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

May 29, 2020

Mr. Harry Dhami
Office of Statewide Health Planning and Development
Accounting and Reporting Systems Section
2020 West El Camino Ave, Suite 1100
Sacramento, CA 95833

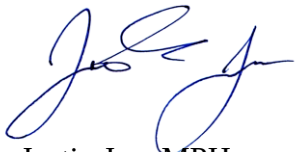
Dear Mr. Dhami,

On behalf of Providence Saint John's Health Center, I am pleased to provide you the:

- 2019 Community Health Needs Assessment
- 2020 to 2022 Community Health Improvement Plan
- 2019 Annual Update to the Community Benefit Plan

Please let me know if I can be of any further assistance.

Sincerely,



Justin Joe, MPH
Director, Community Health Investment
Providence Saint John's Health Center
Justin.Joe@providence.org

Providence Saint John's Health Center

2019 Community Health Needs Assessment

2020 – 2022 Community Health Improvement Plan

2019 Annual Update to the Community Benefit Plan

Saint John's Health Center

PROVIDENCE Health & Services

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Westside Service Area

Community Health Needs Assessment 2019

Providence Saint John's Health Center

Santa Monica, California

This CHNA was conducted in partnership with The Center for Nonprofit Management (CNM)
Los Angeles, CA

To provide feedback about this Community Health Needs Assessment or obtain a printed copy without charge, email Justin Joe at Justin.Joe@providence.org.

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Acknowledgements

We are grateful for the participation of our community members who provided feedback during the Community Health Needs Assessment process, which will inform the subsequent Community Health Improvement Plan.

Community Input and Hospital Collaboration

The 2019 Providence Saint John's Health Center Community Health Needs Assessment (CHNA) key informant interview data collection process was conducted by Saint John's Community Health Investment staff in collaboration with the Cedars Sinai Medical Center (Los Angeles, CA), Kaiser Permanente Medical Center (West Los Angeles, CA), and UCLA Health System (Westwood, CA). In addition, Saint John's conducted two listening sessions with community members in partnership with Venice Family Clinic and Virginia Avenue Park.

Consultants

Established in 1979 by the corporate and foundation community as a professional development and management resource for the burgeoning nonprofit sector, the Center for Nonprofit Management (CNM) is the premier Southern California source for management education, training, and consulting throughout the region.

The CNM team has extensive CHNA experience in assisting hospitals, nonprofits and community- based organizations on a wide range of assessment and capacity building efforts from conducting needs assessments to the development and implementation of strategic plans to the evaluation of programs and strategic initiatives. Team members have been involved in conducting more than 36 CHNAs for hospitals throughout Los Angeles County and San Diego County.

Executive Summary

Introduction

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

Our Community Benefit program is guided by the Mission of Providence Saint John's Health Center,

> **"As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable."**

Today, Providence Saint John's is a nationally recognized 266-bed hospital with physicians, nurses, volunteers and support staff who work as a team to provide the best possible medical care to its patients and the community. In line with both its Catholic Mission and its responsibilities as a non-profit health care provider, Providence Saint John's commitment to the poor and vulnerable includes partnerships with many outstanding Westside nonprofits who deliver vital services for those living in poverty. The People Concern, Saint Joseph Center, Venice Family Clinic, and WISE & Healthy Aging are just a few examples of community partners who are serving the community in their area of expertise.

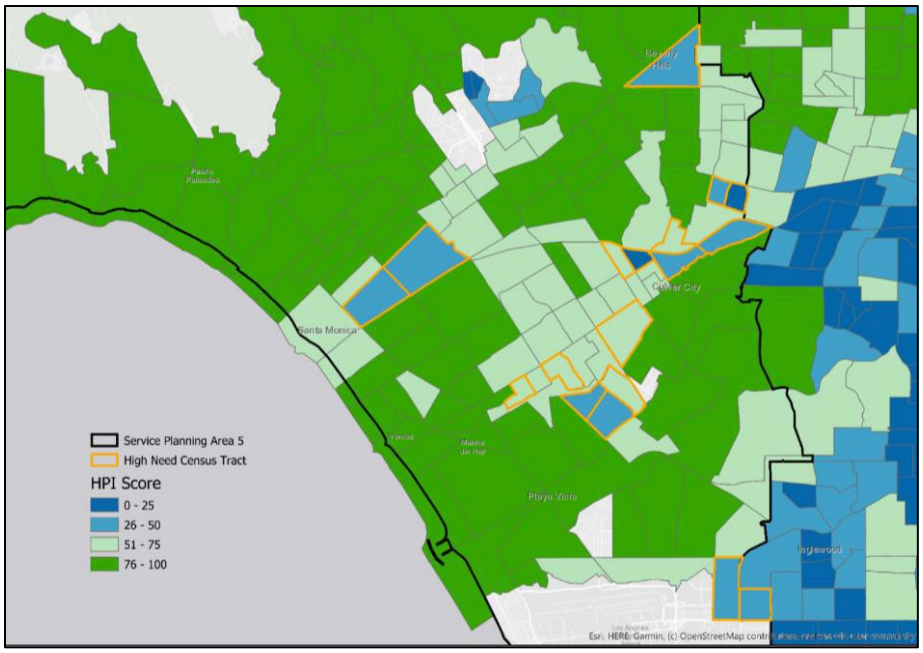
Our Community

The service area defined for the Providence Saint John's Health Center (PSJHC) CHNA includes the ZIP codes located within Service Planning Area (SPA) 5 of Los Angeles County. The planning area includes the communities located on the west side of the county (referred to as "the Westside" locally, and in this report), and represents the area where a significant portion (over 70%) of the patients served by the hospital resides. SPA 5 was used as the target geographic area for this CHNA since it closely matched where a majority of PSJHC's patients reside. Using the SPA definition also helped with the collection of data from the L.A. County Department of Public Health and other government agencies that use these boundaries when conducting studies. The area includes 20 distinct communities and 30 ZIP codes (see Figure_ES 1)

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

For purposes of this CHNA, in alignment with our Mission to pay special attention to the poor and vulnerable, we utilized the California Healthy Places Index developed by the Public Health Alliance of Southern California to identify 18 specific "high need" census tracts within SPA 5. These 18 census tracts, outlined in yellow in Figure_ES 2, scored lower than other California census tracts across a composite of 25 community conditions that predict life expectancy. Throughout this CHNA, when mapped data were available by census tract, the "high need" census tracts outlined in yellow have been carried over to highlight the status in those specific target neighborhoods.

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



CHNA Framework

To ensure Saint John's continues to stay at the forefront of Community Benefit reporting, programs, and partnerships, we updated the process to include a CHNA Oversight Committee of the Community Ministry Board. This oversight committee was responsible for the prioritization process, and we are grateful to the Providence representatives and external stakeholders who participated in the process (see Appendix 6 for a list of members).

Another important factor in establishing the CHNA framework is compliance with IRS Schedule H Regulations, which became effective in 2015. In addition to a required definition of the "community" to be served by the Community Benefit Plan, the IRS also requires broad public input, a description of the process and methods used to collect primary and secondary data, and an evaluation of the impact of programs on addressing significant needs. Specifically, input is expected from the Public Health Department, members of underserved communities and/or the organizations that represent the medically underserved and low- income populations.

Changes in reimbursement models are encouraging hospitals to think about population health models that incentivize keeping people healthy. There is increasing recognition that many other factors beyond the health care system play an even larger role in the health of the community. Increasingly, these factors are referred to as Social Determinants of Health, or the conditions in which people are born, grow, live, work and age. For example, the neighborhood and physical environment where a person grows up, as well as the education they receive, the food they eat, and their social support systems all contribute to the health of that individual and the community. Each of these factors contribute to economic stability, or instability, as the case may be. For these reasons, the CHNA takes a close look at these factors and the disparities that exist between high need communities and neighborhoods, compared to the broader community, within the Saint John's Service Area.

CHNA Process and Methods

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

Secondary data collection included the review of demographic, insurance, mortality, morbidity, mental health, economic and social determinant data from multiple sources. The secondary data sources included the following: the U.S. Census, Los Angeles Homeless Services Authority, Think Health L.A. Database, Community Commons Database, California Health Interview Survey Dataset, L.A. County Department of Public Health, and California Department of Public Health. Truven Analytics/ Dignity Health provided Community Need Index data, the Public Health Alliance of Southern California provided Healthy Places Index data, and the City of Santa Monica provided community specific data.

Once the information and data were collected and analyzed by staff members, the following nine key areas were identified as community needs for the Community Health Needs Assessment Oversight Committee to prioritize, listed here in alphabetical order:

- Access to Health Care
- Behavioral Health
- Chronic Diseases
- Early Childhood Development
- Economic Insecurity
- Food Insecurity
- Homelessness and Housing Instability
- Oral Health Care
- Services for Seniors

The following table presents key findings for each identified health need base on stakeholder input (listed in alphabetical order):

Table_ES 1. Key Findings Summarized for Identified Health Needs

Identified Health-Related Need	Key Findings
Access to Health Care	• Local stakeholders suggested working on improving care coordination and patient support: To help people know about the resources they qualify for and to help patients navigate the complexity of the health care system, stakeholders suggested using community health workers. This strategy could help address transportation, insurance, cultural, and language barriers often cited as factors hindering access to care. • Six of the eighteen high-need census tracts fall within a primary care shortage area.
Behavioral Health, including mental health and substance use treatment	• Stakeholders spoke to a variety of factors that make accessing behavioral health care challenging. Their primary concern was the lack of free or low- cost treatment options for mental health services and substance use treatment. Additionally, there is a lack of licensed behavioral health providers on the Westside, particularly providers who accept Medi-Cal or who speak languages other than English. • Stakeholders shared that stigma is a barrier to addressing behavioral health challenges because the stigma around utilizing mental health services makes people less

Identified Health-Related Need	Key Findings
	likely to accept or seek services, as well as less likely to talk about mental illness and substance use.
Chronic Diseases	• Secondary data from the LA County Department of Public Health showed lower morbidity and mortality rates across the board for various chronic diseases in SPA 5 as compared to the rest of LA County. • Stakeholders spoke to the importance of addressing other social determinants of health, such as access to health care, stable housing, community safety, and food security, to improve chronic diseases. By addressing these other health needs, people would be better able to get the health care they need, improve their eating and exercising habits, and manage their chronic diseases.
Early Childhood Development	• There are not enough resources for infants/toddlers and their parents. Licensed child care centers only have the capacity to serve 13% of Los Angeles County's children under the age of 5. • The Los Angeles County Child Care Planning Committee 2017 Needs Assessment reported the cost of care for a young child is high. A family's average cost of care in Los Angeles County is $10,303 a year per preschooler in center-based care and $8,579 a year per preschooler in a family child care home. Care for infants and toddlers is even more expensive, with an annual cost of $14,309 in an early care and education center and $9,186 in a family child care home.
Economic Insecurity	• Stakeholders identified two main causes of economic insecurity on the Westside: lack of jobs that pay a living wage and a high cost of living in local communities. Stakeholders explained the amount of money people get paid in their jobs is not sufficient to cover rent, food, medical bills, etc. • 43.5% of households in SPA 5 spend 30% or more of their income on housing.

Identified Health-Related Need	Key Findings
Food Insecurity	• 30.5% of households in SPA 5 with incomes <300% Federal Poverty Level are food insecure. This is 1.3% higher than all of LA County. • The current political climate has created fear related to immigration. Some undocumented immigrants expressed concern about applying for food assistance programs because of new proposed public charge laws. • There are 57,032 individuals who are eligible, but not yet enrolled in CalFresh within SPA 5. In the 18 identified "high-need" census tracts there are a total of 8,753 eligible but unenrolled individuals.
Homelessness and Housing Instability	• According to the 2019 Greater Los Angeles Homeless Count, Los Angeles County has 58,936 people experiencing homelessness—a 12% increase from the previous year. • In SPA 5 there were 5,262 people experiencing homelessness, which is an increase of 20% from 2018. SPA 5 had the highest increase of all eight SPAs in LA County in total homeless population between 2018 and 2019.
Oral Health Care	• Stakeholders shared the number of affordable dental providers is insufficient to serve the people living on the Westside, especially providers that accept Denti-Cal. • In SPA 5, 13.3% of children ages 3-17 years who did not obtain dental care (including check-ups) in the past year because they could not afford it, compared to 11.5% across LA County.
Services for Seniors	• By 2024, the age group 55 and older is projected to grow by 5.35% (211,001 people) and make up 30.2% of SPA 5's population. • Local stakeholders noted older adults were more vulnerable to housing instability and food insecurity. They also shared that older adults, particularly those who have low incomes, may have more challenges accessing behavioral health care as compared to other populations.

Prioritization Process and Criteria

The CHNA Oversight Committee met on August 27 and September 3, 2019 to prioritize and recommend the top identified health needs. At the first meeting, the CHNA Oversight Committee considered the CHNA Framework, the definition of the community (Service Planning Area 5) and the high need census tracts within the SPA 5 community. The group participated in two panel discussions related to homelessness and food insecurity, and utilized some of the secondary data from the high need census tracts to sharpen the discussion on these two social determinants. This approach was taken to familiarize the group with the identified health needs to be presented in the second meeting and to practice a structured discussion format that would be followed in the second session.

In advance of the second meeting, committee members received a summary of primary and secondary data collected for nine identified health needs. The second meeting began with each member providing input for the nine identified health needs, based upon the primary and secondary data provided by

Providence Saint John's staff. For each identified health need, committee participants were asked to rate the severity of the identified health need, change over time, availability of community resources/assets and community readiness to implement/support programs to address the health need. These criteria formed the initial impressions of committee members. This survey was then followed by a review of the data assembled for each identified health need by Providence Saint John's staff. Half of the meeting time was then set aside to break the CHNA Oversight Committee into three groups to address three questions for each identified need:

- How does this need impact the work of your organization and the clients you serve?
- What other service gaps currently exist?
- What role can Saint John's play in addressing this need?

After each group rotated through the nine topics, a facilitator for each topic reported out the points of consensus that emerged from the committee members. As a final summary of the discussion, each of the participants was given three dots, or "votes" to assign to the identified topics, resulting in a second set of priorities.

2019 Prioritized Health Needs

Results of both the online survey and dot votes were combined to calculate the relative priority rank of each of the nine health needs. Results were as follows:

Table_ES 2. Health-Related Needs in Order of Priority

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

Introduction

Who We Are

Providence Saint John's Health Center

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

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

Providence Saint Joseph Health

PSJHC is a member of Providence St. Joseph Health, which is committed to improving the health of the communities it serves, especially those who are poor and vulnerable. With 51 hospitals, 829 physician clinics, senior services, supportive housing and many other health and educational services, the health system and its partners employ more than 119,000 caregivers (employees) serving communities across seven western states – Alaska, California, Montana, New Mexico, Oregon, Texas and Washington. With system offices based in Renton, Washington, and Irvine, California, the Providence St. Joseph Health family of organizations works together to meet the needs of its communities, both today and into the future.

Our Commitment to Community

As health care continues to evolve, Providence Saint John's Health Center is responding with dedication to its Mission and a desire to create healthier communities, together. Partnering with other non-profits that share our commitment to the poor and vulnerable, we conduct a formal community health needs assessment to learn about the greatest needs and assets in our community, especially considering members of medically underserved, low-income, and minority populations. This assessment helps us consider solutions to fulfill unmet needs while continuing to strengthen local resources. It guides our community benefit investments, not only for our own programs but also for many partners that look to Saint John's to improve the health of entire populations.

During 2018, PSJHC provided $40,443,270 in community benefit in response to unmet needs and to improve the health and well-being of those we serve on LA County's Westside.

Our Mission, Vision, Values and Promise

In line with both its Catholic Mission and its responsibilities as a non-profit health care provider, Providence Saint John's commitment to the poor and vulnerable includes partnerships with many outstanding Westside nonprofits who deliver vital services for those living in poverty.

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

Our Mission

As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Values

Compassion, Dignity, Justice, Excellence, Integrity.

Our Vision

Health for a better world.

Our Promise

Know me, Care for me, Ease my way.

Our Community

This section provides a definition of the community served by the hospital, including a description of the medically underserved, low-income and minority populations.

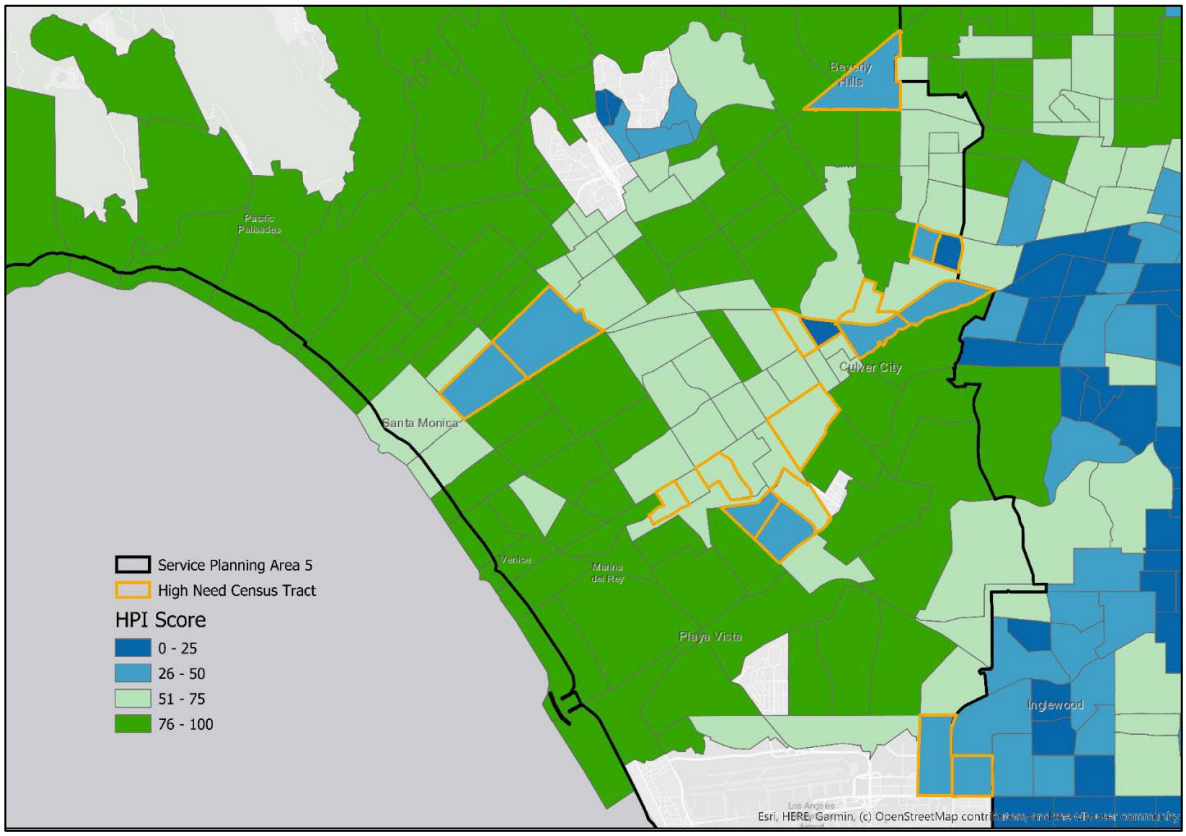
Description of Community Served

The service area defined for the Providence Saint John's Health Center (PSJHC) Community Health Needs Assessment (CHNA) includes the ZIP codes located within Service Planning Area (SPA) 5 of Los Angeles County. The planning area includes the communities located on the west side of the county (referred to as "the Westside" locally, and in this report), and represents the area where a significant portion (over 70%) of the patients served by the hospital resides. SPA 5 was used as the target geographic area for this CHNA since it closely matched where a majority of PSJHC's patients reside. Using the SPA definition also helped with the collection of data from the L.A. County Department of Public Health and other government agencies that use these boundaries when conducting studies. The area includes 20 distinct communities and 30 ZIP codes (see Figure 3).

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

For purposes of this CHNA, in alignment with our Mission to pay special attention to the poor and vulnerable, we utilized the California Healthy Places Index developed by the Public Health Alliance of Southern California to identify 18 specific "high need" census tracts within SPA 5. These 18 census tracts, outlined in yellow in Figure 2, scored lower than other California census tracts across a composite of 25 community conditions that predict life expectancy. Throughout this CHNA, when mapped data were available by census tract, the "high need" census tracts outlined in yellow have been carried over highlight the status in those specific target neighborhoods.

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



Community Demographics

Population and Age Demographics

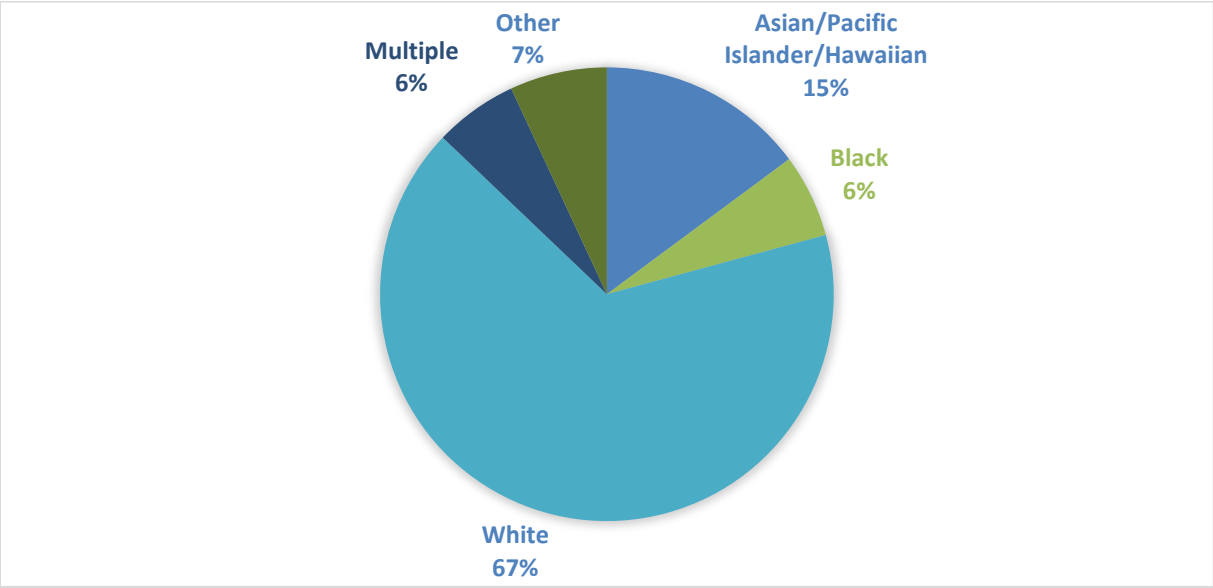
The total population of the PSJHC service area in 2019 is 682,449 persons, which represents a 5.1% increase from the 2010 population, or an additional 32,662 residents living in the area.[1] Examining the total population by gender and age group demonstrates that a majority of residents in the service area are between 20 and 39 years old. Children under the age of 19 comprise 17.6% of the population. This is notable, given that in the state of California, children under the age of 18 make up 22.7% of the population. Adults 60 years of age and older make up 20.5% of the total service area population, which exceeds the state of California at 14.3% of the population.[1] The PSJHC service area is notably older, on average, than the total population of the state of California.

Population by Race/Ethnicity

Among the Westside/ SPA 5 residents, in 2019, 66.8% were White, 14.5% were Asian/Pacific Islander/Hawaiian, 0.4% were Alaska Native or American Indian, 6.0% were African American or Black, and 5.7% were of two or more races. Approximately 17.1% of the residents identify as Latino (see Figure 3).

[1] U.S. Census Bureau, 2013-2017 American Community Survey 5-year Estimates

Figure 3. Self-Reported Race, Westside/ SPA 5



Source: U.S. Census

Table 1. Socioeconomic Data for the Westside/ SPA 5

Socioeconomic Data	
Families Below 200% Federal Poverty Level	23.0%
Unemployment	3.5%
Adults with No High School Diploma	5.6%
Population Age 5+ with Limited English Proficiency	10.8%

Income Levels

In 2019, the median household income of the area varied significantly from a low of $65,417 in Palms to $200,001 in Bel Air. Although the Westside contains many affluent communities, there are areas within SPA 5 with a higher portion of low-income households. Approximately 23.0 % of the population has annual incomes below 200% of the Federal Poverty Level, compared to 39.6 % in Los Angeles County as a whole.

Education Level

The vast majority (94.4 %) of adults age 25+ living in the PSJHC service area have at least graduated from high school. This far exceeds the Los Angeles County average of 78.4 %. PSJHC ZIP codes with lower high school graduation rates include Culver City (90230), Mar Vista (90066), Santa Monica (90404) and Palms (90034).

Economic Indicators

The percentage of unemployment across SPA 5 is 3.5%, lower than the average of 4.5% in Los Angeles County. The number of owner-occupied housing units in the area is 40.5%, which is lower than the Los Angeles County average of 45.9%. Of the occupied housing units, approximately 46% have one or more substandard conditions. Almost half (48.6%) of residents in the service area are considered housing cost burdened, meaning they spend more than 30% of their income on housing.

Language Proficiency

Within the PSJHC service area, approximately 10.8% of the general population age 5 and older has limited English proficiency; 23.7% of Latinos living within the service area have limited English proficiency. Within Los Angeles County, 56.6% of residents speak a language other than English at home. Far fewer households (35.7%) in the PSJHC service area speak a language other than English at home, with the highest concentrations in Beverly Hills, Palms and Culver City.

Health Professions Shortage Area and Medically Underserved Populations[2]

The PSJHC service area has a large supply of physicians due in part that there is a large medical school and academic medical center in the vicinity. However, the providers in the area are not equally accessible to all residents. The Health Resources & Services Administration (HRSA) defines a Health Professional Shortage Area (HPSA) as a shortage of primary care, dental care or mental health providers by geographies or populations. Six of the eighteen high-need census tracts (see the Healthy Places Index Map on page 8 of this report) fall within a primary care shortage area. During community stakeholder interviews, many participants echoed the need for more providers who accept Medi-Cal in their areas and that transportation is a barrier to accessing care. A large portion of Santa Monica has a shortage of primary care providers (see Health Professions Shortage Area Map in Appendix 1).

Disparities by Race/Ethnicity

On average, the population of the PSJHC service area is older, better educated and more likely to be employed and be fluent in English than the overall population of Los Angeles County. However, while the median household income by ZIP code within the PSJHC service area is high compared to the median of Los Angeles County ($62,751), patterns of household income vary by racial/ethnic group within each ZIP code within SPA 5. For example, the median income of Black families in SPA 5 is only 68.5% of the median of white families in SPA 5. The median income of Latino families in SPA 5 is 62.2% the median of white families in SPA 5.

The census tracts with relatively higher concentrations of families living below 200% Federal Poverty Level (FPL) are located along the 10 and 405 freeways, around the UCLA and VA campuses, into Mid-City and adjacent to Inglewood. These are also areas with higher concentrations of Asian and Latino residents (see Appendix 1).

[2] http://publichealth.lacounty.gov/plan/docs/SPA5Supplement.pdf

Overview of CHNA Framework

This section provides a summary of the framework that guided the design of Providence Saint John's Community Health Needs Assessment.

To ensure Saint John's continues to stay at the forefront of Community Benefit reporting, programs, and partnerships, we updated the process to include a CHNA Oversight Committee of the Community Ministry Board. This oversight committee was responsible for the prioritization process, and we are grateful to the Providence representatives and external stakeholders who participated in the process (see Appendix 6 for a list of members).

Another important factor in establishing the CHNA framework is compliance with IRS Schedule H Regulations, which became effective in 2015. In addition to a required definition of the "community" to be served by the Community Benefit Plan, the IRS also requires broad public input, a description of the process and methods used to collect primary and secondary data, and an evaluation of the impact of programs on addressing significant needs. Specifically, input is expected from the Public Health Department, members of underserved communities and/or the organizations that represent the medically underserved and low- income populations.

Changes in reimbursement models are encouraging hospitals to think about population health models that incentivize keeping people healthy. There is increasing recognition that many other factors beyond the health care system play an even larger role in the health of the community. Increasingly, these factors are referred to as the Social Determinants of Health, or the conditions in which people are born, grow, live, work and age. For example, the neighborhood and physical environment where a person grows up, as well as the education they receive, the food they eat, and their social support systems all contribute to the health of that individual and the community. Each of these factors contribute to economic stability, or instability, as the case may be. For these reasons, the CHNA takes a close look at these factors and the disparities that exist between high need communities and neighborhoods, compared to the broader community, within the Saint John's Service Area.

CHNA Process and Methods: Data Collection and Collaboration

This section provides a summary of the collaborating partners, stakeholder engagement, data collection and synthesis methods used in Providence Saint John's Community Health Needs Assessment.

Community Input: Qualitative Data

Providence Saint John's Health Center recognizes the value in having community members and community stakeholders share their perspectives during the Community Health Needs Assessment (CHNA) process. As the people who live and work on the Westside, they have first-hand knowledge of the needs and strengths of their community and their opinions help to shape our future direction.

Providence Saint John's Health Center conducted listening sessions with community members and interviews with community stakeholders, including LA County Department of Public Health, as part of their collection of primary data. These elements of qualitative data, or data in the form of words instead of numbers, provide additional context and depth to the CHNA that may not be fully captured by quantitative data alone. Key takeaways gathered through organizational leader interviews and community resident listening sessions are included in this report.

Solicited CHNA Comments from the Public

The 2016 Providence Saint John's Community Health Needs Assessment is publicly available on Providence Saint John's website, with a point of contact listed in the report. No written comments on the 2016 Community Health Needs Assessment and Implementation Strategy report were received from the public to betaken into account for the 2019 Community Health Needs Assessment.

Collaborative Partners

As part of the primary data collection process, Providence Saint John's Health Center worked in collaboration with the Cedars Sinai Medical Center (Los Angeles, CA), Kaiser Permanente Medical Center (West Los Angeles, CA), and UCLA Health System (Westwood, CA) to collect and analyze the information. Together, the four hospital systems collaborated on several components of the CHNA including:

- Developing a list of key community stakeholders/leaders to be included in the telephone interviews
- Compiling the list of questions to be used in the telephone interviews to identify the key community needs and contributing factors

Once the CHNA for each hospital is completed, the hospitals intend to continue the collaborative efforts begun with the CHNA process to identify a common health need that they can work on together. There are plans to incorporate one or more common priority needs into the implementation strategies of the participating hospitals.

Quantitative Data

Secondary data collection included the review of demographic, insurance, mortality, morbidity, mental health, economic and social determinant data from multiple sources. The secondary data sources included the following: the U.S. Census, Los Angeles Homeless Services Authority, Think Health L.A. Database, Community Commons Database, California Health Interview Survey Dataset, L.A. County Department of Public Health, and California Department of Public Health. Truven Analytics/ Dignity Health provided Community Need Index data and the City of Santa Monica provided community specific data.

Additionally, primary quantitative data were collected from PSJHC's electronic health record system to review avoidable Emergency Department use and potentially avoidable inpatient admissions.

Data Limitations and Information Gaps

The secondary data allow for an examination of the broad health needs within a community. However, these data have limitations, as is true with any secondary data:

- Data are not always available at the ZIP code level, therefore Los Angeles County level data, as well as SPA 5 level data, were utilized when data were not available at a more granular level.
- Disaggregated data for age, ethnicity, race, and gender are not available for all data indicators, which limited the examination of disparities of health issues within the community.
- At times, a stakeholder-identified health issue may not have been reflected by the secondary data indicators.
- Data are not always collected on an annual basis, meaning that some data are several years old.

Identified Health Needs

Once the information and data were collected and analyzed by staff members, the following nine key areas, listed below in alphabetical order, were identified as significant health needs. These needs were then discussed in the prioritization process, described in the next section of this report:

- Access to Health Care
- Behavioral Health
- Chronic Diseases
- Early Childhood Development
- Economic Insecurity
- Food Insecurity
- Homelessness and Housing Instability
- Oral Health Care
- Services for Seniors

Prioritized Significant Community Health Needs

This section describes the significant health needs identified during the CHNA process as well as the criteria used to prioritize the needs.

Prioritization Process and Criteria

The 2019 CHNA process included a prioritization process involving a facilitated group session that engaged the 2019 Community Health Needs Assessment Oversight Committee representing key community stakeholders. Committee members were given surveys so that they could provide input on the severity of the identified community health needs as well as their insight on the resources that are available to address each health need.

The list of significant health needs included:

- Access to Health Care
- Behavioral Health
- Chronic Diseases
- Early Childhood Development
- Economic Insecurity
- Food Insecurity
- Homelessness and Housing Instability
- Oral Health Care
- Services for Seniors

The survey included an assessment of:

- Severity, or the perceived impact of the health need on the community;
- Change over time, or the determination if the health need has improved, stayed the same or worsened;
- Resources, or the availability of resources in the community to address the health need; and
- Community readiness to effectively implement and support groups to address this health need.

Providence Saint John's staff provided committee members with data packets related to each of the nine health needs identified above (See Appendix 1: Fact Sheets on Health Indicators).

In smaller groups, participants considered the data while discussing and identifying key issues or considerations that were shared with the larger group. During the breakout session, the Committee was divided into three separate groups. The nine health needs identified in the CHNA were split into three sections (three needs per section) and committee members rotated from one section to the next answering the following questions about each need:

- How does this need impact the work of your organization and the clients you serve?
- What are other service gaps?
- What role can Providence Saint John's Health Center play in addressing this need?

After discussing each health need and addressing these questions, committee members were given three stickers, which they used to further prioritize these health need(s).

List of Significant Health Needs in Priority Order

The significant health needs were then ranked based on score of severity, change over time, resources in the community and Saint John's ability to respond. The ranking also took into account the stakeholder votes following group dialogue. Results were as follows:

Table 2. Health Needs in Order of Priority

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

Description of Significant Community Health Needs

This section provides primary and secondary data to characterize the significant health needs identified and prioritized during the Providence Saint John's Community Health Needs Assessment process.

Homelessness and Housing Instability

Primary Data—Service Provider and Community Resident Input

Stakeholders shared that having a safe, stable place to live is foundational to a person's wellbeing. Therefore, addressing homelessness and housing instability is an urgent need. Stakeholders shared the following factors that contribute to homelessness and housing instability:

- Behavioral health challenges
- Lack of affordable housing options: finding locations to build affordable housing is challenging because of the NUMBY (not in my backyard) attitude
- Economic insecurity and a lack of living wage jobs

Stakeholders identified several populations that are most impacted by homelessness and housing instability:

- People with low-incomes, especially older adults and young people
- People of color

Effective strategies to address homelessness and housing instability shared by stakeholders include the following:

- Build affordable housing
- Increase access to job training programs
- Provide multi-disciplinary support teams for people experiencing homelessness

Secondary Data—Homelessness

The Los Angeles Homeless Services Authority (LAHSA) conducts a yearly point-in-time count called the Greater Los Angeles Homeless Count. Moderated by the U.S. Department of Housing and Urban Development, LAHSA conducts the nation's largest homeless census count with the help of volunteers over the course of three days and nights. Results are published on LAHSA's website and are available here: https://www.lahsa.org/documents.

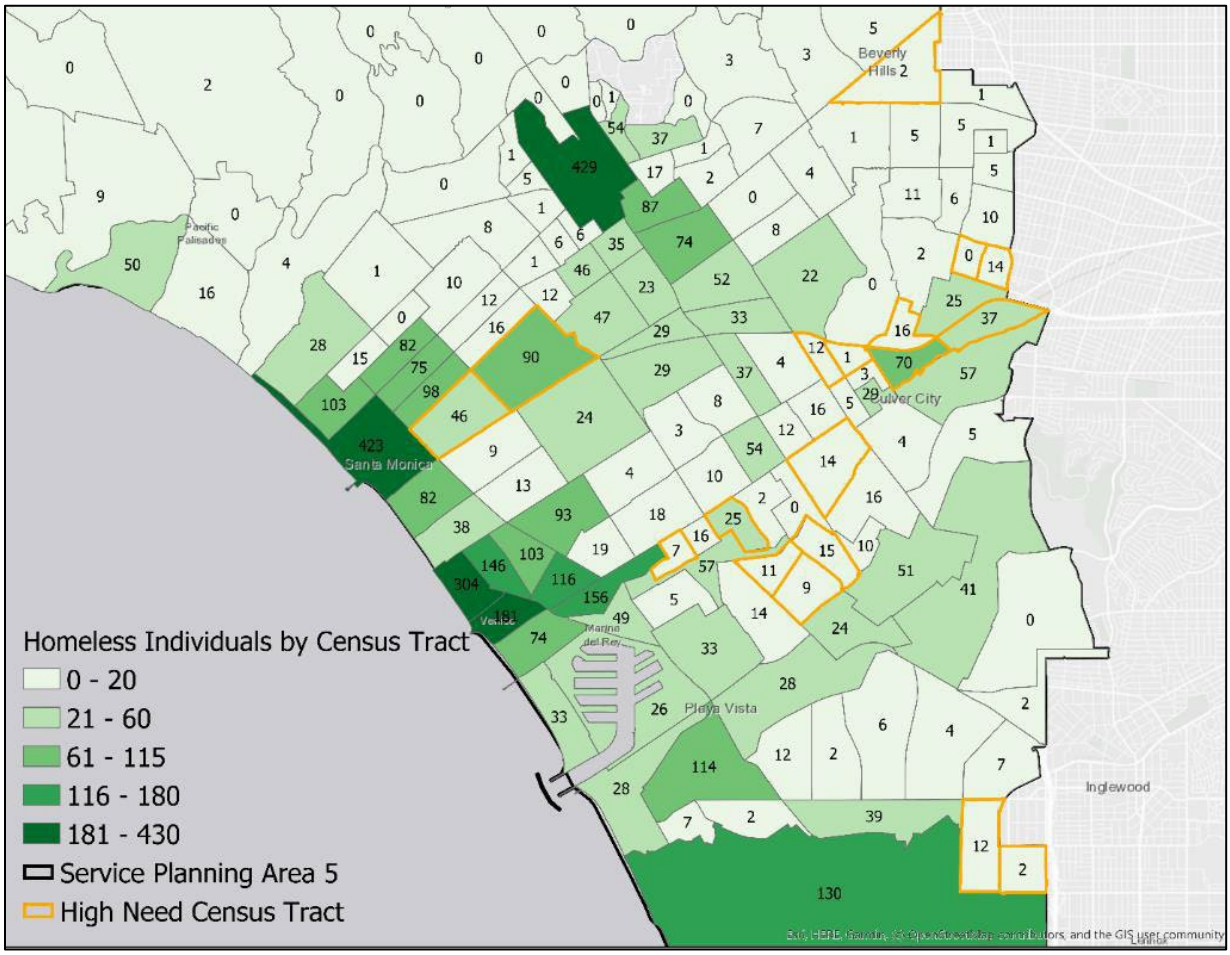
The following table displays the results of the 2019 Greater Los Angeles Homeless Count with a focused look at the results of SPA 5 and the City of Santa Monica. All geographic areas of interest show an increase in people experiencing homelessness within just one year. The number of people experiencing homelessness in SPA 5 increased 20% from 2018 to 2019, while Santa Monica increased 11%, similar to that of LA County.

Table 3. 2019 Point-In-Time Homeless Count

Geographic Area	Sheltered	Unsheltered	Total	% Change 2018 - 2019
Los Angeles County	14,722	44,214	58,936	+12%
SPA 5	884	4,378	5,262	+20%
Santa Monica	250	752	1,002	+11%
Santa Monica*	331	654	985	+3%

**Data acquired from Santa Monica's city reported count, which does not include a multiplier utilized in LAHSA's county-wide calculation*

Figure 4. 2019 Homeless Count by Census Tract in SPA 5



- The largest concentration of people experiencing homelessness are found in the city of Santa Monica, which accounts for about 20% of people experiencing homelessness in SPA 5 according to the 2019 Greater Los Angeles Homeless Count.
- Homeless counts in West Los Angeles are evenly spread throughout the census tracts whereas Westwood has a large concentration in a single census tract with 429 individuals experiencing homelessness accounted for in the recent homeless count.
- There is a stretch of census tracts that begins in Playa Vista and runs through Mar Vista and Culver City which contains much higher counts of individuals than the neighboring census tracts.
- A total of 383 individuals were identified in Saint John's designed "high need" census tracts in the Greater Los Angeles Homeless Count.

Behavioral Health (Including Mental Health and Substance Use)

Primary Data—Service Provider and Community Resident Input

Most of the stakeholders identified behavioral health, including mental health and substance use, as an urgent need. While some stakeholders placed more importance on either the substance use or mental health components, many named both as needs and identified them as overlapping and linked. Therefore, they are presented here together. Stakeholders named a variety of contributing factors to the community's behavioral health challenges:

- Access to behavioral healthcare
- Homelessness
- Integration of behavioral health care and primary care
- Stigma

Stakeholders identified several populations that are most affected by behavioral health challenges:

- Young people
- People experiencing homelessness and people with low incomes
- Older adults

Common themes for effective strategies to address behavioral health challenges include the following:

- Integrate behavioral health care and primary care
- Increase community education and awareness around mental health and substance use
- Implement targeted outreach to groups needing services

Secondary Data—Behavioral Health Status Indicators

Table 4. Behavioral Health Status Indicators Comparing SPA 5 and LA County

Health Status Indicator	SPA 5	Los Angeles County	Differences Between SPA 5 and County
Percent of adults reporting their health to be fair or poor	10.0%	21.5%	-11.5%
Average number of days in past month adults reported regular daily activities were limited due to poor physical/mental health	1.8	2.3	-0.5
Percent of adults at risk for major depression	6.8%	11.8%	-5.0%
Adults who ever seriously thought about committing suicide (2017)	13.20%	9.60%	3.60%
Saw any healthcare provider for emotional-mental and/or alcohol-drug issues in past year (2016)	24.80%	12.30%	12.50%
Adults who sought help for self-reported mental/emotional and/or alcohol-drug issues and received treatment (2017)	55.00%	60.10%	-5.10%

Source: 2015 Los Angeles County Health Survey

Overall, those in SPA 5 were less likely to report their health as fair or poor, and slightly less at risk for major depression and less likely to have thought seriously about committing suicide. In addition, they were more likely to have seen a healthcare provider for emotional, mental or alcohol/drug issues in the past year.

Economic Insecurity

Primary Data—Service Provider and Community Resident Input

Stakeholders agreed there are two main causes of economic insecurity on the Westside: lack of jobs that pay a living wage and the high cost of living. Stakeholders explained the amount of money people get paid in their jobs is not sufficient to cover rent, food, medical bills, etc. Therefore, people are forced to make hard decisions around how they spend their money. This high cost of living coupled with low-incomes leads to economic insecurity. Economic insecurity leads to homelessness/housing instability, food insecurity, and challenges paying for medical services.

Economic insecurity affects many people, particularly individuals and families with low incomes, but some of the groups identified by stakeholders are the following:

- People of color
- People re-entering the work force who were formerly incarcerated
- Older adults

Stakeholders shared the following strategies for addressing economic insecurity:

- Increase job training and skill building programs for young people
- Increase affordable housing options and improve home ownership opportunities

Secondary Data—Los Angeles County Department of Public Health Key Indicators

Below is a table of indicators related to economic insecurity prepared by the Los Angeles County Department of Public Health. These indicators were calculated from the 2015 Los Angeles County Health Survey, which is a population-based telephone survey designed to measure the health needs and behaviors of Los Angeles residents. Data for these variables were only available at the SPA level and not the census tract level.

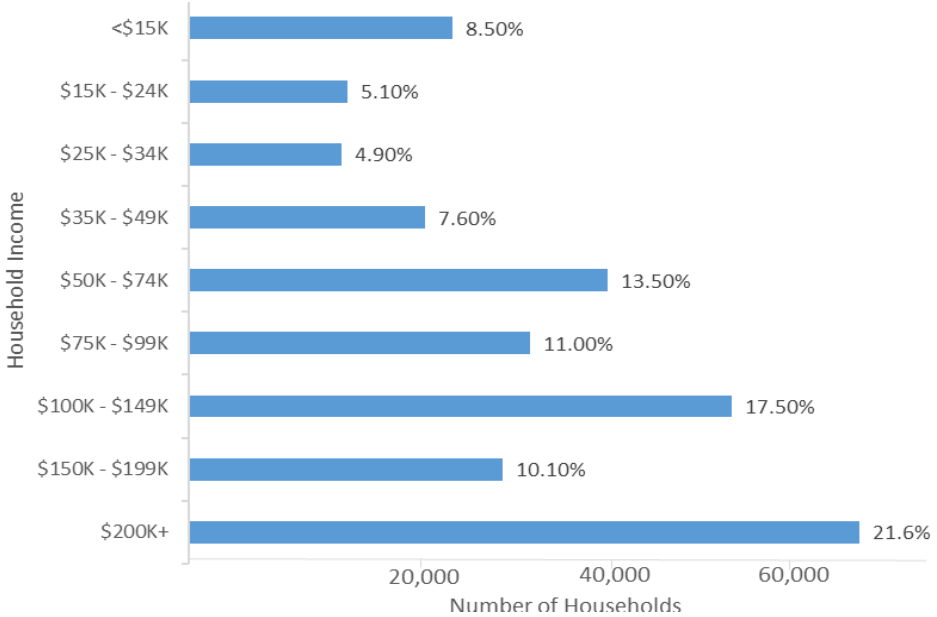
Table 5. Economic Insecurity Indicators Comparing SPA 5 and LA County

Economic Insecurity Indicator	SPA 5	Los Angeles County	Difference Between SPA 5 and County
Percent of adults who completed high school	93.6%	77.6%	16.0%
Percent of adults who are employed	61.6%	56.6%	5.0%
Percent of population with household incomes <100% Federal Poverty Level (FPL)	11.6%	17.8%	-6.2%
Percent of households (owner/renter-occupied) who spend ≥30% of their income on housing.	43.5%	48.0%	-4.5%
Percent of households with incomes <300% FPL who are food insecure	30.5%	29.2%	1.3%

Source: U.S. Census, American Community Survey 5-Year Estimates, 2013-2017

Those in SPA 5 were more likely to have a high school degree and be employed. In addition, they were less likely be in the lowest level of poverty and more likely to rent than own a house. However, a greater percentage of households living below 300% FPL were food insecure in SPA 5 compared to LA County.

Figure 5. SPA 5 2019 Income Distribution



Access to Health Care

Primary Data—Service Provider and Community Resident Input

Stakeholders identified improved access to care as a need on the Westside. Stakeholders emphasized that addressing access to care needs to involve ensuring care is coordinated, culturally responsive, and high quality. Stakeholders named a variety of contributing factors to the community's access to health care challenges:

- Inefficient public transportation
- High cost of care and lack of knowledge about support resources
- Fear related to immigration status and cultural/language barriers
- Long wait times and not enough providers
- Lack of coordination in the health care system

While different populations may experience different barriers to accessing the health care services they need, stakeholders identified a few populations that may especially face challenges with access to care:

- Immigrants, particularly undocumented immigrants, and people who do not speak English
- People without insurance
- People with low-incomes

Stakeholders shared the following strategy for addressing access to health care challenges:

- Better care coordination and patient support

Primary Data—Avoidable Emergency Department Visits at PSJHC

Utilizing an algorithm developed by the NYU Center for Health and Public Service Research, emergency department visits over a one-year period from May 2018 – April 2019 were categorized as avoidable and not avoidable visits. Avoidable ED visits by payor can be used as a gauge of access to care. For ED visits by patients with Medicaid (Medi-Cal) at Saint John's, nearly half were avoidable.

Table 6. Avoidable Emergency Department Visits at PSJHC May 2018- April 2019

Payor	Avoidable ED Cases	Not Avoidable ED Cases	Total ED Cases	% Avoidable ED Cases
Capitation	152	333	485	31.3%
Commercial	2,295	6,170	8,465	27.1%
Medicaid	3,027	3,778	6,805	44.5%
Medicare	1,887	4,091	5,978	31.6%
Other	1	0	1	100.0%
Other Government	46	92	138	33.3%
Self Pay	510	784	1,294	39.4%
Grand Total	**7,918**	**15,248**	**23,166**	**34.2%**

Secondary Data—Access to Medical Care

Overall, SPA 5 performs more favorably than LA County on a series of access to care indicators, with the exception of the number of children who did not obtain dental care in the past year because they could not afford it.

Table 7. Access to Care Indicators Comparing SPA 5 and LA County

Access to Care Indicators	SPA 5	Los Angeles County	Difference Between SPA 5 and County
Percent of children ages 0-17 years who are insured	97.0%	96.6%	0.4%
Percent of adults ages 18-64 years who are insured	95.3%	88.3%	7.0%
Percent of children ages 0-17 years with a regular source of health care	93.4%	94.3%	-0.9%
Percent of adults 18-64 years with a regular source of health care	78.8%	77.7%	1.1%
Percent of adults who did not see a dentist or go to a dental clinic in the past year	28.9%	40.7%	-11.8%
Percent of children ages 3-17 years who did not obtain dental care (including check-ups) in the past year because they could not afford it	13.3%	11.5%	1.8%

Source: 2015 Los Angeles County Health Survey

Overall those in SPA 5 were on par with indicators in the county. The percent of children under the age of 18 with a regular source of health care, however, was slightly lower than that of the county.

Services for Seniors

Primary Data—Service Provider and Community Resident Input

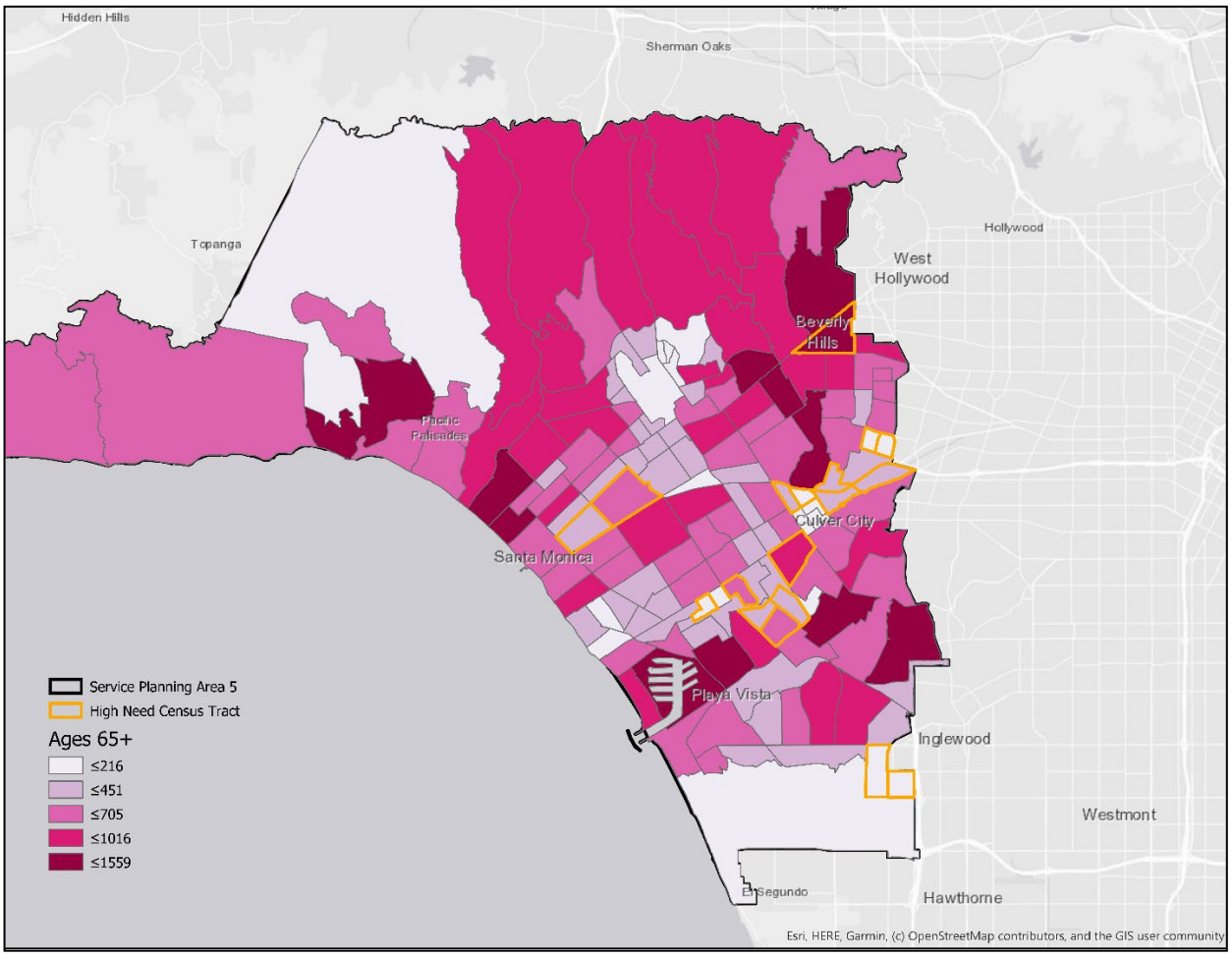
Stakeholders shared that the number of seniors in the service area experiencing economic insecurity has increased substantially in the past ten years. Additionally, the number of seniors experiencing poor

access to nutritious food, transportation, gero-psychological health care and services to maintain chronic health conditions has increased. Stakeholders expressed the growing senior population coupled with a relative lack of accessible and affordable services, and combined with the unique experiences of seniors living without close contact with friends and extended families, increases the significance of the health needs of this population.

Secondary Data—Senior Population in Service Planning Area 5

- SPA 5 has a growing senior population when looking at both the 55+ and 65+ population.
- By 2024, the age group 55 will grow by 5.35% and make up 30.2% of SPA 5's population

Figure 6. Seniors Ages 65+ by Census Tract in SPA 5



Secondary Data—Changes to CalFresh Eligibility Requirements

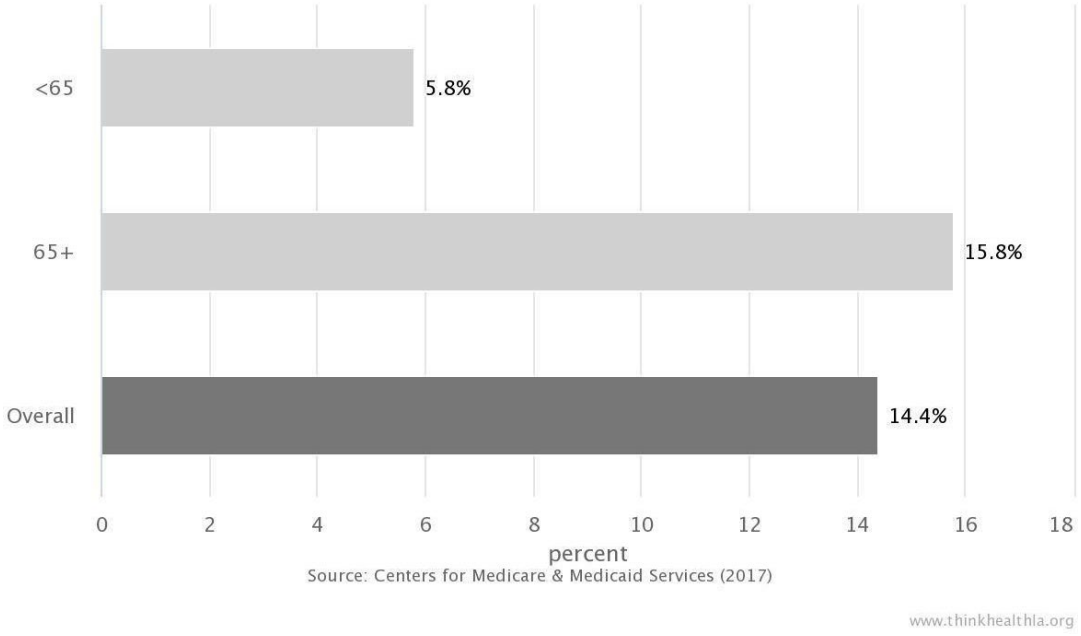
Beginning June 1, 2019, seniors who receive Supplemental Security Income (SSI)/State Supplementary Payment (SSP) are now eligible to enroll in CalFresh benefits without affecting their current SSI/SSP benefits.

According to the Department of Public Social Services, the expansion to SSI/SSP recipients will impact an estimated 212,309 households in Los Angeles County who were ineligible for CalFresh before the changes introduced by Assembly Bill 1811. Additionally, an estimated 11,239 active households with SSI/SSP recipients will see an increase in their CalFresh benefits.

Secondary Data—Alzheimer's and Dementia

The Centers for Medicare and Medicaid Services show that the percentage of Medicare beneficiaries who were treated for Alzheimer's disease or dementia has seen an increasing trend in Los Angeles County with the largest spike between the years 2015 and 2016, when the percentage increased by 2.3%.

Figure 7. Percent of Population by Age in LA County with Alzheimer's Disease or Dementia



Secondary Data—Falls

From the 2015 Los Angeles County Health Survey we see that Service Planning Area 5 has a slightly higher incidence of falls for its senior population when compared to Los Angeles County.

Table 8. Incidence of Falls for Senior Population in SPA 5 Compared to LA County

Falls for Senior Population Indicator	SPA 5	Los Angeles County	Difference Between SPA 5 and County
Percent of adults ages 65+ years who have fallen in the past year	27.8%	27.1%	0.7%

Source: 2015 Los Angeles County Health Survey

Early Childhood Development

Primary Data—Service Provider and Community Resident Input

Many stakeholders agreed that early childhood development is a concern for the service area. The availability of affordable, accessible early childhood development and educational resources pertains to the following:

- A healthy start for young children means fewer health care and educational expenses down the road
- Lack of affordable early childhood education is a barrier to employment for parents
- Early childhood centers and programs are an important source of connectedness for foster youth
- An increase in immigration into the community means a greater demand for accessible early childhood education
- If a parent is also suffering from health or other stressors, young children may not get services they need
- Quality early education and developmental supports contributes to behavioral health as well as physical health, and are foundational to community health.

Secondary Data—Early Childhood Education (ECE) Access Gap

The Advancement Project is an organization tasked with addressing systems changes through the expansion of opportunities in educational systems, the creation of healthy communities and by shifting public investments towards equity. As part of their work, Advancement Project has released a compilation of ECE Access Gap profiles for legislative districts, supervisorial districts and LAUSD school board districts.

Since the profiles use different geographic boundaries than the Service Planning Areas, District 50 was chosen as the nearest approximation for the Saint John's service area.

Table 9. Children Without a Licensed Child Care Center Seat in District 50

Location	Children Ages 0-2 Without Seats (#; %)	Children Ages 2-4 Without Seats (#; %)
District 50	9,731; 96%	1,425; 14%

- Santa Monica ZIP codes 90403 and 90402 rank among the top ZIP codes in District 50 with the most children lacking seats to a licensed child care center seats.
- 100% of children ages 0 – 2 in ZIP code 90402 do not have access to a licensed child care center seat, while 95.9% of children ages 2- 4 lack access to a seat in ZIP code 90402.

Food Insecurity

Primary Data—Service Provider and Community Resident Input

Stakeholders discussed how food insecurity is linked to many other health-related needs, such as housing and economic insecurity. Stakeholders identified a few main contributing factors to food insecurity:

- Increased access to unhealthy foods and decreased access to good quality, nutritious foods in low-income neighborhoods
- Economic insecurity
- Immigration and fear

Stakeholders named the following populations as particularly affected by food insecurity:

- People with low incomes
- Undocumented immigrants
- Older adults

The following strategies improve access to nutritious, good quality food:

- Improve nutrition standards for school meals

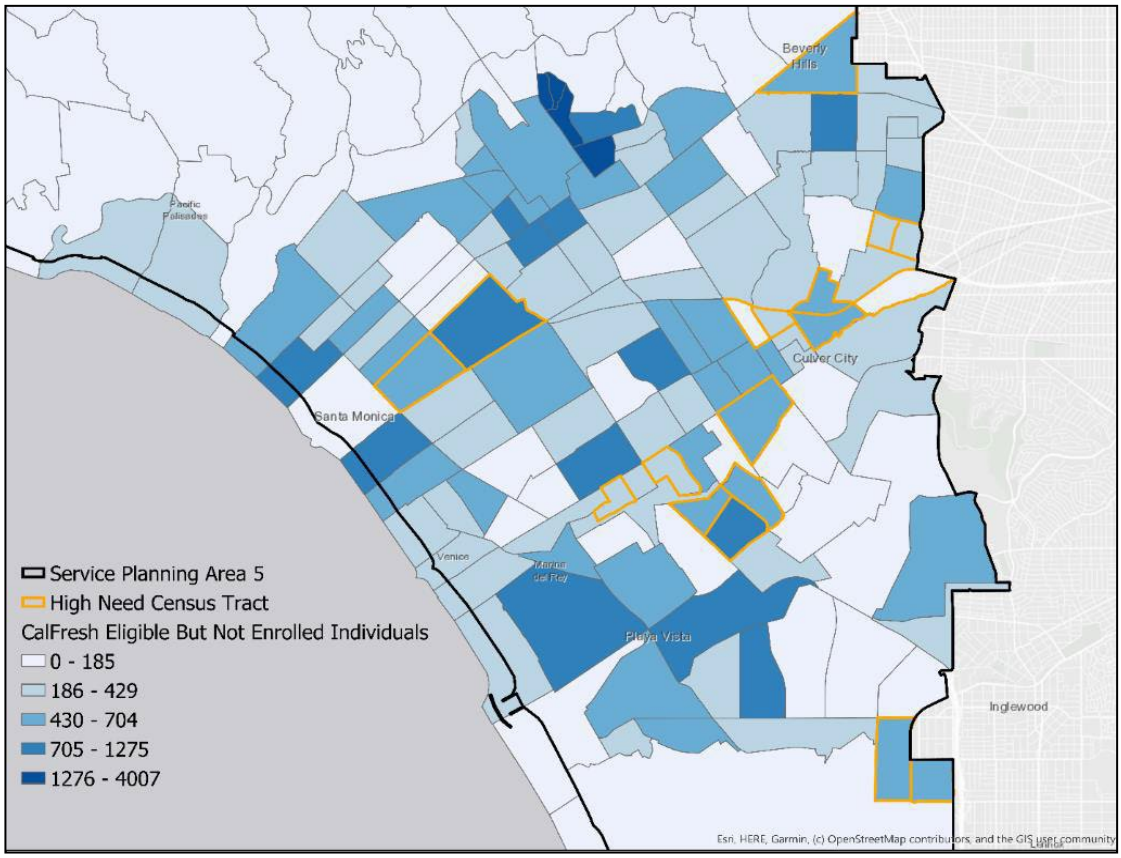
Secondary Data—CalFresh/ Food Stamp Enrollment

Table 10. Household Government Assistance by Area

Household Government Assistance Variable	SPA 5	Saint John's High Need Census Tracts	Los Angeles County
2013-2017 ACS Households Receiving Food Stamps/CalFresh	6,047	1,612	294,372
2013-2017 ACS Households Receiving Food Stamps/CalFresh (%)	2.07%	5.34%	8.93%

In looking at households that were receiving CalFresh/Food Stamp benefits in 2017, SPA participation is 4.3 times lower than that of LA County. Looking specifically at Saint John's high-need areas, CalFresh participation is more than double that in SPA 5 level, but still less than at the county level. While some of the reason for lower participation is due to ineligibility because of higher household incomes, there are still 57,032 CalFresh eligible individuals who are not enrolled to receive benefits within SPA 5. In the identified "high-need" census tracts there are a total of 8,753 eligible but unenrolled individuals.

Figure 8. CalFresh Eligible but Unenrolled Individuals in SPA 5



Chronic Diseases

Primary Data—Service Provider and Community Resident Input

While participants were asked about diabetes, obesity, heart disease, hypertension, asthma, cancer, stroke, HIV, and liver disease, stakeholders primarily discussed diabetes, obesity, and heart disease. Stakeholders particularly focused on the connection between obesity and diabetes and healthy habits. Stakeholders named a variety of contributing factors to the community's chronic disease challenges:

- Lack of access to health care services
- Homelessness
- Poverty and food insecurity
- Unhealthy behaviors

Stakeholders identified several populations that are most affected by chronic diseases:

- Young people
- People with low-incomes and/or those experiencing homelessness

Stakeholders spoke to the importance of addressing other social determinants of health, such as access to

health care, stable housing, community safety, and food security, to improve chronic diseases. By addressing these other health-related needs, people would be better able to get the health care they need, improve their eating and exercising habits, and manage their chronic diseases. To address obesity and diabetes in young people, stakeholders noted providing healthy food for school meals and increasing physical activity time as important strategies.

Secondary Data—Los Angeles County Indicators

Table 11. Chronic Disease Indicators in SPA 5 Compared to LA County

	SPA 5	Los Angeles County	Difference Between SPA and County
Obesity			
Percent of adults who are obese (BMI≥30.0)	10.3%	23.5%	-13.2%
Diabetes			
Percent of adults ever diagnosed with diabetes	4.5%	9.8%	-5.3%
Diabetes-related hospital admissions (per 10,000 population)	7.07	15.74	-8.67
Diabetes-specific death rate (per 100,000 population)	10.46	24.21	-13.75
Cardiovascular Disease			
Hypertension-related hospital admissions (per 10,000 population)	1.44	5.10	-3.66
Percent of adults ever diagnosed with hypertension	17.1%	23.5%	-6.4%
Coronary heart disease-specific death rate (per 100,000 population population)	76.03	108.10	-32.07
Stroke-specific death rate (per 100,000 population)	27.18	36.20	-9.01
Respiratory Disease			
Percent of children ages 0-17 years with current asthma (ever diagnosed with asthma and reported still have asthma and/or had an asthma attack in the past year)	6.7%	7.4%	-0.7%
Pediatric asthma-related hospital admissions per 10,000 child population	4.14	10.82	-6.68
COPD specific mortality rate (per 100,000 population)	18.09	29.88	-11.79
Liver Disease			
Liver disease-specific death rate (per 100,000 population)	4.80	13.70	-8.90

Special note on diabetes and pre-diabetes:

- According the California Health Interview Survey, the prevalence of diabetes for Los Angeles County has increased dramatically from 6.90% in 2003 to 12.10% in 2017.
- Adults who have ever been told they have pre-diabetes has risen by over 10% since the year 2009. As of 2017, the California Health Interview Survey reveals that 17.40% of the adult population in Los Angeles has been told they have pre-diabetes or borderline diabetes.

Oral Health

Primary Data—Service Provider and Community Resident Input

Stakeholders shared the number of affordable dental providers is insufficient to serve the people living on the Westside. Stakeholders shared the following themes related to the factors that contribute to oral health care being a need:

- Lack of affordable dental care and providers who accept Denti-Cal
- Lack of knowledge of the importance of preventive dental care

Stakeholders named the following populations as particularly needing improved dental care:

- Adults who are uninsured or on Denti-Cal

To address the oral health needs of the Westside, stakeholders shared the following strategies:

- Implement universal dental screening programs in schools
- Increase the number of low-cost dental providers

Secondary Data—Access to Dental Care

Table 12. Dental Care Access Indicators in SPA 5 Compared to LA County

Access to Dental Care Indicator	SPA 5	Los Angeles County	Difference Between SPA 5 and LA County
Percent of adults who did not see a dentist or go to a dental clinic in the past year	28.9%	40.7%	-11.8%
Percent of children ages 3-17 years who did not obtain dental care (including check-ups) in the past year because they could not afford it	13.3%	11.5%	1.8%
Adults who have insurance that pays for part or all of dental care (CHIS, 2017)	67.7%	61.1%	6.6%
Children who have insurance that pays for part or all of dental care (CHIS, 2017)	77.7%*	86.1%	-8.4%

*Source: 2015 Los Angeles County Health Survey *Statistically unstable due to small sample size*

Adults in SPA 5 were more likely to see a dentist or go to a dental clinic in the past year and have insurance that pays for part or all of dental care compared to adults in LA County overall. Although, a greater percentage of children 3-17 years did not obtain dental care in the past year because of cost in SPA 5 compared to LA County. Additionally, fewer children have dental insurance in SPA 5 compared to LA County.

Available Resources to Address Identified Needs

Understanding the potential resources to address significant health needs is fundamental to determining current state capacity and gaps. Resources potentially available to address these needs are vast in the Westside area of Los Angeles. There are numerous health care providers, social service non-profit agencies, faith-based organizations, and private and public school systems that contribute resources to address these identified needs. For a list of resources available to potentially address significant health needs, go to Appendix 4.

Evaluation of 2016 Community Health Improvement Plan Impact

In 2016, Providence Saint John's Health Center adopted the following five strategies in response to the identified health needs from the Community Health Needs Assessment:

Strategy #1: Work with physicians and community partners to improve access to primary and specialty care on the Westside for Medi-Cal and uninsured patients.

Strategy # 2: Develop and expand education, screening and support programs to help address chronic disease in the area.

Strategy # 3: Provide programs and improve access to resources focused on better nutrition and reducing obesity in the community.

Strategy # 4: Expand mental health and substance use services in the community to vulnerable populations.

Strategy # 5: Expand services and outreach to patients experiencing homelessness coming to Providence Saint John's Health Center and to those living in the community.

Since homelessness has risen to the top priority need in 2019, it is worth noting that PSJHC has invested significant resources to addressing this need, even as rates of homelessness has increased in the Saint John's service area and Los Angeles County as a whole for the past three years. Grants totaling $450,000 were awarded to The People Concern to provide housing and case management services for people experiencing homelessness, and $525,000 to Venice Family Clinic to provide medical care for patients experiencing homelessness. PSJHC was also the lead recipient with The People Concern and Saint Joseph Center of a collaborative $636,881 grant to provide services for the local homeless population awarded by the Well Being Trust. Providence Saint John's employs two coordinators based in its Emergency Department to navigate and link patients experiencing homelessness to shelters and the SPA 5 Coordinated Entry System. This program has been viewed as a model for other local hospitals on the Westside and throughout Los Angeles, and it has made efforts to collaboratively share best practices and lessons learned in order to build capacity of other hospitals to have coordinators in their Emergency Departments. For additional description of impact made across all five of these strategies see Appendix 5.

2019 CHNA Governance Approval

This community health needs assessment was adopted on October 23, 2019 by the Providence Saint John's Health Center Community Ministry Board.

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Chief Executive
Providence Saint John's Health Center

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COMMUNITY HEALTH IMPROVEMENT PLAN

2020 - 2022

Providence Saint John's Health Center

To provide feedback about this CHIP or obtain a printed copy free of charge, please email justin.joe@providence.org

Saint John's Health Center

PROVIDENCE Health & Services

CONTENTS

EXECUTIVE SUMMARY

Who We Are

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

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

Our Commitment to Community

As health care continues to evolve, PSJHC is responding with dedication to its Mission and a desire to create healthier communities, together. Partnering with other non-profits that share our commitment to the economically poor and vulnerable, we conduct a formal community health needs assessment (CHNA) to learn about the greatest needs and assets in our community, especially considering members of medically underserved, low-income, and minority populations. This assessment helps us consider solutions to fulfill unmet needs while continuing to strengthen local resources. It guides our community benefit investments, not only for our own programs but also for many partners that look to PSJHC to improve the health of entire populations.

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

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

Description of Community Served

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

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

Providence Saint John's Health Center Community Health Improvement Plan Initiatives

As a result of the findings of our 2019 Community Health Needs Assessment (CHNA) and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, Providence Saint John's Health Center will focus on the following areas for its 2020-2022 Community Benefit efforts:

INITIATIVE 1: STRENGTHEN INFRASTRUCTURE OF CONTINUUM OF CARE FOR PATIENTS EXPERIENCING HOMELESSNESS

As a hospital that sees a significant number of patients experiencing homelessness that come in through our emergency departments for care, we will partner with our local homeless service providers to strengthen the ability to connect these patients experiencing homelessness to the rapidly changing environment of resources in LA County. In addition to facilitating better handoffs and coordination of care, we will focus on the gap of available recuperative care/interim shelter beds for patients experiencing homelessness that are not sick enough to be admitted into a hospital but need a temporary place to heal that is safer than being discharged to their previous unhoused situation.

INITIATIVE 2: IMPROVE ACCESS TO HEALTH CARE SERVICES

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

INITIATIVE 3: IMPROVE ACCESS TO BEHAVIORAL HEALTH AND REDUCE STIGMA

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

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

Providence has a long history in employing Community Health Workers (CHWs) in a diverse breadth of roles in programs that address social determinants of health. These roles typically have fallen into three categories: case management, health education, and assistance with enrollment into public benefits (i.e. Medicaid/Medi-Cal and SNAP/CalFresh). These jobs create an entry point for people to work in the health care industry while allowing Providence to effectively provide culturally competent care within specific underserved communities. In addition to continuing our own employment model of CHWs, we will partner with Charles Drew University to develop and implement a CHW Academy. This CHW Academy will provide formal training and facilitate paid internships for CHWs at PSJHC and other health care organizations who have an interest in incorporating a CHW workforce in their organizations.

Responding to the COVID-19 Pandemic

The 2020 Community Health Improvement Planning (CHIP) process was disrupted by the SARS-CoV-2 virus and COVID-19, which has impacted all of our communities. While we have focused on crisis response, it has required a significant re-direction of resources and reduced community engagement in the CHIP process.

This CHIP is currently designed to address the needs identified and prioritized through the 2019 CHNA, though COVID-19 will have substantial impacts on our community needs. These impacts are likely to exacerbate some of the needs identified, and cause others to rise in level of priority. While this is a dynamic situation, we recognize the greatest needs of our community will change in the coming months, and it is important that we adapt our efforts to respond accordingly. Additionally, the data projections included were crafted based on data collection and project forecasting done prior to the COVID-19 pandemic, so may be modified as we understand adjusted resources and priorities within our communities in the aftermath of the pandemic.

MISSION, VISION, AND VALUES

Our Mission	As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.
Our Vision	Health for a Better World.
Our Values	Compassion — Dignity — Justice — Excellence — Integrity

INTRODUCTION

Who We Are

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

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

Our Commitment to Community

PSJHC dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. During 2019, our ministry provided over $39 million in community benefit[1] in response to unmet needs and to improve the health and well-being of those we serve on LA County's Westside.

Planning for the Uninsured and Underinsured

Our mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why PSJHC has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients.

One way PSJHC informs the public of FAP is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial

[1] A community benefit is an initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives: a. Improves access to health services; b. Enhances public health; c. Advances increased general knowledge; and/or d. Relieves government burden to improve health. Note: Community benefit includes both services to the economically poor and broader community. To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following: 1) community health needs assessment developed by the ministry or in partnership with other community organizations; 2) documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; 3) or the involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third party insurers are offered an opportunity to complete the Patient Financial Assistance Application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible. For information on our Financial Assistance Program please visit https://www.providence.org/obp/ca

OUR COMMUNITY

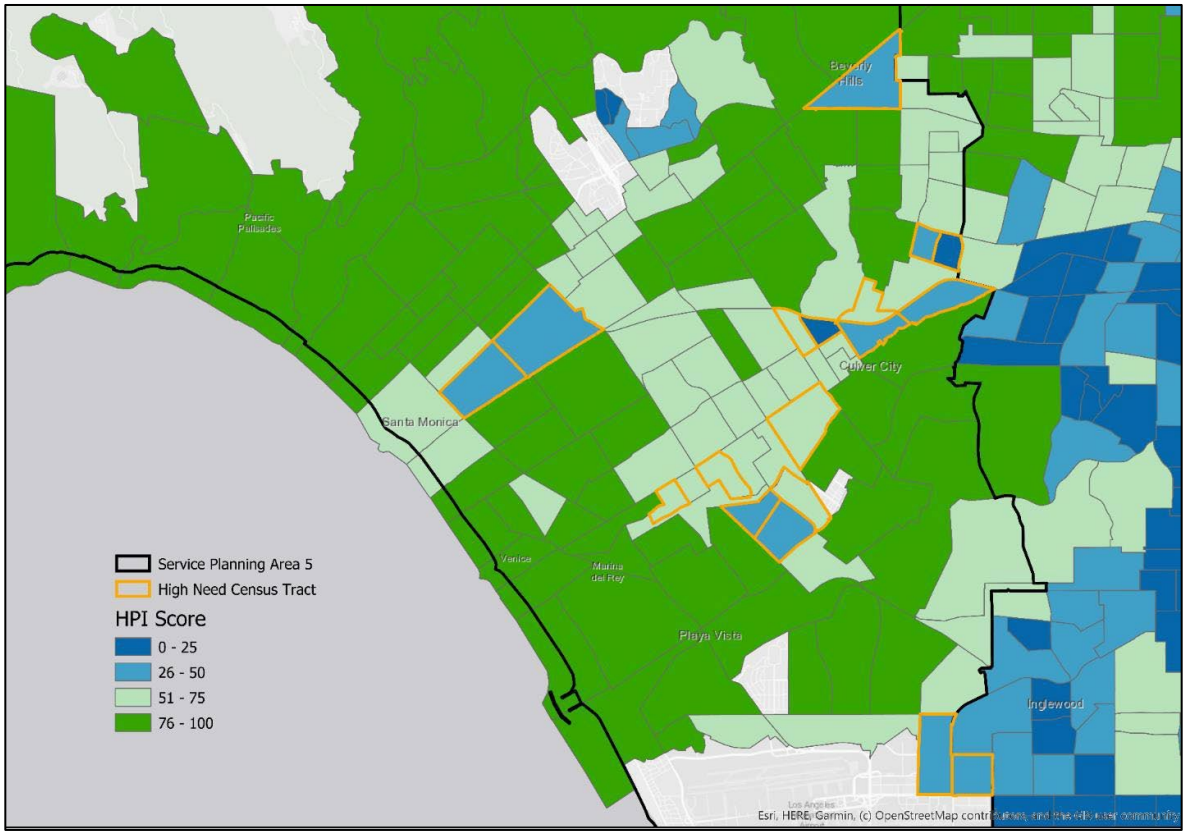
Description of Community Served

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

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

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

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



COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

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

Secondary data collection included the review of demographic, insurance, mortality, morbidity, mental health, economic and social determinant data from multiple sources. The secondary data sources included the following: the U.S. Census, Los Angeles Homeless Services Authority, Think Health L.A. Database, Community Commons Database, California Health Interview Survey Dataset, L.A. County Department of Public Health, and California Department of Public Health. Truven Analytics/ Dignity Health provided Community Need Index data, the Public Health Alliance of Southern California provided Healthy Places Index data, and the City of Santa Monica provided community specific data.

Identification and Selection of Significant Health Needs

Once the information and data were collected and analyzed by staff members, the following nine key areas were identified as community needs for the Community Health Needs Assessment Oversight Committee to prioritize, listed here in alphabetical order:

- Access to Health Care
- Behavioral Health
- Chronic Diseases
- Early Childhood Development
- Economic Insecurity
- Food Insecurity
- Homelessness and Housing Instability
- Oral Health Care
- Services for Seniors

Community Health Needs Prioritized

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

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

Needs Beyond the Hospital's Service Program

No hospital facility can address all of the health needs present in its community. The following community health needs identified in the CHNA will not be address and an explanation is provided below:

- Oral Health: This was identified as the lowest priority need in the 2019 CHNA. Furthermore, our health facilities do not provide oral health care, and it is not our area of expertise within the Providence health system in the Los Angeles region. However, there are a number of community partners including local Federally Qualified Health Clinics who are focusing on increasing access to oral health care—especially for the Medi-Cal population. For community members in need of these services we refer them to these providers of low-cost dental care.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

Based on the prioritized needs, Providence staff developed four strategic initiatives that address eight of the nine prioritized health needs. Considered were the existing programs and resources that PSJHC has in place to address these needs and the landscape of community partners to collaborate with together.

PSJHC anticipates that implementation strategies may change and therefore, a flexible approach is best suited for the development of its response to the CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by Providence Saint John's Health Center in the enclosed CHIP.

Addressing the Needs of the Community: 2020- 2022 Key Community Benefit Initiatives and Evaluation Plan

INITIATIVE #1: STRENGTHEN INFRASTRUCTURE OF CONTINUUM OF CARE FOR PATIENTS EXPERIENCING HOMELESSNESS

Community Need Addressed

- Homelessness and Housing Instability
- Economic Insecurity

Goal (Anticipated Impact)

Improve the ability to care for patients experiencing homelessness or at risk of becoming homeless

- Reduce the number of people experiencing homelessness

Scope (Target Population)

Patients experiencing homelessness or at risk of becoming homeless

Table 1. Strategies and Strategy Measures for Addressing Homelessness and Housing Insecurity

Strategies	Strategy Measure	Baseline	FY20 Target	FY22 Target
1. CHW Homeless Navigators: Hospital emergency department-based Community Health Workers that assist patients experiencing homelessness with discharge to shelter or homeless service providers	• Number of patients screened for homelessness • Number of Patients linked to homeless services provider • Number of patients discharged to temporary/permanent housing	• 660 patients screened for homelessness • 65 patients linked to homeless services provider • 105 patients discharged to temporary/permanent housing	• 700 patients screened for homelessness • 150 patients linked to homeless services provider • 100 patients discharged to temporary/ permanent housing	• 10% increase in patients screened for homelessness as compared to 2021 target • 10% increase in patients linked to homeless service provider as compared to 2021 target • 10% increase in number of patients discharged to temporary/ permanent housing as compared to 2021 target
2. Provide or facilitate funding to homeless service providers: Bring financial support to local organizations either through directly awarding grants or by facilitating grant awards from external funders	• Funding directed towards local homeless service providers	• Total of $200,000 awarded to two local homeless services organizations	• Maintain sources of sustainable funding for homeless service providers	• Maintain sources of sustainable funding for homeless service providers • Identify at least one collaborative funding opportunity from external funder

3. Recuperative Care: Improve the infrastructure of available recuperative care/interim shelter for patients experiencing homelessness that are not medically stable enough to be discharged back to the streets	• Identify target population, Interventions and partners to support L.A. Service Area housing initiative • Support policies to increase temporary housing as a pathway to permanent supportive housing	No baseline. New program for 2020	• Partner with Stakeholders to complete landscape analysis related to recuperative care • Establish consensus among stakeholders as to the # of recuperative care beds in L.A. County • Identify gaps/ improvements that would increase # recuperative care/ temporary housing beds for patients who are unsheltered • Partner with PSJH advocacy and other stakeholders to support policy changes that reimburse recuperative care/ temporary housing services for homeless • Increase support for local policies that ease construction/	• 2% baseline increase in # of temporary housing/ recuperative care beds available to PSJH patients in L.A. Service Area • Develop standards that define spectrum of temporary housing options for individuals experiencing homelessness that lead to permanent supportive housing • Increase scope of covered Medi-Cal benefits to include recuperative care • Increase number of recuperative care beds available to patients discharged from hospitals who do not have shelter • Partner with key stakeholders to

			remodeling regulations for temporary housing facilities, including case management/housing navigation services • Identify opportunities to leverage existing resources to support recuperative care/ temporary housing priorities	increase # of recuperative care beds and related support services including housing navigation and case management services

Evidence Based Sources

Approved Strategies to Combat Homelessness. *Los Angeles County Homeless Initiative. https://homeless.lacounty.gov/wp-content/uploads/2017/01/HI-Report-Approved2.pdf*

Resource Commitment

Homeless Care Navigators, Funding for Recuperative Care Beds, Grant funding to homeless service providers

Key Community Partners

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

INITIATIVE #2: IMPROVE ACCESS TO HEALTH CARE SERVICES

Community Need Addressed

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

Goal (Anticipated Impact)

Improve access to quality health care services for vulnerable populations

- Reduce the utilization of emergency departments for "avoidable," non-emergency visits
- Reduce the rates of uninsured people in the community
- Increase the percentage of the population who receive flu shots

Scope (Target Population)

Uninsured and underinsured populations in low-income communities

Table 2. Strategies and Strategy Measures for Addressing Access to Health Care Services

Strategies	Strategy Measure	Baseline	FY20 Target	FY22 Target
1. Provide/facilitate funding and in-kind support for access to care to local community agencies	• Funding directed towards access to health care programs	• $375,000 in grants to local organizations awarded for access to care in 2019	• Maintain sources of sustainable funding for access to care	• Maintain sources of sustainable funding for access to care • Identify at least one collaborative funding opportunity from external funder
2. Increase availability of testing and vaccinations for COVID-19 and Flu	• Number of flu shots provided • Number of COVID-19 testing locations established	• No baseline, new program for 2020	• Identify collaborative partnership with other health systems to increase access to COVID-19 testing and/or flu shots	• Target benchmarks to be determined based on identified collaborative project in 2020.

Evidence Based Sources

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

Resource Commitment

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

Key Community Partners

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

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

Community Need Addressed

- Behavioral Health
- Early Childhood Development

Goal (Anticipated Impact)

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

Scope (Target Population)

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

Table 3. Strategies and Strategy Measures for Addressing Behavioral Health

Strategies	Strategy Measure	Baseline	FY20 Target	FY22 Target
1. **Child and Family Development Center:** Address Birth Trauma	• Number of clients referred to Post-Partum Support Groups • Number of clients referred to the Perinatal Support Meetings • Number of clients referred to Bringing Baby Home group	• 10 clients participating in a post-partum support group	• Establish the Bringing Home Baby Group • Establish the Peri-Natal Support meeting	• Have at least 10 clients in each of the three groups
2. **Child and Family Development Center:** Capacity building for local organizations through trauma informed trainings	• Number of in-service trainings provided to schools • Number of in-service trainings provided to after school care facilities	• 10 in-service trainings provided at schools • No baseline for after school care facilities. New for 2020.	• 12 in-service trainings at various schools • 2 in-service trainings at after school childcare facilities	• 16 in-service trainings at various schools • 4 in service trainings at after school childcare facilities
3. **Child and Family Development Center:** Provide programs that support the social emotional functioning of young children	• Conduct a trauma informed parenting group • Provide mental health education at local libraries • Provide Infant Massage groups in the community	• 1 mental health education sessions • Infant Massage in one on one setting only with clients	• Provide at least 1 trauma informed parenting groups • Provide at least 2 mental health education sessions in the community • Provide at least 1 Infant Massage group in the community	• Provide at least 2 trauma informed parenting groups • Provide at least 4 mental health education sessions in the community • Provide at least 2 Infant Massage groups in the community

4. Mental Health Education and Prevention: Health Educators and CHWs paired together teach free community-based courses in English and Spanish on mental health awareness and coping skills	• Number of participants completing Mental Health First Aid (MHFA) • Number of participants completing Creating Healthier Attitudes Today (CHAT)	• No baseline, new program for 2020	• 140 people trained in Mental Health First Aid* • 50 people participate in Creating Healthier Attitudes Today*	• 10% increase in people trained in MHFA from 2021 baseline • 10% increase in CHAT participants from 2021 baseline

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

Evidence Based Sources

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

Resource Commitment

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

Key Community Partners

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

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

Community Need Addressed

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

Goal (Anticipated Impact)

- Increase the number of Community Health Workers employed in health care settings in roles that address social determinants of health
- Reduce food insecurity
- Reduce the number of people that are eligible but unenrolled in CalFresh/SNAP benefits

Scope (Target Population)

- Workforce development for employees without a college degree
- Services for residents of low-income neighborhoods, especially Spanish speaking communities

Table 4. Strategies and Strategy Measures for Training and Deploying Community Health Workers

Strategies	Strategy Measure	Baseline	FY20 Target	FY22 Target
1. CalFresh Enrollment Assistance : CHWs provide outreach and one-on-one application assistance with CalFresh applications	Number of people enrolled in CalFresh	No baseline, new program for 2020.	100 people enrolled in CalFresh	20% increase from 2021 baseline in people enrolled in CalFresh
2. Health Education and Prevention Classes: Health Educators and CHWs paired together teach free community based courses in English and Spanish on nutrition, mental health awareness, and coping skills	• Number of participants in FEAST • Number of people trained in Mental Health First Aid (MHFA) • Number of participants in Creating Healthier Attitudes Today	• 61 people participated in FEAST in 2019 • No baseline for MHFA, new program for 2020 • No baseline for CHAT, new program for 2020.	• 80 people will participate in the FEAST* program • 140 people trained in Mental Health First Aid* • 50 people participate in Creating Healthier Attitudes Today*	• 25% increase from 2021 baseline in FEAST participants • 10% increase from 2021 baseline in MHFA participants • 10% increase from 2021 baseline in CHAT participants
3. CHW Academy: In collaboration with Charles Drew University, develop an academy for Community Health Workers that focus on integration into health care organizations	Number of CHW students who complete program	New program for 2020	• 20 CHW students enrolled in program	• 25% increase from 2021 in CHW students enrolled • Additional sustainable funding for CHW Academy identified and secured beyond pilot grant funding

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

Evidence Based Sources

- Center for Disease Control and Prevention: Community Health Worker Toolkit https://www.cdc.gov/dhdsp/pubs/toolkits/chw-toolkit.htm
- LA Department of Public Health: Food Insecurity in Los Angeles County http://www.publichealth.lacounty.gov/ha/docs/2015LACHS/LA_HEALTH_BRIEFS_2017/LA%20Health_FoodInsecurity_finalB_09282017.pdf
- Mental Health First Aid Research Summary https://www.mentalhealthfirstaid.org/cs/wp-content/uploads/2013/10/2018-MHFA-Research-Summary.pdf

Resource Commitment

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

Key Community Partners

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

2020-2022 CHIP GOVERNANCE APPROVAL

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

DocuSigned by:
Michael Ricks
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Michael Ricks
Chief Executive
Providence Saint John's Health Center

DocuSigned by:

James H. Fordyce
Chair, Community Ministry Board
Providence Saint John's Health Center

Joel Gilbertson
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To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Improvement Plans please email CommunityBenefit@providence.org.

APPENDICES

Appendix 1: Definition of Terms

Community Benefit: An initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives:

a. Improves access to health services;
b. Enhances public health;
c. Advances increased general knowledge; and/or
d. Relieves government burden to improve health.

Community benefit includes services to persons living in poverty, persons who are vulnerable, and the broader community.

To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following:

a. Community health needs assessment developed by the ministry or in partnership with other community organizations;
b. Documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; or
c. The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

Health Equity: Healthy People 2020 defines *health equity* as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."

Social Determinants of Health: Powerful, complex relationships exist between health and biology, genetics, and individual behavior, and between health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies. These factors, which influence an individual's or population's health, are known as *determinants of health*. *Social determinants of health* are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Initiative: An initiative is an umbrella category under which a ministry organizes its key priority efforts. Each effort should be entered as a program in CBISA Online (Lyon Software). Please be sure to report on all your Key Community Benefit initiatives. If a ministry reports at the initiative level, the goal (anticipated impact), outcome measure, strategy and strategy measure are reported at the initiative level. Be sure to list all the programs that are under the initiative. Note: All Community Benefit initiatives must submit financial and programmatic data in CBISA Online.

Program: A program is defined as a program or service provided to benefit the community (in alignment with guidelines) and entered in CBISA Online (Lyon Software). Please be sure to report on all community benefit programs. Note: All community benefit programs, defined as "programs", are required to include financial and programmatic data into CBISA Online.

Goal (Anticipated Impact): The goal is the desired ultimate result for the initiative's or program's efforts. This result may take years to achieve and may require other interventions as well as this program. (E.g. increase immunization rates; reduce obesity prevalence.).

Scope (Target Population): Definition of group being addressed in this initiative: specific description of group or population included (or not included, if relevant) for whom outcomes will be measured and work is focused. Identify if this initiative is primarily for persons living in poverty or primarily for the broader community.

Outcome measure: An outcome measure is a quantitative statement of the goal and should answer the following question: "How will you know if you're making progress on goal?" It should be quantitative, objective, meaningful, and not yet a "target" level.

Providence Saint John's Health Center

2019 Update to the Community Benefit Plan

Saint John's
Health Center

PROVIDENCE Health & Services

Table of Contents

PREFACE

In accordance with Senate Bill 697, Community Benefit Legislation, Providence Saint John's Health Center submits this Community Benefit Plan for 2019. Senate Bill 697 requires a not-for profit hospital in California to complete the following activities:

- Review and reaffirm its mission statement to ensure that its policies integrate and reflect the public interest in meeting its responsibilities as a not-for-profit organization

- Complete a community needs assessment every three years, evaluating the health needs of the community served by the hospital.

- File a community benefit update annually, documenting activities that the hospital has undertaken to address community needs within its mission and financial capacity; and to the extent practicable, assign and report the economic value of community benefit provided in furtherance of its plan.

A Santa Monica Community Access Plan Annual Implementation Report is also included, as specified by the City of Santa Monica Development Agreement. This requires that Providence Saint John's Health Center complete the following on an annual basis:

- File the hospital's Community Benefit Plan with the City of Santa Monica 60 days prior to submission to the state

- Assign and report the cost of programs and services provided by the Health Center according to a five item framework that includes:

    - Cash and in-kind support of the Santa Monica-Malibu Unified School District
    - Cash and in-kind support of local non-profit organizations
    - Medical and mental health services provided based on referrals from local non-profit organizations
    - Medical and mental health services provided based on referrals from the Santa Monica-Malibu Unified School District
    - Community services available to the general community that promote health education and preventive services

PROVIDENCE SAINT JOHN'S HEALTH CENTER: A BRIEF INTRODUCTION

For seventy-five years, Saint John's Health Center has offered a range of health care programs and services unparalleled on the Westside of Los Angeles. Saint John's Health Center was acquired by Providence Health and Services in March 2014 and is now called Providence Saint John's Health Center. The Mission of the Sisters of Charity of Leavenworth, who established the hospital, matches very closely with the Sisters of Providence making for a smooth transition with the change in ownership. In 2016, Providence Health and Services combined with St. Joseph Health to form Providence St. Joseph Health.

In addition to primary care, Providence Saint John's has built a reputation as a leading provider of specialty care by responding to the needs of our patients and community. Providence Saint John's houses many premier programs, including:

Child and Family Development Center: The Center provides a comprehensive range of culturally sensitive and linguistically responsive mental health, outreach, developmental and educational services. Services are offered to children, adolescents, and their families at the Center, school sites, homes and other locations in the community in English and Spanish. The Center is recognized as a community mental health center by the L.A. County Department of Mental Health.

Emergency Care: Providence Saint John's 24-hour Emergency Department is a crucial facility for the Westside. Care is provided by board-certified attending physicians and Emergency Department nurses certified in advanced life support and pediatric life support.

Maternal and Child Health: Our Obstetrics program includes Labor, Delivery and Recovery suites, Mother-Baby couplet care unit, Neonatal Intensive Care Unit, Lactation services, and a support program for breastfeeding mothers.

Cancer: Providence Saint John's Health Center cancer treatment program is approved by the American College of Surgeons Commission on Cancer. The John Wayne Cancer Institute (JWCI) at Providence Saint John's Health Center is a cancer research institute dedicated to the understanding and curing of cancer. Institute highlights include one of the largest melanoma centers in the U.S., a top ranked breast center, a surgical oncology fellowship program, and one of the largest specimen repositories in the U.S.

Cardiac Care: Providence Saint John's program includes a wide range of diagnostic and therapeutic cardiac services, including leadership in transfusion-free medicine and bloodless cardiac surgery, percutaneous coronary interventions, ablations, and traditional cardiac surgeries.

Orthopedics: Specializing in joint and spinal surgery, Providence Saint John's has been recognized as a top 100 orthopedics specialty hospital for hip replacements. Providence Saint John's provides leadership in the anterior approach to hip replacements.

SECTION 1: EXECUTIVE SUMMARY

Mission, Core Values and Foundational Beliefs
Providence Saint John's Health Center mission statement, the core values of Providence St. Joseph Health, and the foundational beliefs of the Catholic Health Association guide our commitment to improving the health of individuals and the communities we serve, especially those who are poor and vulnerable. The Mission permeates the everyday life of Providence Saint John's.

Definition of Community
For community benefit planning purposes, Providence Saint John's Health Center defines its service area to include the cities and neighborhood areas surrounding the Health Center, and the addresses of patients using the hospital's services. The service area is identified as Service Planning Area (SPA) 5 which includes communities such as Santa Monica, Malibu, Pacific Palisades, Venice, Marina del Rey, Mar Vista, Playa Vista, Westwood, Brentwood, and parts of West Los Angeles.

Identifying and Prioritizing Community Needs
Providence Saint John's conducts a Community Health Needs Assessment every three years, per SB697, and uses this assessment as the basis for identifying health needs. PSJHC updated the needs assessment in 2019 using data from governmental and private agencies as well as consultation from the leaders of local non-profit agencies and feedback from local residents. The entire Community Health Needs Assessment is posted on the Providence St. Joseph Health website at:
https://www.psjhealth.org/community-benefit/community-health-needs-assessments

Categories of Community Need Addressed in the Benefit Plan
This Community Benefit Plan includes objectives and supporting programs and services for the following categories of needs, ranked in priority order:

- Benefit for persons living in poverty
- Benefit for the general population

These categories reflect how Providence Saint John's understands its multiple roles in the community: first, as a Catholic health care ministry, and second as a healthcare provider and community partner.

Community Benefit Plan Activities
We seek to grow a healthier community by partnering and collaborating with residents and organizations in our community. Programs and services provided by the Health Center in calendar year 2019 to address community health needs include the following:

- Charity care for patients without the ability to pay for necessary treatment.
- Financial and in-kind support of local nonprofit organizations focused on serving vulnerable persons.
- Child and Family Development Center programs, providing outpatient mental health services for children and families, persons who are deaf and/or hard of hearing, persons with developmental disabilities, individuals and families affected by child abuse; therapeutic preschool, school-based mental health outreach to at-risk youth, community-based therapy services for youth, and community outreach.

- Dedicated program providing temporary supportive care and shelter to homeless persons discharged from the hospital.
- Collaboration in increasing the access to care for low and moderate income Westside area individuals and families, including must needed services like obstetrical care.
- Community education programs on topics of interest
- Partnerships with local faith communities and nonprofits to address growing health issues and concerns in the community
- Education and internship programs for nurses, physicians, psychologists, social workers, and allied health professionals.
- Support for medical and community health research

Economic Value of Community Benefit Provided

During calendar year 2019, the economic value of community benefit provided by Providence Saint John's Health Center is estimated at $39,458,371 (includes Charity Care, Medi-Cal Shortfall and Community Benefit Services) with an additional $75,092,017in Medicare shortfall. Furthermore, the Providence Saint John's Health Center Affiliation Fund provided $957,000 in separate grant funding to local non-profit agencies health care services and access thereto, including wellness programs, health research, and health education, public/private partnerships formed to improve health, directly and through grant making, to the residents in Saint John's Health Center's service area.

SECTION 2: MISSION, CORE VALUES AND FOUNDATIONAL BELIEFS

Providence Saint John's Health Center Mission Statement and the Core Values of Providence St. Joseph Health guide our organization's commitment to creating a healthier community and permeate the everyday life of the organization. The Mission Statement and Core Values are as follows:

Providence Saint John's Health Center Mission Statement
As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Providence Saint John's Health Center Core Values

Compassion

- We reach out to people in need and give comfort as Jesus did
- We nurture the spiritual, physical and emotional well-being of one another and those we serve
- Through our healing presence, we accompany those who suffer.

Dignity

- We value, encourage and celebrate the gifts in one another.
- We respect the inherent dignity and worth of every individual.
- We recognize each interaction as a sacred encounter.

Justice

- We foster a culture that promotes unity and reconciliation.
- We strive to care wisely for our people, our resources and our earth.
- We stand in solidarity with the most vulnerable, working to remove the causes of oppression and promoting justice for all.

Excellence

- We set the highest standards for ourselves and our ministry
- Through transformation and innovation, we strive to improve the health and quality of life in our communities.
- We commit to compassionate, safe and reliable practices for the care of all.

Integrity

- We hold ourselves accountable to do the right thing for the right reasons.
- We speak truthfully and courageously with generosity and respect.
- We pursue authenticity with humility and simplicity.

Catholic Health Association Foundational Beliefs
Providence Saint John's Health Center's community benefit programs are rooted in the Catholic Health Association core set of beliefs:

- Those living in poverty and at the margins of society have a moral priority for services.
- Not-for-profit health care has a responsibility to work to improve health in communities by focusing on prevention
- Community members and organizations should be actively involved in health care community benefit programs
- Demonstrating the value of community service is imperative
- Integrate community benefit programs throughout the organization

- Leadership commitment leads to successful community benefit programs
- Those living in poverty and at the margins of society have a moral priority for services
- Not-for-profit health care has a responsibility to work to improve health in communities by focusing on prevention
- Community members and organizations should be actively involved in health care community benefit programs
- Demonstrating the value of community service is imperative
- Integrate community benefit programs throughout the organization
- Leadership commitment leads to successful community benefit programs

SECTION 3: DEFINITION AND DESCRIPTION OF OUR COMMUNITY

In defining its community for purposes of this report, we used the Providence Saint John's Health Center 2016 Community Health Needs Assessment. We considered the location of the hospital and the surrounding communities, and the zip codes reported in addresses of our patients on entry into the hospital for services.

Definition of Community
Providence Saint John's Health Center defined its "community" to include the following cities and neighborhood areas (ZIP codes are shown in parentheses):

- Bel Air (90077)
- Beverly Hills (90210, 90211, 90212)
- Brentwood (90049)
- Century City (90067)
- Cheviot Hills/Rancho Park (90064)
- Culver City (90230, 90232)
- Landera Heights (90056)
- Malibu (90263, 90265)
- Mar Vista (90066)
- Marina del Rey (90292)
- Pacific Palisades (90272)
- Palms (90034)
- Playa del Rey (90293)
- Playa Vista (90094)
- Santa Monica (90401, 90402, 90403, 90404, and 90405)
- Venice (90291)
- West Fairfax (90035)
- West Los Angeles (90025, 90073)
- Westchester (90045)
- Westwood (90024, 90095)

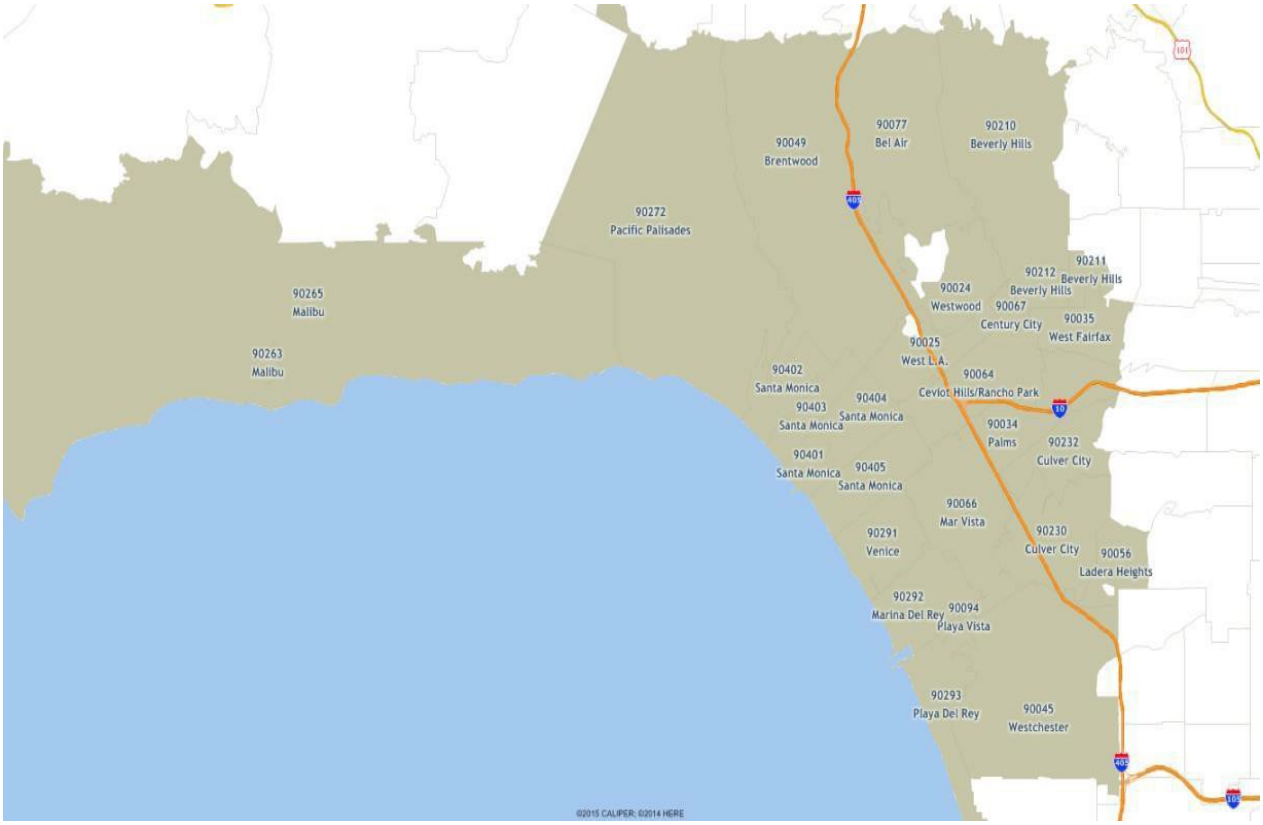
Providence Saint John's Health Center is located in ZIP code 90404, in the City of Santa Monica. Four other hospitals are physically located in the Health Center's service area (ZIP code location of each hospital shown in parenthesis):

- UCLA Santa Monica Medical Center, Santa Monica (90404)
- UCLA Ronald Regan Medical Center, Westwood (90095)
- Kaiser Permanente – West Los Angeles Medical Center (90034)
- Cedars Sinai Marina Del Rey Hospital (90292)

In addition, other area hospitals used by residents of the service area include Cedars-Sinai Medical Center (Los Angeles) and Centinela Hospital Medical Center (Inglewood).

FIGURE 3.1: MAP OF SAINT JOHN'S HEALTH CENTER SERVICE AREA

The Primary Service Area is used for Community Benefit Planning Purposes



Description of Our Community

The 2016 Community Needs Assessment utilized information from a variety of sources – Truven Health Analytics, (a national vendor of demographic data), Los Angeles County Department of Public Health, California Department of Public Health, Think Health L.A., The City of Santa Monica, Community Commons, Ask CHIS, and the U.S. Bureau of the Census. The area studied for the Community Needs Assessment included Service Planning Area 5 (SPA 5) of Los Angeles County in which Providence Saint John's Health Center is located and most of the communities served by the facility.

Demographics:

- Based on estimates provided by the Think Health L.A. database, the 2016 population of SPA 5 is estimated at 674,787 persons.
- Within SPA 5, the majority of residents are White (68.5 percent). Approximately 15.4 percent of residents are Hispanic, 13.4 percent are Asian/Pacific Islander, 6.0 percent are Black, and 6.2 percent are of other races.
- Among persons age 5 years and older in the service area, 86.7 percent speak English most often at home, 8.4 percent speak Spanish most often, 1.7 percent speak an Asian language most often and 3.2 percent speak some other language most often at home.

- Among persons 25 years and older living in SPA 5, 6.4 percent have less than a high school education (no high school diploma), 12.5 percent are high school graduates, 25.2 percent have completed some college (no degree), and 55.8 percent have college, graduate or professional degrees.
- There are an estimated 25.5 percent of households in SPA 5 with children.
- Approximately 11.9 percent of the households in SPA 5 have incomes less than 100% of the Federal Poverty Level.
- Based on data collected by the County, in SPA 5 it is estimated that 3.0 percent of children (age 0-17) are uninsured. Approximately 4.7% of adults (age 18-64) in SPA 5 are estimated to be uninsured.
- Based on 2016 Claritas demographic data it is estimated that 16.3% of the population in SPA 5 is 65 years and older.
- Health status indicators reported from L.A. County Department of Public Health showed that for SPA 5:
    - 84.5% of live births were to mothers who received prenatal care in the first trimester.
    - 45.8% of adults (age 18+) were vaccinated for influenza in the past year.
    - 10.0% of adults reported their health to be fair or poor.
    - 21.2% of adults (age 18-64) in the area reported no regular source of medical care.
    - 13.1% of adults and 4.3% of children were estimated to have difficulty accessing medical care over the past year.
    - 28.9% of adults have not received dental care in the past year and 13.3% of children (age 3-17) did not obtain dental care in the past year because they could not afford it.
    - 14.2% of adults and 7.9% of children (age 3-17) tried to get mental or behavioral health care during the past year.
    - 17.1% of adults have been diagnosed with hypertension in the area and 24.4% of adults have been diagnosed with high cholesterol.
- Data collected by the County on nutrition, physical fitness and obesity for residents of SPA 5 showed:
    - 10.3% of adults in SPA 5 are obese.
    - 31.1% of adults are overweight.
    - 58.0% of adults living in SPA 5 don't obtain the recommended amount of aerobic and muscle-strengthening exercises each week.
    - 17.6% of children (age 6-17) obtain the recommended amount of exercise each week.
    - 20.9% of adults consume five or more servings of fruits and vegetables a day.
    - 18.2% of adults living in the area are estimated to binge drink.
    - 30.5% of households with incomes <300 of the FPL are food insecure.
    - 14.3% of children drink at least one soda or sweetened drink per day.

SECTION 4: COMMUNITY BENEFIT PLANNING PROCESS

The 2019 Community Benefit Update is linked to the 2016 Community Health Needs Assessment Plan, which is posted on Providence Saint John's website at: https://www.psjhealth.org/community-benefit/community-health-needs-assessments

Providence Saint John's conducts assessments every three years, and the results are used as the basis of our community benefit planning. The secondary data used in the 2016 assessment is summarized in Section 3 of this Annual Update. The second part of our community health needs assessment process is the Community Consultation.

Community Consultation
As part of the 2016 Community Health Needs Assessment, 41 community leaders from local organizations – city and county health and human services offices, education (kindergarten through high school and community college), free and community clinics, and nonprofit agencies – were interviewed via phone during a period from September 2015 to October 2015. Questions focused on opinions regarding top health needs in the community, issues/challenges/barriers related to these health needs, and what resources (if any) are currently available to address these needs. These interviews were conducted in collaboration with UCLA Health System, Kaiser Permanente West L.A. and Cedars-Sinai Medical Center.

Top health needs identified from the primary and secondary data are as follows:

Access to affordable primary and specialty care

- There are few physicians on the Westside who accept Medi-Cal and a limited number accepting
- Medicare.
- The number of persons covered by Medi-Cal in the service area has increased by over 55,000 persons with the expansion under the Affordable Care Act.
- Close to one out of ten people living in the service area report having no regular source of medical care.

Better management and prevention of chronic illness

- The senior population is growing in the area with over 16 percent of the population now 65 or over.
- Heart disease and stroke remain the leading causes of death in the area.
- Approximately 46 percent of adults in the area are estimated to have pre-diabetes.

Need for more prevention programs focused on reducing obesity and improving nutrition

- Obesity rates are on the rise in the area with 53.3 percent of adults being overweight and obese and 40.7 percent of teens being overweight and obese.
- The number of adults reporting to be food insecure in the area is estimated to be approximately
- 43 percent.
- Estimates show that only 11 percent of households eligible for government funded food assistance participate in the program.

Improve access to affordable mental health and substance abuse programs

- There are limited inpatient mental health beds, especially programs serving youth, in the
- Westside area.
- Area residents expressed concern over the growing use of drugs and alcohol and the impact that economic and social pressures have on their use.
- Approximately 23.6 percent of adults and 21.6 percent of teens living in the area have expressed a need for mental health and/or substance abuse services.

Growing number of homeless persons living in the area

- Individuals with annual incomes below 200% of the Federal Poverty Level represent 24 percent of residents living in the area.
- Approximately 48 percent of households in the area spend more than 30 percent of their monthly income on housing costs.
- A mild climate, expanded services for homeless, and increase development in the downtown L.A. area have resulted in more homeless persons coming to the Westside.
- With new development increasing in the area there has been a reduction in the available supply of affordable housing.

SECTION 5: PRIORITY COMMUNITY NEEDS

As part of the assessment process, Providence Saint John's Health Center reviewed secondary data on the community and worked with internal and external stakeholders to help prioritize the list of needs and issues identified through this study. The following needs were identified as key priorities that the Health Center should focus on over the next several years.

- Increase access to affordable primary and specialty care.
- Offer programs and resources to better manage and prevent chronic illnesses.
- Develop more programs focused on reducing obesity and improving nutrition in the community.
- Improve access to affordable mental health and substance abuse programs.
- Offer programs and services to assist the growing number of homeless persons living in the area.

SECTION 6: COMMUNITY BENEFIT PLAN STRATEGIES AND METRICS

Based on the identified priority needs discussed previously, Providence Saint John's created an implementation strategy and metrics to address the key priorities identified above. In addition, the key partners that the Health Center will work with to address the needs were also identified. This section provides a summary of these key strategies and metrics developed to address the priority needs identified in the service area, as described in the chart below:

Providence Saint John's Health Center 2017-19 Community Benefit Strategies

Priority Need	Target Group	Strategy	Metrics	Community Partners
Access to affordable primary and specialty care	Poor and Vulnerable	Work with physicians and community partners to improve access to specialty care.	Improve access for Medi-Cal patients to obstetrical and G.I. services. Expand access to 2-3 more medical specialties for Medi-Cal and uninsured patients	-Doctors of Saint John's -Providence Medical Institute -Venice Family Clinic -Westside Family Health Center
Growing rate of chronic disease impacting the area	General Community	Develop and expand education, screening and support programs to help address chronic disease in the area.	Develop partnerships with local faith communities to conduct chronic disease education and screening programs Develop chronic disease support groups Conduct 4 community education forums focused on chronic disease. Implement ongoing free chronic disease screening programs. Develop case management program for medically fragile	-City of Santa Monica -Two local faith congregations -Santa Monica Family YMCA -WISE and Healthy Aging

Growing rates of obesity and poor nutrition	-General Community -Poor and Vulnerable	Provide programs and improve access to resources focused on better nutrition and reducing obesity in the community.	Implement eight healthy eating education programs in the community. Link 300 people with government food assistance benefits. Partner with three area grocery stores to conduct nutrition education programs. Develop walking groups at two partnering church locations.	-Meals on Wheels West -St. Joseph Center -Pico Youth and Family Center -Boys and Girls Club of Santa Monica -Santa Monica Family YMCA -City of Santa Monica -Area Grocery Stores -St. Anne School
Mental health and substance abuse treatment	-Poor and Vulnerable -Children	Expand mental health and substance abuse services in the community to vulnerable populations.	Expand the preschool consultation program to seventeen sites. Expand program for new mothers dealing with post-partum depression. Provide at least 2 community benefit grants per year to local nonprofit organizations addressing substance abuse treatment and mental health for low-income persons.	-Area Preschools -Safe Place for Youth -Step Up on Second -Venice Family Clinic -Westside Family Health Center

Growing rate of homelessness in the area	-Poor and Vulnerable	Expand services and outreach to homeless patients coming to PSJHC and those living in the community.	Expand the Homeless Care Coordination Program at PSJHC. Become an approved provider to access the Coordinated Entry System client database. Work with The People Concern on the development of their wellness program for homeless clients.	-St. Joseph Center -The People Concern -Trinity Care Hospice -Upward Bound House -Venice Family Clinic – Homeless Medical Care Program -Westside Coalition

SECTION 7: COMMUNITY BENEFIT PLAN UPDATE

This section includes a description of the programs and services provided by Providence Saint John's Health Center in 2019 that support the Community Benefit Plan Strategies and Metrics described above in Section 6.

Work with physicians and community partners to improve access to primary and specialty care on the Westside for Medi-Cal and uninsured patients.

- In 2019 Providence Saint John's provided $2,326,793 in charity care serving 301 persons.
- During 2019 Providence Saint John's provided $28,636,743 in unpaid costs of Medi-Cal serving
- 3,921 persons.
- The Health Center provided $5,729 in free medications to patients who were uninsured and unable to afford the prescriptions.
- Grants totaling $225,000 were provided to the two community clinics in the area (Venice Family Clinic and Westside Family Health Center).
- PSJHC maintained a contract with L.A. Care Health Plan that allows obstetrical patients from Venice Family Clinic and Westside Family Health Center to deliver at the hospital.
- PSJHC provided free laboratory and imaging services to uninsured patients referred from the area clinics totaling $116,591 in 2019.
- PSJHC continued to operate the Cleft Palate Clinic, serving 84 patients in 2019.

Develop and expand education, screening and support programs to help address chronic disease in the area.

- PSJHC continued the Community Health Partnership Program in 2019 working in local community sites, such as St. Anne's Church, Mar Vista Garden and Virginia Avenue Park., offering health screenings and health presentations by clinicians.
- Providence Saint John's offered three community education forums in 2019 focused on (1) Heart Health and Strength, (2) Genetics and Cancer and (3) Diet, Nutrition, and Cancer.

Provide programs and improve access to resources focused on better nutrition and reducing obesity in the community.

- Started offering FEAST program in Santa Monica. FEAST (Food, Education, Access and Support, Together) is a 16-week nutrition program dedicated to exposing community residents to healthy and affordable recipes and improving social, emotional and physical wellness. There were 2 cohorts of the FEAST program in 2019, serving a total of 13 people.

Expand mental health and substance abuse services in the community to vulnerable populations.

- The therapeutic preschool operated by the Providence Saint John's Child and Family Development Center (CFDC) enrolled 30 children in 2019.
- In 2019, PSJHC provided support to the CFDC, offering counseling services to low income children and their families, child abuse prevention and treatment services, on-site school counseling services, and services for preschool age children, including one of the only therapeutic preschools in the area.

Expand services and outreach to homeless patients coming to Providence Saint John's Health Center and to those living in the community.

- The Homeless Care Navigation Program made 650 referrals to homeless service agencies for patients experiencing homelessness in 2019
- PSJHC provided $150,000 in grant funding to The People Concern (formerly OPCC) to support homeless services in the community.
- The Health Center provided over $298,000 in financial support for post-acute care services for medically indigent patients, including over $256,000 for homeless patients being discharged from the hospital and needing follow-up care.

Providence Saint John's Health Center program services for each community benefit program/service are summarized in Table 7.1 and Table 7.2. Each table includes the following:

- Program/service name and department responsible for program coordination
- Description of the program/service
- Number served in 2019
- The category where unreimbursed costs are reported according to the framework established by Senate Bill 697 (see Table 8.1)

TABLE 7.1: BENEFIT FOR PERSONS LIVING IN POVERTY

Program/Service And description	Description of Program/Service	Calendar year 2019 Number Served	SB 697 Category
Charity Care services to patients who could not afford to pay	Services to hospital patients who could not afford to pay	301 patients	Medical Care Services
Unpaid Cost of Medi-Cal services to patients	Services to hospital patients with Medi-Cal insurance coverage	3,921 patients	Medical Care Services
Imaging and lab services for Venice Family Clinic and Westside Family Health Center patients	Diagnostic services for patients referred by the Venice Family Clinic and Westside family Health Center at no cost to patient	1,366 patients	Medical Care Services
Financial support and collaboration with Venice Family Clinic	Grant to provide operating support for Homeless Clinic program to improve access to primary and specialty care for homeless patients	111 patients	Other Services to Vulnerable Populations
Financial support and collaboration with The People Concern	Grant to provide operating support for the Wellness Beds program located at The People Concern	50 persons served	Other Services to Vulnerable Populations

TABLE 7.1 (Cont'd) Program/Service And description	Description of Program/Service	Calendar year 2019 Number Served	SB 697 Category
Westside Access Task Force	Staff work with community partners to increase access to healthcare for low income children and uninsured adults on Medi-Cal	SPA 5 low income residents	Other Services to Vulnerable Populations
Westside Family Health Center	Grant to provide operating support for prenatal and pediatric care for underserved mothers and children	145 patients served	Other Services to Vulnerable Populations
Medication Assistance through Saint John's Pharmacy	Free prescriptions provided for patients who cannot afford their discharge medications	74 patients served	Medical Care Services
Cleft Palate and Craniofacial Clinic	Patients with craniofacial anomalies receive coordinated, longitudinal, interdisciplinary team care	84 patients received care	Other Services to Vulnerable Populations
Mental Health Services through Saint John's Child & Family Development Center	Diverse range of child, adult and family services in response to community needs, including: Outpatient mental health for children and families	485 unduplicated persons served	Medical Care – Low Margin Service
	Therapeutic preschool (intensive day treatment)	30 unduplicated persons served	
	Outpatient mental health for persons with developmental disabilities	51 unduplicated persons served	
	Outpatient mental health services for individuals and families impacted by child abuse	91 unduplicated persons served	
	School-based mental health outreach to at-risk youth	309 unduplicated persons served	
	Perinatal Wellness Program for children from ages birth to one	118 unduplicated persons served	

TABLE 7.2: BENEFIT FOR THE GENERAL POPULATION

Program/Service	Description of Program/Service	Calendar year 2019 Number Served	SB697 Category
Unpaid Cost of Medicare	Services for hospital patients with Medicare insurance coverage	6,343 hospital encounters (4,959 patients)	Medical Care Services
Community Education Services	Diverse range of free public health and wellness education	175 persons served (duplicated)	Other – Broader Community
Community Organization Support	Paid and volunteer hours of employees and senior executives who participate in various community boards and committees	12 Providence Saint John's employees served on the boards and/or committees of local nonprofit agencies	Other Services-Broader Community
Education and Training of Nursing Staff	Health center served as a clinical site for nursing students from UCLA, Santa Monica College and Mount St. Mary's.	237 students were supervised by Providence Saint John's employees as part of their academic training in nursing	Research, Education, & Training
Rideshare Program	Program encourages employees to use transportation	During 2019, employees reported 420 trips where they came to work using some form of public transit, biking, walking, telecommuting, or carpooling.	Other Services-Broader Community

SECTION 8: ECONOMIC VALUE OF COMMUNITY BENEFIT

During calendar year 2019, the economic value of community benefit provided by Providence Saint John's Health Center is estimated at $39,458,371 (includes Charity Care, Medi-Cal Shortfall and Community Benefit Services) with an additional $75,092,017 in Medicare shortfall. Furthermore, the Providence Saint John's Health Center Affiliation Fund provided $957,000 in separate grant funding to non-profit agencies serving communities in the Providence Saint John's service area.

Table 8.1 summarizes the unreimbursed costs of these community benefits according to the framework specifically identified by Senate Bill 697:

- Medical care services
- Other services for vulnerable populations (Poor and underserved; seniors, children and youth)
- Other services for the broader community
- Health research, education, and training programs

TABLE 8.1 ECONOMIC VALUE OF COMMUNITY BENEFIT PROVIDED BY PROVIDENCE SAINT JOHN'S HEALTH CENTER JANUARY 1, 2019 THROUGH DECEMBER 31, 2019

Senate Bill 697 Category	Programs and services Included	Expense
Medical Care Services	Unpaid cost of Medicare program	$75,092,017
	Charity Care	$2,326,793
	Low Margin service ; Child and Family Development Center (CFDC) and Cleft Palate Clinic	$6,539,074
	Unpaid cost of Medi-Cal program	$28,636,743
	All other Medical Care Services	$434,256
Other Services for Vulnerable Populations	Grants to agencies that serve persons living in poverty, grants for services to local schools, seniors and children, cost of Community Benefit program	$836,212
Other Services -- Broader Community	Community outreach, community health education	$269,419
Health Research, Education and Training Programs	Support for health research, nursing and other education programs	$415,874
	TOTAL–not including Medicare	**$39,458,371**
	Medicare	**$75,092,017**
	Total including Medicare	**$114,550,388**

Source: Providence Saint John's Health Center Finance and other coordinating departments.

TABLE 8.2 ECONOMIC VALUE OF COMMUNITY BENEFIT PROVIDED BY PROVIDENCE SAINT JOHN'S AFFILIATION FUND

Table 8.2 identifies nonprofit agencies which were awarded grants by the Saint John's Health Center Affiliation Fund, which provided $745,000 in 2017-18, $748,000 in 2018-19 and $957,000 in 2019-20, as follows:

Grants to Non Profit Agencies in Saint John's Service Area from Affiliation Fund	**2017-18**	**2018-19**	**2019-20**
Bandini Foundation	$0	$0	$27,000
Boys and Girls Club of Santa Monica	$30,000	$30,000	$30,000
Catholic Big Brothers Big Sisters	$50,000	$35,000	$25,000
Catholic Charities of Los Angeles, Inc.	$0	$0	$50,000
CLARE/MATRIX	$100,000	$100,000	$100,000
Claris Health	$0	$0	$25,000
Didi Hirsch	$100,000	$100,000	$100,000
OPICA	$0	$0	$23,000
Pacific Palisades Task Force on Homelessness	$50,000	$50,000	$0
Safe Parking LA	$0	$0	$68,000
Safe Place for Youth	$42,000	$42,000	$42,000
St. Monica Catholic Schools	$0	$0	$50,000
Santa Monica Family YMCA	$20,000	$0	$6,000
Santa Monica-Malibu Education Foundation	$50,000	$50,000	$50,000
The People Concern	$50,000	$50,000	$50,000
UCLA Health Sound Body Sound Mind Foundation	$120,000	$120,000	$90,000
UCLA VA Family Resource and Well-Being Center	$58,000	$96,000	$96,000
Vision to Learn	$0	$0	$50,000
Westside Food Bank	$75,000	$75,000	$75,000
TOTAL CASH TO NON PROFITS AGENCIES	**$745,000**	**$748,000**	**$957,000**

SECTION 9: SANTA MONICA COMMUNITY ACCESS PLAN

During 2019, the economic value of community programs and services provided by Providence Saint John's Health Center based on the five categories identified in the Community Access Plan is estimated at $14,864,497. In addition, the Saint John's Health Center Affiliation Fund provided cash grants to nonprofits that serve the Santa Monica community in the amount of $503,000.

Table 9.1 summarizes the unreimbursed costs of these programs and services according to the framework specified in the Santa Monica Development Agreement:

- In-kind and cash support to the Santa Monica-Malibu Unified School District (SM-MUSD)
- In-kind and cash support to local non-profit agencies that serve Santa Monica residents
- Charitable medical and mental health services provided to patients that are clients of and directly referred by local non-profit organizations and residents of Santa Monica
- Charitable medical and mental health services provided to patients that are students and directly referred by the SM-MUSD
- Free community services available to the general Santa Monica community that promote health education and preventive health services

Using the same categories of need identified in Section 7, Table 9.1, Table 9.2, and Table 9.3 summarize the program/service and department responsible for program coordination; description of the program/service; number served in 2019; the Community Access Plan Category where unreimbursed costs are reported; and the estimated percentage of Santa Monica residents/organizations served by the program/service. It should be noted that due to differences in reporting for the Community Benefit Plan under SB 697, federal IRS requirements and the Santa Monica Community Access Plan, some programs/services we have used our best efforts to estimate the information required by the Santa Monica Community Access Plan. In general, these reporting differences include: the percent of the unpaid cost of Medi-Cal patients who do not report a Santa Monica address, the unpaid cost of Medicare, education and training of health professionals for schools outside of Santa Monica. It should also be noted that this report uses net expense reported using changes mandated by federal rules authorized by the 2007 Affordable Care Act, (ACA). The ACA states that, effective 2014, community benefit expense is offset by restricted grants and endowments. This applies to CFDC program costs, which received grants and endowment funds.

TABLE 9.1: ESTIMATED ECONOMIC VALUE OF PROGRAMS/SERVICES PROVIDED TO SANTA MONICA RESIDENTS AND NON PROFITS JANUARY 1, 2019 THROUGH DECEMBER 31, 2019

Development Agreement category	Reported costs attributed to the City of Santa Monica	January 1 through December 31, 2019
Cash support to the Santa Monica-Malibu Unified School District	N/A	**T=$0**
Cash grants and support to local non-profit organizations. List of grants reported in Appendix C[a]	Grants and Financial Support: $603,799	**T=$603,799**
Cost of charitable medical and mental health services provided to patients based on referrals from local non-profit organizations[b]	Traditional Charity $681,751 Medi-Cal $10,647,156 CFDC $1,577,167 Cleft Palate Clinic $10,035 Lab & Radiology services $116,591 Medications $5,729 Post-acute care – homeless $256,250	**T= $13,294,679**
Cost of charitable medical and mental health services provided to patients referred by SM-MUSD to Saint John's CFDC[c]	At Risk Youth & Children's Services $538,449	**T= $538,449**
Community services available to the general Santa Monica community that promote health education and preventive health services[d]	38% of responding attendees at Community Health Ed classes list SM addresses $53,283 SM based nursing & health profession interns $374,287	**T= $427,570**
	GRAND TOTAL	**$14,864,497**

Source: Providence Saint John's Health Center coordinating departments.

a) Includes cash grants to all agencies listed in Appendix C

b) Includes charity care at cost, Medi-Cal shortfall and recuperative care post discharge expense for residents of Santa Monica

c) Includes the unreimbursed costs of Saint John's Child & Family Development Center At-Risk-Youth services.

d) Includes educational classes available to Santa Monica residents, and hospital-based training and education of nursing and other health professional students either attending colleges and schools in Santa Monica or students and/or interns living in Santa Monica

TABLE 9.2: 2019 BENEFIT FOR PERSONS LIVING IN POVERTY

Per the Development Agreement Community Access Plan

Category of Community Support	Benefit	Description	2019 - Number of patients and/or services	Percent based in Santa Monica
Cash support of SM-MUSD	N/A	N/A	N/A	N/A
Cash support to local non-profit organizations	Venice Family Clinic	Provide operating support for Homeless Health Care program	111 patients served	100%
Cash support to local non-profit organizations	The People Concern (formerly OPCC)	Provide operating support for Wellness Beds program	50 persons served	100%
Cash support to local non-profit organizations	Westside Family Health Center	Provide operating support grant for prenatal and	145 patients served	100%
In-kind support to local non-profit Organizations	Free imaging and lab services for	Venice Family Clinic And Westside Family Health Center	1,366 patients	100%
Cost of Charitable Medical & Mental Health services	Medication Assistance	Free prescriptions provided for patients who cannot afford their	74 persons	100%
Cost of Charitable Medical & Mental Health services	Child and Family Development Center (CFDC)	Outpatient mental health for children and families	485 clients served, 178 live in SM	37%
		Outpatient mental health for families with children age 0-5	118 clients, 23 live in SM	19%
		Therapeutic preschool (intensive day treatment)	30 children served; 11 live in SM	37%
		Outpatient mental health services for individuals and families impacted by child abuse	91 clients, 7 live in SM	8%
		Outpatient mental health services for at-risk children, youth and their families, in collaboration with the City of Santa Monica and SM-MUSD	309 persons served	100%

TABLE 9.3: 2019 BENEFIT FOR THE GENERAL COMMUNITY

Per the Development Agreement Community Access Plan

Program/Service (Coordinating Department)	Description of Program/Service	2019 Number Served	CAP Category	% Based in Santa Monica
Cost of Community Health Education Services	Diverse range of free health education, support groups and wellness services for the public	175 people attended health education classes, approximately 66 residing in SM	Community Services	Average 38% of attendees live in SM zip codes
Cost of health professionals education & internship	Training site for nursing and other health professionals	243 students trained with approximately 218 based in SM	Community Services	90%

TABLE 9.4: ADDITIONAL BENEFIT PROVIDED BY SAINT JOHN'S AFFILIATION FUND

In addition to the community benefits detailed in Table 9.1 and Appendix C, Saint John's Health Center Affiliation Fund provided cash grants to nonprofits that provide health care services and access thereto, including wellness programs, health research, and health education, public/private partnerships formed to improve health, directly and through grant making, to the residents in Saint John's Health Center's service area. The cash grants given to nonprofits that serve the Santa Monica community include:

Agency / Nonprofit	**2017-18 Cash Grant**	**2018-19 Cash Grant**	**2019-20 Cash Grant**
Boys and Girls Club of Santa Monica	$30,000	$30,000	$30,000
CLARE/MATRIX	$100,000	$100,000	$100,000
Santa Monica-Malibu Education Foundation	$50,000	$50,000	$50,000
Santa Monica Family YMCA	$20,000	$0	$6,000
St. Monica Catholic Schools	$0	$0	$50,000
Westside Food Bank	$75,000	$75,000	$75,000
Catholic Charities of Los Angeles, Inc.	$0	$0	$50,000
Safe Place for Youth	$42,000	$42,000	$42,000
The People Concern	$50,000	$50,000	$50,000
Vision to Learn	$0	$0	$50,000
TOTAL	**$367,000**	**$347,000**	**$503,000**

APPENDIX A: PROVIDENCE SAINT JOHN'S PARTICIPATION IN COMMUNITY AGENCIES

Providence Saint John's Senior Management and other Health Center personnel actively participate on the following boards and committees of community agencies. An asterisk indicates board commitment is held by a member of the Health Center's executive team.

- Autism Advisory Board
- California Professional Society on the Abuse of Children (CAPSAC)
- Child Abuse Professional Providers Association (CAPPA)
- Hospital Association of Southern California*
- Human Relations Council of the Santa Monica Bay Area
- Interagency Council on Abuse and Neglect (ICAN)
- Institute of Contemporary Psychology
- John Adams Middle School Student Success Team meetings
- Los Angeles Unified School District (LAUSD)
- Los Angeles Service Area 5 Provider Advisory Committee
- Los Angeles County Department of Mental Health Networking meetings
- Los Angeles United School District fair for parents of deaf and hard of hearing children
- Lincoln School Counselor Meetings
- Meals On Wheels West
- The People Concern (formerly Ocean Park Community Center)
- Safe Place for Youth
- Santa Monica Chamber of Commerce*
- Santa Monica Child Care Task Force Santa Monica College — Child Development Department
- Santa Monica Early Childhood Task Force
- Santa Monica Youth Resource Team
- Santa Monica-Malibu Unified School District
- Social Action Task Force
- Virginia Ave. Park
- Venice Family Clinic
- Westside Coalition for Housing, Hunger and Health
- Westside Child Trauma Council
- Westside Children's Center
- Westside Diabetes Task Force
- Westside Directors (UCLA/Connections for Children)
- Westside Domestic Violence Coalition
- Westside Family Health Center
- West Los Angeles Department of Mental Health child mental health providers group
- Westside Coalition
- WISE & Healthy Aging
- Youth Resource Team of Virginia Avenue Park
- YMCA of Santa Monica

Providence Saint John's Health Center Staff 2019 Nonprofit Affiliations

Rebecca Refuerzo Director of Saint John's Child & Family Development Center (CFDC)	• Los Angeles County Department of Mental Health Executive Provider monthly meetings • Early Childhood Task Force
Ruth Cañas Director of Saint John's Child & Family Development Center (CFDC)	• Association of Community Health Service Agencies • Los Angeles County Department of Mental Health Executive Provider monthly meetings
Noa Saadi CFDC Program Coordinator	• Santa Monica Youth Resource Team
Kabretta Wright CFDC Program Coordinator	• Santa Monica Early Childhood Task Force advisory board - Stop the Violence Program
Lisa Margolis CFDC Program Manager, Outpatient Services	• Westside Partnerships for Families Collaborative Meeting • Venice Family Clinic Early Head Start Healthcare Advisory Committee • Los Angeles County Partnership For Families Collaborative Meeting
Mayra Mendez, PhD, LMFT CFDC Program Coordinator	• UCLA Advisory Board, Developmentally Disabled/Mental Health
Laura Benavente, CFDC Early Childhood Directions	• Co-Chair, Santa Monica Child & Early Education Task Force
Justin Joe Director of Community Health Investment	• Westside Access Task Force, ED Workgroup
Christina Crawford Community Health Supervisor	• St. Anne's School Support Council • Westside Health, Hunger, and Housing Coalition
Marco Paz CFDC Program Coordinator	• Los Angeles County Department of Child & Family Services
Martha Andreani CFDC Quality Assurance Specialist	• Los Angeles County Department of Mental Health Continuous Quality Initiative
Lara Sando CFDC Program Coordinator	• Santa Monica Child & Early Education Task Force • Association of Community Health Service Agencies

APPENDIX B: PROVIDENCE SAINT JOHN'S COMMUNITY PARTNERS

Appendix B includes members of two key partnerships involving participation of the Health Center:

- 2019 Community Health Needs Assessment Oversight Committee
- Westside Health Access: ED Workgroup

APPENDIX B-1: 2019 COMMUNITY HEALTH NEEDS ASSESSMENT OVERSIGHT COMMITTEE

Providence Saint John's Community Health Needs Assessment Oversight Committee was an ad hoc committee of the Saint John's board and provided consultation to the 2019 Community Health Needs Assessment. This group was composed of 50% community stakeholders (incorporating the City's required members under the Development Agreement) and 50% Providence employees or affiliate entities and chaired by a Member of the Saint John's Community Ministry Board.

Organization	**Representative**	**Title**
Venice Family Clinic	Liz Forer	Chief Executive Officer
The People Concern	John Maceri	Chief Executive Officer
City of Santa Monica	Setareh Yavari	Manager, Human Services Division
WISE and Healthy Aging	Grace Cheng Braun	President and CEO
Santa Monica School District	Susan Samarge-Powell	Director, Child Development Services
Los Angeles County Department of Public Health	Jan King	Area Health Officer, SPA 5 (West) and SPA 6 (South)
Santa Monica College	Michael Tuitasi	Vice President, Student Affairs
Santa Monica College	Susan Fila	Director of Health and Wellbeing
Westside Coalition	Darci Navi	Director
City of Santa Monica	Nat Trives	Former Mayor
Providence Saint John's Health Center	Carlie Galloway	Lead Clinical Social Worker
	Paul Makareweicz	Director, Mission Integration
	Bob Frank	Director, Food & Nutrition Services
	Ruth Canas	Executive Director, Child and Family Development Center
	Wendy Merritt	Director, Foundation Relations
	Russ Kino	Physician
	Giancarlo Lyle-Edrosolo	Chief Nursing Officer
	Randy Roisman	Chief Financial Officer
RAND Corporation Providence Saint John's Health Center	Iao Katagiri, Committee Chair	Senior Advisor, Community Relations Board Secretary for Community Ministry Board

APPENDIX B-2: WESTSIDE HEALTH ACCESS: ED WORKGROUP

Saint John's participates in a workgroup focused on improving coordination of care for frequent users of the area hospitals' emergency departments, especially for those who are homeless. The organizational members of this workgroup include:

- Cedars-Sinai Medical Center
- Kaiser Permanente West Los Angeles
- L.A. County Department of Public Health
- Providence Saint John's Health Center
- The People Concern
- Saint Joseph Center
- Venice Family Clinic
- Westside Family Health Center
- UCLA Health System

APPENDIX C: PSJHC'S CROSS-YEAR COMPARISON CAP PLAN ACTUALS

Line		2016	2017	2018	2019
1	**Actuals provided in annual report**				
2	In-kind & cash support to SM residents	13,869,215	10,658,823	14,932,714	13,898,478
3	In-kind & cash support to SMMUSD	463,046	537,074	451,831	538,449
4	Charitable mental & medical services Unreimbursed costs for services to SM residents	12,594,873	10,075,723	14,552,714	13,294,679
5	Charitable mental & medical services to SMMUSD students	413,046	487,074	451,831	538,449
6	Free health education, training, support groups to the community	1,177,649	685,994	327,296	427,570
7	TOTAL	15,509,910	11,881,891	15,711,841	14,864,497
8	**Minimum amount required per the Development Agreement**	956,973	971,328	985,898	1,000,686
9	**Detail of Actuals: In-kind and Cash**				
10	Support to Santa Monica Residents: In-kind	12,594,873	10,075,723	14,552,714	13,294,679
11	Support to Santa Monica Residents: Cash	1,274,342	583,100	380,000	603,799
12	Support to SMMUSD: In-kind	413,046	487,074	451,831	538,449
13	Support to SMMUSD: Cash	50,000	50,000	-	-
14	Total Cash (includes SM-MUSD)	1,324,342	633,100	380,000	603,799
15	Total In-kind (includes SM-MUSD)	13,007,919	10,562,797	15,004,545	13,833,128
16	**Cash Gifts to Santa Monica Non-Profit Agencies (In-Kind NOT included)**				
17	Venice Family Clinic Total (Nurse Practitioner clinic and Respite Program Support)	445,000	175,000	175,000	175,000
18	SMMUSD Total (School Nursing)	50,000	50,000	-	*
19	OPCC Total (Respite Wellness Program)	334,325	150,000	150,000	150,000
20	Westside Family Health Center (Peds & OB Care)	123,517	50,000	50,000	50,000
21	St Joseph Center (Bread and Roses and Case Mgt)	50,000	24,500	-	50,000
22	Pico Youth & Family Center (Violence Reduction Program)	25,000	10,000	-	-
23	WISE & Healthy Aging (Seniors at Risk)	185,000	69,300	5,000	83,799
24	St Anne School (School Nurse/Health Program)	50,000	40,000	-	50,000
25	Upward Bound Hose Annual Total (Case Mgt.)	15,000	15,000	-	-
26	Boys & Girls Clubs of Santa Monica	15,000	10,000	-	*
27	Santa Monica College Foundation	-	-	-	-
28	Step Up On Second	-	10,000	-	-
29	Westside Coalition	2,500	1,000	-	-
30	Safe Place for Youth	14,000	5,500	-	*
31	Meals on Wheels West	15,000	10,000	-	45,000
32	Achievable Foundation Clinic	-	7,800	-	-
33	Santa Monica Family YMCA	-	5,000	-	*
35	TOTAL CASH TO SM AGENCIES - SHOULD MATCH Line 14	1,324,342	633,100	380,000	603,799
	* Saint John's Affiliation Fund provided cash grants to these nonprofits that serve the Santa Monica community. See Table 9.4.				

APPENDIX D: MULTI-YEAR COMPARISON OF PROVIDENCE SAINT JOHN'S COMMUNITY ACCESS PLAN TO DEVELOPMENT AGREEMENT REQUIREMENT

The Community Access Plan is that part of the 1997 Development Agreement that applies to the Community Benefit provided by Providence Saint John's Health Center. Providence Saint John's computes the Community Benefit reported to the State that apply only to residents/nonprofits of the City of Santa Monica, and the homeless.

The 1997 Development Agreement established a schedule of the estimated value, at cost, of community benefit provided to residents of Santa Monica. We take those community benefit reported to the State of California, per SB697, and report to the City only those benefit provided to Santa Monica residents/nonprofits, and to the homeless. The initial 1998 requirement was $732,000 and increases by 1.5% each year. Listed below are the community benefit requirements from 2013 to 2019 and those costs provided by Providence Saint John's Health Center to Santa Monica residents:

Year	**Required** (1.5% increase per year)	**Provided**
2013	$915,170	$5,353,900
2014	$928,897	$5,876,605
2015	$942,831	$19,288,094
2016	$956,973	$15,509,910
2017	$971,328	$11,881,891
2018	$985,898	$15,711,841
2019	$1,000,686	$14,864,497

Providence Saint John's fully complies with the spirit and intent of the Development Agreement.

Providence Saint John's Health Center

Appendices:
2019 Community Health Needs Assessment

Saint John's Health Center

PROVIDENCE Health & Services

Appendix 1 – Fact Sheets on Health Indicators

Access to Health Care

Primary Data

Community Stakeholder Interviews

Stakeholders identified improved access to care as a need on the Westside. Stakeholders emphasized that addressing access to care challenges needs to involve ensuring care is coordinated, culturally responsive, and high-quality. Stakeholders named a variety of contributing factors to the community's access to health care challenges:

- Inefficient public transportation: Participants shared many of the people they serve take the bus to access services. Because of how vast Los Angeles is, people may need to devote a lot of time to getting to their health care appointments, which is challenging for people who are working or those without cars. Additionally, if a patient has to travel long distances for a specialist or affordable care, transportation may be an even greater issue.
- High cost of care and lack of knowledge about support resources: Patients, particularly those who are uninsured, may not be able to get the care they need because of the cost. While there are some affordable health care options, patients may not know about these resources or be able to travel to those affordable services.
- Fear related to immigration status and cultural/language barriers: Stakeholders shared patients may avoid seeking medical services because of increased fear regarding immigration status. Additionally, cultural and language barriers can make navigating the health care system more challenging.
- Long wait times and not enough providers: Stakeholders explained that there are not enough providers to serve all of the people in Los Angeles, leading to long wait times for appointments. This is particularly true for appointments with specialists and providers who accept Medi-Cal.
- Lack of coordination in the health care system: Because there is little coordination among health care systems, people have to navigate multiple providers and hand offs on their own.

While different populations may experience different barriers to accessing the health care services they need, stakeholders identified a few populations that may especially face challenges with access to care:

- Immigrants, particularly undocumented immigrants, and people who do notspeak English: People who are unfamiliar with navigating the health care system or who do not speak English may not know of the resources available to them. Fear due to the current political climate has discouraged undocumented immigrants from seeking services.
- People without insurance: Patients without insurance may not seek medical services because of the cost of care.
- People with low incomes: People with low incomes may not be able to afford medical care, even with insurance. Additionally, they may not have access to a car, making transportation to appointments a barrier.

Stakeholders shared the following strategy for addressing access to health care challenges:

- Better care coordination and patient support: To help people know about the resources they qualify for and to help patients navigate the complexity of the health care system, stakeholders suggested using community health workers. This strategy could help address transportation, insurance, cultural, and language barriers.

Venice Family Clinic Listening Session

Providence Saint John's Health Center completed one listening session with four participants at Venice Family Clinic. Participants shared what makes it easier and harder for them to get the health care services they need, particularly once they are enrolled in health insurance.

Health care utilization

Participants seek services at community clinics, such as Venice Family Clinic, or an emergency room. Typically they use the emergency room after hours when clinics are closed or for severe injuries and illnesses that require immediate care.

Barriers to seeking medical care

- Long wait times for an appointment
- High cost of care and the potential for unknown fees
- Confusion over health insurance benefits

Resources that make accessing care easier

- Free transportation to appointments with Medi-Cal
- Case workers

Gaps in services

- Classes and one-on-one help to better understand health insurance benefits
- In-person support rather than just over the phone
- Comprehensive health coverage, including dental and vision benefits
- Longer appointments to allow for sufficient time to cover all of a patient's needs

Virginia Avenue Park Listening Session

Vision for a Healthy Community

Listening session participants were asked, "What makes a healthy community? How can you tell when your community is healthy?" Participants described their vision for a healthy community. The following theme was shared:

- Health care is accessible: Participants stressed the importance of accessible health care, including mental, physical, dental, and preventative care. The idea of "whole body wellness" was important, meaning people can take care of their mental and emotional health, as well as their physical health. Specifically, there should be mental health services for youth.

Community Issues

Participants were asked, "What are the most important issues that must be addressed to improve the health of the community?" Community members shared the issues they are most concerned about. The

following theme was shared:

- Lack of affordable, local health services, particularly dental services: Santa Monica lacks local, affordable health care services. Participants were particularly concerned about dental care, stating that when they are referred for dental care they are often referred outside of their community. They would like more local resources, especially because public transportation makes traveling for appointments challenging.

Opportunities for Providence Saint John's Health Center to Partner with Virginia Avenue Park
Participants were asked, "How can Providence Saint John's Health Center partner with Virginia Avenue Park?" The following theme was shared:

- Provide on-site health services: Participants want Providence Saint John's Health Center to provide medical services and health education at Virginia Avenue Park. They suggested offering preventive health services, such as annual exams and immunizations, at the Park and offering health information at health fairs. They also thought Providence Saint John's Health Center could bring a mobile medical unit to the Park to provide local access to specialists.

Secondary Data

Table_Apx 1. Access to Care Key Indicators Comparing SPA 5 to LA County from the LA County Health Survey

Access to Care Indicator	SPA 5	Los Angeles County	Difference Between SPA 5 and LA County
Percent of children ages 0-17 years who are insured	97.0%	96.6%	0.4%
Percent of adults ages 18-64 years who are insured	95.3%	88.3%	7.0%
Percent of children ages 0-17 years with a regular source of health care	93.4%	94.3%	-0.9%
Percent of adults 18-64 years with a regular source of health care	78.8%	77.7%	1.1%
Percent of adults who did not see a dentist or go to a dental clinic in the past year	28.9%	40.7%	-11.8%
Percent of children ages 3-17 years who did not obtain dental care (including check-ups) in the past year because they could not afford it	13.3%	11.5%	1.8%

Source: 2015 Los Angeles County Health Survey

The Health Resources & Services Administration (HRSA) defines a Health Professional Shortage Area (HPSA) as shortages of primary care, dental care or mental health providers by geographies or populations. The map below shows the boundary of SPA 5 along with high-need census tracts and HPSAs for primary care.

Figure_Apx 1. Primary Care Health Professional Shortage Areas in SPA 5

- Six of the eighteen high-need census tracts fall within a primary care shortage area.
- During community stakeholder interviews, many participants echoed the need for more providers in their areas and shared that transportation is a barrier in to accessing available providers. A large portion of Santa Monica has a shortage of primary care providers.

Table_Apx 2. Use of Internet for Health or Medical Information in LA County Based on English Proficiency

Used the internet for health or medical information in past year (Los Angeles County)	How well respondent speaks English			
	Very well	Well	Not well / not at all	All
	%	%	%	%
Used for internet for health information	64.4%	35.2%	16.9%	40.7%
Did not use the internet for health information	28.0%	44.4%	35.3%	34.9%
Does not use the internet	7.6%	20.3%	47.8%	24.4%

Source: 2016 California Health Interview Survey

Navigation of the healthcare system continues to be a large obstacle for many people in Los Angeles County and we see that as English proficiency decreases, the likelihood of individuals accessing information through the internet decreases. Much of the underserved population are not native English speakers and this may contribute to the barriers many face with healthcare access.

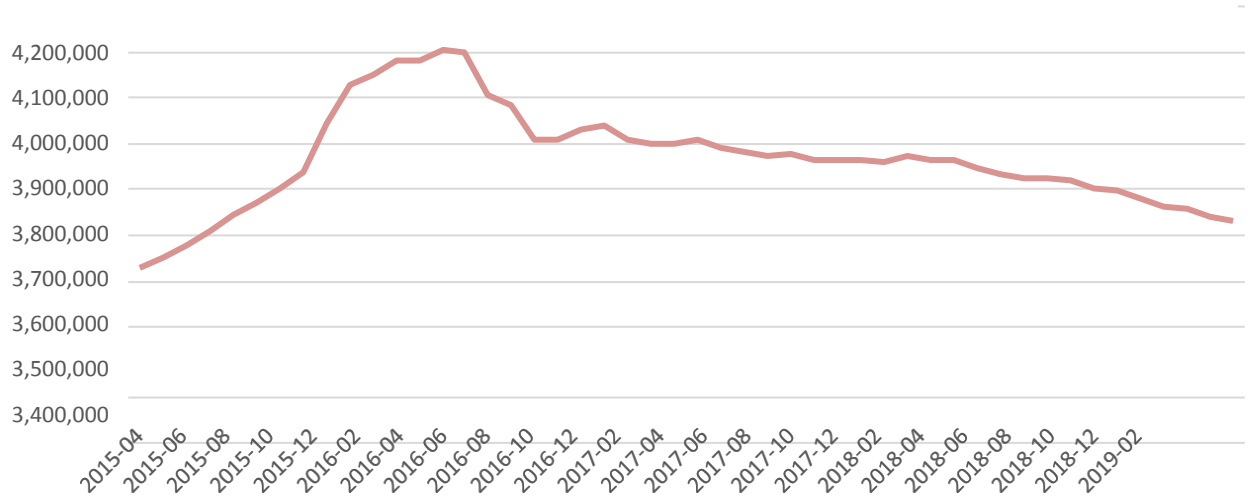
Medi-Cal Eligibility

Since the Patient Protection and Affordable Care Act (ACA) many Californians have now become eligible to enroll and receive Medi-Cal benefits. As of March 2019, there are currently 1,225,668 Medi-Cal beneficiaries in Los Angeles due to the ACA expansion to adults ages 19 to 64. Additionally, Medi-Cal currently covers 233,196 undocumented individuals in Los Angeles County.

Table_Apx 3. Medi-Cal Beneficiaries by the ACA Expansion by Race and Ethnicity

ACA Expansions Adult Ages 19- 64 Enrollees as of March 2019							
County	American Indian/ Alaska Nnative	Asian	Black	Hispanic	Not Reported	White	Grand Total
Los Angeles	1,948	138,069	132,842	659,278	88,329	205,202	1,225,668

Figure_Apx 2. Monthly Medi-Cal Beneficiaries Counts for Los Angeles County



After the introduction of the Affordable Care Act, Medi-Cal enrollments soared between 2015 and the middle of 2016. Mid 2016 through early 2017 saw a stabilization of enrollments followed by a downward trend of enrollment since mid 2017.

Behavioral Health, including Mental Health and Substance Use

Primary Data

Community Stakeholder Interviews

Most of the stakeholders identified behavioral health, including mental health and substance use, as an urgent need. While some stakeholders placed more importance on either the substance use or mental health components, many named both as needs and identified them as overlapping and linked. Therefore, they are presented here together. Stakeholders named a variety of contributing factors to the community's behavioral health challenges:

- Access to behavioral health care: Stakeholders spoke to a variety of factors that make accessing behavioral health care challenging. Their primary concern was the lack of free or low-cost treatment options for mental health services and substance use treatment. Additionally, there is a lack of licensed behavioral health providers on the Westside, particularly providers who accept Medi-Cal or who speak languages other than English.
- Homelessness: Stakeholders saw behavioral health and homelessness as directly related. Patients experiencing homelessness are harder to reach and require more comprehensive services to address both their housing and behavioral health needs. Without housing, many patients lack a stable environment to address their behavioral health needs. Strategies for addressing populations experiencing homelessness and with behavioral health challenges include wrap-around case management, street outreach, and addressing needs in a primary care setting.
- Integration of behavioral health care and primary care: Stakeholders saw the fragmented health care delivery system as a contributing factor to the Westside's behavioral health challenges. Funding streams and reimbursement requirements have made accessing medical care and behavioral health care two separate processes. Therefore, patients with behavioral health needs are not being connected to behavioral health care through their primary care provider. Additionally, the lack of integration makes the system more complicated and confusing for patients. Many stakeholders identified an overlap between behavioral health needs and chronic diseases, therefore, by integrating services, providers would be able to more efficiently meet patients' needs.
- Stigma: Stakeholders shared stigma is a barrier to addressing behavioral health challenges because it makes people less likely to accept or seek services, as well as less likely to talk about mental illness and substance use. This further isolates people and causes misconceptions. Effective strategies for addressing stigma are more education so that people can better understand mental health and integration of behavioral health care and medical care so that behavioral health is normalized as a part of health care.

Stakeholders identified several populations that are most affected by behavioral health challenges:

- Young people: Stakeholders shared young people may not be able to access the mental health services they need. Additionally, they were concerned about increased vaping and exposure to marijuana.

- People experiencing homelessness and people with low-incomes: Stakeholders identified people with low-incomes and people experiencing homelessness as having a harder time accessing mental health and substance use services.
- Older adults: Stakeholders shared that older adults, particularly those who have low incomes, may have more challenges accessing behavioral health care. Social isolation, poverty, and chronic conditions may contribute to their behavioral health needs.

Common themes for effective strategies to address behavioral health challenges include the following:

- Integrate behavioral health care and primary care: As stated above, stakeholders identified integration of behavioral health care and primary care as the most effective strategy for addressing behavioral health needs in the community. Doing so decreases stigma, normalizes behavioral health care as part of a person's wellbeing, and improves access to care.
- Increase community education and awareness around mental health and substance use: Stakeholders shared that because of stigma people do not always talk about mental health challenges. Therefore, increasing education around the signs of suicide and giving people language to talk about mental health is important for reducing stigma and increasing attention to the need. Additionally, education around the risks of substance use, particularly for young people, is an important step in preventing substance use disorder and substance use related injury and death.
- Implement targeted outreach to groups needing services: To improve access to behavioral health care, stakeholders thought meeting people where they are is an important strategy. They noted including a mental health specialist on street outreach teams is important, as well as making home visits to homebound older adults. A crucial component to this outreach is ensuring that those people doing the outreach can reach non-English speakers and are culturally diverse.
- Increase school-based mental health providers: There need to be more school-based mental health providers and providers who serve patients on Medi-Cal and who are uninsured.

Secondary Data

Los Angeles County Indicators

Table_Apx 4. Health Status Indicators in SPA 5 Compared to LA County

Health Status Indicator	SPA 5	Los Angeles County	Difference Between SPA 5 and LA County
Percent of adults reporting their health to be fair or poor	10.0%	21.5%	-11.5%
Average number of days in past month adults reported regular daily activities were limited due to poor physical/mental health	1.8	2.3	-0.5
Percent of children ages 0-17 years who have special health care needs	20.2%	14.5%	5.7%
Percent of adults at risk for major depression	6.8%	11.8%	-5.0%

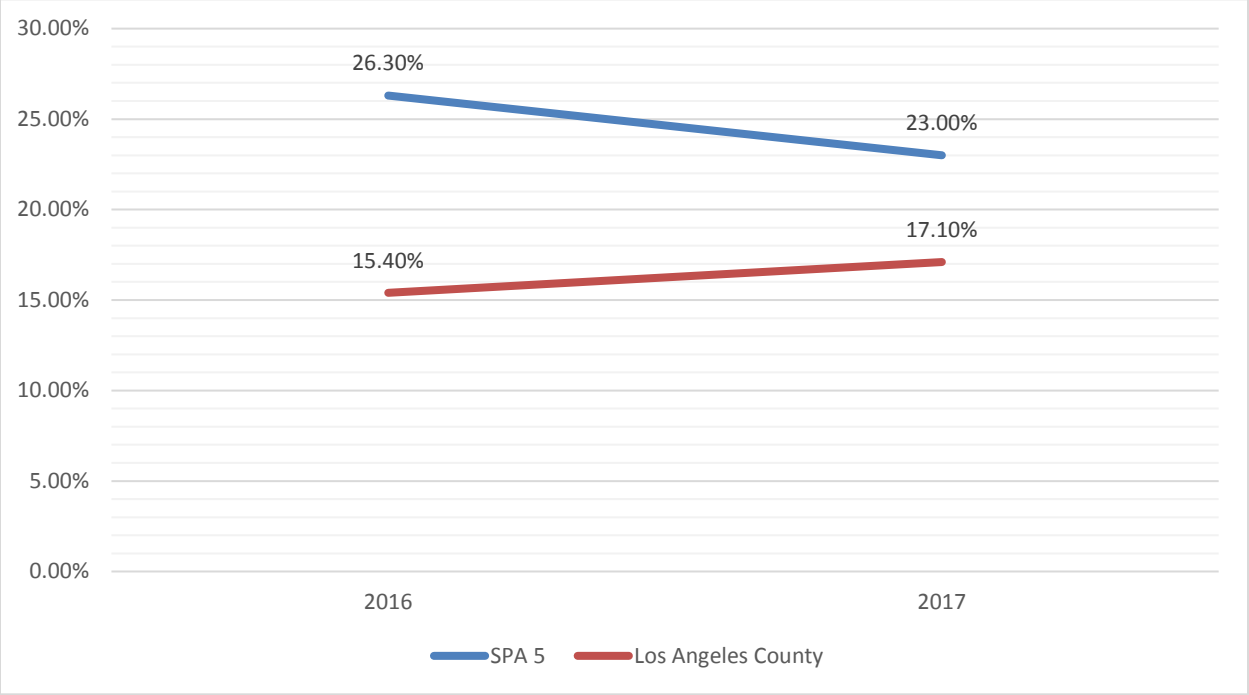
California Health Interview Survey

The following indicators are taken from the California Health Interview Survey (CHIS). CHIS is a health survey conducted on a continuous basis by the UCLA Center for Health Policy Research in collaboration with the Department of Health Care Services and the California Department of Public Health. Currently the most recent date for CHIS data through the self-service portal "AskCHIS" is from the year 2017, however, data from previous years were used when service planning areas values were deemed statistically unstable.

Table_Apx 5. Behavioral Health Indicators in SPA 5 Compared to LA County from the California Health Interview Survey

Behavioral Health Indicator	SPA 5	Los Angeles County	Difference Between SPA 5 and LA County
Adults who ever seriously thought about committing suicide (2017)	13.20%	9.60%	3.60%
Saw any healthcare provider for emotional mental and/or alcohol-drug issues in past year (2016)	24.80%	12.30%	12.50%
Adults who sought help for self-reported mental/emotional and/or alcohol-drug issues and received treatment (2017)	55.00%	60.10%	-10.10%

Figure_Apx 3. Percent of Adults Who Needed Help for Emotional/Mental Health Problems or Substance Use



Chronic Diseases

Primary Data

Community Stakeholder Interviews

Participants were asked about diabetes, obesity, heart disease, hypertension, asthma, cancer, stroke, HIV, and liver disease. Stakeholders primarily discussed diabetes, obesity, and heart disease. Stakeholders particularly focused on the connection between obesity and diabetes and healthy habits. Stakeholders named a variety of contributing factors to the community's chronic disease challenges:

- Lack of access to health care services: Stakeholders shared that barriers to accessing health care services, such as long wait times, cost of care, and complexity navigating the health care system, make managing chronic diseases challenging.
- Homelessness: Without a stable place to live, managing chronic diseases, taking medications in a timely manner, and maintaining healthy habits is more challenging.
- Poverty and food insecurity: Especially related to diabetes and obesity, people who do not have access to or are unable to afford good quality, nutritious foods are more likely to eat unhealthy foods, leading to obesity and diabetes.
- Unhealthy behaviors: Children in particular may be less likely to play outdoors or exercise leading to obesity and diabetes. Unsafe neighborhoods, violence, lack of affordable organized physical activity programs, unsafe sidewalks, and increased use of technology could all contribute to these unhealthy behaviors.

Stakeholders identified several populations that are most affected by chronic diseases:

- Young people: Participants were particularly concerned about increasing rates of diabetes and obesity in young people and the potential long-term effect onhealth.
- People with low-incomes and/or experiencing homelessness: For people with low-incomes it can be difficult to afford healthy food and necessary medications to manage chronic diseases. Additionally, people experiencing homelessness may need to prioritize other needs, such as

finding a place to sleep or staying safe, over managing their disease.

Stakeholders spoke to the importance of addressing other social determinants of health, such as access to health care, stable housing, community safety, and food security, to improve chronic diseases. By addressing these other health-related needs, people would be better able to get the health care they need, improve their eating and exercising habits, and manage their chronic diseases. To address obesity and diabetes in young people, stakeholders noted providing healthy food for school meals and increasing physical activity time as important strategies.

Secondary Data

Los Angeles County Indicators

Table_Apx 6. Chronic Disease Indicators in SPA 5 Compared to LA County

	SPA 5	Los Angeles County	Difference Between SPA 5 and LA County
Obesity			
Percent of adults who are obese (BMI≥30.0)	10.3%	23.5%	-13.2%
Diabetes			
Percent of adults ever diagnosed with diabetes	4.5%	9.8%	-5.3%
Diabetes-related hospital admissions (per 10,000 population)	7.07	15.74	-8.67
Diabetes-specific death rate (per 100,000 population)	10.46	24.21	-13.75
Cardiovascular Disease			
Hypertension-related hospital admissions (per 10,000 population)	1.44	5.10	-3.66
Percent of adults ever diagnosed with hypertension	17.1%	23.5%	-6.4%
Coronary heart disease-specific death rate (per 100,000 population population)	76.03	108.10	-32.07
Stroke-specific death rate (per 100,000 population)	27.18	36.20	-9.01
Respiratory Disease			
Percent of children ages 0-17 years with current asthma (ever diagnosed with asthma and reported still have asthma and/or had an asthma attack in the past year)	6.7%	7.4%	-0.7%
Pediatric asthma-related hospital admissions per 10,000 child population	4.14	10.82	-6.68
COPD specific mortality rate (per 100,000 population)	18.09	29.88	-11.79
Liver Disease			
Liver disease-specific death rate (per 100,000 population)	4.80	13.70	-8.90

Diabetes and Pre-diabetes

Special note on diabetes and pre-diabetes:

- According the California Health Interview Survey, the prevalence of diabetes for Los Angeles County has increased dramatically from 6.90% in 2003 to 12.10% in 2017.
- Adults who have ever been told they have pre-diabetes has risen by over 10% since the year 2009. As of 2017, the California Health Interview Survey reveals that 17.40% of the adult population in Los Angeles has been told they have pre-diabetes or borderline diabetes.

The data from the table below come from 2017 California Health Interview Survey and shows the percent of Los Angeles County residets that have been diagnosed with a chronic disease by race and ethnicity.

Table_Apx 7. Percent of Residents in LA County Diagnosed with a Chronic Disease by Race and Ethnicity

Race/Ethnicity	Diagnosed with Diabetes	Diagnosed with High Blood Pressure	Diagnosed with Asthma	Diagnosed with Any Heart Disease
Latino	14.5%	28.5%	14.0%	5.6%
White	8.0%	33.1%	17.1%	9.5%
African American	19.9%	45.2%	20.5%	8.2%
American Indian/Alaska Native	-	20.9%*	22.8%*	-
Asian	9.2%*	20.8%*	9.1%	2.8%*
Native Hawaiian/Pacific Islander	-	35.1%*	-	-
Two or More Races	-	16.4%*	29.6%*	3.5%*
All	12.1%	30.0%*	15.1%	6.6%

**Statistically unstable*

- Latinos and African American residents have higher incidences of diagnosed diabetes compared to other races.

Early Childhood Education

Primary Data

Many stakeholders agreed that early childhood development is a concern for the service area. The availability of affordable, accessible early childhood development and educational resources pertains to the following:

- A healthy start for young children means fewer health care and educational expenses down the road
- Lack of affordable early childhood education is a barrier to employment for parents
- Early childhood centers and programs are an important source of connectedness for foster youth
- An increase in immigration into the community means a greater demand for accessible early childhood education
- If a parent is also suffering from health or other stressors, young children may not get services they need
- Quality early education and developmental supports contributes to behavioral health as well as physical health, and are foundational to community health.

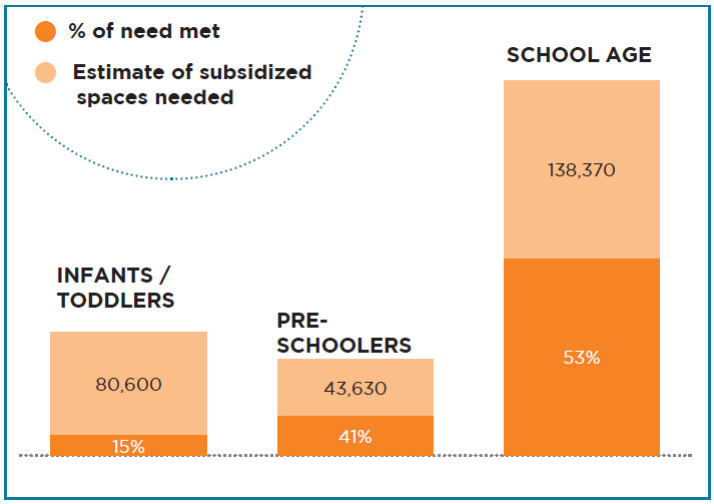
Secondary Data

The State of Early Care and Education in Los Angeles County: Los Angeles County Child Care Planning Committee 2017 Needs Assessment

The Los Angeles County Child Care Planning Committee in partnership with the Los Angeles County Office for the Advancement of Early and Education and First 5 LA explored the resources and gaps in early care and education. Their findings were focused on the access and quality of early care and education as well as the early care and education workforce.

- **There are not enough resources for infants/toddlers and their parents**: The 2017 Needs Assessment found that licensed centers only have the capacity to serve 13% of Los Angeles County's children under the age of 5. There is a need to support low-income working parents of children ages 0- 5 through subsidized early care and education programs. Currently, 13% of eligible infants and toddlers are served compared to 41% of eligible preschoolers and 53% of eligible school age children.

Figure_Apx 4. Unmet Need for Subsidies Among Low-Income Families in LA County by Age Group



- **The cost of care for a young child is high:** A family's average cost of care in Los Angeles County is $10,303 a year per preschooler in center-based care and $8,579 a year per preschooler in a family child care home. Care for infants and toddlers is even more expensive, with an annual cost of $14,309 in an early care and education center and $9,186 in a family child care home.
- **Education and professional development of the early care and education workforce is hindered by costs, availability of classes and language barriers:** Quality of care for early care and education is directly linked to a highly-qualified workforce yet half of the local workforce does not possess a college degree. Early educators also value professional development as a means to increase knowledge but cite costs as a top barrier.

Table_Apx 8. Barriers to Participating in ECE Professional Development in LA County

Barriers to Participating in Professional Development	Percentage of Los Angeles County ECE Providers Who Marked that Barrier
I don't have enough money for tuition or training expenses	55%
I don't have enough time	42%
I am not able to get into the courses or trainings that I need	25%
I don't have the math skills I need	20%
I don't have the English language skills I need	17%
I don't have the support from my employer	16%
I don't have reliable transportation	16%
I don't have support from my family	14%
I don't have childcare or dependent care	13%
I don't have access to a reliable computer or internet connection	13%

Data Source: LA Advance spring 2016 early educator survey – From Table D.4 Barriers for Consortium program participants' participation in PD: Spring 2016 (LA Advance Spring 2016 Analysis).

Early Childhood Education (ECE) Access Gap

The Advancement Project is an organization tasked with addressing systems changes through the expansion of opportunities in educational systems, the creation of healthy communities and the shift of public investments towards equity. As part of their work, Advancement Project has released a compilation of ECE Access Gap profiles for legislative districts, supervisorial districts and LAUSD school board districts.

Since the profiles use different geographic boundaries than the Service Planning Areas, District 50 was chosen as the nearest approximation for the Saint John's service area.

Table_Apx 9. Children Without a Licensed Child Care Seat in District 50

Location	Children Ages 0-2 Without Seats (#; %)	Children Ages 2-4 Without Seats (#; %)
District 50	9,731; 96%	1,425; 14%

- Santa Monica ZIP codes 90403 and 90402 rank among the top ZIP codes in District 50 with the most children lacking access to a licensed child care center seat.
- 100% of children ages 0 – 2 in ZIP code 90402 do not have access to a licensed child care center seat, while 95.9% of children ages 2- 4 lack access to a seat in ZIP code 90402.

Table_Apx 10. Kindergarten Readiness Indicators in Santa Monica

Kindergarten Readiness Indicator	2012/13	2013/14	2014/15	2015/16	2016/17
Children entering kindergarten very ready in communication skills and general knowledge	31.6%	33.2%	40.0%	42.0%	38.0%
Children entering kindergarten very physically ready for school	32.3%	30.8%	34.0%	36.0%	37.0%
Children entering kindergarten very ready in communication skills and general knowledge	11.0%	34.0%	20.0%	36.0%	44.0%
Children identified as very socially ready for kindergarten	28.6%	24.1%	32.0%	32.0%	29.0%
Children identified as very emotionally ready for kindergarten	33.7%	31.7%	42.0%	43.0%	38.0%

Economic Insecurity

Primary Data

Community Stakeholder Interviews

Stakeholders agreed there are two main causes of economic insecurity on the Westside: lack of jobs that pay a living wage and the high cost of living. Stakeholders explained the amount of money people get paid in their jobs is not sufficient to cover rent, food, medical bills, etc. Therefore, people are forced to make hard decisions around how they spend their money. This high cost of living coupled with low-incomes leads to economic insecurity. Economic insecurity leads to homelessness/housing instability, food insecurity, and challenges paying for medical services.

Economic insecurity affects many people, particularly individuals and families with low incomes, but some of the groups identified by stakeholders are the following:

- People of color
- People re-entering the work force who were formerly incarcerated
- Older adults

Stakeholders shared the following strategies for addressing economic insecurity:

- Increase job training and skill building programs for young people: Stakeholders suggested investing in young people, particularly those from families with low incomes, to provide the support and training to help them gain skills for better paying jobs.
- Increase affordable housing options and improve homeownership opportunities: Stakeholders noted the cost of housing on the Westside is so high that families are unable to afford other necessities. Therefore, increasing affordable housing options or helping families own a home would reduce their economic insecurity.

Virginia Avenue Park Listening Session

Vision for a Healthy Community

Listening session participants were asked, "What makes a healthy community? How can you tell when your community is healthy?" Participants described their vision for a healthy community. The following themes were shared:

People can't afford to live in the community

Participants noted that housing and childcare need to be affordable in the community. Particularly, there need to be resources to help families with low incomes afford basic necessities.

There are economic and educational opportunities

Participants noted the importance of access to employment opportunities for all people. In a healthy community, all people have financial security. Participants shared that a healthy community has good schools, as well as arts and music opportunities.

Community Issues

Participants were asked, "What are the most important issues that must be addressed to improve the health of the community?" Community members shared the issues they are most concerned about. The following themes were shared:

Lack of affordability due to high cost of housing and food
The primary concern for participants was how expensive Santa Monica is to live, including the cost of housing and the price of goods in the local stores. They noted there are too many people in Santa Monica for the available housing units, making it unaffordable. Participants said there are no affordable grocery stores nearby.

Lack of job opportunities that pay a living wage
Participants shared there is a lack of job opportunities, particularly ones that pay a living wage and are inclusive of people of color. Participants shared that because of a lack of opportunities to better their situation, "[they] remain low income." They specifically noted that these job opportunities should be within their community and individuals should not have to travel far to work.

Secondary Data

Los Angeles County Department of Public Health Key Indicators

Below is a table of indicators related to economic insecurity prepared by the Los Angeles County Department of Public Health. These indicators were calculated from the 2015 Los Angeles County Health Survey, which is a population-based telephone survey designed to measure the health needs and behaviors of Los Angeles residents. Data for these variables were only available at the SPA level and not the census tract level.

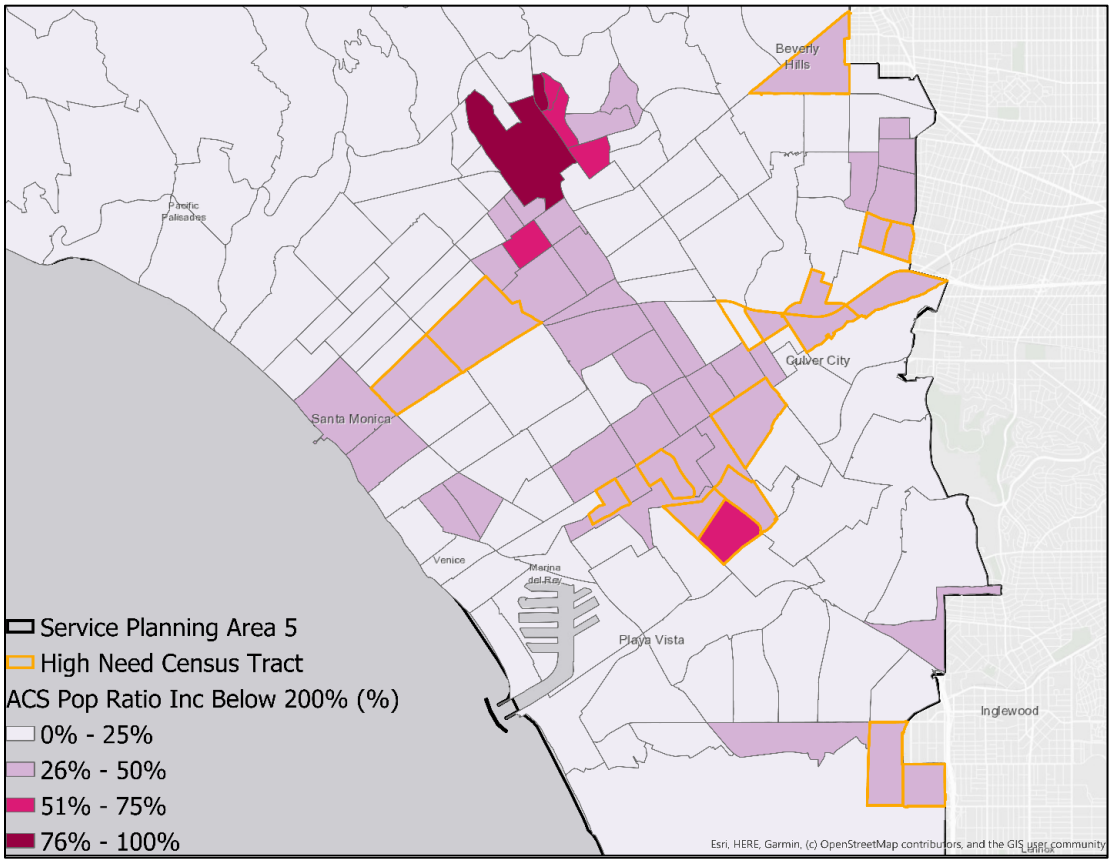
Table_Apx 11. Economic Insecurity Indicators Comparing SPA 5 and LA County

Economic Insecurity Indicator	SPA 5	Los Angeles County	Difference Between SPA 5 and County
Percent of adults who completed high school	93.6%	77.6%	16.0%
Percent of adults who are employed	61.6%	56.6%	5.0%
Percent of population with household incomes <100% Federal Poverty Level (FPL)	11.6%	17.8%	-6.2%
Percent of households (owner/renter-occupied) who spend ≥30% of their income on housing.	43.5%	48.0%	-4.5%
Percent of households with incomes <300% FPL who are food insecure	30.5%	29.2%	1.3%

Source: U.S. Census, American Community Survey 5-Year Estimates, 2013-2017

Service Planning Area 5 has a much higher high school completion rate than Los Angeles County as well as high employment rates and fewer households who fall under 100% the Federal Poverty Level.

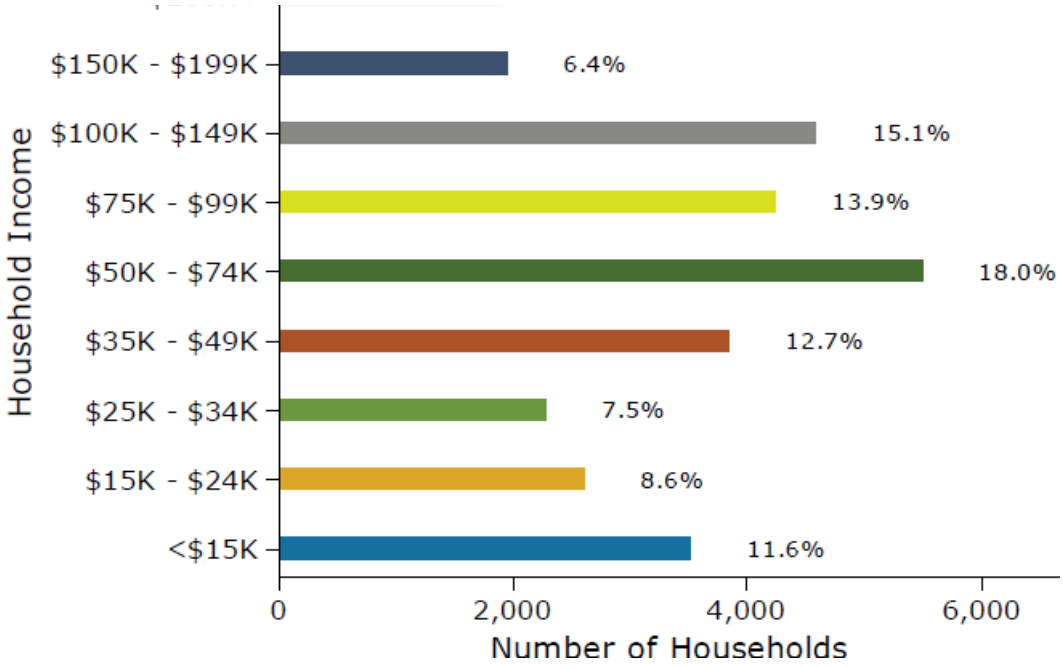
Figure_Apx 5. Percent of Population Below 200% Federal Poverty Level by Census Tract



Seventeen of eighteen high-need census tracts are in the at least the second quartile for percent of population below 200% the Federal Poverty Level with one high-need community in Playa Vista reaching the third quartile. Fifty-four percent of the population in this high-need community have incomes that are below 200% the federal poverty level.

The only census tracts in the fourth quartile for this indicator are census tracts around UCLA which have a large student population.

Figure_Apx 6. SPA 5 Income Distribution



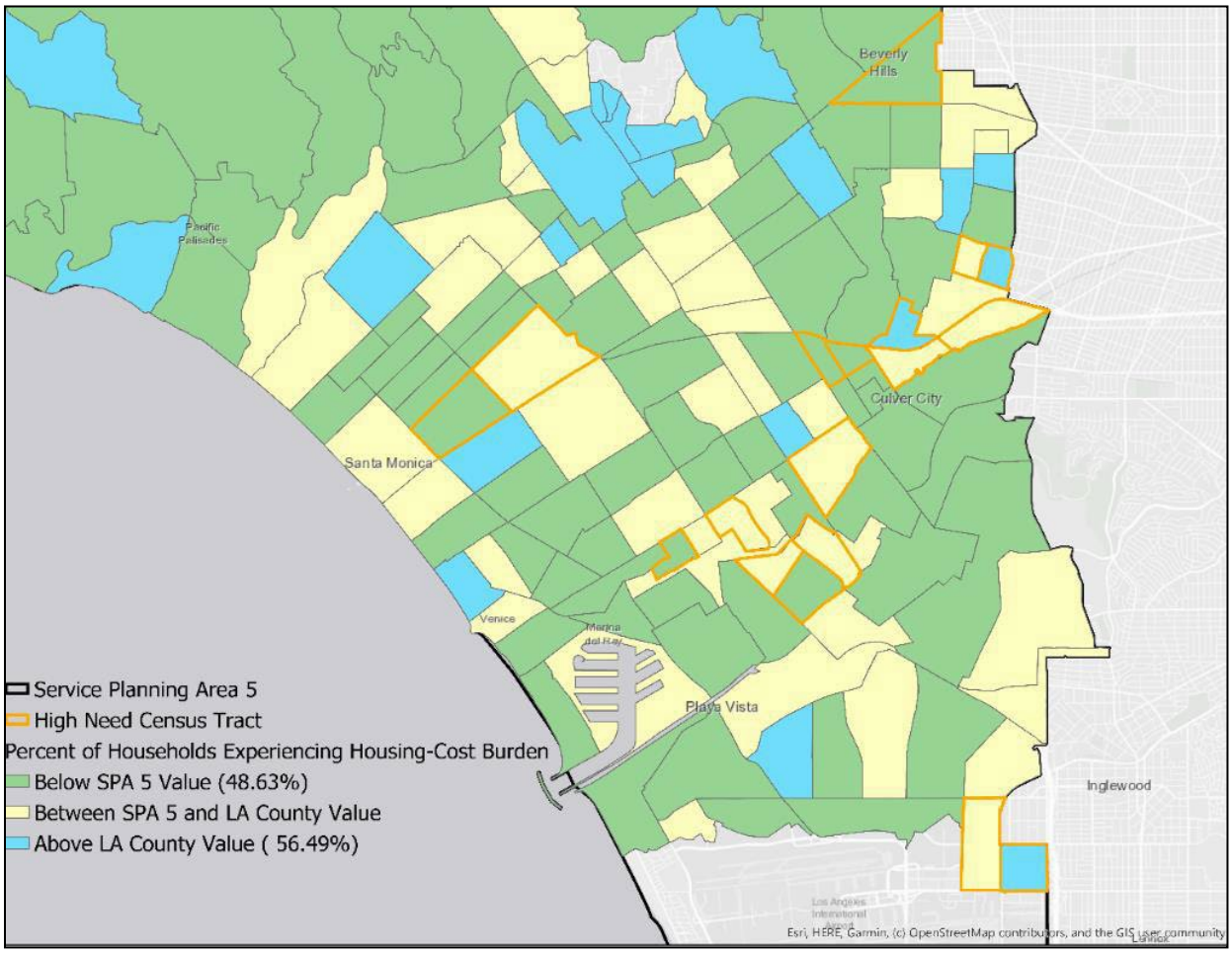
Housing-Cost Burden

Throughout this section we will consider households that pay 30 percent or more of their income on housing costs as "housing-cost burdened" while those households that pay 50 percent or more of their income on housing costs as "severely housing-cost burdened."

Table_Apx 12. Housing-Cost Burden Variables

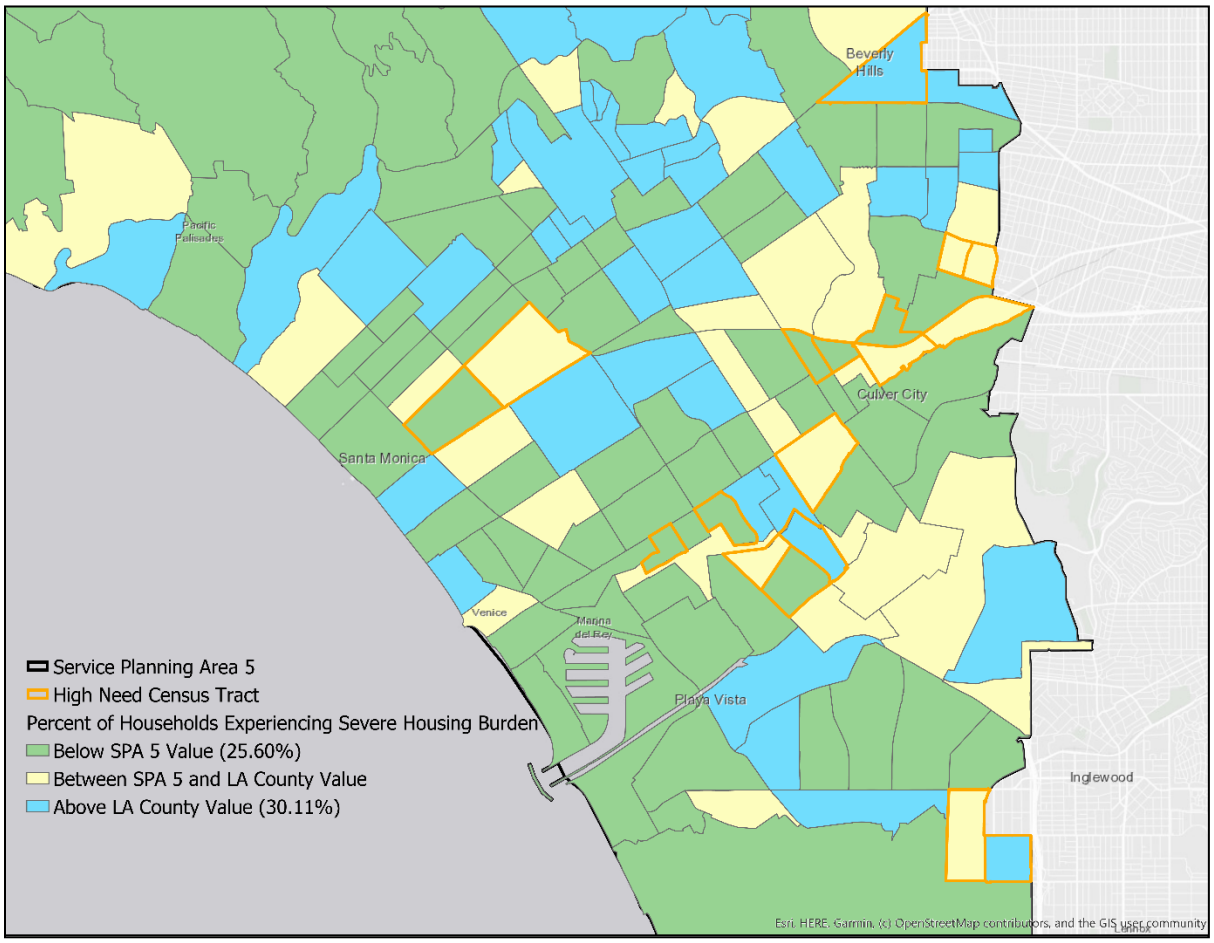
Housing-Cost Burden Variable	SPA 5	Saint John's High Need Census Tracts	Los Angeles County
2013-2017 ACS Households: Renter Households That Are Housing-Cost Burdened (#; %)	84,716; 48.6%	12,437; 51.01%	1,006,798; 56.49%
2013-2017 ACS Households: Renter Households That Are Severely Housing-Cost Burdened (#; %)	44,780; 25.60%	6,106; 25.10%	536,832; 30.11%

Figure_Apx 7. Renter Households Experiencing Housing-Cost Burden in SPA 5



Nine of the eighteen high-need communities are above the SPA 5 average for percent of households experiencing housing-cost burden and three high-need communities are above the Los Angeles County benchmark.

Figure_Apx 8. Renter Households Experiencing Severe Housing-Cost Burden



Ten of the eighteen high-need communities are above the SPA 5 average for percent of households experiencing severe housing-cost burden and two high-need communities are above the Los Angeles County benchmark.

Food Insecurity

Primary Data

Stakeholders discussed how food insecurity is linked to many other health-related needs, such as housing and economic insecurity. Stakeholders identified a few main contributing factors to food insecurity:

- Increased access to unhealthy foods and decreased access to good quality, nutritious foods in low- income neighborhoods: Stakeholders shared there are typically more fast food restaurants located in low-income neighborhoods. On the other hand, there may be fewer grocery stores, and the quality of the fruits and vegetables is typically poorer.
- Economic insecurity: Low incomes, coupled with high cost of housing means that families do not have as much money available to buy healthy foods. Stakeholders shared that by the end of the month many families are seeking assistance to cover their bills. While there might be farmers markets in these neighborhoods, the produce is typically more expensive.
- Immigration and fear: The Supplemental Nutrition Assistance Program (SNAP) program, also known as CalFresh, helps families cover the cost of food, but some families with undocumented members choose not to sign up for benefits because of fear related to immigration and public charge. Stakeholders noted that the current political climate has made signing people up for food benefits more difficult.

Stakeholders named the following populations as particularly affected by food insecurity:

- People with low incomes: With the high cost of living on the Westside, people with low incomes may not be able to afford high-quality, nutritious food.
- Undocumented immigrants: The current political climate has created fear related to immigration. Some undocumented immigrants may not apply for food assistance programs because of new public charge laws.
- Older adults: Stakeholders shared older adults may have a harder time accessing nutritious, good-quality food because they have difficulty leaving the house, are unable to drive, or cannot afford food.

The following strategies improve access to nutritious, good quality food:

- Improve nutrition standards for school meals: Stakeholders shared offering healthy free and reduced cost breakfasts and lunches in schools ensures children get healthy meals each day. Specifically important is not just providing food to children, but setting high nutritional standards for the food.

Secondary Data

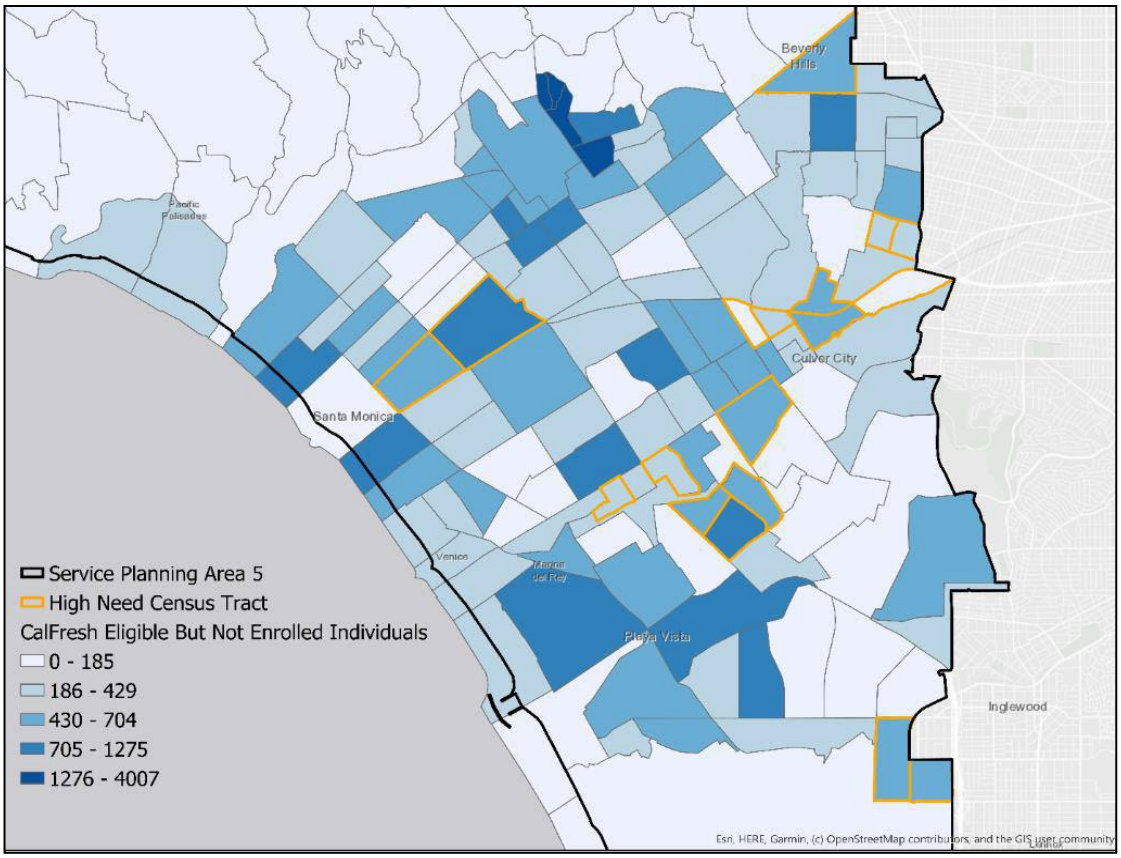
CalFresh/Food Stamp Enrollment

Table_Apx 13. Household Government Assistance by Area

Household Government Assistance Variable	SPA 5	Saint John's High Need Census Tracts	Los Angeles County
2013-2017 ACS Households Receiving Food Stamps/CalFresh	6,047	1,612	294,372
2013-2017 ACS Households Receiving Food Stamps/CalFresh (%)	2.07%	5.34%	8.93%

- In looking at households that were receiving CalFresh/Food Stamp benefits in 2017, SPA 5's participation is 4.3 times lower than that of LA County.
- Looking specifically at Saint John's high-need areas, CalFresh participation more than doubled compared to SPA 5, but is still lower than that of the county.

Figure_Apx 9. CalFresh Eligible but Unenrolled Individuals in SPA 5



While some of the reason for lower participation is due to ineligibility because of higher household incomes, there are still 57,032 CalFresh eligible individuals who are not enrolled to receive benefits within SPA 5. In the identified "high-need" census tracts there are a total of 8,753 eligible but unenrolled individuals.

Table_Apx 14. Food Insecurity Indicator in SPA 5 and LA County

Food Insecurity Indicator	SPA 5	Los Angeles County
Percent of households with incomes <300% Federal Poverty Level who are food insecure	30.5%	29.2%
Percent of children with excellent or good access to fresh fruits and vegetables in their community	92.7%	75.0%
Percent of adults who consume five or more servings of fruits & vegetables a day	20.9%	14.7%
Percent of children who drink at least one soda or sweetened drink a day	14.3%	39.2%

Los Angeles County Department of Public Health Key Indicators

Table_Apx 14 includes food insecurity and nutrition related indicators prepared by the Los Angeles County Department of Public Health. These indicators were calculated from the 2015 Los Angeles County Health Survey, which is a population-based telephone survey designed to measure the health needs and behaviors of Los Angeles residents. Data for these variables was only available at the Service Planning Area (SPA) level.

Homelessness and Housing Instability

Primary Data

Stakeholders shared that having a safe, stable place to live is foundational to a person's wellbeing. Therefore, addressing homelessness and housing instability is an urgent need. Stakeholders shared the following factors that contribute to homelessness and housing instability:

- Behavioral health challenges: Stakeholders saw substance use and mental illness as strong contributors to homelessness on the Westside. Behavioral health challenges make accessing stable housing and employment more difficult, contributing to poverty. They shared that homelessness can

makes behavioral health challenges worse and behavioral health challenges can make ending homelessness harder.

- Lack of affordable housing options and NIMBYism: Stakeholders shared the cost of housing on the Westside is too expensive. There are not enough affordable housing options. Even if people receive Section 8 housing vouchers, there are not apartments that will accept the voucher. This leads to people needing to move to more affordable areas, further from their work, leading to transportation challenges and stress. Additionally, finding locations to build affordable housing is challenging because of the NIMBY (not in my backyard) attitude.
- Economic insecurity and a lack of living wage jobs: The amount of money people are able to make in their jobs is not enough to meet the high cost of living on the Westside. Lack of a living wage, combined with high cost of living keeps people in poverty, contributing to income inequality.

Stakeholders identified several populations that are most affected by homelessness and housing instability:

- People with low-incomes: Stakeholders shared that people with low-incomes are more likely to be economically insecure. Financial setbacks or unexpected expenses can make them unable to pay their rent.
- Older adults: Stakeholders expressed a concern for the seemingly increasing number of older adults experiencing housing instability and homelessness. Older adults may not be able to afford the increasing housing costs, have high medical costs, or be living in a place that is not safe for them but be unable to move.
- Young people: Stakeholders noted that young people, particularly transitional age youth, are often lacking sufficient support services. There is a gap in services for young people leaving foster care and shelters for youth. Youth experiencing homelessness may be harder to identify if they are couch surfing or sleeping in their car.
- People of color: Stakeholders shared people of color experience racism and discrimination which contribute to economic insecurity and poorer mental health, which are connected with homelessness and housing instability.

Effective strategies to address homelessness and housing instability shared by stakeholders include the following:

- Build affordable housing: Stakeholders shared an important step in addressing homelessness is increasing the availability of affordable housing, including permanent supportive housing. With Measure H and Proposition HHH, new streams of funding are helping to improve the availability of housing.
- Increase access to job training programs: Job training programs are important for people to obtain better paying jobs, increase economic insecurity, reduce poverty, and prevent homelessness.
- Provide multi-disciplinary support teams for people experiencing homelessness: Stakeholders shared homelessness is a complicated issue that often intersects with other issues. Therefore, to address the needs of people experiencing homelessness, clients should be supported by people with varying specialties, such as a case manager, mental health professional, etc. In this way, multiple support people can work together to better address these intersecting needs.

Secondary Data

Homelessness

The Los Angeles Homeless Services Authority (LAHSA) conducts a yearly point-in-time count called the Greater Los Angeles Homeless Count. Moderated by the U.S. Department of Housing and Urban Development, LAHSA conducts the nation's largest homeless census count with the help of volunteers over the course of three days and nights. Results are published on LAHSA's website and are available here: https://www.lahsa.org/documents.

The following table displays the results of the 2019 Greater Los Angeles Homeless Count with a focused look at the results of SPA 5 and the city of Santa Monica. All geographic areas of interest show an increase in people experiencing homelessness within just one year. The number of people experiencing homelessness in SPA 5 increased 20% from 2018 to 2019, while Santa Monica increased 11%, similar to that of LA County.

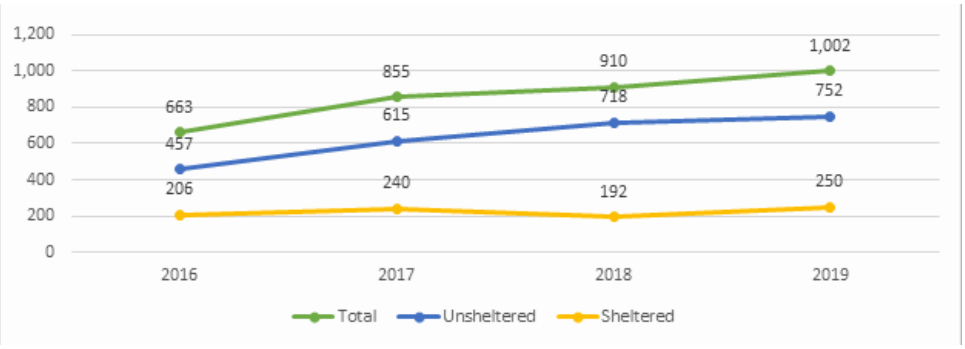
Table_Apx 15. 2019 Point-In-Time Homeless Count

Geographic Area	Sheltered	Unsheltered	Total	% Change 2018 - 2019
Los Angeles County	14,722	44,214	58,936	+12%
SPA 5	884	4,378	5,262	+20%
Santa Monica	250	752	1,002	+11%
Santa Monica*	331	654	985	+3%

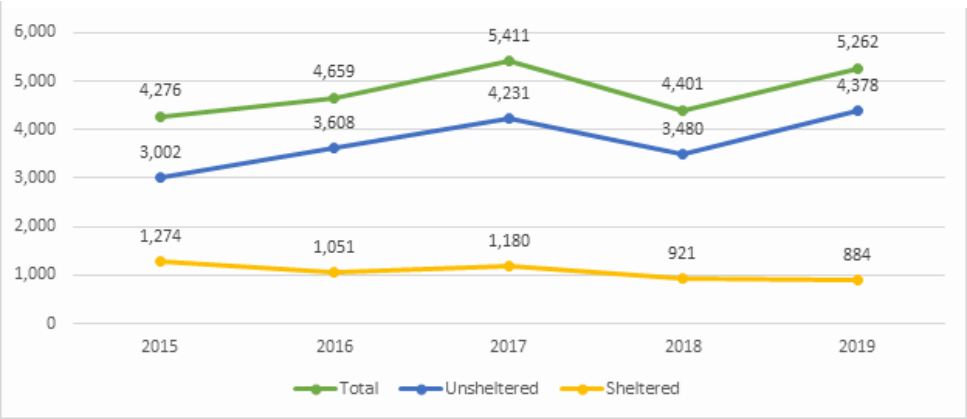
**Data acquired from Santa Monica's city reported count, which does not include a multiplier utilized in LAHSA's county-wide calculation*

SPA 5 had the highest change of all eight SPAs in LA County in total homeless population between 2018 and 2019.

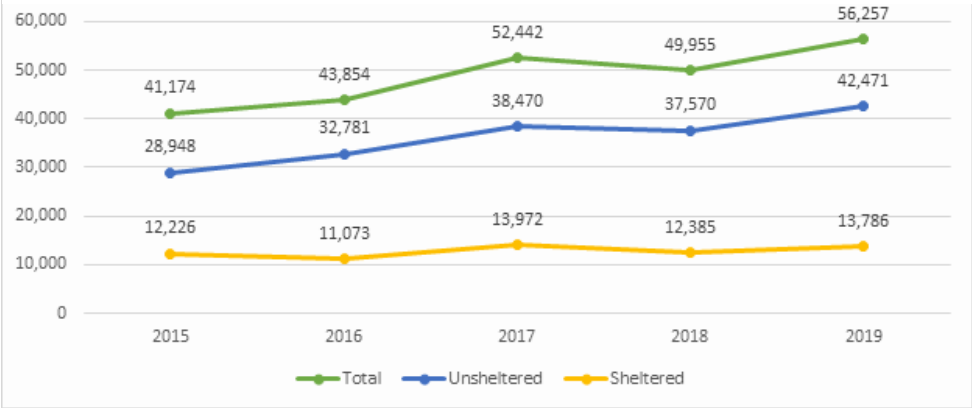
Figure_Apx 10. Total People Experiencing Homelessness in the City of Santa Monica, Living Unsheltered and Sheltered



Figure_Apx 12. Total People Experiencing Homelessness in SPA 5, Living Unsheltered and Sheltered



Figure_Apx 11. Total People Experiencing Homelessness in LA County, Living Unsheltered and Sheltered



- Of all 5,262 persons experiencing homelessness in SPA 5, 87% of those are individuals, 13% are family members and 0.1% are unaccompanied minors.
- Like Los Angeles County, the unsheltered homeless population for SPA 5 has had an increasing trend between the years 2015 and 2019.
- SPA 5 has seen a decrease in the sheltered homeless population between the years 2017 and 2019.
- The city of Santa Monica has seen consistent yearly increases in total and unsheltered homeless populations since 2016 with a slight dip in the sheltered homeless population in the year 2018.

Table_Apx 16. 2019 Point-In-Time Homeless Count – SPA 5 Race and Ethnicity Table

Race/Ethnicity	Sheltered	Unsheltered	Total	Prevalence of Homeless Pop.	Percent Change 2018-2019
American Indian/ Alaska Native	5	125	130	2%	-10%
Asian	11	48	59	1%	+34%
Black/African American	419	999	1,418	27%	-4%
Hispanic/ Latino	234	873	1,107	21%	+31%
Native Hawaiian/ Other Pacific Islander	4	24	28	0.5%	+75%
White	194	2,091	2,285	43%	+31%
Multi- Racial/Other	17	218	235	4%	+84%

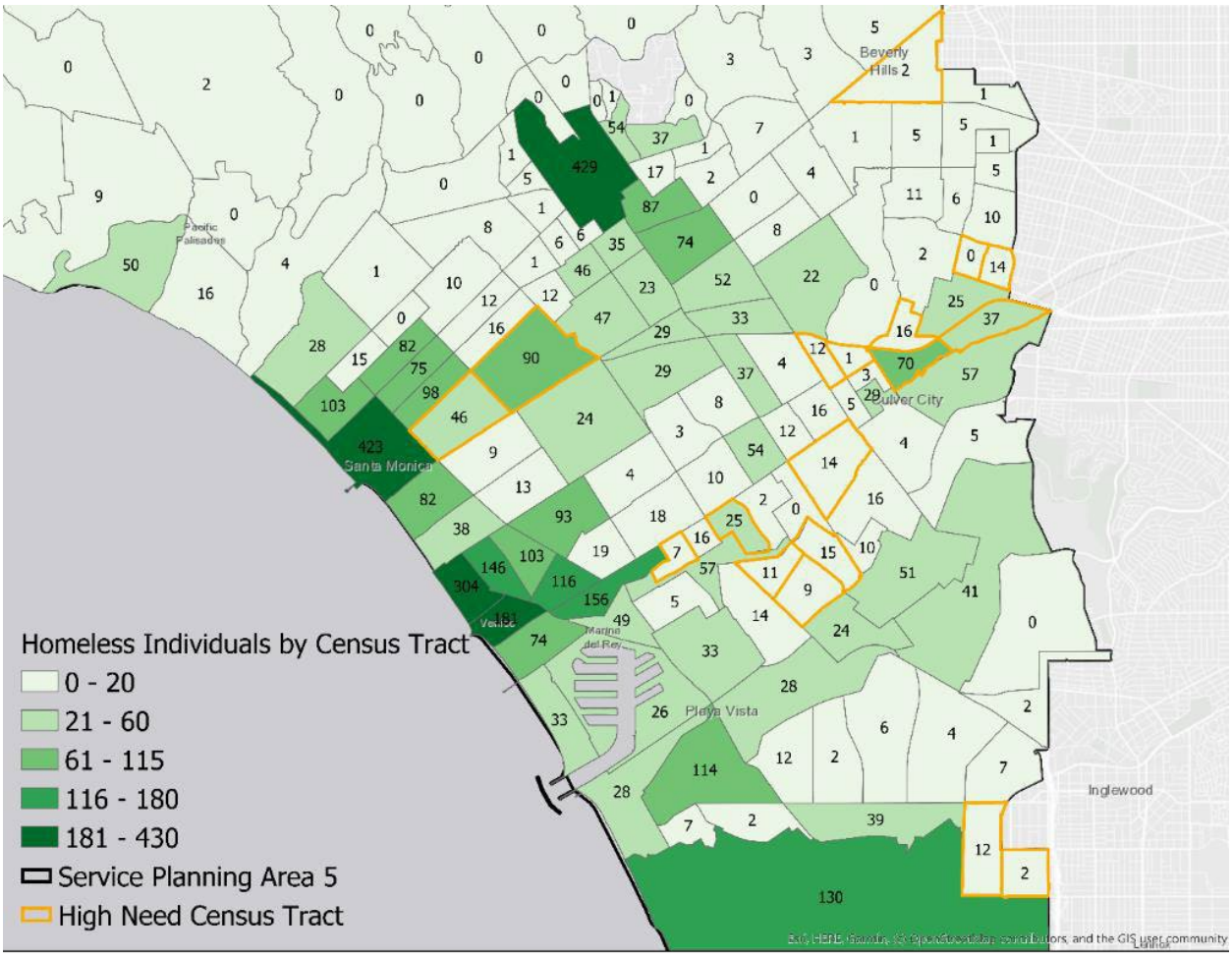
- 71% of all persons experiencing homelessness are men and when looking at race and ethnicity, the largest groups are White (43%), Black/African American (27%), and Hispanic/Latino (21%).

Table_Apx 17. 2019 Point-In-Time Homeless Count – SPA 5 Age Table

Age Group	Sheltered	Unsheltered	Total	Prevalence of Homeless Population	Total Percent Change 2018 – 2019
Under 18	227	158	385	7%	+1%
18 - 24	64	388	452	9%	+61%
25 - 54	401	2,670	3,071	58%	+20%
55 - 61	98	759	857	16%	+33%
62 and Over	94	403	497	9%	-9%

- The largest age group for those experiencing homelessness are ages 25 – 55, making up 58% of all persons experiencing homelessness.

Figure_Apx 13. 2019 Homeless County by Census Tract in SPA 5



- The largest concentration of people experiencing homelessness are found in the city of Santa Monica, which accounts for about 20% of people experiencing homelessness in SPA 5 according to the 2019 Greater Los Angeles Homeless Count.
- Homeless counts in West Los Angeles are evenly spread throughout the census tracts whereas Westwood has a large concentration in a single census tract with 429 individuals experiencing homelessness accounted for in the recent homeless count.
- There is a stretch of census tracts that begins in Playa Vista and runs through Mar Vista and Culver City which contains much higher counts of individuals than the neighboring census tracts.
- A total of 383 individuals were identified in Saint John's designed "high need" census tracts in the Greater Los Angeles Homeless Count.

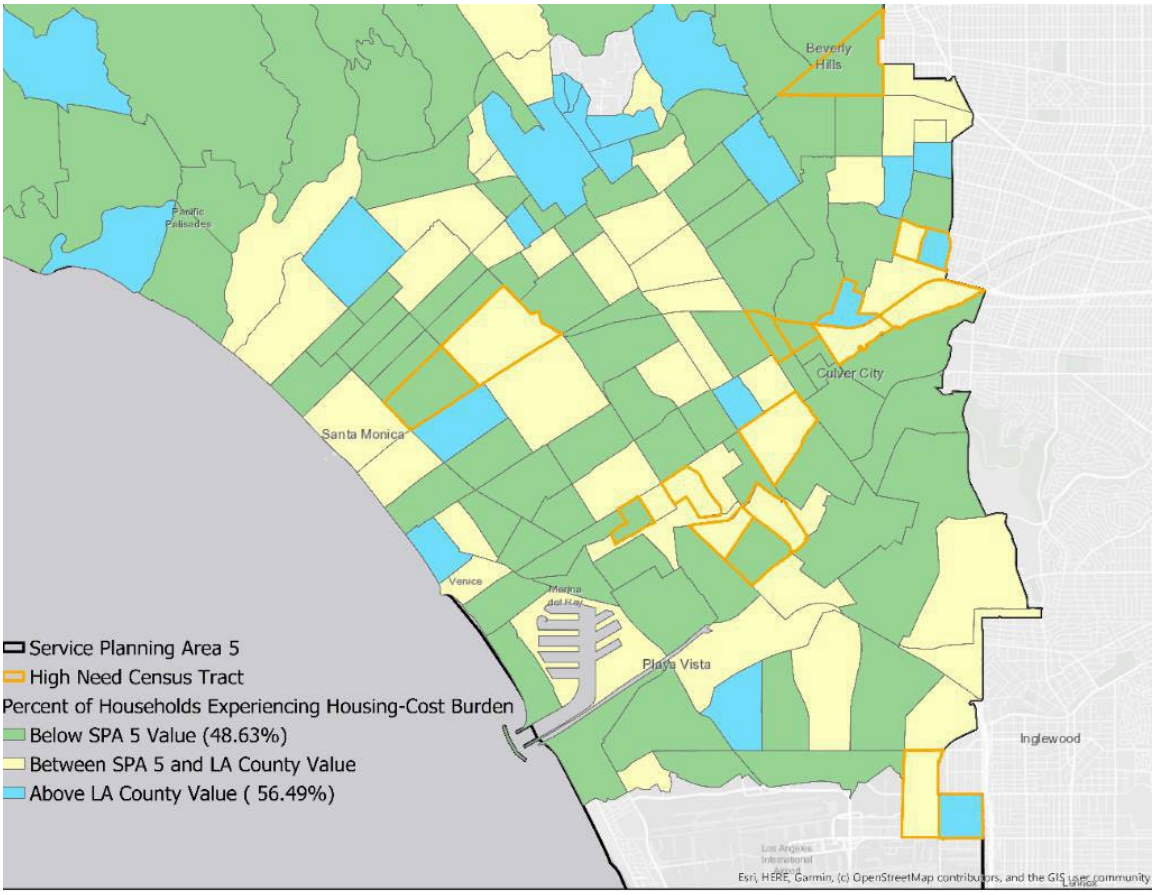
Housing-Cost Burden

Throughout this section we will consider households that pay 30 percent or more of their income on housing costs as "housing-cost burdened" while those households that pay 50 percent or more of their income on housing costs as "severely housing-cost burdened".

Table_Apx 18. Housing-Cost Burdened Households

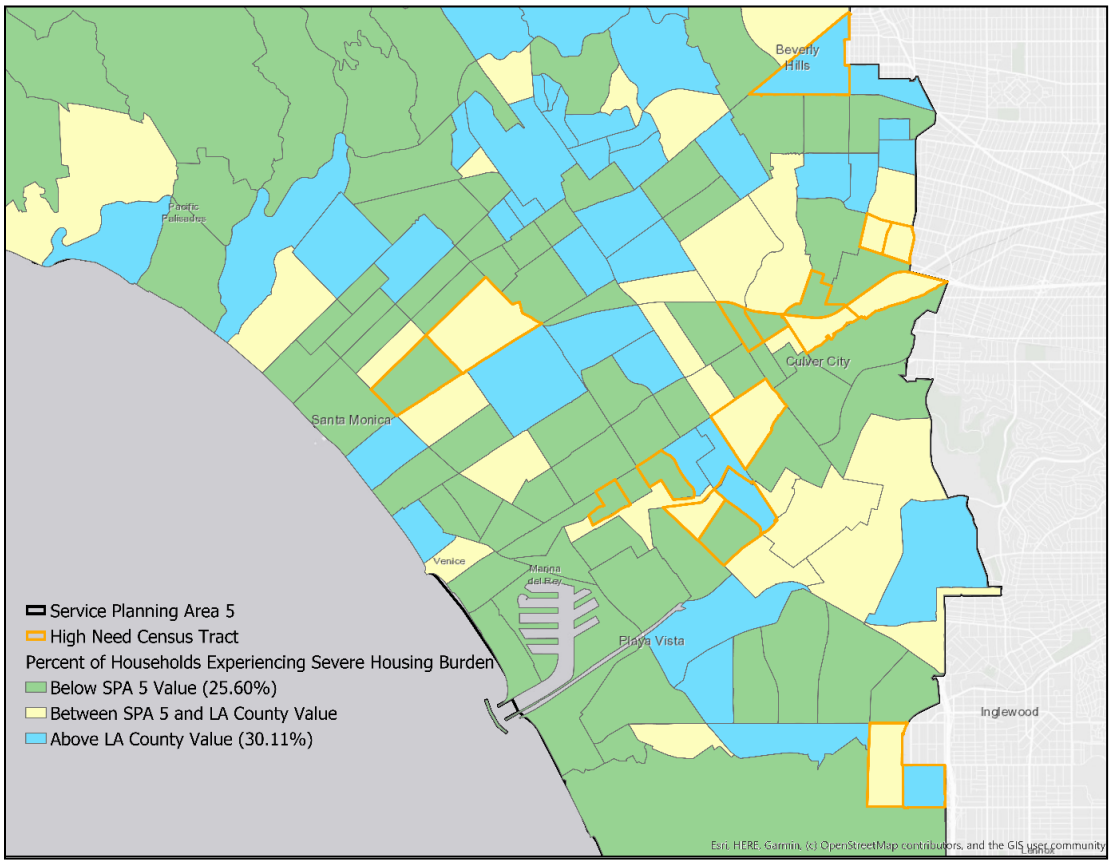
Variable	SPA 5	Saint John's High Need	Los Angeles County
2013-2017 ACS Households: Renter Households That Are Housing-Cost Burdened (#; %)	84,716; 48.63%	12,437; 51.01%	1,006,798; 56.49%
2013-2017 ACS Households: Renter Households That Are Severely Housing-Cost Burdened (#; %)	44,780; 25.60%	6,106; 25.10%	536,832; 30.11%

Figure_Apx 14. Renter Households Experiencing Housing-Cost Burden



Nine of the eighteen high-need communities are above the SPA 5 average for percent of households experiencing housing-cost burden and three high-need communities are above the Los Angeles County benchmark.

Figure_Apx 15. Renter Households Experiencing Severe Housing-Cost Burden



Ten of the eighteen high-need communities are above the SPA 5 average for percent of households experiencing severe housing-cost burden and two high-need communities are above the Los Angeles County benchmark.

Oral Health Care

Primary Data

Community Stakeholder Interviews

Stakeholders shared the number of affordable dental providers is insufficient to serve the people living on the Westside. Stakeholders shared the following themes related to the factors that contribute to oral health care being a need:

- Lack of affordable dental care and providers who accept Denti-Cal: While Medi-Cal offers dental care for low-income adults, called Denti-Cal, many dental providers do not accept this insurance and the scope of services covered is limited. Therefore, many adults with low- incomes experience barriers accessing affordable dental care.
- Lack of knowledge of the importance of preventive dental care: Stakeholders shared the people they serve are often unaware of the connection between oral health and the rest of their body. Therefore, there is a need for more education for adults and starting good oral health habits for children.

Stakeholders named the following populations as particularly needing improved dental care:

- Adults who are uninsured or on Denti-Cal: There is a lack of affordable dental care and providers who accept Denti-Cal. Therefore, adults who are uninsured or on Denti-Cal have a harder time accessing and affording the care they need.
- Veterans: The VA system only covers dental services tied to an injury while serving, therefore, veterans may not be able to access the preventive dental care they need.

To address the oral health needs of the Westside, stakeholders shared the following strategies:

- Implement universal dental screening programs in schools: Stakeholders have seen success with implementing universal screenings for oral health in schools. This provides an opportunity to educate families on the importance of dental care.
- Increase the number of low-cost dental providers: Some Federally Qualified Health Centers offer dental services, but some do not. Expanding the number of providers who accept Denti-Cal and offering services for patients who are uninsured would improve access.

Virginia Avenue Park Listening Session---Community Issues

Participants were asked, "What are the most important issues that must be addressed to improve the health of the community?" Community members shared the issues they are most concerned about. The following themes were shared:

Lack of affordable, local health services, particularly dental services

Santa Monica lacks local, affordable health care services. Participants were particularly concerned about dental care, stating that when they are referred for dental care they are often referred outside of their community. They would like more local resources, especially because public transportation makes traveling for appointments challenging.

Secondary Data

Los Angeles County Key Indicators from the 2015 Los Angeles County Health Survey

Table_Apx 19. Dental Care Access Indicators in SPA 5 Compared to LA County

Dental Care Indicator	SPA 5	Los Angeles County	Difference Between SPA 5 and LA County
Percent of adults who did not see a dentist or go to a dental clinic in the past year	28.9%	40.7%	-11.8%
Percent of children ages 3-17 years who did not obtain dental care (including check-ups) in the past year because they could not afford it	13.3%	11.5%	1.8%

California Health Interview Survey

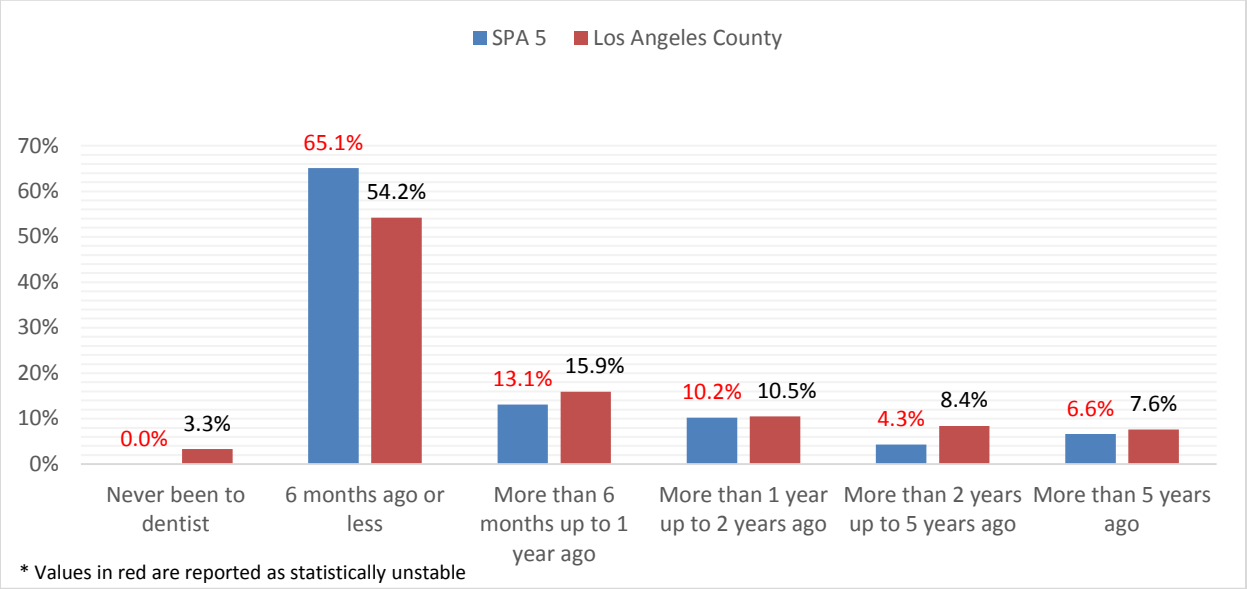
The following indicators are taken from the most recent California Health Interview Survey (CHIS). CHIS is a health survey conducted on a continuous basis by the UCLA Center for Health Policy Research in collaboration with the Department of Health Care Services and the California Department of Public Health. Currently the most recent date for CHIS data through the self-service portal "AskCHIS" is from the year 2017. Due to sample sizes and estimation methodologies, service planning areas may be statistically unstable. Values that are statistically unstable will be displayed in red.

Table_Apx 20. Dental Insurance Indicators in SPA 5 and LA County

Dental Insurance Indicator	SPA 5	Los Angeles County
Adults who have insurance that pays for part or all of dental care(CHIS, 2017)	67.7%	61.1%
Children who have insurance that pays for part or all of dental care (CHIS, 2017)	77.7%*	86.1%

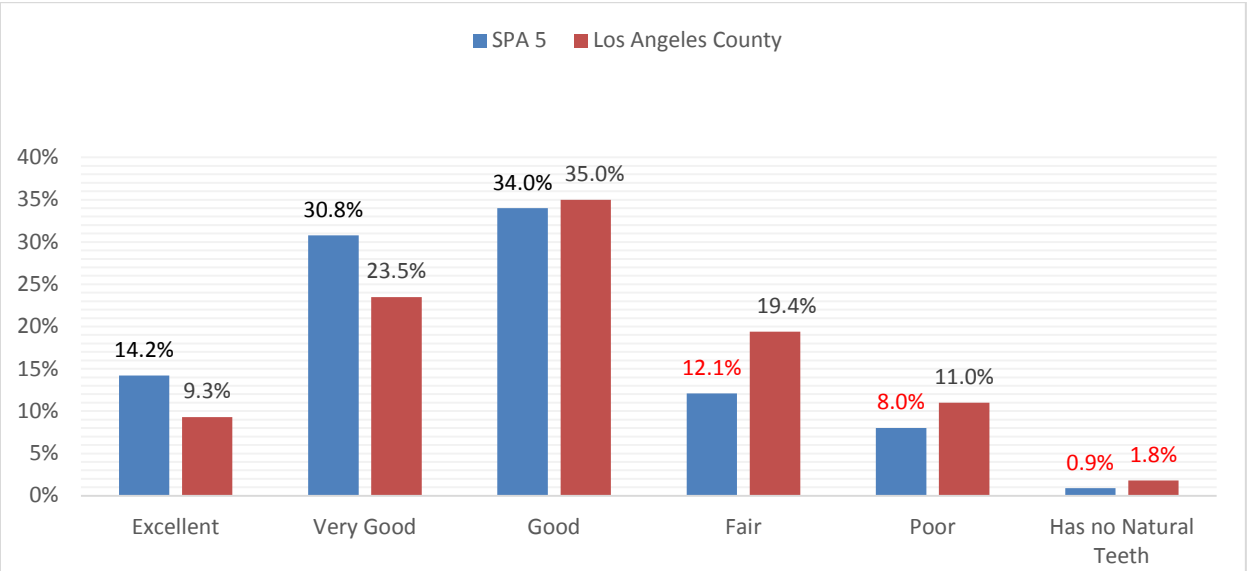
**Statistically unstable*

Figure_Apx 16. Time Since Last Dental Visit (Adults, 2017)



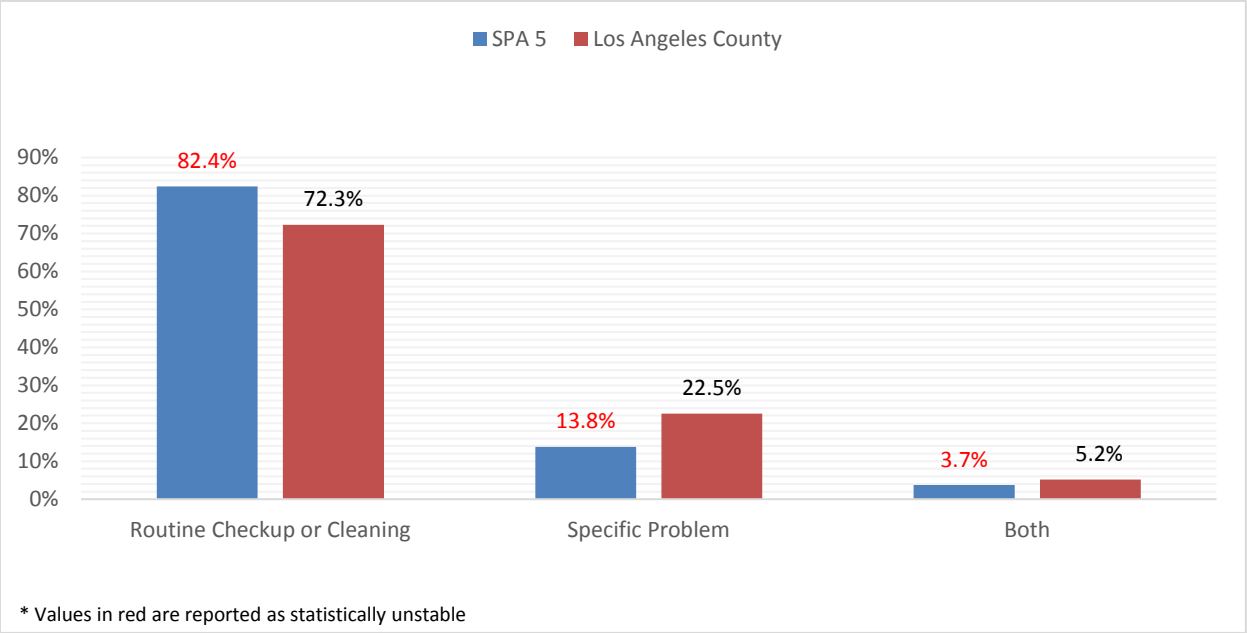
* Values in red are reported as statistically unstable

Figure_Apx 17. Condition of Teeth (Adults, 2017)



* Values in red are reported as statistically unstable

Figure_Apx 18. Reason for Last Dental Visit (Adults, 2017)



* Values in red are reported as statistically unstable

Services for Seniors

Primary Data

Community Stakeholder Interviews

Behavioral Health

- Older adults: Stakeholders shared that older adults, particularly those who have low incomes may have more challenges accessing behavioral health care. Social isolation, poverty, and chronic conditions may contribute to their behavioral health needs.
- Implement targeted outreach to groups needing services: To improve access to behavioral health care, stakeholders thought meeting people where they are is an important strategy. They noted including a mental health specialist on street outreach teams is important, as well as making home visits to **homebound older adults**. A crucial component to this outreach is ensuring that those people doing the outreach can reach non-English speakers and are culturally diverse.

Housing

- Older adults: Stakeholders expressed a concern for the seemingly increasing number of older adults experiencing housing instability and homelessness. Older adults may not be able to afford the increasing housing costs, have high medical costs, or be living in a place that is not safe for them but unable to move.

Food Insecurity

- Older adults: Stakeholders shared older adults may have a harder time accessing nutritious, good quality food because they have difficulty leaving the house, are unable to drive, or cannot afford food.

Economic Insecurity

Economic insecurity affects many people, particularly individuals and families with low incomes, but some of the groups identified by stakeholders are the following:

- People of color
- People re-entering the work force who were formerly incarcerated
- Older adults

Virginia Avenue Park Listening Session--vision for a Healthy Community

Listening session participants were asked, "What makes a healthy community? How can you tell when your community is healthy?" Participants described their vision for a healthy community. The following theme was shared:

No one feels unheard or forgotten

Participants shared that all people should feel heard and valued in a healthy community. They specifically spoke to acknowledging and supporting undocumented individuals. Additionally, participants noted that families with low-incomes and **older adults** are supported and heard in a healthy community.

Secondary Data

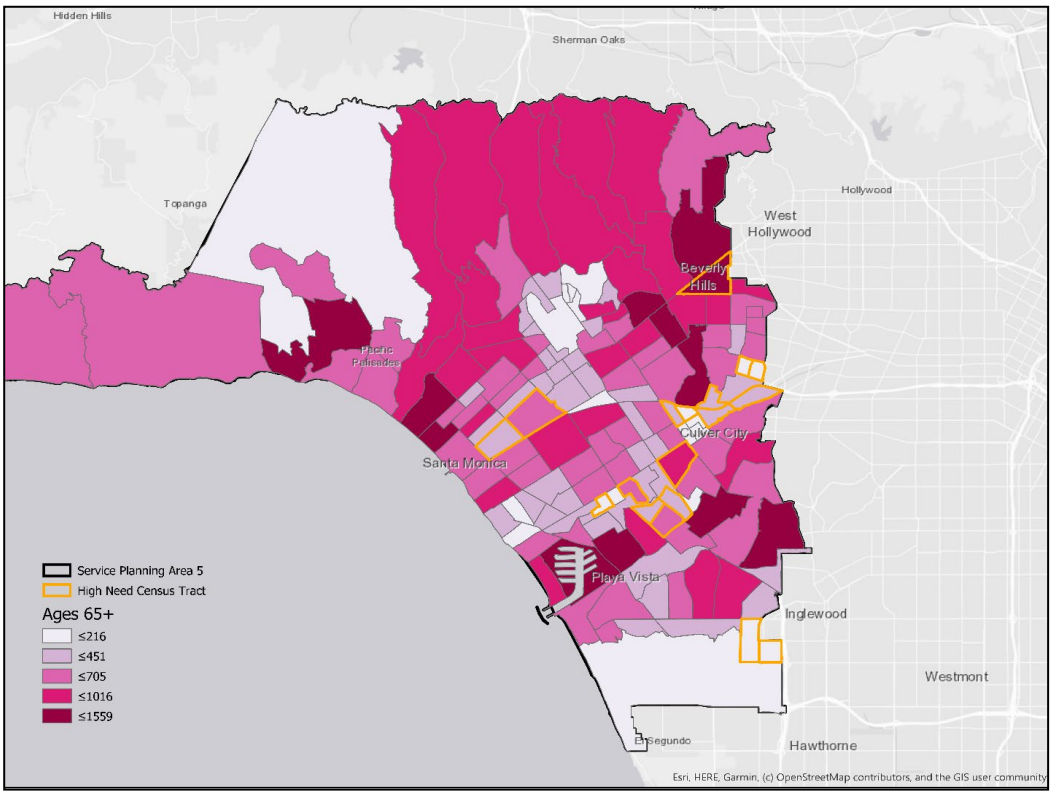
Senior Population in Service Planning Area 5

Table_Apx 21. Senior Population in SPA 5 in 2019 and Projected for 2024

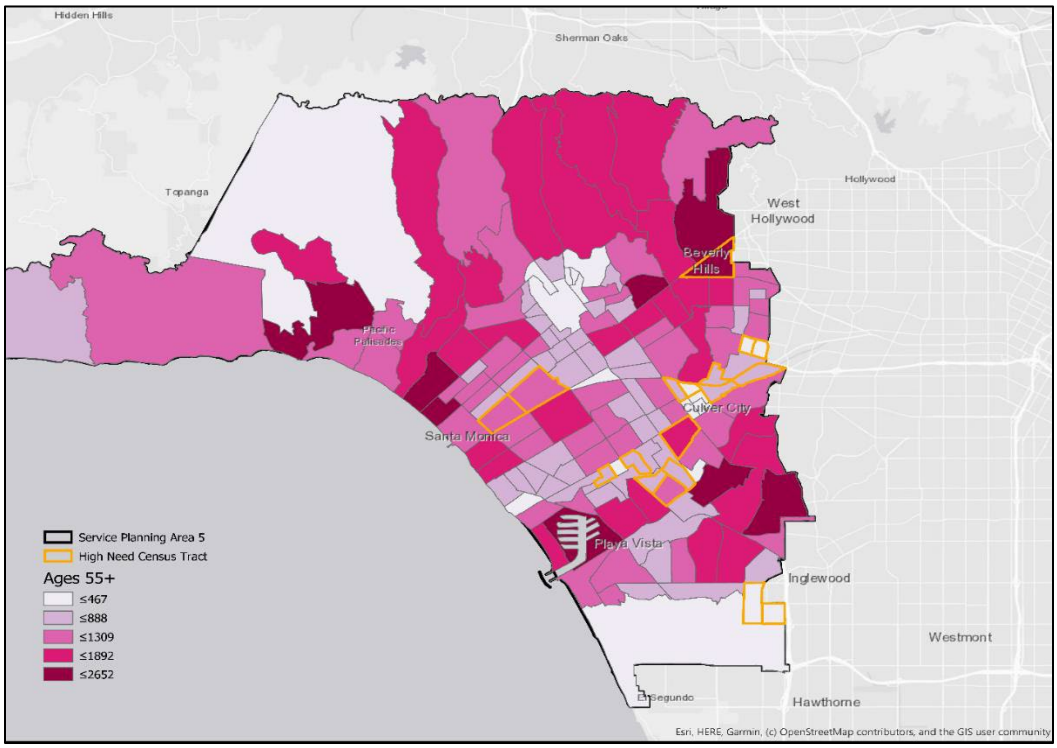
Population by Age	2019 Population (#; %)	2024 Project Population (#; %)
0-4	28,306; 4.2%	29,706; 4.2%
5-9	28,466; 4.2%	28,359; 4.1%
10-14	30,217; 4.4%	28,326; 4.1%
15-19	38,631; 5.7%	37,641; 5.4%
20-24	54,939; 8.1%	54,757; 7.8%
25-34	113,085; 16.6%	122,617; 17.5%
35-44	98,586; 14.5%	101,128; 14.5%
45-54	87,472; 12.9%	85,678; 12.3%
55-64	84,840; 12.5%	82,856; 11.8%
65-74	64,131; 9.4%	68,998; 9.9%
75-84	34,050; 5.0%	41,416; 5.9%
85+	17,258; 2.5%	17,731; 2.5%
55+	200,279; 29.5%	211,001; 30.2%
65+	115,439; 17.0%	128,145; 18.3%

- The senior population is projected to grow when looking at both the 55+ and 65+ populations.
- By 2024, the age group 55 is expected to grow by 5.35% and make up 30.2% of SPA 5's population

Figure_Apx 19. Seniors Ages 65+ by Census Tract in SPA 5



Figure_Apx 20. Seniors Ages 55+ by Census Tract in SPA 5



Changes to CalFresh Eligibility Requirements

Beginning June 1, 2019, seniors who receive Supplemental Security Income (SSI)/State Supplementary Payment (SSP) will now be eligible to enroll in CalFresh benefits without affecting their current SSI/SSP benefits.

According to the Department of Public Social Services, the expansion to SSI/SSP recipients will impact an estimated 212,309 households in Los Angeles County who were ineligible for CalFresh before the changes introduced by Assembly Bill 1811. Additionally, an estimated 11,239 active households with SSI/SSP recipients will see an increase in their CalFresh benefits.

Senior Homeless Population

Table_Apx 22. 2019 Point-In-Time Homeless County in SPA 5 by Age Group

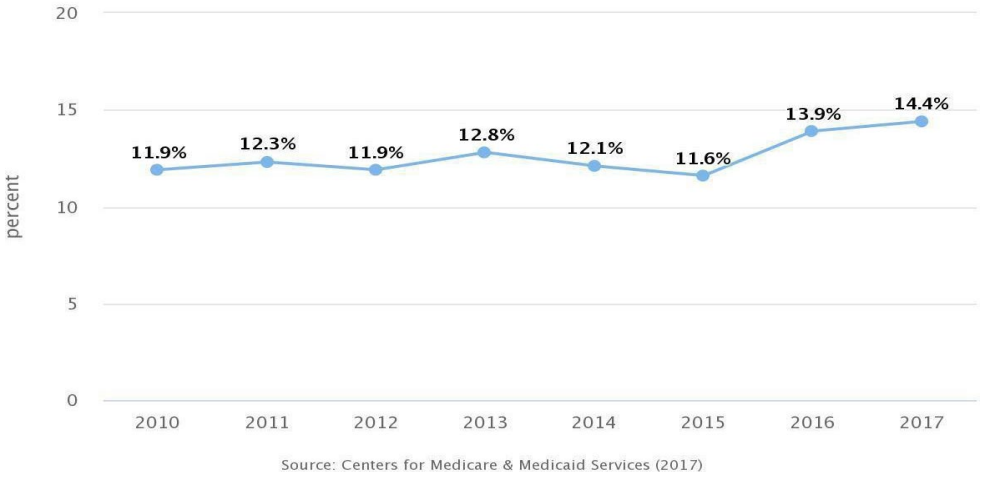
Age Group	Sheltered	Unsheltered	Total	Prevalence of Homeless Population	Total Percent Change 2018 - 2019
55 - 61	98	759	857	16%	+33%
62 and Over	94	403	497	9%	-9%

- According to the 2019 Los Angeles Homeless Services Authority (LAHSA) Point-In-Time Homeless Count, individuals ages 55 and over make up 25% of the total homeless population in SPA 5.
- The age group 55- 61 years has seen an increase in individuals experiencing homelessness by 33% since 2018.

Alzheimer's and dementia

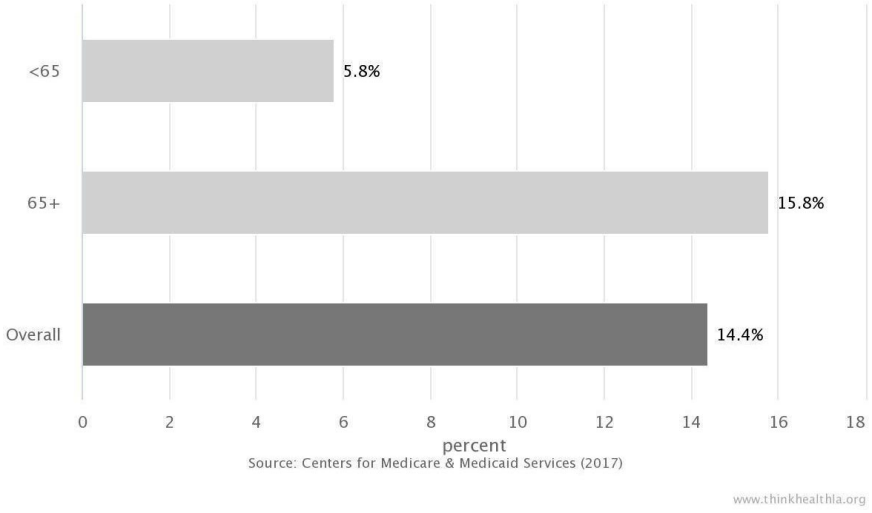
The Centers for Medicare and Medicaid Services show that the percentage of Medicare beneficiaries who were treated for Alzheimer's disease or dementia has seen an increasing trend in Los Angeles County with the largest spike between the years 2015 and 2016 where the percentage increased by 2.3%.

Figure_Apx 21. Alzheimer's Disease or Dementia in Medicare Population in LA County



- When looking at Medicare beneficiaries who are over the age of 65, we see that 15.8% are treated for Alzheimer's disease or dementia.

Figure_Apx 22. Percent of Population by Age in LA County with Alzheimer's Disease or Dementia



Below we have Alzheimer's disease-specific death rate per 100,000 population for Service Planning Area 5 and Los Angeles County. These data come from the key indicators provided by the Los Angeles County Department of Public Health.

Table_Apx 23. Alzheimer's Disease-Specific Death Rate in SPA 5 Compared to LA County

Alzheimer's Disease Indicator	SPA 5	Los Angeles County	Difference Between SPA 5 and LA County
Alzheimer's disease-specific death rate (per 100,000 population)	40.33	38.74	1.59

Falls

From the 2015 Los Angeles County Health Survey we see that Service Planning Area 5 has a slightly higher rate of falls for its senior population when compared to Los Angeles County.

Table_Apx 24. Incidence of Falls for Senior Population in SPA 5 Compared to LA County

Falls for Senior Population Indicator	SPA 5	Los Angeles County	Difference Between SPA 5 and LA County
Percent of adults ages 65+ years who have fallen in the past year	27.8%	27.1%	0.7%

Appendix 2 –Additional Quantitative Data

2019 CHNA Common Metrics - South Bay

	St. John's Service Area	Los Angeles County	California	United States
% Population below 200% FPL	**23.0%**	**39.6%**	**35.2%**	**33.6%**
Language spoken at home other than English	**35.7%**	**56.7%**	**44.0%**	**21.2%**
Top 5 Zip Codes				
90211	55.2%			
90210	48.9%			
90034	47.9%			
90230	47.0%			
90025	43.0%			
Bottom 5 Zip Codes				
90293	22.3%			
90402	20.2%			
90265	18.6%			
90272	17.5%			
90056	11.7%			

Median HH income	$92,878	$62,751	$69,051	$58,100
Top 5 Zip Codes				
90077	$200,001			
90272	$200,001			
90210	$162,456			
90402	$157,242			
90265	$151,621			
Bottom 5 Zip Codes				
90066	$76,276			
90024	$74,167			
90401	$67,528			
90404	$65,561			
90034	$65,417			

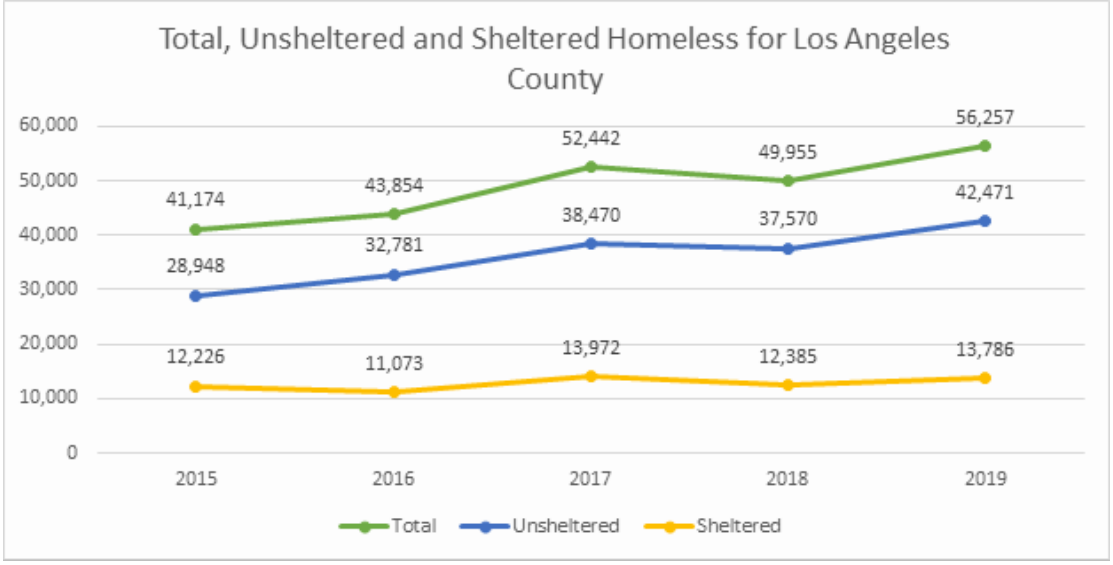
% Population with at least a HS diploma	94.4%	78.4%	82.6%	87.7%
Top 5 Zip Codes				
90094		99.0%		
90402		98.5%		
90272		98.3%		
90263		97.8%		
90056		97.8%		
Bottom 5 Zip Codes				
90025		92.2%		
90034		90.9%		
90404		89.9%		
90066		88.6%		
90230		87.6%		

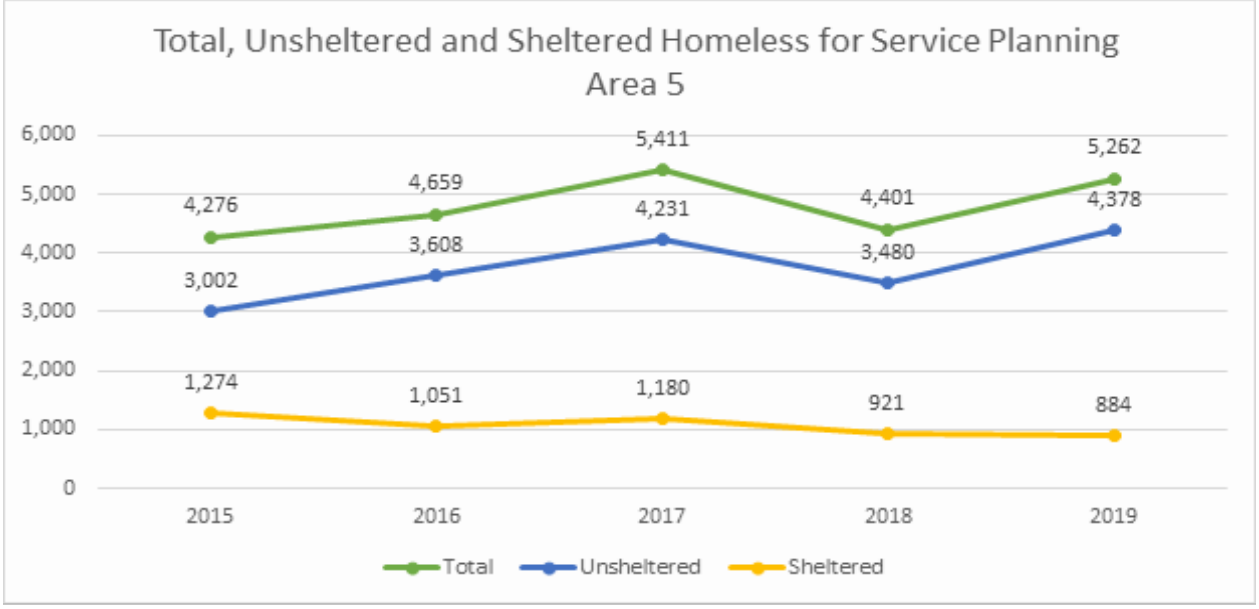
% Labor force employed	96.5%	95.5%	95.3%	95.2%
Top 5 Zip Codes				
90064	97.4%			
90049	97.3%			
90077	97.2%			
90402	97.1%			
90210	97.1%			
Bottom 5 Zip Codes				
90404	95.5%			
90094	95.5%			
90056	95.4%			
90212	94.9%			
90401	94.4%			

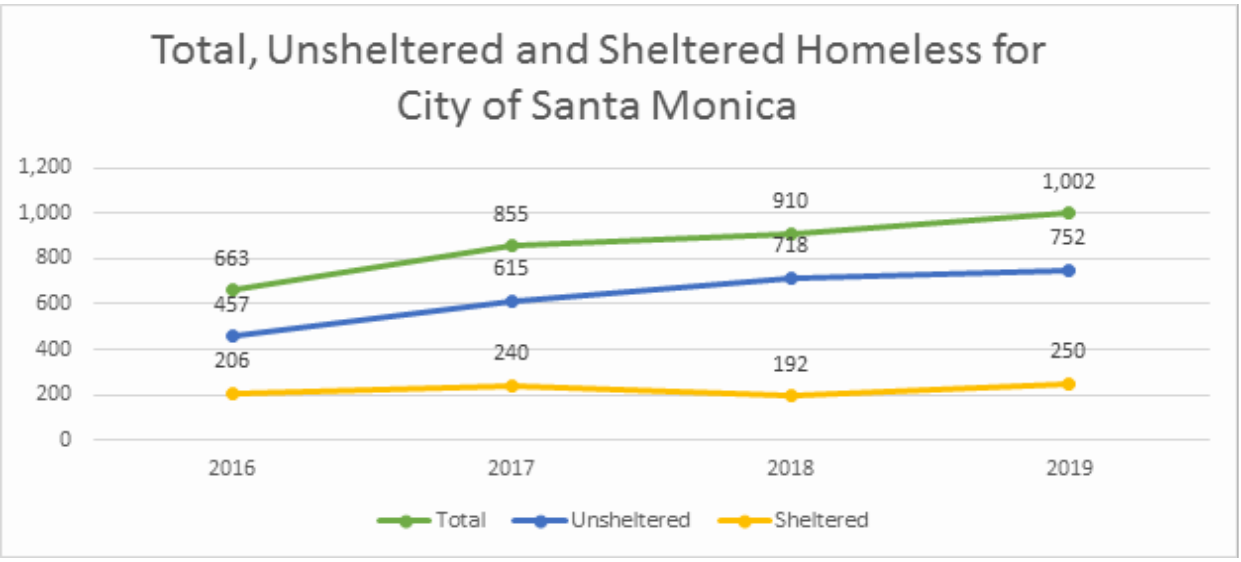
Severe Housing Cost Burden	26.2%	30.6%	27.9%	24.1%
Top 5 Zip Codes				
90024	44.8%			
90067	43.7%			
90035	33.0%			
90094	32.0%			
90402	31.7%			
Bottom 5 Zip Codes				
90404	21.7%			
90293	21.1%			
90232	21.0%			
90292	18.2%			
90263	0.0%			

Chronic Homelessness					
Top 5 Zip Codes					
	90056	5.2%			
	90404	4.3%			
	90230	4.1%			
	90035	3.7%			
	90066	3.4%			
Bottom 5 Zip Codes					
	90212	0.3%			
	90077	0.2%			
	90210	0.2%			
	90067	0.0%			
	90263	0.0%			

2019 Point-In-Time Homeless County				
Geographic Area	**Sheltered**	**Unsheltered**	**Total**	**Percent Change 2018 - 2019**
Los Angeles County	14,722	44,214	58,.936	+12%
SPA 5	884	4,378	5,262	+20%
Santa Monica	250	752	1,002	+11%




Total, Unsheltered and Sheltered Homeless for Service Planning Area 5
6,000
5,000
4,000
3,000
2,000
1,000
0
4,276
4,659
5,411
4,401
5,262
3,002
3,608
4,231
3,480
4,378
1,274
1,051
1,180
921
884
2015
2016
2017
2018
2019
Total
Unsheltered
Sheltered


Total, Unsheltered and Sheltered Homeless for City of Santa Monica
1,200
1,000
800
600
400
200
0
663
855
910
1,002
457
615
718
752
206
240
192
250
2016
2017
2018
2019
Total
Unsheltered
Sheltered

2019 Point-In-Time Homeless Count – Service Planning Area 5 Race and Ethnicity Table					
Race/Ethnicity	Sheltered	Unsheltered	Total	Prevalence of Homeless Pop.	Percent Change 2018-2019
American Indian/ Alaska Native	5	125	130	2%	-10%
Asian	11	48	59	1%	+34%
Black/African American	419	999	1,418	27%	-4%
Hispanic/ Latino	234	873	1,107	21%	+31%
Native Hawaiian/ Other Pacific Islander	4	24	28	0.5%	+75%
White	194	2,091	2,285	43%	+31%
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2019 Point-In-Time Homeless Count – Service Planning Area 5 Age Table					
Age Group	Sheltered	Unsheltered	Total	Prevalence of Homeless Population	Total Percent Change 2018 -2019
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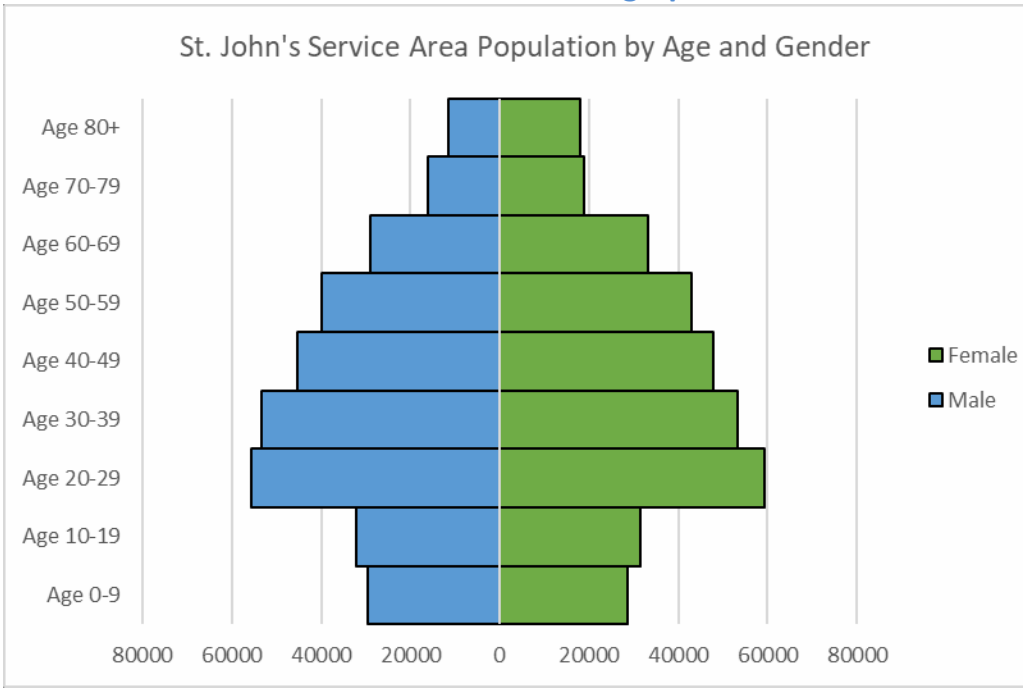
25 - 54	401	2,670	3,071	58%	+20%
55 - 61	98	759	857	16%	+33%
62 and Over	94	403	497	9%	-9%

Providence Saint John's Service Area Demographics



Saint John's Service Area Population by Race

Race	Population Count	Population %	Los Angeles County Benchmark
White	455,629	66.7%	54.8%
Black	40,863	5.9%	9.3%
American Indian	2,785	0.4%	1.6%
Asian	97,680	14.3%	16.0%
Pacific Islander	1,157	0.2%	0.5%
Other Race	45,495	6.7%	22.0%
Multiple Races	38,840	5.7%	2.2%
Total Population	**682,449**	**100%**	
Hispanic Population	116,325	17.1%	48.4%
Minority Population	286,829	42.0%	N/A

Location of Individuals of Colorin Providence Saint John's Service Area

Approximate Saint John's Service Area

		Prevention Quality Indicators (Per 1,000 Admissions) by Hospital Facility 2018												
Facility	**Grouping**	**PQI #01 Diabetes Short-term Complications Admission Rate**	**PQI #02 Perforated Appendix Admission Rate**	**PQI #03 Diabetes Long-term Complications Admission Rate**	**PQI #05 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate**	**PQI #07 Hypertension Admission Rate**	**PQI #08 Heart Failure Admission Rate**	**PQI #09 Low Birthweight Rate**	**PQI #10 Dehydration Admission Rate**	**PQI #11 Community Acquired Pneumonia Admission Rate**	**PQI #12 Urinary Tract Infection Admission Rate**	**PQI #14 Uncontrolled Diabetes Admission Rate**	**PQI #15 Asthma in Younger Adults Admission Rate**	**Lower Extremity Amputation Among Patients with Diabetes**
735-PROVIDENCESTJOHNSHEALTHCENTER	Facility Level	1.47	3.58	2.85	14.85	1.63	22.64	25.62	3.26	15.72	11.73	1.87	1.59	0.41
Southern California Average	Facility Level	4.95	3.82	6.62	17.47	2.94	35.09	38.89	5.20	13.22	12.71	4.03	3.32	1.17
Facility	**Age Group**													
735- PROVIDENCEST JOHNS HEALTHCENTER	18 to 39 years	4.57	5.40	0.83	-	-	2.08	21.37	0.83	3.32	2.91	1.25	1.59	-
735- PROVIDENCEST JOHNS HEALTHCENTER	40 to 64 years	1.69	5.07	5.07	12.79	2.03	15.55	46.08	2.03	9.46	3.38	1.35	-	1.01
735- PROVIDENCEST JOHNS HEALTHCENTER	65 to 74 years	0.43	4.71	2.57	18.62	2.14	18.00	-	3.00	17.15	9.00	2.14	-	0.86
735- PROVIDENCEST JOHNS HEALTHCENTER	75+ years	0.22	1.10	2.63	13.98	1.97	40.74	-	5.48	25.84	23.00	2.41	-	-
735 - PROVIDENCE ST JOHNS HEALTH CENTER Total		**1.47**	**3.59**	**2.85**	**14.77**	**1.63**	**22.75**	**24.08**	**3.26**	**15.82**	**11.66**	**1.88**	**1.59**	**0.41**
Facility	**Gender**													
735- PROVIDENCEST JOHNS HEALTHCENTER	FEMALE	1.46	2.39	1.73	18.99	1.46	17.16	29.47	3.33	13.97	12.5	0.67	0.45	1.33
735- PROVIDENCEST JOHNS HEALTHCENTER	MALE	1.47	5.48	4.63	9.7	1.9	31.59	22.09	3.16	18.74	10.32	3.79	9.55	8.42
735 - PROVIDENCE ST JOHNS HEALTH CENTER Total		**1.47**	**3.59**	**2.85**	**14.77**	**1.63**	**22.75**	**25.62**	**3.26**	**15.82**	**11.66**	**1.88**	**1.59**	**4.08**
Facility	**Gender**													
735- PROVIDENCEST JOHNS HEALTHCENTER	CAPITATION	-	2.40	7.19	26.38	4.80	26.38	-	9.59	21.58	11.99	7.19	-	-

735- PROVIDENCEST JOHNS HEALTHCENTER	COMMERCIAL	0.86	5.81	1.29	4.62	0.43	3.87	25.45	1.29	5.59	2.37	0.86	0.49	-
735- PROVIDENCEST JOHNS HEALTHCENTER	MEDICAID	11.33	1.13	12.46	33.01	2.27	47.57	36.14	1.13	18.12	9.06	3.40	8.15	2.27
735- PROVIDENCEST JOHNS HEALTHCENTER	MEDICARE	0.65	2.26	2.43	16.87	2.10	33.31	-	4.69	22.96	19.24	2.10	-	0.49
735- PROVIDENCEST JOHNS HEALTHCENTER	OTHER	-	-	-	-	-	-	-	-	-	-	-	-	-
735- PROVIDENCEST JOHNS HEALTHCENTER	OTHER GOVERNMENT	-	-	-	-	-	-	-	-	-	-	-	-	-
735- PROVIDENCEST JOHNS HEALTHCENTER	SELF PAY	-	8.62	-	16.95	8.62	8.62	-	-	-	8.62	-	-	-
735 - PROVIDENCE ST JOHNS HEALTH CENTER Total All Payors	**1.47**	**3.58**	**2.85**	**14.85**	**1.63**	**22.64**	**25.62**	**3.26**	**15.72**	**11.73**	**1.87**	**1.59**	**0.41**	**735 - PROVIDENCE ST JOHNS HEALTH CENTER Total All Payors**

Avoidable Emergency Department Visits

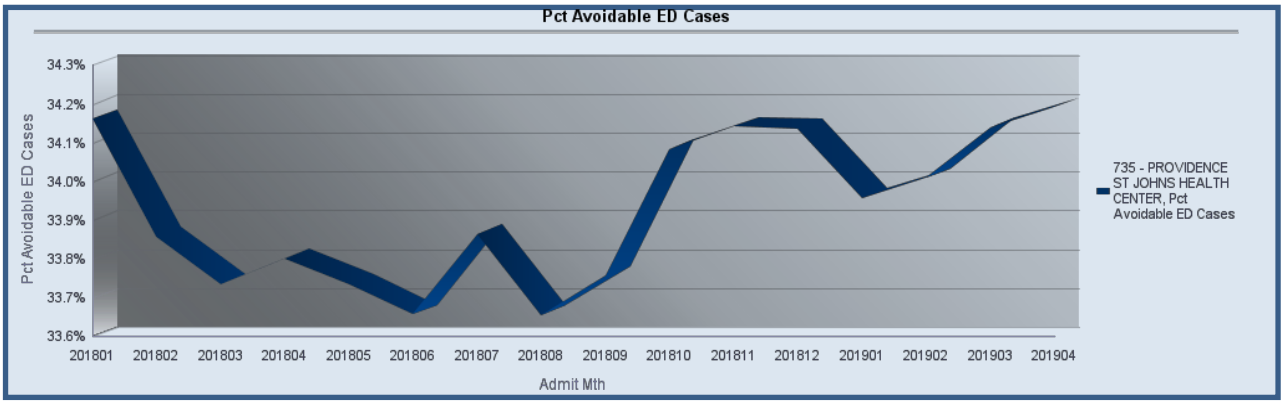
Avoidable ED visits by payor can be used as a gauge of access to care. The following data indicate that in the Providence Saint John's Emergency Department, nearly half of avoidable Emergency Department visits are made by individuals supported by Medicaid.

1 Payor Group Hyperion	idable ED Cases	t Avoidable ED Cases	otal ED Cases	oidable ED Cases
Capitation	152	333	485	31.3%
Commercial	2,295	6,170	8,465	27.1%
Medicaid	3,027	3,778	6,805	44.5%
Medicare	1,887	4,091	5,978	31.6%
Other	1		1	100.0%
Other Government	46	92	138	33.3%
Self Pay	510	784	1,294	39.4%
Grand Total	**7,918**	**15,248**	**23,166**	**34.2%**

Avoidable ED Visits Detail Tables (May 2018 - April 2019) Rolling Year Period Ending 201904

Enc Region	Pct Avoidable ED Cases	Avoidable ED Cases	Total ED Cases
Southern California - Los Angeles	37.7%	110,557	292,953

Enc Facility Desc	Pct Avoidable ED Cases	Avoidable ED Cases	Total ED Cases
710 - Providence St Joseph Medical Center	36.0%	19,887	55,245
720 - Providence Holy Cross Medical Center	40.4%	35,012	86,763
725 - Providence Tarzana Medical Center	37.9%	15,498	40,896
735 - Providence St John's Health Center	34.2%	7,921	23,167
762 - Providence Lcm Med Center Torrance	35.1%	18,178	51,860
772 - Providence Lcm Med Center San Pedro	40.1%	14,061	35,022



Pct Avoidable ED Cases	2018											
Enc Facility Desc	2018 JAN	2018 FEB	2018 MAR	2018 APR	2018 MAY	2018 JUN	2018 JUL	2018 AUG	2018 SEP	2018 OCT	2018 NOV	2018 DEC
735 - Providence St Johns Health Center	34.2%	33.9%	33.7%	33.8%	33.7%	33.7%	33.9%	33.7%	33.8%	34.1%	34.1%	34.1%

Avoidable ED Cases	2018											
Enc Facility Desc	2018 JAN	2018 FEB	2018 MAR	2018 APR	2018 MAY	2018 JUN	2018 JUL	2018 AUG	2018 SEP	2018 OCT	2018 NOV	2018 DEC
735 - Providence St Johns Health Center	7,223	7,217	7,285	7,332	7,329	7,349	7,436	7,451	7,531	7,656	7,755	7,791

Total ED Cases	2018											
Enc Facility Desc	2018 JAN	2018 FEB	2018 MAR	2018 APR	2018 MAY	2018 JUN	2018 JUL	2018 AUG	2018 SEP	2018 OCT	2018 NOV	2018 DEC
735 - Providence St Johns Health Center	21,144	21,316	21,595	21,692	21,725	21,835	21,958	22,139	22,310	22,463	22,715	22,823

Pct Avoidable ED Cases	2019			
Enc Facility Desc	2019 JAN	2019 FEB	2019 MAR	2019 APR
735 - Providence St Johns Health Center	34.0%	34.0%	34.1%	34.2%

Avoidable ED Cases	2019			
Enc Facility Desc	2019 JAN	2019 FEB	2019 MAR	2019 APR
735 - Providence St Johns Health Center	7,776	7,812	7,893	7,921

Total ED Cases	2019			
Enc Facility Desc	2019 JAN	2019 FEB	2019 MAR	2019 APR
735 - Providence St Johns Health Center	22,899	22,971	23,120	23,167

Top 20 MSDRGs, ICD-10 Sub Categorizations and ICD-10 Codes for AED Visits From May 2018 to April 2019

Rank	MSDRG Code Desc	Cases	% of Total Cases
1	897 - Alcohol/Drug Abuse Or Dependence W/O Rehabilitation Therapy W/O Mcc	722	9.1%
2	603 - Cellulitis W/O Mcc	640	8.1%
3	153 - Otitis Media & Uri W/O Mcc	634	8.0%
4	690 - Kidney & Urinary Tract Infections W/O Mcc	561	7.1%
5	203 - Bronchitis & Asthma W/O Cc/Mcc	421	5.3%
6	392 - Esophagitis, Gastroent & Misc Digest Disorders W/O Mcc	413	5.2%
7	552 - Medical Back Problems W/O Mcc	399	5.0%
8	607 - Minor Skin Disorders W/O Mcc	379	4.8%
9	103 - Headaches W/O Mcc	371	4.7%
10	149 - Disequilibrium	309	3.9%
11	885 - Psychoses	306	3.9%
12	556 - Signs & Symptoms Of Musculoskeletal System & Conn Tissue W/O Mcc	300	3.8%
13	950 - Aftercare W/O Cc/Mcc	297	3.7%
14	880 - Acute Adjustment Reaction & Psychosocial Dysfunction	278	3.5%
15	305 - Hypertension W/O Mcc	222	2.8%
16	951 - Other Factors Influencing Health Status	179	2.3%
17	125 - Other Disorders Of The Eye W/O Mcc	113	1.4%
18	195 - Simple Pneumonia & Pleurisy W/O Cc/Mcc	94	1.2%
19	881 - Depressive Neuroses	89	1.1%
20	761 - Menstrual & Other Female Reproductive System Disorders W/O Cc/Mcc	81	1.0%
	Top 20 MSDRGs Grand Total	6,808	85.9%

Rank	Principal ICD Dx Sub Categorization	Cases	% of Total Cases
1	Mental and behavioral disorders due to psychoactive substance use	773	9.8%
2	Infections of the skin and subcutaneous tissue	640	8.1%
3	Other diseases of the urinary system	507	6.4%
4	Acute upper respiratory infections	493	6.2%
5	General symptoms and signs	449	5.7%
6	Chronic lower respiratory diseases	404	5.1%
7	Other dorsopathies	378	4.8%
8	Symptoms and signs involving cognition, perception, emotional state and behavior	339	4.3%
9	Other joint disorders	313	4.0%
10	Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	287	3.6%
11	Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	229	2.9%
12	Hypertensive diseases	223	2.8%
13	Noninfective enteritis and colitis	195	2.5%
14	Symptoms and signs involving the skin and subcutaneous tissue	190	2.4%
15	Mood [affective] disorders	163	2.1%
16	Symptoms and signs involving the digestive system and abdomen	147	1.9%
17	Influenza and pneumonia	120	1.5%
18	Diseases of middle ear and mastoid	118	1.5%
19	Dermatitis and eczema	117	1.5%
20	Other acute lower respiratory infections	104	1.3%
	Top 20 ICD-10 Sub Categorizations Grand Total	6189	78.1%

Rank	Principal ICD Dx Code Desc	Cases	% of Total Cases
1	R51 - Headache	353	4.5%
2	F10.120 - Alcohol abuse with intoxication, uncomplicated	316	4.0%
3	R42 - Dizziness and giddiness	308	3.9%
4	I10 - Essential (primary) hypertension	222	2.8%
5	J06.9 - Acute upper respiratory infection, unspecified	216	2.7%
6	K52.9 - Noninfective gastroenteritis and colitis, unspecified	194	2.4%
7	J02.9 - Acute pharyngitis, unspecified	176	2.2%
7	M54.5 - Low back pain	176	2.2%
9	N39.0 - Urinary tract infection, site not specified	175	2.2%
10	N30.00 - Acute cystitis without hematuria	172	2.2%
11	J40 - Bronchitis, not specified as acute or chronic	167	2.1%
12	F41.9 - Anxiety disorder, unspecified	160	2.0%
13	R19.7 - Diarrhea, unspecified	134	1.7%
14	F10.129 - Alcohol abuse with intoxication, unspecified	103	1.3%
15	N30.01 - Acute cystitis with hematuria	102	1.3%
16	J45.901 - Unspecified asthma with (acute) exacerbation	99	1.2%
17	M54.2 - Cervicalgia	96	1.2%
18	L03.116 - Cellulitis of left lower limb	95	1.2%
19	F32.9 - Major depressive disorder, single episode, unspecified	87	1.1%
20	J20.9 - Acute bronchitis, unspecified	86	1.1%
	Top 20 ICD-10 Codes Grand Total	3437	43.4%

Appendix 3 –Additional Qualitative Data: Community Input[4]

Listening Session Participants

Location	Date and Time	Language	Number of Participants
Virginia Avenue Park	4/23/19, 6:30pm	glish with Spanish interpretation	11
Venice Family Clinic	5/15/19, 5:30pm	glish with Spanish interpretation	4
		Total Participants	**15**

Stakeholder Interview Participants and Organizations

Organization	Name	Title	Sector
Boys and Girls Clubs of Santa Monica	Ashley Metoyer	Sr. Director of Organizational Impact	Community based organization, youth programming
California Community Foundation	Rosemary Veniegas, PhD	Senior Program Officer, Health	Community based organization, social justice and advocacy
Catholic Charities of LA	Lorri Perreault	Regional Director, Our Lady of the Angels Region	National organization, homeless services
Community Clinic Association of Los Angeles County	Nina Vaccaro	Chief Operating Officer	Community based organization, health care
Didi Hirsch Mental Health Services	Kita Curry, PhD	President/ Chief Executive Officer	Community based organization, behavioral health
Jewish Family Services of Los Angeles	Eli Veitzer	President/ Chief Executive Officer	National organization, social services
L.A. Care Health Plan	Alison Klurfeld	Director, Safety Net Programs and Partnerships	Community based organization, health care coverage

Los Angeles County Department of Mental Health	Jacquelyn Wilcoxen	District Chief	Government, behavioral health
Los Angeles County Department of Public Health	Jan King, MD	Area Health Officer (SPA 5 and 6)	Government, public health
Los Angeles County Department of Public Health	John Connolly, PhD	Division Director, Substance Abuse Prevention and Control	Government, public health
Public Health, Mental Health and Health Services	Angelica Ayala	Associate Health Deputy	Government, public health
Los Angeles LGBT Center	Kari Pacheco	Co-Director of Health Services	Community based organization, social services, health, and advocacy
Los Angeles Unified School District	William Celestine	Director of Wellness Programs	School district, education
Maternal Mental Health NOW	Kelly O'Connor Kay	Executive Director	Community based organization, behavioral health
Meals on Wheels West	Chris Baca	Executive Director	National organization, food security
Saban Community Clinic	Armen Arshakyan, MD	Chief Medical Officer	Community based organization, health care
Safe Place for Youth	Alison Hurst	Founding Executive Director	Community based organization, homelessness
Santa Monica College	Michelle King	Director, Career and Contract Education	College, education
Santa Monica-Malibu Unified School District	Lora Morn	Coordinating Nurse/ Head of Student Health Services	School district, education

St. Joseph Center	Va Lecia Adams Kellum	President/ Chief Executive Officer	Community based organization, homelessness
The Achievable Foundation	Carmen Ibarra	Chief Executive Officer	Community based organization, health care
The L.A. Trust for Children's Health	Maryjane Puffer	Executive Director	Community based organization, health care and advocacy
The People Concern	John Maceri	Chief Executive Officer	Community based organization, social services
UCLA Bicycle Academy	Michael Cahn, PhD	Founder	Group, transportation
UCLA David Geffen School of Medicine	Patrick Dowling, MD	Chair, Department of Family Medicine	University, health care
UCLA/ VA Veteran Family Wellness Center	Tess Banko	Executive Director	Community based organization, health care
UniHealth Foundation	Jennifer Vanore, PhD	President/ Chief Operating Officer	Community based organization, health grantmaking
Venice Family Clinic	Anita Zamora	Chief Operations Officer	Community based organization, health care
WISE & Healthy Aging	Grace Cheng Braun	President/ Chief Executive Office	Community based organization, senior services
Workforce Development, Aging and Community Services	Cynthia Banks	Director, Community Senior Citizen Services	Community based organization, workforce development

Qualitative Data: Listening Sessions and Stakeholder Interviews Prepared for Providence Saint John's Health Center, Community Partnerships Community Health Needs Assessment 2019

Prepared by Catherine Romberger, MPH, Community Health Data Analyst, Providence St. Joseph Health

For edits or comments please email catherine.romberger@providence.org

Listening Session Findings

Virginia Avenue Park Listening Session

One listening session, with eleven participants, was conducted in English with real-time Spanish interpretation with community members at Virginia Avenue Park. The goal of the session was to better understand the health needs of the Santa Monica community, particularly how Providence Saint John's Health Center can partner with the Virginia Avenue Park to better meet those needs.

Demographics

Seven out of eleven participants chose to complete the demographics questionnaire. Of those seven participants, six primarily spoke Spanish and one spoke English. Five identified as female, all were parents, and a majority were ages 40-54 years. Six of the participants lived in the zip code 90404 and one lived in 90405.

Vision for a Healthy Community

Listening session participants were asked, "What makes a healthy community? How can you tell when your community is healthy?" Participants described their vision for a healthy community. The following themes were shared:

No one feels unheard or forgotten

Participants shared that all people should feel heard and valued in a healthy community. They specifically spoke to acknowledging and supporting undocumented individuals. Additionally, participants noted that families with low-incomes and older adults are supported and heard in a healthy community.

People are positive

Participants spoke to a general "positivity within the community members," where everyone is thriving and has the opportunity to grow.

Health care is accessible

Participants stressed the importance of accessible health care, including mental, physical, dental, and preventative care. The idea of "whole body wellness" was important, meaning people can take care of their mental and emotional health, as well as their physical health. Specifically, there should be mental health services for youth.

People can afford to live in the community

Participants noted that housing and childcare need to be affordable in the community. Particularly, there need to be resources to help families with low-incomes afford basic necessities.

There are economic and educational opportunities

Participants noted the importance of access to employment opportunities for all people. In a healthy

community, all people have financial security. Participants shared that a healthy community has good schools, as well as arts and music opportunities.

Community Issues

Participants were asked, "What are the most important issues that must be addressed to improve the health of the community?" Community members shared the issues they are most concerned about. The following themes were shared:

Lack of affordability due to high cost of housing and food

The primary concern for participants was how expensive Santa Monica is to live, including the cost of housing and the price of goods in the local stores. They noted there are too many people in Santa Monica for the available housing units, making it unaffordable. Participants said there are no affordable grocery stores nearby.

Lack of job opportunities that pay a living wage

Participants shared there is a lack of job opportunities, particularly ones that pay a living wage and are inclusive of people of color. Participants shared that because of a lack of opportunities to better their situation, "[they] remain low income." They specifically noted that these job opportunities should be within their community and individuals should not have to travel far to work.

Lack of affordable, local health services, particularly dental services

Santa Monica lacks local, affordable health care services. Participants were particularly concerned about dental care, stating that when they are referred for dental care they are often referred outside of their community. They would like more local resources, especially because public transportation makes traveling for appointments challenging.

Racism and a lack of accountability from individuals and institutions in positions of power

Participants were concerned about the racism they see within institutions, such as hospitals, and discrimination against individuals who do not speak English. Participants shared their own experiences of racism in the community and ways they have been discriminated against. Participants believe their community needs increased accountability by individuals with privilege and institutions in power, particularly related to issues of homelessness, poverty, and racism. Participants emphasized that the racism in their community "has to be changed from the top," meaning that individuals and institutions in positions of power should be responsible for making their community more inclusive of all people.

Virginia Avenue Park Strengths

Participants were asked, "In what ways does the Virginia Avenue Park help you, your family, and your community be healthy? Community members shared the strengths of the Virginia Avenue Park. The following themes were shared:

Opportunities for building community connection and relationships

All participants agreed Virginia Avenue Park is an important asset to their community and noted "the Park is the center of the community." Participants were enthusiastic about how Virginia Avenue Park has helped bring community members together and created friendships. One participant shared, "the Park is like my family."

A safe, welcoming place where people can share their cultures
Participants happily shared the ways in which Virginia Avenue Park has helped them feel safe and welcome. They shared that while there is racism in their community, they see the Park as a nice place for people of color to gather, meet other people, and share their culture. Particularly important was the fact that community members who are undocumented can still access resources for free at Virginia Avenue Park and are not excluded. One participant said, "The Park has allowed all our cultures to shine with events and groups."

Free resources and available support
Participants are very happy with the many events, such as the farmers market, that take place at Virginia Avenue Park. They are grateful for the on-site resources, such as the library for kids, and all of the information the Park shares with community members that helps them stay informed. The fact that the resources, programs, and parking are free was important to participants.

Opportunities for Growth and Improvement
Participants were asked, "What additional services or activities would you like to see added at the Virginia Avenue Park to improve wellness for you, your family, and your community?" The following themes were shared:

Address racism and disparities in the community
Participants thought Virginia Avenue Park could play a role in undoing the racism in their community and support more economic opportunities for all people.

Offer free legal advice
Participants noted they would like free legal advice available at Virginia Avenue Park.

Opportunities for Providence Saint John's Health Center to Partner with Virginia Avenue Park
Participants were asked, "How can Providence Saint John's Health Center partner with Virginia Avenue Park?" The following themes were shared:

Increase cultural relevance in cooking classes
Participants shared that while they enjoy the FEAST cooking class that Providence Saint John's Health Center hosts at Virginia Avenue Park, they thought the recipes and ingredients do not reflect their cultures. They would like to see the class be more inclusive of their cultures and the food they typically eat.

Provide on-site health services
Participants want Providence Saint John's Health Center to provide medical services and health education at Virginia Avenue Park. They suggested offering preventive health services, such as annual exams and immunizations, at the Park and offering health information at health fairs. They also thought Providence Saint John's Health Center could bring a mobile medical unit to the Park to provide local access to specialists.

Venice Family Clinic Listening Session
One listening session, with four participants, was conducted in English with real-time Spanish interpretation at Venice Family Clinic. The goal of the session was to better understand what helps and hinders people from accessing the health care services they need, particularly once they are enrolled in

health insurance.

Demographics

Of the four participants, three were primarily Spanish speaking. Three identified as female, all were parents, and all said they currently are enrolled in health insurance. Three participants were between the ages of 55 to 64 years and one was between the ages of 25 and 39. Two participants lived in the zip code 90405, one in 90025, and one in 90230.

Health Care Utilization

Participants were asked the following questions about their health care utilization: "Where do you go if you or a member of your family is sick or has an injury?" "When would you choose to go to the emergency room?" And, "Do you have a doctor you would consider your primary care provider?" Their responses were the following:

Seeking medical care

Participants shared they usually seek medical care for a sick or injured family member at a community clinic, such as Venice Family Clinic, or an emergency room.

Emergency room use

Participants usually use the emergency room in the case of a severe injury, like a skateboarding accident, or when their children are very sick and they need immediate care. They typically use the emergency room after hours when clinics are closed.

Primary care physician utilization

Some of the participants said they do have a primary care provider and prefer to receive care from them over the emergency room. They dislike seeing a new doctor every time they visit a clinic.

Barriers to seeking medical care

Participants were asked, "Have you ever decided not to get health care services when you thought you needed them? If yes, what were the reasons?" and "If you are enrolled in health insurance, such as Medi-Cal, what are some of the challenges you've had in getting the care you need?" Their responses were the following:

Long wait times for an appointment

Participants shared appointments are scheduled too far in the future. If people need care quickly for an illness or injury it is challenging to get immediate care in a community clinic.

High cost of care and the potential for unknown fees

When insurance requires a co-pay or does not cover the cost of care, participants said they may avoid seeking medical care. Additionally, they sometimes receive surprise bills in the mail after appointments that discourages them from seeking care in the future.

Confusion over health insurance benefits

Participants discussed not understanding their insurance benefits, which services are or are not covered, and where they can use their insurance. They shared they are not always sure if they are enrolled in insurance and the call wait times for assistance are too long.

Resources that Make Accessing Care Easier

Participants were asked, "What's working? What are the resources that currently make it easier for you to get the health care that you need?" and "What resources make it easier for you to understand and use your health insurance?" Their responses were the following:

Free transportation to appointments
Participants shared that Medi-Cal helps them with free rides to their appointments which they appreciate.

Case workers
The Prenatal Wellness Program at Providence Saint John's Health Center provides a case worker who gives helpful guidance.

Gaps in services

Participants were asked, "What's needed? What more could be done to help you get the health care services you need?" and "What more could be done to help people understand their health insurance after enrolling?" Their responses were the following:

Classes and one-on-one help to better understand health insurance benefits
Participants spoke to wanting someone to walk them through their health insurance benefits. They thought one-on-one guidance or classes would be beneficial. They also want someone to help them determine which health insurance is best for them and their family and offer a breakdown of the different plans.

In-person support rather than just over the phone
Participants want to be able to get help in-person instead of just over the phone about their health insurance. This may be particularly important for older adults.

Comprehensive health coverage, including dental and vision benefits
Participants spoke to wanting health care coverage that includes dental and eye care.

Longer appointment times
Participants shared the appointments usually feel short and they would like more time to discuss their concerns. They think having longer appointment options would be helpful because they do not always feel heard during quick appointments.

Limitations

Community-based organizations recruited the people they serve to participate in listening sessions and those interested and available attended. Only one listening session was conducted on each topic and the number of participants was small. Therefore, their voices do not represent the entire community and the data are not generalizable beyond the context in which it was gathered. Listening sessions were not conducted in languages other than English and Spanish.

Note-takers were recording themes and information by hand in a fast-paced environment. Therefore, they may not have been able to capture all of the information shared in the sessions. To compensate for this, three sets of notes were collected. Additionally, because the note-takers were quickly documenting the themes, their own perspectives and biases may have influenced their interpretation of certain

comments. Because of the fast-paced nature of the sessions, very few complete and reliable quotes were collected by the note-takers. Therefore, very few quotes are included in the findings. Additionally, for comments made in Spanish, some note-takers chose to translate in real-time, documenting their notes in English, while others took notes in Spanish and then were translated later. Real-time interpretation may be influenced by the note-takers' understanding of a comment or personal bias. Translation after the session may have lacked context.

Multiple facilitators were used for the listening sessions. Therefore, facilitators' emphasis on certain questions, examples given, and feedback (verbal or through body language) may have influenced the conversations.

The analysis was completed by only one analyst and is therefore subject to influence by the analyst's unique identities and experiences.

Stakeholder Interview Findings

Prioritized Health-Related Needs

Stakeholders were asked, "What are the most significant health issues or needs in the communities you serve, considering their importance and urgency?" As a follow-up, stakeholders were asked to elaborate on these needs by explaining contributing factors, groups most affected, and effective strategies for addressing these needs. The following health-related needs are ranked in order based on the number of stakeholders who identified them as a priority:

1. **Behavioral health, including mental health and substance use**

Most of the stakeholders identified behavioral health, including mental health and substance use, as an urgent need. While some stakeholders placed more importance on either the substance use or mental health components, many named both as needs and identified them as overlapping and linked. Therefore, they are presented here together. Stakeholders named a variety of contributing factors to the community's behavioral health challenges:

- Access to behavioral health care: Stakeholders spoke to a variety of factors that make accessing behavioral health care challenging. Their primary concern was the lack of free or low-cost treatment options for mental health services and substance use treatment. Additionally, there is a lack of licensed behavioral health providers on the Westside, particularly providers who accept Medi-Cal or who speak languages other than English.

- Homelessness: Stakeholders saw behavioral health and homelessness as directly related. Patients experiencing homelessness are harder to reach and require more comprehensive services to address both their housing and behavioral health needs. Without housing, many patients lack a stable environment to address their behavioral health needs. Strategies for addressing populations experiencing homelessness and with behavioral health challenges include wrap-around case management, street outreach, and addressing needs in a primary care setting.

- Integration of behavioral health care and primary care: Stakeholders saw the fragmented health care delivery system as a contributing factor to the Westside's behavioral health challenges. Funding streams and reimbursement requirements have made accessing medical care and behavioral health care two separate processes. Therefore, patients with behavioral health needs are not being connected to behavioral health care through their primary care provider.

Additionally, the lack of integration makes the system more complicated and confusing for patients. Many stakeholders identified an overlap between behavioral health needs and chronic diseases, therefore, by integrating services, providers would be able to more efficiently meet patients' needs.

- Stigma: Stakeholders shared stigma is a barrier to addressing behavioral health challenges because it makes people less likely to accept or seek services, as well as less likely to talk about mental illness and substance use. This further isolates people and causes misconceptions. Effective strategies for addressing stigma are more education so that people can better understand mental health and integration of behavioral health care and medical care so that behavioral health is normalized as a part of health care.

Stakeholders identified several populations that are most affected by behavioral health challenges:

- Young people: Stakeholders shared young people may not be able to access the mental health services they need. Additionally, they were concerned about increased vaping and exposure to marijuana.

- People experiencing homelessness and people with low-incomes: Stakeholders identified that people with low-incomes and people experiencing homelessness may have a harder time accessing mental health and substance use services.

- Older adults: Stakeholders shared that older adults, particularly those who have low-incomes may have more challenges accessing behavioral health care. Social isolation, poverty, and chronic conditions may contribute to their behavioral health needs.

Common themes for effective strategies to address behavioral health challenges include the following:

- Integrate behavioral health care and primary care: As stated above, stakeholders identified integration of behavioral health care and primary care as the most effective strategy for addressing behavioral health needs in the community. Doing so decreases stigma, normalizes behavioral health care as part of a person's wellbeing, and improves access to care.

- Increase community education and awareness around mental health and substance use: Stakeholders shared that because of stigma people do not always talk about mental health challenges. Therefore, increasing education around the signs of suicide and giving people language to talk about mental health is important for reducing stigma and increasing attention to the need. Additionally, education around the risks of substance use, particularly for young people, is an important step in preventing substance use disorder and substance use related injury and death.

- Implement targeted outreach to groups needing services: To improve access to behavioral health care, stakeholders thought meeting people where they are is an important strategy. They noted including a mental health specialist on street outreach teams is important, as well as making home visits to homebound older adults. A crucial component to this outreach is ensuring that those people doing the outreach can reach non-English speakers and are culturally diverse.

2. Homelessness and housing instability

Stakeholders shared that having a safe, stable place to live is foundational to a person's wellbeing. Therefore, addressing homelessness and housing instability is an urgent need. Stakeholders shared the following factors that contribute to homelessness and housing instability:

- Behavioral health challenges: Stakeholders saw substance use and mental illness as strong contributors to homelessness on the Westside. Behavioral health challenges make accessing stable housing and employment more difficult, contributing to poverty. They shared that homelessness can makes behavioral health challenges worse and behavioral health challenges can make ending homelessness harder.

- Lack of affordable housing options and NIMBYism: Stakeholders shared the cost of housing on the Westside is too expensive. There are not enough affordable housing options. Even if people receive Section 8 housing vouchers, there are not apartments that will accept the voucher. This leads to people needing to move to more affordable areas, further from their work, leading to transportation challenges and stress. Additionally, finding locations to build affordable housing is challenging because of the NIMBY (not in my backyard) attitude.

- Economic insecurity and a lack of living wage jobs: The amount people are able to make in their jobs is not enough to meet the high cost of living on the Westside. Lack of a living wage, combined with high cost of living keeps people in poverty, contributing to income inequality.

Stakeholders identified several populations that are most affected by homelessness and housing instability:

- People with low-incomes: Stakeholders shared that people with low-incomes are more likely to be economically insecure. Financial setbacks or unexpected expenses can make them unable to pay their rent.

- Older adults: Stakeholders expressed a concern for the seemingly increasing number of older adults experiencing housing insecurity and homelessness. Older adults may not be able to afford the increasing housing costs, have high medical costs, or be living in a place that is not safe for them but unable to move.

- Young people: Stakeholders noted that young people, particularly transitional age youth, are often lacking sufficient support services. There is a gap in services for young people leaving foster care and shelters for youth. Youth experiencing homelessness may be harder to identify if they are couch surfing or sleeping in their car.

- People of color: Stakeholders shared people of color experience racism and discrimination which contribute to economic insecurity and poorer mental health, which are connected with homelessness and housing insecurity.

Effective strategies to address homelessness and housing instability shared by stakeholders include the following:

- Build affordable housing: Stakeholders shared an important step in addressing homelessness is increasing the availability of affordable housing, including permanent supportive housing. With

Measure H and Proposition HHH, new streams of funding are helping to improve the availability of housing.

- Increase access to job training programs: Job training programs are important for people to obtain better paying jobs, increase economic insecurity, reduce poverty, and prevent homelessness.

- Provide multi-disciplinary support teams for people experiencing homelessness: Stakeholders shared homelessness is a complicated issue that often intersects with other issues. Therefore, to address the needs of people experiencing homelessness, clients should be supported by people with varying specialties, such as a case manager, mental health professional, etc. In this way, multiple support people can work together to better address these intersecting needs.

3. Chronic diseases, including diabetes, obesity, heart disease, hypertension, HIV, asthma, cancer, stroke, and liver disease

While participants were asked about diabetes, obesity, heart disease, hypertension, asthma, cancer, stroke, HIV, and liver disease, stakeholders primarily discussed diabetes, obesity, and heart disease. HIV is included in the section regarding sexually transmitted infections. Stakeholders particularly focused on the connection between obesity and diabetes and healthy habits. Stakeholders named a variety of contributing factors to the community's chronic disease challenges:

- Lack of access to health care services: Stakeholders shared that barriers to accessing health care services, such as long wait times, cost of care, and complexity navigating the health care system, make managing chronic diseases challenging.

- Homelessness: Without a stable place to live, managing chronic diseases, taking medications in a timely manner, and maintaining healthy habits is more challenging.

- Poverty and food insecurity: Especially related to diabetes and obesity, people who do not have access to or are unable to afford good quality, nutritious foods are more likely to eat unhealthy foods, leading to obesity and diabetes.

- Unhealthy behaviors: Children in particular may be less likely to play outdoors or exercise leading to obesity and diabetes. Unsafe neighborhoods, violence, lack of affordable organized physical activity programs, unsafe sidewalks, and increased use of technology could all contribute to these unhealthy behaviors.

Stakeholders identified several populations that are most affected by chronic diseases:

- Young people: Participants were particularly concerned about increasing rates of diabetes and obesity in young people and the potential long-term effect on health.

- People with low-incomes and/or experiencing homelessness: For people with low-incomes it can be difficult to afford healthy food and necessary medications to manage chronic diseases. Additionally, people experiencing homelessness may need to prioritize other needs, such as finding a place to sleep or staying safe, over managing their disease.

Stakeholders spoke to the importance of addressing other social determinants of health, such as access to health care, stable housing, community safety, and food security, to improve chronic diseases. By addressing these other health needs, people would be better able to get the health care they need, improve their eating and exercising habits, and manage their chronic diseases. To address obesity and diabetes in young people, stakeholders noted providing healthy food for school meals and increasing physical activity time as important strategies.

4. Access to health care

Stakeholders identified improved access to care as a need on the Westside. Stakeholders emphasized that addressing access to care challenges needs to involve ensuring care is coordinated, culturally responsive, and high-quality. Stakeholders named a variety of contributing factors to the community's access to health care challenges:

- Inefficient public transportation: Participants shared many of the people they serve take the bus to access services. Because of how widespread Los Angeles is, people may need to devote a lot of time to getting to their health care appointments, which is challenging for people who are working or those without cars. Additionally, if a patient has to travel long distances for a specialist or affordable care, transportation may be an even greater issue.

- High cost of care and lack of knowledge about support resources: Patients, particularly those who are uninsured, may not be able to get the care they need because of the cost. While there are some affordable health care options, patients may not know about these resources or be able to travel to those affordable services.

- Fear related to immigration status and cultural/language barriers: Stakeholders shared patients may avoid seeking medical services because of increased fear regarding immigration status. Additionally, cultural and language barriers can make navigating the health care system more challenging.

- Long wait times and not enough providers: Stakeholders explained that there are not enough providers to serve all of the people in Los Angeles, leading to long wait times for appointments. This is particularly true for appointments with specialists and providers who accept Medi-Cal.

- Lack of coordination in the health care system: Because there is little coordination among health care systems, people have to navigate multiple providers on their own.

While different populations may experience different barriers to accessing the health care services they need, stakeholders identified a few populations that may especially face challenges with access to care:

- Immigrants, particularly undocumented immigrants, and people who do not speak English: People who are unfamiliar with navigating the health care system or who do not speak English may not know of the resources available to them. Fear due to the current political climate has discouraged undocumented immigrants from seeking services.

- People without insurance: Patients without insurance may not seek medical services because of the cost of care.

- People with low-incomes: People with low-incomes may not be able to afford medical care, even with insurance. Additionally, they may not have access to a car, making transportation to appointments a barrier.

Stakeholders shared the following strategy for addressing access to health care challenges:

- Better care coordination and patient support: To help people know about the resources they qualify for and to help patients navigate the complexity of the health care system, stakeholders suggested using community health workers. This strategy could help address transportation, insurance, cultural, and language barriers.

5. Economic insecurity

Stakeholders agreed that there are two main causes of economic insecurity on the Westside: lack of jobs that pay a living wage and the high cost of living. Stakeholders explained the amount of money people get paid in their jobs is not sufficient to cover rent, food, medical bills, etc. Therefore, people are forced to make hard decisions around how they spend their money. This high cost of living coupled with low-incomes leads to economic insecurity. Economic insecurity leads to homelessness/housing instability, food insecurity, and challenges paying for medical services.
Economic insecurity affects many people, particularly individuals and families with low-incomes, but some of the groups identified by stakeholders are the following:

- People of color
- People re-entering the work force who were formerly incarcerated
- Older adults

Stakeholders shared the following strategies for addressing economic insecurity:

- Increase job training and skill building programs for young people: Stakeholders suggested investing in young people, particularly those from families with low-incomes, to provide the support and training to help them gain skills for better paying jobs.

- Increase affordable housing options and improve home ownership opportunities: Stakeholders noted the cost of housing on the Westside is so high that families are unable to afford other necessities. Therefore, increasing affordable housing options or helping families own a home would reduce their economic insecurity.

6. Oral health care

Stakeholders shared the number of affordable dental providers is insufficient to serve the people living on the Westside. Stakeholders shared the following themes related to the factors that contribute to oral health care being a need:

- Lack of affordable dental care and providers who accept Denti-Cal: While Medi-Cal offers dental care for low-income adults, called Denti-Cal, many dental providers do not accept this insurance and the scope of services covered is limited. Therefore, many adults with low-incomes experience barriers accessing affordable dental care.

- Lack of knowledge of the importance of preventive dental care: Stakeholders shared the people they serve are often unaware of the connection between oral health and the rest of their body.

Therefore, there is a need for more education for adults and starting good oral health habits for children.

Stakeholders named the following populations as particularly needing improved dental care:

- Adults who are uninsured or on Denti-Cal: There is a lack of affordable dental care and providers who accept Denti-Cal. Therefore, adults who are uninsured or on Denti-Cal have a harder time accessing and affording the care they need.

- Veterans: The VA system only covers dental services tied to an injury while serving, therefore, veterans may not be able to access the preventive dental care they need.

To address the oral health needs of the Westside, stakeholders shared the following strategies:

- Implement universal dental screening programs in schools: Stakeholders have seen success with implementing universal screenings for oral health in schools. This provides an opportunity to educate families on the importance of dental care.

- Increase the number of low-cost dental providers: Some Federally Qualified Health Centers offer dental services, but some do not. Expanding the number of providers who accept Denti-Cal and offering services for patients who are uninsured would improve access.

Other Health-Related Needs

Stakeholders were asked to discuss major barriers or challenges related to the needs listed above as well as the following needs: community safety, food insecurity, preventive practices, sexually transmitted infections, and transportation. The following paragraphs share the dominant themes related to each of the needs not already discussed:

Community Safety

Stakeholders shared the importance of people feeling safe in their community. They named a few contributing factors to a lack of community safety:

- Gun violence and gangs
- Untreated mental illness and substance use
- Crime

Improved community safety is particularly needed for people who identify as LGBTQ who may experience violence and discrimination based on their identity.

Stakeholders shared the following strategies for improving community safety:

- Address behavioral health challenges
- Partner with police departments to discuss ways to address gun violence, gangs, and crime

Additionally, stakeholders noted when people feel safe they are more likely to be outside playing and exercising. Improving community safety is important for improving chronic diseases, particularly obesity and diabetes. It is also important for improving people's levels of stress, which could contribute to improved mental wellbeing.

Food insecurity

Stakeholders discussed how food insecurity is linked to many other health-related needs, such as housing and economic insecurity. Stakeholders identified a few main contributing factors to food insecurity:

- Increased access to unhealthy foods and decreased access to good quality, nutritious foods in low-income neighborhoods: Stakeholders shared there are typically more fast food restaurants located in low-income neighborhoods. On the other hand, there may be fewer grocery stores, and the quality of the fruits and vegetables are typically worse.

- Economic insecurity: Low-incomes, coupled with high cost of housing means that families do not have as much money available to buy healthy foods. Stakeholders shared that by the end of the month many families are seeking assistance to cover their bills. While there might be farmers markets in these neighborhoods, the produce is typically more expensive.

- Immigration and fear: The Supplemental Nutrition Assistance Program (SNAP) program, also known as CalFresh, helps families cover the cost of food, but some families with undocumented members choose not to sign up for benefits because of fear related to immigration and public charge. Stakeholders noted that the current political climate has made signing people up for food benefits more difficult.

Stakeholders named the following populations as particularly affected by food insecurity:

- People with low-incomes: With the high cost of living on the Westside, people with low-incomes may not be able to afford high-quality, nutritious food.

- Undocumented immigrants: The current political climate has created fear related to immigration. Some undocumented immigrants may not apply for food assistance programs because of new public charge laws.

- Older adults: Stakeholders shared older adults may have a harder time accessing nutritious, good quality food because they have difficulty leaving the house, are unable to drive, or cannot afford food.

The following strategies improve access to nutritious, good quality food:

- Improve nutrition standards for school meals: Stakeholders shared offering healthy free and reduced cost breakfasts and lunches in schools ensures children get healthy meals each day. Specifically important is not just providing food to children, but setting high nutritional standards for the food.

Preventive practices

Stakeholders spoke to the need for more preventive practices to reduce the number of people who have chronic diseases, sexually transmitted infections (STIs), dental problems, and substance use disorder. They shared that without good preventive services, more people are going to develop illnesses and health issues, which can become costly and complicated quickly. Stakeholders discussed several barriers to sufficient preventive practices on the Westside:

- Funding: Not enough money is being dedicated to preventing health problems and the money that is being given is not integrated well with the larger health care system. Therefore, investing

more money in education and resources to prevent diabetes, obesity, STIs, and dental problems is important.

- Awareness of available support resources and lack of health education: People need more health education and more knowledge of the resources available to keep them healthy. Stakeholders shared there needs to be more information about the importance of dental care, more sex education related to STI prevention, and more resources around nutrition and exercise. They also shared there needs to be more education in the community regarding the risk of drug use, specifically aimed at young people.

- Challenges accessing primary care services: Lack of preventive practices and challenges accessing health care are linked. When people cannot access care, they also end up not accessing preventive services. Therefore, addressing challenges to access to care is beneficial to improving preventive practices.

Sexually transmitted infections

Stakeholders discussed the increasing rate of sexually transmitted infections (STIs) on the Westside. In general, they thought increased access to PrEP (Pre-Exposure Prophylaxis), used to prevent HIV, has reduced the number of people getting HIV, but may contribute to increasing rates of STIs due to decreased condom use. Stakeholders mentioned several challenges to addressing STIs:

- Funding: Stakeholders agreed there is not enough funding for STI testing and treatment.
- Lack of health education and outreach to groups more at risk: With reduced funding, there is a lack of sex education in schools. Stakeholders shared there is a need for improved education and targeted outreach to populations that may be more at risk for STIs. Sex education specifically needs to be more inclusive of people with disabilities and special needs, as well as people identifying as LGBTQ.

Stakeholders shared young people, particularly those who identify as LGBTQ, are more at risk for STIs. One strategy to address this disparity is to provide school-based health care and dedicated time in a clinic just for teens. Other strategies include providing free condoms, improving sex education in schools, and using peer educators.

Transportation

Stakeholders saw transportation as a contributing factor to many of the health-related needs already discussed, especially access to care and food security. Because of the high cost of housing in the Los Angeles area, people may be forced to live farther away from where they work, increasing the importance of an efficient public transportation system. They shared the following challenges:

- Fragmented and insufficient public transportation system: Stakeholders thought the public transportation system takes too long and is generally fragmented. Many people need to take two or three buses to get to work or their doctor's office. In particular, getting to specialists' offices can be challenging.

- High cost of public transportation: For people with low-incomes especially, the cost of the public transportation system can be a barrier.

An inefficient and fragmented public transportation system means people have a harder time getting to the grocery store and more challenges accessing healthy food. Additionally, with more time commuting,

people have less time with their families and available to cook healthy meals. Stakeholders identified people with low-incomes as more affected by transportation challenges because they may be more dependent on public transportation.
Stakeholders shared the following strategies for addressing transportation challenges:

- Offer free bus tickets or rides to appointments: Stakeholders shared that providing free public transportation vouchers or free rides through Lyft or Uber for medical appointments improves access to care.

Gaps in Services

Stakeholders were asked "What health or social services are most challenging to access or are missing in the community and why?" The dominant themes shared were the following:

- Behavioral health services: Stakeholders identified affordable mental health and substance use services as the main gap in services in their community. They said there need to be more school-based mental health providers and providers who serve patients on Medi-Cal and who are uninsured.

- Health education: Stakeholders identified a general lack of health education in their community to help improve people's health literacy. They shared there are not enough programs to educate people on managing their chronic diseases, oral health, STIs, and the risks of substance use.

- Affordable housing: Stakeholders shared there is a lack of affordable housing and challenges finding locations to build more.

- Dental services: There is a lack of affordable dental providers, especially those who accept Denti-Cal and a lack of education about the importance of oral health.

Opportunities to Work Together

A common theme throughout the interviews was the lack of communication and coordination between different systems despite how linked all of these needs are. Stakeholders want to see more collaboration between organizations and sectors. The dominant themes for opportunities to work together were the following:

- Improved coordination between health care and social service organizations: Multiple stakeholders discussed the importance of health care and social service organizations collaborating on care, particularly for patients experiencing homelessness or with complex health needs. They discussed implementing improved discharge planning and putting patient navigators or social workers in the Emergency Department (ED) to better connect patients to housing, social services, and follow-up care.

- Improved coordination between hospitals: Stakeholders spoke to the need for better communication between health care providers and improved sharing of health records between hospitals. They described the current system as fragmented and confusing. This would improve continuity of care, especially for patients who frequently use the ED.

Limitations

While stakeholders were intentionally recruited from a variety of types of organizations, there may be

some selection bias as to who was selected as a stakeholder.

The stakeholder interviews were not recorded. Therefore, direct quotes were not included. Note-takers recorded comments in a fast-paced environment. Therefore, they may not have been able to capture all of the information shared in the interviews.

Multiple facilitators were used for the stakeholder interviews. Therefore, facilitators' emphasis on certain questions, examples given, and feedback (verbal or through body language) may have influenced the conversations.

The analysis was completed by only one analyst and is therefore subject to influence by the analyst's unique identities and experiences.

Key Takeaways

The following graphic shares the key takeaways from the three qualitative data sources:

Virginia Avenue Park: Health needs and opportunities for partnership

- **Community issues:**
  - Lack of affordability due to high cost of housing and food
  - Lack of job opportunities that offer a living wage
  - Lack of affordable, local health services, particularly dental services for adults
  - Racism and a lack of accountability from individuals and institutions in positions of power
- **Opportunities for Saint John's Health Center to partner with Virginia Avenue Park**
  - Increase cultural relevance in cooking classes
  - Provide on-site health services, particularly specialty care

Venice Family Clinic: Access to health care

- **Barriers to seeking medical care:**
  - Long wait times for an appointment
  - High cost of care and the potential for unknown fees
  - Confusion over health insurance benefits
- **Gaps in services:**
  - Classes and one-on-one help to better understand health insurance benefits
  - In-person support rather than just over the phone
  - Comprehensive health coverage, including dental and vision benefits
  - Longer appointment times

Stakeholder Interviews

- **Health-related needs listed in order of prioritization:**
  - Behavioral health, including mental health and substance use
  - Homelessness and housing instability
  - Chronic diseases, in particular diabetes, obesity, and heart disease
  - Access to health care
  - Economic insecurity
  - Oral health care
- **Gaps in services:**
  - Behavioral health services, including affordable mental health and substance use services
  - Health education related to managing chronic diseases, oral health, STIs, and substance use
  - Affordable housing
  - Dental services, particularly for adults on Denti-Cal

Protocols

Virginia Avenue Park Script

INSTRODUCTORY ACTIVITY

I'd like to start this conversation by hearing your descriptions of your communities because I know that we all have different ways of thinking about our communities and all of those ideas at valid. Community can include family or neighbors, or maybe it includes coworkers or friends. It can be where we live, work, or pass time. Let's go around the table and please share your first name and a brief description of your community.

Facilitator introduces self, models sharing description.

Then everyone goes in a circle, introducing self and saying a few words about their community.

Thank you all for sharing. That leads into what we're going to talk about next: the health of your community.

CONTEXT

What we were hoping to talk about today is: **What are the health needs of your community and how can the Virginia Avenue Park better meet those needs*?***

We're going to start by talking about the health of the community. Then we'll talk about how the Virginia Avenue Park helps make the community healthier and ways that the Park could improve. The information from this session could be used to inform what types of classes to keep or add more of?

PURPOSE 1. VISION. Now take a minute to think about your community. **How can you tell when your community is healthy?**

Instructions: write ideas on the poster

PURPOSE 2. NEEDS. So we've talked about what a healthy community looks like. Now let's talk about the health related needs in your community.

What are the most important issues that must be addressed to improve the health of your community?

Probe if needed:

- *Tell me more about the mental and emotional needs of your community.*
- *Tell me more about the needs related to nutrition and physical activity. Instructions: write ideas on the poster*

PURPOSE 3. BENEFITS. Thank you for sharing the most important issues in your community. Let's explore how the Virginia Avenue Park addresses those needs.

In what ways does the Virginia Avenue Park help you, your family, and your community be healthy?

Probe if needed:

- *Does the Virginia Avenue Park address the mental and emotional health needs of thecommunity?*

- *Does the Virginia Avenue Park help people in the community be more connected and less isolated?*
- *Does the Virginia Avenue Park address the nutrition and physical activity needs of the community?*

Instructions: write ideas on the poster.

PURPOSE 4. OPPORTUNITIES. We want to ensure the services at the Virginia Avenue Park meet the needs of the community. We are always open to suggestions for classes to add or change.

What additional services or activities would you like to see added at the Virginia Avenue Park to improve wellness for you, your family, and your community?

Probe if needed: What kinds of classes do you want to see added? Instructions: write ideas on the poster.

CLOSING. Thank you all for sharing your thoughts and opinions with the group today. All of this information is really helpful. Before we finish, **is there anything else related to the topics we discussed today that you think I should know that I haven't asked or that you haven't shared?**

WRAP-UP: Thank participants for coming, describe any next steps. Make sure folks signed in for an appropriate count, and distribute gift cards/incentives as they leave.

Venice Family Clinic Script

INTRODUCTORY ACTIVITY

I'd like to start this conversation by hearing your descriptions of your communities because I know that we all have different ways of thinking about our communities and all of those ideas at valid. Community can include family or neighbors, or maybe it includes co-workers or friends. It can be where we live, work, or pass time. Let's go around the table and please share your first name and a brief description of your community.

Facilitator introduces self, models sharing description.

Then everyone goes in a circle, introducing self and saying a few words about their community

Thank you all for sharing. That leads into what we're going to talk about next: the health of your community.

CONTEXT

What we were hoping to talk about today is: ***How do you and your family get the health care services you need?***

This is a really big question and we're going to talk through it step by step. We're going to talk about how you access health care services, so where you go to get medical attention and when. We'll also talk about what makes it easier and harder to get those services that you need.

PURPOSE 1. UTILIZATION. We're going to first talk about where and when you seek health care services. **Where do you go if you or a member of your family is sick or has an injury?**

Instructions: write ideas on the poster.

One of the locations mentioned was the emergency room [OR I didn't hear anyone mention the emergency room]. **When would you choose to go to the emergency room?**

Probe if needed: What are the reasons you would choose to go to the emergency room over a doctor's office or urgent care facility?

Instructions: write ideas on the poster.

Some of you mentioned going to a clinic. **Do you have a doctor you would consider your primary care provider? Why or why not?**

PURPOSE 2. BARRIERS. So we've talked about where you go to receive health care services. Now let's talk about what makes it harder for you to get the services you need.

Have you ever decided not to get health care services when you thought you needed them? If yes, what were the reasons?

Probe if needed: Do you have enough time to seek health care services?

Instructions: write ideas on the poster.

Here we have a list of the reasons why you all have decided not to get health care services. You mentioned the following reasons: [reference list from previous question.] **If you are enrolled in health insurance, such as Medi-Cal, what are some of the challenges you've had in getting the care you need?**

Instructions: write ideas on the poster.

PURPOSE 3. ASSETS. So you've told us about where you go for health services and what makes it harder to get the care you need. Let's explore what makes it easier for you to get health care services.

What's working? What are the resources that currently make it easier for you to get the health care that you need?

Probe if needed: Are there places/people/programs that help you get the care you need? Instructions: write ideas on the poster.

What resources made it easier for you to understand and use your health insurance?

Probe if needed: Was the information packet you received with your health insurance helpful?

Instructions: write ideas on poster.

PURPOSE 4. NEEDS. Now that we know what makes it easier and harder for you to get the health care services that you need, let's talk about what you need more of.

What's needed? What more could be done to help get the health care services you need?

Instructions: write ideas on the poster.

We also want to make sure everyone has the help they need to use their health insurance benefits. **What more could be done to help people understand their health insurance after enrolling?**

Instructions: write ideas on the poster.

CLOSING. Thank you all for sharing your thoughts and opinions with the group today. All of this

information is really helpful. Before we finish, **is there anything else related to the topics we discussed today that you think I should know that I haven't asked or that you haven't shared?**

WRAP-UP: Thank participants for coming, describe any next steps. Make sure folks signed in for an appropriate count, and distribute gift cards/incentives as they leave.

Stakeholder Interview Facilitator Guide

INTRODUCTION

Cedars-Sinai (Cedars-Sinai Medical Center and Marina Del Rey Hospital), Kaiser Permanente West Los Angeles Medical Center, Providence Saint John's Health Center, and UCLA

Health (Ronald Reagan UCLA Medical Center; UCLA Medical Center, Santa Monica; and Resnick Neuropsychiatric Hospital at UCLA) are working in partnership to conduct a Community Health Needs Assessment as required by state and federal regulations. The Community Health Needs Assessment identifies and assesses the health needs of the communities served by the hospitals.

Participation in this interview is voluntary and you have the right to not answer questions. Your name and organizational affiliation will be listed in the needs assessment. But I want to assure you that the information you provide will be kept confidential and your responses will not be linked to you personally.

The interview will last approximately one hour. By agreeing to go ahead with the interview, you are indicating your consent to respond to the following questions.

The shared service area for the hospitals is focused on West Los Angeles, Central Los Angeles and South Central Los Angeles. The service area includes large portions of LA County Service Planning Areas 4, 5 and 6. [Note: interviewer will have the service area lists.]

1. What are the most significant health issues or needs in the communities you serve, considering their importance and urgency?
2. What factors or conditions cause or contribute to these health needs? (social, cultural, behavioral, environmental or medical)
3. Who or what groups, in the community, are most affected by these needs? (e.g., youth, older residents, racial/ethnic groups, specific neighborhoods
4. What do you think are effective strategies or actions for addressing these needs?

As part of the Community Health Needs Assessment process, we have reviewed health data and information and identified some significant health needs in the community. In preparation for this interview, I sent you a survey link that lists these needs and asks you to prioritize them.

I am going to review the list of identified health needs and would like you to discuss your perspective on the issues surrounding each of the needs, and what you consider to be the challenges and barriers people face in addressing these health needs.

In addition, as understanding the resources available to address health needs is an important part of the

needs assessment process, I'd also like you to identify the available services, programs and community efforts, you are aware, to address each of the health needs.

Health Need	**Issues/Challenges/Barriers** What are some major barriers or challenges to addressing these needs?
Access to care	
Chronic diseases (asthma, cancer, diabetes, heart disease, stroke, HIV, liver disease)	
Community safety	
Dental care	
Economic insecurity	
Food insecurity	
Housing/homelessness	
Mental health care	
Overweight and obesity (healthy eating and physical activity)	
Preventive practices	
Sexually Transmitted Infections	
Substance abuse	
Transportation	

Health Need	**Resources: Services, Programs and/or Community Efforts** Where do community residents go to receive help or obtain information for this health need?
Access to care	
Chronic diseases (asthma, cancer, diabetes, heart disease, stroke, HIV, liver disease)	
Community safety	
Dental care	
Economic insecurity	

Food insecurity	
Housing/homelessness	
Mental health care	
Overweight and obesity (healthy eating and physical activity)	
Preventive practices	
Sexually Transmitted Infections	
Substance abuse	
Transportation	

5. What health or social services are most challenging to access or are missing in the community and why? [DO NOT SAY ALOUD: This could include access to medical care that is affordable or free, health education workshops, dental care, vision care, substance abuse services, mental health care, etc. Are there socio-economic, behavioral, environmental or clinical factors that contribute to this? Does this affect certain sub- populations more than others?]
6. What are the potential areas for collaboration or coordination among hospitals, community organizations, and/or businesses (i.e. health or social providers, local government, etc.) to address community health needs or specific socio-economic, behavioral, environmental or clinical factors?
7. What else is important for us to know about significant health needs in the community?

Your responses have been very helpful. Thank you for your time.

Appendix 4: Available Resources to Address Identified Needs

Community Assets including Existing Health CareFacilities, Organized by Health Need

Health-Related Need	Resources: Services, Programs and/or Community Efforts
Access to care	AIDS Project LA Arthritis Foundation Asian Americans Advancing Justice Asian Pacific Policy and Planning Council Black Women for Wellness California Endowment California Pan-Ethnic Health Network Care Harbor Los Angeles Children's Institute, Inc. Community Clinic Association of Los Angeles County Eisner Health First 5 Los Angeles Health Access California Health Care Partners Healthy Start Program in Los Angeles Unified School District Hope Street Family Center Irma Colen Health Center Kaiser Permanente Kedren Community Health Center Korean American Family Services Korean American Special Education Center Korean Health, Education, Information and Research Center Korean Resource Center Koreatown Youth + Community Center LA Best Babies Network LA Care Health Plan LA Care's Family Resources Centers LA Department of Health Services Latino Coalition for a Healthy California Legal Aid Foundation of LA Los Angeles Department of Public Social Services Los Angeles LGBT Center Maternal and Child Health Access Maternal Mental Health NOW Milken Family Foundation Medical Building North Westwood Neighborhood Council Northeast Valley Health Corporation Partners in Care Foundation Planned Parenthood Los Angeles Prevention Institute Providence Saint John's Health Center

	Saban Community Clinic Simms/Mann Health and Wellness Center St. John's Well Child and Family Center The Children's Partnership UCLA Healthy Campus Initiative UCLA Operation MEND Valley Care Community Consortium Venice Family Clinic Veterans Affairs Watts Healthcare Watts Learning Center Watts Neighborhood Council West Valley Mental Health Center Westside Collaborative Westside Family Health Center Westside Family Health Center
Chronic diseases (asthma, cancer, diabetes, heart disease, stroke, HIV, liver disease)	American Cancer Center Kaiser Permanente LA Care Health Plan Marina Del Rey Hospital Providence Saint John's Health Center Venice Family Clinic Westside Family Health Center Wise & Healthy Aging
Community safety	Asian Pacific Islander Domestic Violence Taskforce Asian Pacific Islander Human Trafficking Taskforce Bridge to Home Culver City Police Department Los Angeles County Department of Children and Family Services Los Angeles Police Department Parks After Dark Safe Place for Youth Santa Monica Cradle to Career Santa Monica Police Department VA Response Team (unsure what this is) Watts Gang Taskforce
Dental care	Center for Oral Health Dentex Dental Los Angeles Chargers TeamSmile Saban Community Clinic St. John's Well Child Clinic UCLA Dental Program UCLA Dental Program on VA Campus UCLA Mobile Dental Program Venice Family Clinic
Economic insecurity	Archdiocesan Youth Employment Services of Catholic Charities of Los Angeles, Inc. Bet Tzedek Legal Services

	Brotherhood Crusade Chrysalis Foundation for Women Warriors Homeboy Industries Hope for LA Public Counsel Safe Place for Youth St. Joseph Center UNITE-LA WorkSource
Food insecurity	AIDS Project LA CalFresh Catholic Charities of LA Community Health Councils Food Forward Harvest Table Jewish Family Service of Los Angeles Kaiser Permanente Los Angeles Coalition to End Hunger and Homelessness Los Angeles Food Policy Council Los Angeles Regional Food Bank Meals on Wheels Oriental Mission Church Project Angel Food St. Joseph Center St. Margaret's Center, Inglewood Westside Food Bank
Housing/homelessness	Catholic Charities of LA Community Corporation of Santa Monica Eisner Pediatric & Family Medical Center Harvest Home Homeless programs on VA campus Housing Works Los Angeles Homeless Services Authority People Assisting the Homeless Safe Place for Youth SHARE! St. Joseph Center Step up on Second The Housing Authority of the City of Los Angeles The People Concern Upward Bound House Venice Community Housing Venice Family Clinic Venice Forward Volunteers of America Westside Homeless Shelter
Mental health care	Active Minds UCLA

	Didi Hirsch Mental Health Services Edelman Westside Mental Health Center Exceptional Children's Foundation Exodus Recovery Family Service of Santa Monica Give an Hour Headspace Los Angeles Department of Mental Health Mental Health Hotlines National Alliance on Mental Illness Pacific Clinics Providence Saint John's Child and Family Development Center Special Service for Groups St. Joseph Center Suicide Prevention Lifeline Teen Line The National Child Traumatic Stress Network The Soldiers Project Veteran's Crisis Line
Overweight and obesity (healthy eating and physical activity)	Boys and Girls Clubs of America CicLAvia GoNoodle Grand Masters Cycling Kaiser Permanente LA County Department of Public Health Los Angeles County Bicycle Coalition Los Angeles County Bike Coalition Parks and Recreation Programs Providence Saint John's Health Center Community Partnership Program Summer Night Lights UCLA Bicycle Academy Velo Club LaGrange Venice Family Clinic YMCA
Preventive practices	Boys & Girls Clubs of Santa Monica Cedars-Sinai HealthCare Partners Kaiser Permanente St. Joseph Center UCLA Venice Family Clinic Watts Healthcare Whole Health for Life Program at the VA
Sexually Transmitted Infections	AIDS Healthcare Foundation AIDS Project Los Angeles Common Ground Los Angeles County Department of Public Health Planned Parenthood Los Angeles

	Safe Place for Youth UCLA Health USC Venice Family Clinic Westside Family Health Center Westside Family Health Center
Substance abuse	Alliance for Housing and Healing Asian American Drug Abuse Program Asian Pacific Counseling and Treatment Center CLARE/ MATRIX Didi Hirsch Mental Health Services McIntyre House Phoenix House Safe Refuge Self-Help and Recovery Exchange (SHARE!) St. Joseph Center Substance Abuse Service Helpline Substance abuse treatment programs at the VA Tarzana Treatment Centers
Transportation	Access Transportation Services Big Blue Bus of Santa Monica Bird Electric Scooters FAME Corporations International Institute of Los Angeles LA Metro Uber

Existing Health Care Facilities in the Community to Address Significant Health Needs

Providence Saint John's Health Center and partners cannot address the significant community health needs independently. Improving community health requires collaboration across community stakeholders. Below outlines a list of community resources potentially available to address identified community needs

Organization or Program	Description	Associated Community Need
Venice Family Clinic	Federally qualified health center providing medical services to the low-income, Medi-Cal recipients and the homeless	Access to Care Growing # of homeless Mental Health
Westside Family Health Center	Federally qualified health center providing medical services to the low-income and Medi-Cal recipients	Access to Care Mental Health
The Achievable Foundation	Federally qualified health center providing medical services to the low-income and Medi-	Access to Care

	Cal recipients	
Providence Medical Institute	Medical foundation including primary and specialty care physicians	Access to Care
Local Churches	Faith communities to partner with PSJHC to focus on reducing chronic illnesses and assist those to better manage their disease	Chronic Illness Obesity and Nutrition
YMCA of Santa Monica	The YMCA offers programs to reduce the risk for chronic diseases such as diabetes	Chronic Illness Obesity and Nutrition
WISE & Healthy Aging	WISE and Healthy Aging offers programs to reduce and manage chronic illnesses and offers community case management for at-risk seniors	Chronic Illness
City of Santa Monica Office of Civic Wellbeing	The Office of Civic Wellbeing is taking a more proactive approach to develop citywide initiatives to focus on improving residents' health status	Chronic Illness Obesity and Nutrition
Meals on Wheels West	This programs offers nutritious meals to those who are homebound and on fixed incomes	Obesity and Nutrition
St. Joseph Center	This organization provides a food pantry and prepared meal program to the homeless and those who are living in poverty	Obesity and Nutrition Homelessness
Pico Youth and Family Center	This organization is incorporating fitness and nutrition education into its mix of programs for adolescents and young adults	Obesity and Nutrition
Boys and Girls Club of Santa Monica	Programs geared to youth including a focus on improving nutrition and physical activity for this population	Obesity and Nutrition
St. Anne School	Program focused on healthy eating to be offered to the students	Obesity and Nutrition
Safe Place for Youth	Organization offers counseling services to homeless youth	Mental Health
Step Up on Second	Program offers substance abuse treatment services to the homeless	Substance abuse
Santa Monica Malibu Unified School District	The Child Family Development Center partners with the School District to provide early intervention services to at-risk children	Mental Health
The People Concern/OPCC	Provides shelter, housing and wrap around services to homeless persons	Homelessness

Upward Bound House	Provides housing and transitional shelter to homeless families living on the Westside	Homelessness
Trinity Care Hospice	Provides hospice services to patients including those who are low-income	Homelessness
Westside Coalition	Coordinates housing and other resources for the homeless living on the Westside	Homelessness
UCLA Santa Monica Medical Center	The hospital is helping to lead a collaborative project addressing the need of homeless patients with terminal illnesses needing hospice care	Homelessness
Local Preschools	The Child Family Development Center is working in partnership with the School District and local preschools to identify children at risk for behavioral and mental health issues	Mental Health

Appendix 5 - Evaluation of 2016 Community Health Improvement Plan Impact

The following is an overview, evaluating the CHIP efforts and their impact on the identified needs.

Strategy #1: Work with physicians and community partners to improve access to primary and specialty care on the Westside for Medi-Cal and uninsured patients.

- In 2018 Providence Saint John's provided $3,008,588 in charity care serving 420 persons.
- During 2018 Providence Saint John's provided $29,052,170 in unpaid costs of Medi - Cal serving 3,511 persons.
- The Health Center provided $67,150 in free medications to patients who were uninsured and unable to afford the prescriptions.

Grants totaling $225,000 were provided to the two community clinics in the area (Venice Family Clinic and Westside Family Health Center).

- PSJHC maintained a contract with L.A. Care Health Plan, a publicly accountable Medi-Cal HMO that supports hospital deliveries for patients of two federally qualified health centers, Venice Family Clinic and Westside Family Health Center.
- PSJHC provided free laboratory and imaging services to uninsured patients referred from the area clinics totaling $128,138 in 2018.
- PSJHC continued to operate the Cleft Palate Clinic, serving 89 patients in 2018.

Strategy # 2: Develop and expand education, screening and support programs to help address chronic disease in the area.

- PSJHC continued the Community Health Partnership Program in 2018 working in high need census tract sites, St. Anne's Church, Mar Vista Garden and Virginia Avenue Park, to offer health screenings and health presentations by clinicians.
- Providence Saint John's offered eight community education forums in 2018 focused on four topics: stroke, aging, cancer, and women's health (including nutrition, heart disease, breast cancer and skin health

Strategy # 3: Provide programs and improve access to resources focused on better nutrition and reducing obesity in the community.

- Nutrition education programs were provided at three sites.
- Walking groups were initiated at two churches in the community.

Strategy # 4: Expand mental health and substance abuse services in the community to vulnerable populations.

- The therapeutic preschool operated by the Providence Saint John's Child and Family Development Center (CFDC) enrolled 27children in 2018.
- In 2018, PSJHC provided support to the CFDC, offering counseling services to low income children and their families, child abuse prevention and treatment services, on-site school counseling services, and services for preschool age children including one of the only therapeutic preschools in the area.

Strategy # 5: Expand services and outreach to homeless patients coming to Providence Saint John's Health Center and to those living in the community.

- The Homeless Care Navigation Program coordinated 600 referrals for patients experiencing homelessness in 2018 to homeless service agencies.
- PSJHC provided $150,000 in grant funding to The People Concern to support homeless services in the community.
- The Health Center provided over$312,000 in financial support for post-acute care services for medically indigent patients, including over$266,000 for homeless patients being discharged from the hospital and needing follow-up care.

Appendix 6 – CHNA GOVERNANCE

Community Health Needs Assessment Committee

The Saint John's Community Ministry Board authorized the Community Health Needs Assessment Oversight Committee to consider primary and secondary data collected by Saint John's staff and prioritize the identified community health needs for the 2020-2022 cycle. The following is a roster of Committee Members.

Name	Organization
Bob Frank	PSJHC
Randy Roisman	PSJHC
Nat Trives	Former Mayor, City of Santa Monica
John Maceri	The People Concern
Jenny O' Brien	Venice Family Clinic
Wendy Merritt	Saint John's Foundation
Susan Samarge-Powell,	Santa Monica College
Mike Tuitasi	Santa Monica College
Gail Gutierrez	CFDC
Russ Kino	PSJHC
Carlie Galloway	PSJHC
Darci Navi	Westside Coalition
Paul Makareweicz	PSJHC
Jim Tehan	PHS
Setareh Yavari	City of Santa Monica

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