with families during home visits • Home visitors give all families a home safety kit
HSFC's early care and learning centers	• Families learn about milestones of child development • Parents learn the importance of responsive caregiving and keeping their children safe • Families engaged with their children's preschool are less likely to abuse or neglect their children • Participants are routinely screened for IPV and referred for counseling and support as needed

HSFC's Early Head Start Program	• Early Head Start (EHS) is a Federal initiative providing child development and parent support services to low-income pregnant women and families with children birth to 3 years old • Parents learn the importance of responsive caregiving and keeping their children safe • Families learn about milestones of child development • Children who participate have lower rates of child abuse and neglect • Participants are routinely screened for IPV and referred for counseling and support as needed
HSFC's Family Childcare Network	• Parents learn the importance of responsive caregiving and keeping their children safe • Early education and parent support services are provided to low-income families with children birth to 5 yr. • Participants are routinely screened for IPV and referred for counseling and support as needed
HSFC's Early Intervention Program	• Families with infants or toddlers who have a developmental delay or disability or with an established risk condition likely to result in a delay are eligible for services • Specialists evaluate and assess infants and toddlers and provide EI and family support services for young children birth – 3 yr. • Families who understand the nature of their child's delay or disability are less likely to abuse the child • Participants are routinely screened for IPV and referred for counseling and support as needed
LA County Perinatal and Early Childhood Home Visitation Consortium	• Membership includes the majority of organizations providing home visiting services in LA County. • By the end of FY20, the majority of new mothers in LA County will have access to a perinatal and early childhood home visitation program • Families learn about milestones of child development • Families learn about the importance responsive caregiving and keeping their children safe • Participants are routinely screened for IPV and referred for counseling and support as needed
UniHealth Cultural Trauma and Mental Health Resiliency Project	• Joint effort of the six Dignity Health hospitals in Southern California working in tandem to increase the capacity of local community organizations, community members and hospitals to identify mental distress and/or suicidality among at risk youth, and to respond appropriately • Improve access to prevention and early intervention mental health and SUD services, thereby decreasing health disparities, especially for those affected by poverty, racism, adverse childhood experiences, and violence • Improving the mental health of youth will result in decreased conduct problems, aggressive behavior, hyperactivity/attention problems, risky sexual behavior, substance abuse, social deviance

	and anxiety/depression and increased empathy, well-being, quality relationships, prosocial behavior, satisfaction with school, leadership skills, and academic achievement.
Pico Union Family Preservation Program	• Family preservation services are short-term, family-focused services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. • The most common indication for FPS is suspected/documented child abuse or neglect • A support group for women who are victims of IPV is conducted in Spanish every week • An anger management group for men and women is conducted in Spanish every week • A parenting group for men and women is conducted in Spanish every week
Wraparound Services Program	• Wraparound Program provides community-based support and individualized planning for children, including those with severe emotional and behavioral disorders (SED),and their families • The Wraparound Team creates an intensive family preservation plan that supports keeping the child at home with their family. • Parents are referred to the support group for women who are victims of IPV, anger management group, and/or parenting group as needed
Dignity Health Human Trafficking Response Initiative	• CHMC has a Human Trafficking Response Task Force that is responsible for implementing the strategy designed by Dignity Health • The local task force is responsible for staff and provider training • The goal is to identify potential victims of sex and/or labor trafficking in our ED and other hospital units. • CHMC works closely with our community partners, LAPD Vice Squad and Coalition Against Slavery and Trafficking (CAST LA).
Health Ministry Program	• Parish Nurse refers potential victims to community partners providing needed services including shelter services
Stop the Bleed Program	• Stop the Bleed is a national awareness campaign and call-to-action. It is intended to cultivate grassroots efforts that encourage bystanders to become trained, equipped, and empowered to help a bleeding emergency before professional help arrives. • No matter how fast professional emergency responders arrive, bystanders will always be first on the scene. A person who is bleeding can die from blood loss within 5 minutes, therefore it is important to quickly stop the blood loss. Those nearest to someone with life threatening injuries are best positioned to provide first care. • Hospital staff teach Stop the Bleed to interested groups.
Maternity Tours	• Car seat safety is discussed at Maternity Tours • No infant can be released from the hospital without there being an infant car seat installed in the car • Free car seats are given to new parents delivering at CHMC

CA Bridge Program in ED	• Initiate buprenorphine for patient with Opioid Use Disorder in withdrawal • Teach family and friends of patient with OUD how to use naloxone in case of opioid overdose • Substance Use Navigator (SUN) will arrange discharge plan with local MAT provider • If patient with OUD is homeless, he/she may qualify for Bridge Housing for 90 day. The MAT provider must make that request.

Anticipated Impact: CHMC's initiatives to address gang prevention are anticipated to result in: more youth participating in productive learning and fitness activities after school, surrounded by healthy, caring adults with whom they can talk and interact
CHMC's initiatives to address child car seat safety and home safety are anticipated to result in: less severe injuries if the car that the infant/child is riding in is involved in an accident; less accidental injuries involving infants/toddlers if the parents have used a home safety kit to cover plugs, keep cupboard doors shut (especially those with cleaning supplies, etc), and put up a gate by stairs.
CHMC's initiatives to prevent child abuse and neglect are anticipated to prevent children from suffering from ACEs which are known to impose neurobiological and psychosocial effects that often results in health risk behaviors (smoking, drinking, substance use, promiscuity) in adolescence which, in turn, result in long-term consequences such as alcoholism, SUD, chronic disease, mental illness, unemployment, criminal behavior, and homelessness. CHMC's initiatives to address child abuse and neglect are anticipated to ameliorate the long-term consequences of ACEs.
CHMC's initiatives to prevent and/or treat family violence are anticipated to result in: less long-term consequences as a result of being a witness to family violence (one of the ACEs); early intervention with mental health services for those who witnessed family violence; comprehensive services to victims of family violence; youth and children developing healthy coping and communication skills so that they don't resort to physical, verbal, or sexual abuse; parents understanding the potential long-term consequences of a child witnessing family violence.
UniHealth CTMHR Project is anticipated to improve the mental health of youth and decrease suicidality in children and youth.
The CA Bridge program is anticipated to increase access to MAT for OUD and decrease the risk of accidental opioid overdose and death.
Dignity Health's Human Trafficking Response Network is anticipated to identify more victims of sex and/or labor trafficking in our EDs and help them access comprehensive healing services in the community.
The Stop the Bleed Campaign is anticipated to teach more bystanders how to become trained, equipped, and empowered to help a bleeding emergency before professional help arrives thereby saving lives.

Planned Collaboration: All of these programs include planned collaborations.
LA County Perinatal and Early Childhood Home Visitation Consortium membership is a network of approximately 50 perinatal and early childhood home visitation programs, maternal and child health organizations, advocacy groups, and stakeholders. Together, they work to support Los Angeles County's home visitation programs by sharing training and educational resources, researching best practice standards, supporting enhanced referral systems between programs, conducting research and

collecting data on home visiting outcomes, and advocating for systems and policies that recognize the tremendous value of home visitation services.
The CTMHR Project involves collaboration between all six Dignity Health hospitals in Southern CA and their community partners; moreover, each County has its own Community Advisory Committee.
Dignity Health Human Trafficking Response Initiative is a collaborative involving all the Common Spirit Health hospitals; annual conferences bring them together for training and education on best practices and innovative programs.
CA Bridge, a program of the Public Health Institute, is an accelerated training program for healthcare providers, designed to support access to around-the-clock treatment for substance use disorders, urgently needed to confront the opioid epidemic. The CA Bridge model is a significant improvement from traditional hospital strategies that provide referrals but do not directly treat addiction like other life-threatening chronic illnesses. Funded through the Substance Abuse and Mental Health Services Administration's (SAMHSA) State Targeted Response to the Opioid Crisis Grant to the California Department of Health Care Services (DHCS), participating program sites receive allocated funding, training, and technical assistance to launch facility-wide treatment and referral for substance use disorders.

Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs in the most recent CHNA report. The digests include program descriptions and intervention actions, statements of which health needs are being addressed, any planned collaboration, and program goals and measurable objectives.

10th Decile Project

Significant Health Needs Addressed	☒Significant Health Need 1 Housing & Homelessness ☒Significant Health Need 2 Access to Healthcare ☒Significant Health Need 3 Mental Health ☒Significant Health Need 4 Chronic Diseases ☒Significant Health Need 6 Substance Use and Misuse
Program Description	This Dignity Health Community Grant-funded project connects the top 10% highest cost, highest need chronically homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical and behavioral health care services through a collaboration of Corporation for Supportive Housing, JWCH Institute, Inc., and Housing Works.
Community Benefit Category	A3. Health Care Support Services

Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	After 12 mo in supportive housing (SH), 10th Decile individuals placed in SH show: 40% reduction in ER visits; 35% reduction in hospital readmissions 85% of individuals placed in SH during the grant period retain their housing for 12 mo. After 12 mo in SH, of individuals placed in SH: 40% are using primary care; 35% are using Substance Use Disorder (SUD) services; 35% are using mental health services. This work will provide a model for how other hospitals can work with the Health Homes Program (HHP) in Los Angeles County. Corporation for Supportive Housing will communicate this work in order to create a roadmap for how hospitals and service providers can access HHP funding and other new Medi-Cal funding streams in LA County.
Measurable Objective(s) with Indicator(s)	50 CHMC homeless patients have better access to primary care, community-based health services. Ten 10th Decile patients are referred to Housing Works (HW) for the 10th Decile Project. Five high-acuity homeless patients move into temporary supportive housing and are better able to recover from a health crisis. 5 patients are enrolled in Coordinated Entry System, obtain housing vouchers, and move into supportive housing units. HW's continued wraparound services help ensure that patients stay in SH and stabilize their chronic health conditions. Corporation for Supportive Housing will report the number of individuals utilizing community-based health services within JWCH, and the number of individuals enrolled and housed through HW. By the end of the grant period, JWCH is positioned to connect patients to new or existing referral pathways for CHMC's homeless patients. CHMC is able to maximize its utilization of the Homeless Information Management System (HMIS) to better target strategies (such as patient navigators at hospitals), services, and referrals for patients.
Intervention Actions for Achieving Goal	CHN screens patients on-site at CHMC and identifies and refers homeless high utilizers with complex health challenges to community-based health services and to HW. HW dedicates a part-time case manager to CHMC patients in the 10th Decile. HW case management includes care coordination, housing navigation, housing search, and tenancy support services. Corporation for Supportive Housing will convene JWCH, CHMC, and HW to discuss progress against target activities. Corporation for Supportive Housing provides CHMC, JWCH, and HW with targeted technical assistance on funding streams in the HHP.
Planned Collaboration	This projected involves the planned collaboration of CHMC, Corporation for Supportive Housing, JWCH (who hires and supervises the CHN), and Housing Works.

Para Su Salud – Enrollment Assistance Program

Significant Health Needs Addressed	☒Significant Health Need 2 Access to Health Care ☒Significant Health Need 7 Food Insecurity ☒Significant Health Need 9 Preventive Services
Program Description	This is a federally-funded grant program. Health insurance enrollers assist uninsured individuals and families sign up for health and dental health insurance benefits for which they qualify. Recertification is required every 6 mo.
Community Benefit Category	A3. Health Care Support Services

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	The program goal is to enroll uninsured individuals into the health insurance program he/she qualifies for. However, in light of the confusion about the new Public Charge rule, health insurance enrollers will have to debunk many of the incorrect rumors about what counts and what doesn't count when an individual plans to seek a green card. This will make their task more time consuming and fewer people may ultimately enroll out of fear.
Measurable Objective(s) with Indicator(s)	How many people did the enrollers outreach to? How many people did they enroll in health insurance? How many 6 mo recertifications did they complete? Track trend data based on prior 3 yrs and then moving forward.
Intervention Actions for Achieving Goal	The enrollers outreach to a number of different sites in the community as well as at the hospital. They assess each individual in order to determine which health insurance, if any, he/she qualifies for. Then they enroll individuals in that health insurance and explain how it works. They remind the individual that their insurance needs to be recertified every 6 months.
Planned Collaboration	They collaborate with a variety of community sites.

UniHealth Cultural Trauma and Mental Health Resiliency Project

Significant Health Needs Addressed	☒Significant Health Need 3 Mental Health ☒Significant Health Need 6 Substance Use and Misuse ☒Significant Health Need 8 Education
Program Description	This is a joint effort of the six Dignity Health hospitals in Southern California working in tandem to increase the capacity of local community organizations, community members, and hospitals to identify mental distress and/or suicidality among at risk youth, and to respond appropriately. Community partners and selected hospital staff will become certified trainers for Mental Health First Aid, Youth Mental Health First Aid, and Question, Persuade, and Refer (QPR), a suicide prevention curriculum. The certified trainers will then train adults who work with, live with, teach, coach, or minister to at risk youth, i.e., youth who have been affected by poverty, racism, adverse childhood experiences, and violence. Just as CPR helps you assist an individual having a heart attack, Mental Health First Aid helps you assist someone experiencing a mental health or substance use-related crisis. In the Mental Health First Aid course, you learn risk factors and warning signs for mental health and addiction concerns, strategies for how to help someone in both crisis and non-crisis situations, and where to turn for help. Youth Mental Health First Aid is designed for people who routinely interact with youth ages 12-18; The course introduces common mental health challenges for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations. QPR teaches individuals how to prevent the immediate risk for suicide and where to refer the person for professional help. This 3-yr collaborative is jointly funded by the UniHealth Foundation and the Dignity Health Foundation.
Community Benefit Category	A1. Community Health Education

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	There will be more certified trainers of MHFA, YMHFA, and QPR in the community and at the hospital. More community members and hospital staff will be able to identify mental distress and/or suicidality among at risk youth, and respond appropriately. There will be less mental health stigma. More youth will have access to prevention and early intervention mental health and SUD services, thereby decreasing health and educational disparities. Youth suicide rate will decrease.

Measurable Objective(s) with Indicator(s)	Number of certified trainers of MHFA, YMHFA, and QPR trained. Number of community members and hospital staff trained on MHFA, YMHFA, and/or QPR. Impact of receiving this training 6 mo prior to survey. Number of youth accessing mental health and/or SUD services as result of this collaborative. Youth suicide rate in hospital service areas before and after implementation of this project.
Intervention Actions for Achieving Goal	Selected people working for community partners funded by this grant as well as selected hospital staff will become certified trainers of MHFA, YMHFA, and/or QPR. Spanish-speaking staff will become certified in both English and Spanish. Community partners will outreach to their constituents in order to give classes on MHFA, YMHFA, and/or QPR. As a result of interacting with caring adults who have been trained, at risk youth will be identified as being in mental distress and/or suicidal and be referred to those who can help them. Because of decreased stigma, more youth will accept early intervention mental health and/or SUD services and less youth will die by suicide.
Planned Collaboration	This is a planned collaboration involving the six Dignity Health hospitals in Southern California, their grant-funded community partners, and the constituents of these partners – schools, churches, community centers, etc. Dignity Health has hired a project evaluator, the Center for Nonprofit Management.

Diabetes Empowerment Education Program

Significant Health Needs Addressed	. ☒Significant Health Need 4 Chronic Diseases ☒Significant Health Need 7 Food Insecurity ☒Significant Health Need11 Overweight and Obesity
Program Description	CHMC *promotora* teaches 2-hour workshops for 6 consecutive weeks to people with pre-diabetes, diabetes, relatives and caregivers interested in learning how to prevent diabetes in the case of pre-diabetics and/or prevent complications of diabetes by gaining a better understanding of their disease and how to manage it with proper diet, exercise, and medication, if necessary. These workshops are highly interactive so that people can put what they learn into action.
Community Benefit Category	A 1. Community Health Education

Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	.As a result of attending these workshops, attendees with pre-diabetes will be able to prevent or at least postpone the onset of diabetes. As a result of attending these workshops, attendees with diabetes will be able to better manage their disease and thereby prevent complications of their disease. As a result of attending these workshops, relatives and caregivers will learn how they can help their loved one achieve their goal. As a result of attending these workshops, attendees will have less visits to ER and less hospitalizations for glucose control.
Measurable Objective(s) with Indicator(s)	Pre- and post-workshop weight, BP, HbA1c, and cholesterol. Pre- and post-workshop assessment of knowledge about diabetes. Pre- and post-workshop need to go to ER and/or be hospitalized for glucose control. If one could do long-term follow-up on attendees, one could determine how many and when pre-diabetics developed diabetes and how many diabetics developed complications of diabetes and when. However, such studies are extremely difficult to do involving our patient population that moves and changes their phone numbers frequently.
Intervention Actions for Achieving Goal	The Parish Nurse will screen for overweight/obesity, hypertension, HbA1c, and cholesterol before the workshops begin and 3-6 mo after the workshops. The attendees will complete a pre- and post-test to assess their knowledge. Attendees will be asked how many times they went to ER and /or were hospitalized for glucose control during the 6 mo before the workshops and the same time period after the workshops. Attendees will attend the 2-hr workshops on 6 consecutive weeks and implant their action plans that will include recommended changes to their diet, increased physical activity, avoidance of alcohol use, and compliance with taking prescribed medications.
Planned Collaboration	This program involves planned collaboration with a number of schools, churches, community sites, as well as FQHCs,

HSFC Early Head Start Program

Significant Health Needs Addressed	☒Significant Health Need 1 Housing and Homelessness ☒Significant Health Need 2 Access to Health Care ☒Significant Health Need 3 Mental Health ☒Significant Health Need 4 Chronic Diseases

	☒Significant Health Need 5 Economic Insecurity ☒Significant Health Need 6 Substance Use and Misuse ☒Significant Health Need 7 Food Insecurity ☒Significant Health Need 8 Education ☒Significant Health Need 9 Preventive Practices ☒Significant Health Need 10 Birth Indicators
Program Description	This program is funded by a federal grant. Core services of EHS include: early childhood education (ECE); healthcare and mental health services; parenting education; childcare; adult education; and housing, legal, and financial assistance. We have put into place a continuum of home and center-based ECE services that responsively meet the individual and changing needs of young families. Options currently available to families include: 1)home-based services with weekly in-home ECE, along with twice per month socialization opportunities; 2) full-year, full-day center based ECE, with monthly home visits; 3) combination option services, with daily center-based family literacy services, combined with biweekly in-home ECE; and biweekly in-home ECE, concurrent with enrollment in high-quality childcare and bimonthly visits at the childcare site. Priority EHS enrollment is given to: pregnant mom with child already enrolled in EHS; homeless families; foster children; children with special needs; parents interested in ESL or high school diploma/GED studies; and families participating in other HSFC programs. Enrollment priorities reflect 2016 HSFC EHS Community Needs Assessment data that document a high incidence of developmental disabilities and homelessness within the service area; large numbers of recent immigrant, mono-lingual Spanish-speaking young families; and low adult literacy and educational levels.
Community Benefit Category	Community Health Improvement Services: A 1. Community Health Education A 2. Community-based clinical services A 3. Health care support services Community Building Activities: F3. Community Support F5. Leadership Development and Leadership Training for community members
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	1. Promote children's (infant/toddler) overall development 2. Enhance the capacity of parents to nurture and care for their young children 3. Build on existing services and foster community partnerships to increase services for young children and their families 4. Expand staff knowledge, skills, and competencies in working with young children and their families

Measurable Objective(s) with Indicator(s)	Maintain full enrollment throughout the year. At least 10% of EHS children will have a disability Goal 1: 100% of classrooms will provide quality environments that support optimal development; 70% of children who receive at least 6 mo of services will demonstrate age-appropriate development. Goal 2: 80% of parents will acquire skills to support learning and language development; improved school/employment opportunities for 60% of working/studying parents; case management supports for all parents; 100% on-time health screens; 95% current well-child care and immunizations. Goal 3: 60% of parents will participate in leadership and civic engagement opportunities. Goal 4: 75% of teachers will hold a Bachelor's degree or will be progressing toward a BA; 100% of teachers without a degree will progress toward an Associate's degree; 100% of staff will demonstrate professional competency.
Intervention Actions for Achieving Goal	Continue to provide EHS services for qualifying families in our service area in accordance with EHS performance standards and guidance as specified in our contract and implementation plan.
Planned Collaboration	HSFC has signed MOUs with the following organizations: Angelica Church, St.Marks Church, Crystal Stairs Pathways, Children's Learning Center, Museum of Contemporary Art, Enrichment Works, Community Counseling Services, LAUSD, Pacific Asian Consortium in Employment, UCLA, LA City College, West ED, Bresee Foundation, Chrysalis, First 5 LA, LA Conservation Corp, St.Francis Center, Eisner Health, CHMC-Eisner Health Family Practice, WIC, Pico Union Housing Corp, Esperanza Community Housing Corp, Asian Pacific American Legal Center, Lanterman Regional Center, South Central Regional Center, LA County DHS, LA County DCFS, LA Trade Technical College, Abram Friedman Vocational Education Center.

LABBN's Perinatal and Early Chidhood Home Visitation Programs

Significant Health Needs Addressed	☒Significant Health Need 2 Access to Health Care ☒Significant Health Need 3 Mental Health ☒Significant Health Need 4 Chronic Diseases ☒Significant Health Need 5 Economic Insecurity ☒Significant Health Need 6 Substance Use and Misuse ☒Significant Health Need 7 Food Insecurity ☒Significant Health Need 8 Education ☒Significant Health Need 9 Preventive Practices ☒Significant Health Need 10 Birth Indicators

Program Description	LABBN is funded by First 5 LA and LACDPH. LABBN is a community benefit of CHMC where the staff is based. The staff is CHMC employees. LABBN, First 5 LA, PAC/LAC, and Maternal Child Health Access comprise the Family Strengthening Oversite Entity (FSOE). The FSOE oversees and supports the standardization of the Welcome Baby Program to ensure adherence to program fidelity by the Welcome Baby sites across the county. The Oversight Entity also provides training and technical assistance to all home visitors, supports to the Parents as Teachers and Healthy Families America providers and support efforts to maintain referral pathways between Welcome Baby and PAT and HFA providers, as well as other existing home visitation programs throughout the County. Additional responsibilities include the provision of technical assistance to providers utilizing First 5 LA's data management information system; facilitation of cross-site peer learning exchanges; and coordination and support of communication and messaging efforts
Community Benefit Category	Community Health Improvement Services: A1 Community health education A2. Community-based clinical services A3. Health care support services Community-Building Activities: F3. Community support F7. Advocacy for community health improvements & safety F8. Workforce development
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Build and strengthen the knowledge and awareness of WB and PAT and HFA staff on theory, research, and topics that will support their working with families using a strengths-based, client-centered and solution-focused approach for strengthening families Promote the development and application of skills by the WB and PAT and HFA staff that will support their work with families Provide guidance, coaching, and training to WB and PAT and HFA sites to promote implementation of the program models with fidelity Establish a seamless integration of WB into the organizational (hospital) structure Promote the establishment of a strong infrastructure within WB and PAT and HFA sites to ensure that program outcomes are achieved Promote the establishment of a strong infrastructure within WB and PAT and HFA sites to sustain these family strengthening service
Measurable Objective(s) with Indicator(s)	Measurable, observable, and attainable objectives including: □ Outcomes-changes in health/mental health status, developmental status, attitudes, behaviors, knowledge, skills, practices, or policies □ Outputs-the direct result of activities and typically expressed as the number or scope of services and/or products that are delivered or produced

	o # staff trained/yr o #families served/yr □ Major Deliverables-tangible products that are submitted in fulfillment of contract requirements WB and PAT and HFA training, implementation, and cross-site professional development WB and SHV technical assistance Stronger Families Database efforts and coordination WB and SHV evaluation and fidelity oversight Marketing and Communication Perinatal and Early Childhood Home Visitation Consortium Regional Breastfeeding Consortium Key Partner coordination and reporting requirements
Intervention Actions for Achieving Goal	Coordinate and implement two sets of trainings of core topics for new WB and PAT and HFA program staff in conjunction and with participation of MCHA and PAC/LAC as needed annually. Update, as needed, and distribute WB Orientation and Protocols Manuals via online links to 14 WB and all PAT and HFA programs annually Provide training and ongoing TA to WB and PAT and HFA staff as new features are developed for the Stronger Families Database Provide leadership and oversight for database development activities Convene and facilitate one, full day, peer learning workshop within each of the four regions of LA County annually to provide opportunities for cross-site learning for WB and PAT and HFA staff Convene one, full day, peer learning workshop for all WB programs annually and one for all PAT and HFA programs annually. Implement 2 Successful Leadership and Change Management Workshop for new WB and PAT and HFA staff annually Provide Reflective Practice coaching sessions monthly for WB clinical supervisors and separately for PAT and HFA supervisors Conduct annual audits of each WB and/or PAT and HFA site for model fidelity, implementation progress, and to identify any challenges and successes according to the established protocol Coordinate with F5LA staff and all external evaluators of WB and/or PAT and HFA programs Provide marketing and messaging templates to ensure consistent messaging across WB and PAT and HFA sites Convene quarterly meetings of LA County Perinatal and Early Childhood Home Visitation Consortium (LACPECHVC) Plan and convene with Consortium partners monthly workgroup meeting- Referrals, Best Practices, Advocacy, and Data.
Planned Collaboration	The primary partners of the FSOE are: LABBN, First 5 LA, Maternal Child Health Access (MCHA), and the Perinatal Advisory Council: Leadership, Advocacy & Consultation (PAC/LAC). Our hospital partners are: CHMC, Providence Holy Cross Medical Center, Northridge Hospital Medical Center, Valley Presbyterian Hospital, Emanate Health,

	Adventist Health White Memorial Medical Center, St. Francis Medical Center, Centinela Hospital, Miller Children's Hospital, Providence Little Company of Mary, Torrance Memorial Medical Center, St. Mary Medical Center and Martin Luther King Jr. Community Hospital. Our community partners include: Antelope Valley Partners for Health, Children's Bureau, Child and Family Guidance Center, Child Care Resource Center, Children's Center of Antelope Valley, El Nido Family Center, Friends of the Family, SPIRITT Family Services, Foothill Family Services, Human Services Association, Plaza Community Services, The Whole Child, Shields for Families, Children's Institute, South LA BioMed, LA Wellnest, Richstone Family Center, Families in Good Health, The Children's Clinic, and Pacific Asian Counseling Services.

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