# COMMUNITY BENEFIT IMPLEMENTATION PLAN

## 2012 – 2013

### ST. VINCENT MEDICAL CENTER

### LOS ANGELES, CALIFORNIA

*Furthering the Healing Ministry of the Daughters of Charity*

## I. Introduction

St. Vincent Medical Center (SVMC) is a 366-bed, short-term acute care, general hospital located in the downtown area of Los Angeles. SVMC specializes in tertiary level services with a long-standing reputation in cardiac care, organ transplantation, oncology services, orthopedic services and the treatment of hearing disorders. SVMC has an extensive and rich tradition of serving the residents of Los Angeles along with patients from other states and from countries throughout the world. Founded in 1856 by the Daughters of Charity of St. Vincent de Paul and Los Angeles' first hospital, SVMC has been serving the community for over 155 years. As a member of the Daughters of Charity Health System, SVMC continues to uphold its primary mission of providing quality medical services to the most vulnerable populations, the sick, the poor, the elderly and children. SVMC is committed to the fulfillment of the mission of its founding Sisters through the delivery of charitable services and care to the community.

## II. Highlights of 2010 Community Health Needs Assessment

Since the last needs assessment conducted by SVMC in 2007, the communities within SVMC's service area, much like the rest of the nation, have suffered through a devastating economic recession that left many of its residents more vulnerable. Despite the passage of health care reform legislation, many components of which have not taken effect, many participants reported seeing more and more people losing health insurance. Some of this has to do with high unemployment rate, as many people have lost their insurance coverage when they were laid off.

Both quantitative (or secondary) data and qualitative (or focus group and interview) data suggest that there has been a negative trend most prominently in the area of access to health care and three health-related issues: mental health, diabetes and obesity. Services or programs were either eliminated, hospitals were closed, or eligibility became more restricted. Or community members simply could not afford health services, or prioritized them below more basic needs, such as food and shelter. Both providers and community members identified vision and dental services to be especially lacking in the community. The lack of access to health services affected the older adult population and undocumented population disproportionately.

The emergency room continues to be the last resort for many community members who are uninsured or who delay care. Having patients in the emergency room whose symptoms do not warrant emergency care taxes the quality and efficiency of the health care system. Increasingly, though, community clinics are becoming a regular source of care in Los Angeles health care landscape, especially for immigrants. While this cushioned some of economic blows to health access, it also created a seemingly fractured system.

Despite increasing health needs (or because of it), participants believed that there is a community interest in promoting healthy behavior and in focusing on prevention efforts. Access to green space and healthy food options were often cited as top priorities for the community. The quantitative data also suggested that certain health trends, such as smoking cession and breast cancer screening, turned positive, when there were concentrated efforts in social marketing, policy advocacy, and community health promotion and outreach.

Other community services have been similarly impacted by the recession. Consistent with the quantitative data, participants reported that there was a rise in childhood diabetes, as a result of increasing obesity rates in this population. Easy access to fast food and the elimination of physical fitness programs were just two reasons cited for this, as the recession had made the fast food option affordable to many families and, because of shrinking school budgets, many schools did not even offer physical education classes anymore. Participants also believed that the recession also had led to stressors, such as unemployment, overcrowding and financial instability, that further complicates the mental health of many community members. In addition, budget cuts have reduced the availability of mental health services.

Participants expressed optimism that hospitals like SVMC will play a leadership or convening role in improving health outcomes in their communities. Some participants suggested and others cited examples of collaboration between hospitals and clinics, schools and community-based organizations that serve hard-to-reach populations as a crucial strategy in promoting health. The community health promoter or promotora model was especially successful in the Latino community.

## Access

- According to the 2005 California Health Interview Survey, only 3 of the 54 zip codes in SVMC's service area had a 20% uninsured rate for individuals under the age of 65.
- In 2007, the percentage of adults who reported a regular source of care in the Metro and South SPAs of SVMC's service were lower compared to Los Angeles County (74.1% and 79.1% vs. 80.8%) and all other SPAs. However, the Metro and South SPAs have the highest percentage of adults receiving medical services from the Los Angeles County Health Department facilities.
- The percentages of adults and children who did not obtain dental care in the past 12 months because they could not afford it were higher in SVMC's service area than in the Los Angeles County.
- The cost of prescription medication continues to be a problem for low-income, uninsured and under-insured individuals and families. The percentage of adults who did not get their prescription medication in the past year because they could not afford it was higher in SVMC's service area than in the Los Angeles County.

- Two of the biggest barriers to accessing care were transportation and lack of linguistic competence of providers. An additional barrier particular to senior care was a lack of service coordination among an overly fragmented and often competitive long-term care system.
- For community clinics, recent and impending budget cuts, delayed payments, and a growing low-income under-insured population have exacerbated an already overburdened system.

## Mental Health

- The need for mental health services has increased, given the high level of stress due to the worsening economy and unemployment.
- The most frequently cited community mental health issue continues to be depression. Diagnosis of depression had risen since 1999. In particular, women, older adults and American Indians had the highest rate of depression in Los Angeles County.
- In 2007, there were 13.6% of adults diagnosed with depression (up from 12.9% in 2005) in Los Angeles County. The largest increase occurred in SVMC's SPA 4 (11.9% vs. 14.6%). Within SVMC's service area, the percentage of adults diagnosed with depression was 13.6% in SPA 6 and 14.6% in SPA 4.

## Chronic Diseases

- Within SVMC's service area, SPA 4 had an increase in the prevalence rate of diabetes from 2005 to 2007 (14.5% vs. 20.8%). SPA 6 continues to report the highest diabetes prevalence rate in Los Angeles County and California.
- SPA 6 had an increase in the prevalence rate of asthma; while SPA 4 had a decrease.
- SVMC's service area had a 3.0% average increase in heart disease in ten years, compared to an average of 2.7% across all SPAs.
- There was also an increase in hypertension for the SVMC service area. The prevalence of hypertension in Metro SPA 4 had double-digit growth from 1997 to 2007 (13.8% vs. 24.8%). While South SPA 6 continues to have the highest hypertension rates in Los Angeles County at 29.0%.
- Both SPA 4 and SPA 6 had the lowest high blood cholesterol estimates than Los Angeles County and other SPAs.

**Health Behavior and Preventive Care**

- The California Health Interview Survey reported less than half the adults in SVMC's service area consumed at least 5 servings of fruits and vegetables from 2003 to 2005. Regardless of income level or the level of access to fresh fruits and vegetables, consumption differences do not exist among SVMC's service area zip codes.
- From 2005 to 2007, SVMC's service area had an increase in individuals who were overweight or obese. Nearly two-thirds (65.2%) of adults in SVMC's SPA 6 were overweight or obese compared to over half (57.4%) of Los Angeles County adults.

**Cancer**

- In Los Angeles County, 34,335 residents were diagnosed with cancer in 2010. Most cancer incidents were attributed to breast cancer, colon cancer, and cervical cancer. Since 2007, cancer screening rates continues to improve and cancer incidence rates have remained steady.
- In the SVMC service area, more than two-thirds of women 40 years and older reported having a mammogram in 2007 or the previous two years. And nearly three-fourths of women 50 years and older reported having a mammogram in 2007 or the previous two years.
- Colon screening rates varied across Los Angeles County, from a low 35.6% in SVMC's SPA 4 to a high 43.3% in SVMC's SPA 6, compared to median 38.1% for Los Angeles County.
- SVMC Metro SPA (84.6%) and SVMC's South SPA (88.3%) reported higher rates of cervical (pap smear) screenings among women than Los Angeles County (84.4%).

**HIV/AIDS**

- The number of HIV/AIDS cases decreased from 2007 to 2010. However, a disproportionate number of cases were reported among people of color and youths. Hispanic and immigrant groups lacked awareness in HIV prevention and proper use of HIV medication.
- In 2009, SPA 4 had the highest number of adolescents diagnosed with AIDS (74) than other SPAs in Los Angeles County. SPA 6 had the second highest number at 58.
- Although the number of HIV/AIDS cases has decreased, the number of individuals living with HIV has increased as many people living with HIV are living longer as a result of better medication.

**Communicable Diseases**

- The number of pertussis cases has increased in 2010. SVMC's service area had the largest number of reported cases In Los Angeles County. SPA 6 reported the highest number (14) and SPA 4 reported 10 cases.
- Among STDs, the rate of chlamydia in Los Angeles County remained higher than California or the United States. SPA 6 reported the highest rate of chlamydia cases with 960.0 cases per 100,000 in 2007 compared to 859.5 per 100,000 in 2005. In both 2005 and 2008, SPA 6 had the highest rate of chlamydia cases in Los Angeles County.

## *III. St. Vincent Medical Center's Response to Community Needs*

The Community Needs Assessment identified the following areas of greatest need:

- Access to care (service coordination, transportation, linguistic competency)
- Chronic disease prevention and management services (diabetes, cardiovascular disease)
- Nutrition education and obesity prevention programs
- Cancer detection services (breast, cervical and colon)
- Dental Care
- Mental health services (depression)
- Cost of prescription medication
- HIV education programs and proper use of medications for people of color and youth
- STD education and prevention

In accordance with its resources and expertise, St. Vincent Medical Center and its Community Benefit Committee prioritized from among these needs the areas it can have the greatest impact: (1) access to primary and specialty care; (2) chronic disease prevention and management; (3) nutrition education and obesity prevention; and (4) early detection of breast and cervical cancers.

High priority community health needs not addressed in St. Vincent Medical Center include programs on mental health services, dental care, medication costs, and HIV and STD education and prevention. The primary factors contributing to this decision include: (1) lack of expertise (mental health and dental care services; HIV and STD education); (2) limited resources; and, (3) the availability of other providers in the community with more capacity/expertise to address these needs. St. Vincent Medical Center has established referral and collaborative relationships with the following organizations that have capabilities to provide these services:

**Dental Care**

- UCLA School of Dentistry
- USC Ostrow School of Dentistry
- Arroyo Vista Clinic
- Oscar Romero Medical Clinic
- St. Johns Well Child and Family Center

**Mental Health Services**

- Behavioral Health Services
- Korean American Family Service Center
- L.A. County Department of Health Services – Mental Health Services
- APAIT Health Center
- St. Johns Well Child and Family Center

**HIV and STD Education/Prevention**

- Compton Mobile Central Unit
- APAIT Health Center
- KHEIR Clinic
- Watts Healthcare Corporation
- AIDS Foundation
- St. Johns Well Child and Family Center

**Low-Cost Medication Assistance**

- Saban Free Clinic
- THE Clinic
- L.A. County Olive View Hospital

While not identified as a major health issue, St. Vincent Medical Center, in keeping with its mission to serve vulnerable populations, has taken a leadership role in directing some of its community benefit resources to programs that target at-risk youth and their families. The underlying intent is to contribute toward improving economic opportunities, physical health and family relations while also helping to reduce crime, gang involvement and domestic violence. All of these factors have been identified by a growing body of research as vital social determinants to well-being, health and quality of life.

## IV. *Implementation Plans*

Based on community need priorities, available institutional resources and established partnerships with a broad array of agencies, programs, providers and faith- and school-based organizations, St. Vincent Medical Center will implement initiatives, consisting of programs and services, during 2012–2013 that address access to primary and specialty care, chronic disease prevention and management, transportation, insurance and public program enrollment and youth services. Each initiative identifies the respective community need addressed, goals and objectives to be accomplished during the year, evaluation indicators used to measure impact and key collaborating partners.

### Initiative: Health Benefits Resource Center (HBRC)

| Community Need | Goal | Objectives | Evaluation Indicators | Key Community Collaborators |
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| Access to care. | Increase access referral and navigation assistance to low-income individuals and families for health care insurance and government-sponsored programs. | 1. Participate in outreach events and provide information on available health programs and services. HBRC will be attending at least four school-based events and five community health fairs.<br>2. Assist to complete and submit 600 new applica-tions to the appropriate program administrator for determination of medical coverage benefits.<br>3. Assist to complete and submit 260 new CalFresh applications to the Department of Public & Social Services (DPSS) to determine benefit eligibility and benefit allotment.<br>4. Make 1,000 referrals to government and/or private safety net providers | • Number of outreach events attended<br>• Number of new health and CalFresh applica-tions submitted<br>• Number of annual re-determinations<br>• Number of safety net and social support referrals<br>• Number of families assisted with case management/trouble shooting<br>• Number of individuals receiving HBRC flyers<br>• Name, date and location of two major outreach events and four school-based events<br>• Name, date and location of faith- and community-based | • Los Angeles Department of Public Social Services<br>• St. Vincent School & Our Lady of Talpa School<br>• MonSeñor Oscar A. Romero Clinic<br>• Los Angeles Unified School District<br>• El Salvador Consulate<br>• Guatemala Consulate<br>• Korean Consulate<br>• Mexican Consulate<br>• Nicaragua Consulate |

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| | | including; LA County Ability to Pay, Outpatient Reduced Simplified Application (ORSA), Public Private Partnership (PPP), Prescription Program Assistance (PPA), Info Line 211, food banks, housing emergency shelters, So. CA Edison, shoes and/or school uniforms and St. Francis Right to Health Project.<br>5. Assist to complete 50 primary care changes.<br>6. Assist to complete 70 annual re-determinations. | business partners | |

## Initiative: Casa de Amigos de San Vicente

| Community Need | Goal | Objectives | Evaluation Indicators | Key Community Collaborators |
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| Access to academic enrichment assistance, recreational opportunities, gang diversion and youth/ family development programs. | Provide children and their families opportunities to enhance their academic, cultural, spiritual and athletic development. | 1. Maintain and expand the programs and services offered by Casa de Amigos Community Center.<br>2. Provide parents of children enrolled in Casa parenting education programs and access to a community resource library.<br>3. Demonstrate measurable improvement in reading and math skills of children enrolled in Casa academic programs.<br>4. Implement programs that foster parent-child communication and family values.<br>5. Collaborate with agencies that will provide job training programs and job placement opportunities for youth and parents.<br>6. Provide vital social services referrals to Casa participants and their families.<br>7. Improve the health of all participants through involvement in team sports, tournaments, karate training, and self-defense instruction. | • Number of participants served<br>• Evaluation of reading and math skills<br>• Feedback from parents<br>• School progress reports<br>• Assessment of performance in special events | • Boy Scouts of America<br>• Breese Foundation Community Center<br>• CHILL Foundation<br>• Kicks for Kids Galaxy Foundation<br>• Los Angeles Academy of Arts & Enterprise<br>• Los Angeles County Toy Loan Program<br>• Mexican Consulate in Los Angeles<br>• Rampart Village Neighbor-hood Council<br>• Salvation Army Red Shield Youth and Community Center<br>• Union Avenue Elementary |

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| | | 8. Provide a safe environment for recreation and learning for residents in the immediate neighborhood surrounding SVMC. | | |

## Initiative: Multicultural Health Awareness and Prevention (MHAP) Center

| Community Need | Goal | Objectives | Evaluation Indicators | Key Community Collaborators |
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| Access to primary and preventive care, health education, referrals for specialty services, early cancer detection and risk factor reduction for diabetes, obesity and heart disease. | 1. Increase breast cancer awareness and knowledge in the targeted Latino, Korean, Filipino, Thai communities, and other vulnerable populations in central Los Angeles by establishing a lasting breast care network with organized information and resource sharing among health care professionals and women's organizations in these communities.<br>2. Collaborate with faith-based organizations and community organizations to assist underserved populations obtain primary care, health education and screenings, health information, obesity reduction measures, medical referrals and guidance on using health care system.<br>3. Increase community involvement and encourage active participation of community partners and organizations in MHAP | 1. Refer between 800-1000 women for clinical breast examinations and screening mammograms at the SVMC Radiology Department and/or CDC partnering agencies, such as the KHEIR Clinic and Asian Pacific Health Care Venture Clinic. Referrals to clinical breast examinations and annual mammogram screenings through:<br>- 5,000 flyers distributed to 30 health and nonprofit agencies.<br>- A minimum of 15 community presenta-tions per year on the importance of breast cancer early detection through clinical breast examinations, breast cancer screenings, and breast self-examinations.<br>2. Contact up to 100,000 people from multicultural communities and educate them about health issues on cancer, obesity, nutrition, diabetes and hypertension through one-to-one educational | • Number of people screened<br>• Number of patient referrals<br>• Number of educational materials distributed<br>• Number of faith-based organizations affiliated<br>• SVMC Health Fair provider feedback<br>• Number of women screened<br>• Number of cancers detected<br>• Number of annual returns<br>• Number of community events<br>• Number of attendees at community events<br>• Number of women referred for screening (both insured and uninsured)<br>• Community feedback and evaluation<br>• Number of community organizations served<br>• Number of community physicians & nurses contacted<br>• Number of programs conducted<br>• Formal and informal feedback from patients, families and physicians | • Foreign Consulates in Los Angeles<br>- Mexican Consular Office<br>- Central American Consular Offices (El Salvador, Guatemala, Nicaragua, Costa Rica & Honduras)<br>- Korean Consular Office<br>- Philippines Consular Office<br>- Royal Thai Consular Office<br>• Government Organizations<br>- LA City Dept. of Aging<br>- LA County Public Health Department<br>- LAUSD Parent and Community Engagement Unit<br>- Los Angeles Unified School Districts, School of Nursing Services Unit<br>• Government Officials Offices<br>- Office of City Council Member Ed Reyes<br>- Office of City Council Member Eric Garcetti<br>• Health Care Organizations and Medical Providers<br>- AltaMed Health Service<br>- American Cancer Society<br>- American Diabetes Assoc.<br>- Asian Pacific Health Care Venture (APHCV)<br>- KHEIR (Korean Health, Education, and Information Resource) Community Health Center |

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|  | Center community outreach and education program.<br>4. Improve the quality of life of cancer patients through programs that enhance physical and emotional well-being. | contact, group workshops and lectures and other educational messages through media.<br>3. Increase screening services including prevention through multicultural related activities such as community festivals, health fairs and exhibits, and other religious and cultural affairs.<br>4. Conduct at least 12 education classes on obesity and nutrition in the community.<br>5. Continue to participate in at least 12 community health fairs and provide health and safety information to at least 10,000 people.<br>6. Collaborate with partnering organizations, including LAUSD nurses to conduct health education and screening services to low-income and uninsured individuals.<br>7. Continue to implement SVMC annual health fair and maintain a target of more than 1,000 beneficiaries and 25 exhibitors.<br>8. Provide annual flu shots to 1000 patients.<br>9. Continue weekly nutrition and diabetes classes in | • Results of Client Intake Forms Survey | - Forum Medical Group<br>- Behavioral Health Services, Inc.<br>- East Los Angeles Women's Center<br>- St. John's Wellness Child Center<br>- One Legacy<br>- Network for Healthy California<br>• Faith-Based Organizations<br>- Council of Korean Churches in Southern California<br>- Holy Cross Catholic Church<br>- Our Lady of Loretto Church<br>- St. Basil Parish Korean Ministry<br>- St. Columban Catholic Church<br>- St. Gregory Catholic Church<br>- St. John Catholic Church<br>- St. Vincent Catholic Church<br>• Adult and Senior Centers<br>- LA Central Adult Day Care Center<br>- Menorah Housing Foundation<br>- Silverlake Adult Day Care Center<br>- Steel Plaza Senior Apts.<br>- St. Barnabas Senior Center<br>- Terry Senior Apartment<br>- Wilton Korean Senior Housing Center<br>• Community-Based Organizations and Civic Groups<br>- Latino and Other Local Partner Organizations<br>▪ Central American Resource Center (CARECEN) |

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| | | English, Korean and Spanish and expand same services to other multi-cultural communities.<br>10. Continue the tri-lingual health promoter program that provides blood pressure and nutritional screenings, and body composition analysis to multicultural communities.<br>11. Offer cosmetic counseling and education for female cancer patients quarterly. | | ▪ Latina Task Force<br>▪ New Economics for Women<br>▪ Pico Union Neighborhood Council<br>▪ Vision Compromiso Health Network Center<br>- Filipino<br>▪ Filipino American Chamber of Commerce Los Angeles<br>▪ Filipino American Community of Los Angeles (FACLA)<br>▪ Philippine Medical Assoc. of So. Calif. (PMASC)<br>▪ Mother Movement Inc.<br>▪ UERM Medical Alumni Association of SC<br>- Korean<br>▪ Korean American Family Resource Center<br>▪ Korean Council of American Churches<br>▪ Korean Daily – Happy Village<br>- Thai<br>▪ Thai Community Development Center<br>▪ Thai, Inc.<br>▪ Wat Thai of Los Angeles |

## Initiative: Community Diabetes Education Program (CDEP)

| Community Need | Goal | Objectives | Evaluation Indicators | Key Community Collaborators |
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| Chronic disease prevention and management services (diabetes). | 1. Provide undeserved people with diabetes or with pre-diabetes the skills and knowledge necessary to manage/control their diabetes and enable them to live healthier productive lives.<br>2. Provide diabetes awareness and diabetes prevention education to community members at high risk for developing diabetes type II and its complications. | 1. Continue to provide free comprehensive Diabetes Self-Management Education classes to people with diabetes and pre-diabetes.<br>2. Continue to provide free presentations and workshops on healthy life style, nutrition, exercise, and healthy weight to community adults and children at high risk for developing diabetes.<br>3. Continue to identify patients admitted to the hospital with diabetes out-of-control and/or complications of diabetes, and re-channel them to proper management of diabetes by means of appropriate education and training based on findings during assessment.<br>4. Continue with active participation in community outreach by attending large health fairs and community events. Purpose of outreach will be to provide blood glucose screening, diabetes awareness and diabetes. prevention education. | • Number of participants in classes<br>• Number of people screened<br>• Number of educational materials distributed<br>• Number of patient referrals<br>• Number of Health Fairs and community presentations | • Consulate of Costa Rica<br>• Consulate of El Salvador<br>• Consulate of Guatemala<br>• Consulate of Honduras<br>• Consulate of Korea<br>• Consulate of Mexico<br>• Consulate of Nicaragua<br>• Consulate of the Philippines<br>• Consulate of the Royal Republic of Thailand<br>• Holy Cross Community Center<br>• Los Angeles Unified School District<br>• West Coast University |

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| | | Make appropriate referrals and follow ups based on results of screenings.<br>5. Work with partner organizations on different community settings and offer professional support and guidance as needed and as requested.<br>6. Maintain a data base to track classes, screenings, referrals, events participations and sessions with patients. | | |

## Initiative: Asian Pacific Liver Center (APLC)

| Community Need | Goal | Objectives | Evaluation Indicators | Key Community Collaborators |
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| Chronic disease prevention and management services (hepatitis) | Provide education, free screening for those at risk of hepatitis B, and vaccinations for those who are susceptible and to provide culturally-sensitive treatment and surveillance measures for those already affected. | 1. Educate 8,500 Asian Pacific Islanders (API) - Korean, Chinese, Vietnamese, Thai, and Cambodian -- at screening sites and educational venues in the targeted cities of greater Los Angeles.<br>2. Educate 50 physicians who see API patients in the targeted cities on the importance of Hepatitis screenings and treatment through Roundtable dinner meetings hosted by Drs. Ho Bae and Tse-Ling Fong. Physician education will also involve how to diagnose chronic liver disease due to viral hepatitis, how to manage patients who will likely progress to cirrhosis and hepatocellular carcinoma, and the availability of several antiviral therapeutic agents.<br>3. Screen 3,000 total APIs by conducting 24 screening events per year.<br>4. Vaccinate 100 Hepatitis B susceptible individuals. | • Number of patients screened<br>• Number of service agencies and churches/temples affiliated<br>• Number of educational materials distributed<br>• Number of health fairs participated in<br>• Number of hepatitis B patients from screenings seen at the APLC and/or other physician for follow-up care<br>• Health fair provider feedback<br>• Number of medical article publications<br>• Number of completed research projects<br>• Number of physicians who attended hepatitis B educational meeting | • Asian Pacific Health Care Venture (APHCV)<br>• Herald Cancer Association<br>• Korean Health, Education, and Information Resource (KHEIR) Center |

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| | | 5. Ensure that at least 95% of persons tested for hepatitis B have risk factors documented, including country of birth.<br>6. Ensure that at least 99% of cases identified during the project period are reported to surveillance within 6 months of diagnosis date.<br>7. Ensure that at least 95% of persons testing positive for hepatitis B receive their test results.<br>8. For hepatitis B (+) individuals who were diagnosed at APLC screenings, increase referral to counseling, follow-up and linkages to care, treatment and preventive services to 75%.<br>9. Establish new partner-ships with two service agencies, five Churches, and two temples in the Asian Pacific Islander Community.<br>10. Participate in at least seven community health fairs and provide screenings and informa-tion about chronic Hepatitis B.<br>11. Provide culturally-sensitive care and treatment options;<br>12. Offer ongoing support for social aspects of chronic illness management. | | |

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| | | 13. Continue collecting Screening Data.<br>14. Conducting at least 2 Hepatitis B research successfully.<br>15. Continue developing abstracts and manuscripts for national conferences and publications. | | |

## Initiative: Volunteer Services

| Community Need | Goal | Objectives | Evaluation Indicators | Key Community Collaborators |
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| Opportunities for economic and employment development. | To provide opportunities for job training and career development for youth, 16 years of age and older, from lower socioeconomic communities. | 1. Continue participation in government- and privately-sponsored training programs.<br>2. Continue a partnership with LAUSD to provide community classroom and on-the-job training.<br>3. Continue to provide tours of the Medical Center for students and others interested in health care careers.<br>4. Participate in the planning process for high school job training and development programs.<br>5. Develop new partnership with: Cal State L.A. – Internship program; Youth Policy Institute Workforce Department program; the Transportation and Communication Trade and Vocational Training program (TCU) and the L.A. Job Core.<br>6. Collaborate with many career colleges, such as UEI and ATI, to provide training volunteer hours. | • Number of students participating in a job training program<br>• Number of students completing the job training program<br>• Number of students finding employment utilizing their training skills<br>• Supervisor and student's job training checklist<br>• Written evaluations by students taking tours | • American Career College<br>• Archdiocese of Los Angeles<br>• Cal State LA<br>• Concorde Career College<br>• Discovery Internships/Dream Careers, Inc.<br>• Los Angeles City College<br>• Los Angeles School of Global Studies – Miguel Contreras Learning Complex<br>• Los Angeles Unified School District<br>• Loyola High School<br>• Multicultural Area Health Education Center<br>• New Village Charter School<br>• USC Trojan Health Volunteers |

## Initiative: Charity Care

| Community Need | Goal | Objectives | Evaluation Indicators | Key Community Collaborators |
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| Access to primary and specialty care. | Ensure uninsured patients referred to SVMC are provided care, as hospital resources permit. | 1. Maximize the utilization of the QueensCare Fund.<br>2. Collaborate with SVMC Medical Staff in the provision of charity care.<br>3. Provide an avenue for uninsured patients to enroll in health programs. | • Number of patients admitted<br>• Amount spent on charity care<br>• Number of people enrolled into health coverage programs | • QueensCare<br>• St. Vincent Medical Staff |

## Initiative: Services to MediCal Recipients

| Community Need | Goal | Objectives | Evaluation Indicators | Key Community Collaborators |
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| Access to primary and specialty care. | Ensure MediCal patients referred to SVMC are provided inpatient and outpatient care. | Collaborate with SVMC Medical Staff in the provision of inpatient and outpatient care to MediCal eligible patients. | • Number of patients admitted<br>• Net cost of services provided to MediCal patients | • Federal and State governments<br>• SVMC Medical Staff |

## Initiative: Donated Space for Community Use

| Community Need | Goal | Objectives | Evaluation Indicators | Key Community Collaborators |
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| Access to quality housing/lodging, office space and meeting room facilities. | Provide free or discounted office, meeting and lodging space to community organizations and patient families to address the shortage of quality space in the area surrounding the Medical Center. | 1. Continue to provide discounted space for the Knights of Malta Free Clinic.<br>2. Continue to operate the Seton Guest Center.<br>3. Continue to provide discounted parking space for St. Nicholas Church.<br>4. Continue to offer discounted meeting room, parking and audiovisual facilities for community organizations. | • Number of people benefited<br>• Value of donated space<br>• Feedback from tenants and organizations receiving space<br>• Verbal and written communications from families using Seton Guest Center | • Daughters of Charity<br>• Knights of Malta Clinic<br>• SVMC Medical Staff<br>• St. Nicholas Church |

## Initiative: Patient Transportation Service

| Community Need | Goal | Objectives | Evaluation Indicators | Key Community Collaborators |
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| Access to Care | Provide underserved and low-income patients reliable and safe transportation to St. Vincent Medical Center. | 1. Continue to provide taxi vouchers to patients lacking transportation.<br>2. Continue to operate a van service transporting patients to SVMC and home. | • Number of patients served<br>• Feedback from riders<br>• Feedback from hospital departments<br>• Feedback from Medical Staff | • QueensCare<br>• Taxi companies |