San Fernando Valley Joint Community Health Needs Assessment 2019

Providence

Holy Cross Medical Center

Mission Hills, California

Providence

Saint Joseph Medical Center

Burbank, California

Providence | Cedars Sinai

TARZANA MEDICAL CENTER

Tarzana, 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 free of charge, email Ismael Aguila at Ismael.Aguila@Providence.org.

2019 Community Health Needs Assessment

Contents

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 Holy Cross Medical Center, Providence St. Joseph Medical Center, and Providence Tarzana Medical Center Joint Community Health Needs Assessment (CHNA) key informant interview and listening session data collection process was conducted by Providence Community Health Investment staff with support from Valley Care Community Consortium.

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

The Mission of Providence directs special attention to the poor and vulnerable. This statement of organizational purpose reaffirms a commitment to underserved communities and calls us to embrace collaboration, particularly since no single organization can respond to all of the health care pressure points of high need communities. Accordingly, Providence works in collaboration with nonprofit organizations and public entities that share its 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."

The Providence San Fernando Valley Service Area is comprised of three medical centers: Providence Holy Cross Medical Center (Mission Hills), Providence St. Joseph Medical Center (Burbank), and Providence Cedars-Sinai Tarzana Medical Center (Tarzana).

Providence Holy Cross Medical Center (PHCMC) was founded in 1961 by the Sisters of the Holy Cross to serve a growing population in the northern San Fernando Valley. In 1996, the medical center was purchased by Providence Health & Services, which was founded by the Sisters of Providence. These Sisters have been serving the western United States since the mid-1800s and the San Fernando Valley since 1943. PHCMC, a nonprofit health organization, has expanded its facility to 377 beds, serving the health care needs of residents in San Fernando, Santa Clarita and Simi Valleys. To these communities, PHCMC offers a state-of-the-art Cancer Center, a Heart Center, Orthopedics, Neurosciences, and Rehabilitation Services, Women's and Children's Services, as well as a Level II Trauma Center.

Providence Saint Joseph Medical Center (PSJMC) was opened in 1944 by the Sisters of Providence to serve a growing population in the San Fernando Valley. Starting from a small 100-bed facility, PSJMC has grown over the years to become a major health care facility serving the residents of northern Los Angeles County. Providence Saint Joseph Medical Center is a 392-bed licensed acute care facility serving the San Fernando and Santa Clarita Valleys. PSJMC is known for its state-of-the-art technology and high-quality, compassionate care. The 2,500 employees, 400 volunteers, guild members, and over 800 physicians at the medical center share a commitment to provide quality care for all through the Roy & Patricia Disney Family Cancer Center, Bariatric Wellness Center, Stroke Services, Heart and Vascular Institute, Howard and Hycy Hill Neuroscience Institute, Orthopedics Department, Women's Services, and Breast Health Center.

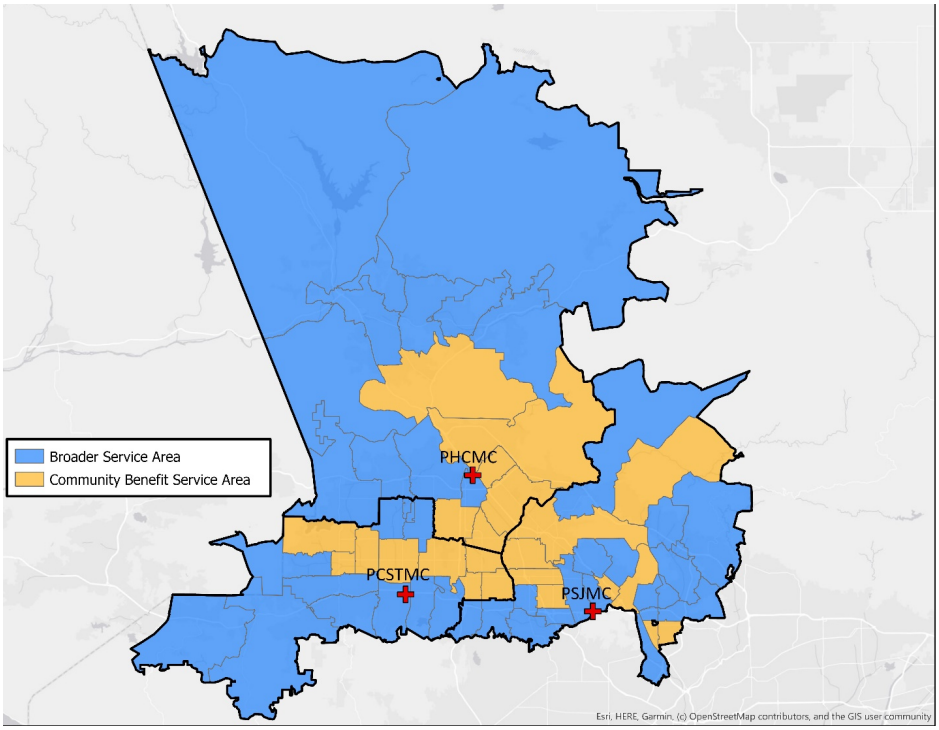
Providence Cedars-Sinai Tarzana Medical Center (PCSTMC) was founded in 1973 and has been serving a rapidly growing West San Fernando Valley community since it opened. The 249-bed hospital is known in the area as a leading health care provider for quality care by delivering babies, providing emergency life-saving care, and performing surgeries and other procedures to improve the health of the community. In 2008, the hospital was purchased by Providence Health & Services. As a non-profit medical center, their community health outreach programs address the needs of underserved communities. In 2019, Providence and Cedars-Sinai Medical Center partnered to operate the medical center jointly, now known as the Providence Cedars-Sinai Tarzana Medical Center.

Our Community

The San Fernando Valley Community encompasses the San Fernando Valley and Santa Clarita Valley regions of Southern California. This community is a dynamic and diverse area with a population that spans the socioeconomic spectrum. Neighborhoods include resource-rich and affluent areas such as Porter Ranch, Calabasas, and Studio City, as well as many low-income, under-resourced areas including, San Fernando, Pacoima, Sylmar, Canoga Park, Reseda, and North Hollywood, amongst others.

The Providence San Fernando Valley (SFV) Service Area is comprised of the service areas of three Providence medical centers including Providence Holy Cross Medical Center (PHCMC; Mission Hills); Providence St. Joseph Medical Center (PSJMC; Burbank); and Providence Cedars-Sinai Tarzana Medical Center (PCSTMC; Tarzana). The SFV Service Area geography is represented by both blue and yellow regions in the map below. Within their respective service area boundaries, each medical center has an identified community benefit service area[1] (highlighted yellow in the map below). The Providence San Fernando Valley Community Benefit Service Area consists of all three medical centers' community benefit service areas. Similarly, the Providence San Fernando Valley Broader Service Area (highlighted in blue in the map below) consists of ZIP codes within the SFV Service Area, but outside of the Community Benefit Service Area. Communities in the Broader Service Area are more resource-rich with a population on the higher end of the socioeconomic spectrum. This service area roughly aligns with Los Angeles County Department of Public Health's Service Planning Area (SPA) 2.

Figure_ES 1. Providence San Fernando Valley Service Area



[1] The Community Benefit Service Area was defined using the Community Need Index (CNI) mapping tool from Dignity Health and Truven Health Analytics. All zip codes with a score of 4 or greater on the scale were included.

CHNA Framework

To ensure Providence San Fernando Valley Community continues to stay at the forefront of Community Benefit reporting and programs, the three hospitals in the SFV Service Area engaged in a joint Community Health Needs Assessment (CHNA). The 2019 joint CHNA furthers the commitment to develop regional strategies and increase collaboration on and recognition of shared challenges and solutions across the geography. 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.

There is increasing recognition that many factors beyond the health care system play an important role in the health of the community. 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 their community. For these reasons, the CHNA takes a close look at these factors, known as Social Determinants, as well as the disparities that exist between high need communities and neighborhoods compared to the broader community within the SFV Service Area.

CHNA Process and Methods

Gathering data for this CHNA involved systematic collection of both primary and secondary data relevant to the SFV Service Area in order to identify the high-priority needs and issues facing the community. For primary data, input was collected from 18 community leaders via phone interviews. In addition, input was collected from 51 residents during six listening sessions at Vaughn Early Learning Center, San Fernando Elementary School, Blythe Street Elementary School, and Guardian Angel Catholic School. Primary quantitative data were collected from Providence's electronic health record system to review avoidable Emergency Department use and potentially avoidable inpatient admissions.

Secondary data collection included socio-economic indicators and mortality and morbidity rates from multiple sources. These sources included the U.S. Census, American Community Survey, the Community Commons Database, the California Health Interview Survey (UCLA), the L.A. County Department of Public Health, the California Department of Public Health, the Public Health Alliance of Southern California, and the Los Angeles Homeless Services Authority.

CHNA Health Indicators and Trends

Once the information and data were collected and analyzed by staff members, the following eight key areas were identified as community needs to be further prioritized by the Community Health Needs Assessment Oversight Committee. Issue briefs encompassing both primary and secondary data were prepared for each identified health need, listed here in alphabetical order:

- Access to Healthcare and Resources
- Prevention and Management of Chronic Diseases

- Behavioral Health, Including Mental Health and Substance Use
- Food Insecurity
- Homelessness and Housing Instability
- Immunization/School Health
- Senior Care
- Violence Prevention

The following table presents key findings from the review of the secondary data and the stakeholder engagements by identified health need:

Table_ES 1. Key Findings Summarized for Identified Health Needs

Identified Health-Related Need	Key Findings
Access to Health Care and Resources	• Since 2009, between 80-90% of the population has reported having a usual source of care in LA County and Service Planning Area (SPA) 2. • 93.9% of adults ages 18-64 were insured in the Broader Service Area; only 82% of adults of the same age were insured in the Community Benefit Service Area. • Community members and stakeholders both identified improving access to health care as a priority in addressing health needs in the San Fernando Valley. • Top barriers to health care access in the SFV Service Area include lack of information needed to navigate the complexities of the health care system, high cost of care, unfamiliar support resources, immigration status, cultural/language barriers, long wait times and not enough providers, and limited coordination among health care providers and systems.
Prevention and Management of Chronic Diseases	• A higher percentage of people face obesity, diabetes, and cardiovascular disease in the Community Benefit Service Area than in the Broader Service Area. • According the California Health Interview Survey, the prevalence of diabetes for Los Angeles County has jumped from 6.9% in 2003 to 12.1% in 2017. • The percent of adults who have ever been told they have pre-diabetes has risen by over 10% since 2009. The 2017 California Health Interview Survey reveals that 17.4% of the Los Angeles County adult population has been told they have pre-diabetes. • Stakeholders identified Latinos and immigrants, particularly new and/or undocumented immigrants as most affected by obesity, diabetes, and hypertension.
Behavioral Health, Including Mental	• Stakeholders identified mental health care as an urgent need, noting that mental health challenges, including depression, anxiety, and stress are some of the most prevalent health and social issues in the community.

Identified Health-Related Need	Key Findings
Health and Substance Use	Participants noted a need for more specialty (substance use, trauma) and integrated behavioral health services for all age levels. • Nearly a quarter of adults (23%) in the Community Benefit Service Area reported their mental health to be "fair or poor" compared to 13% in the Broader Service Area. • The premature death rate due to suicide (measured in total years of potential life lost) is greater in both the Community Benefit Service Area and Broader Service Area than in Los Angeles County (215.5 and 238.7 vs. 209.0 per 100,000 population). • Percent of adults who reported binge drinking in the past 30 days is greater in the Community Benefit Service Area than in the Broader Service Area or Los Angeles County. The percentage of adults throughout LA County reporting engaging in binge drinking is 15.9%. • Stakeholders identified young people, older adults, and immigrants, particularly undocumented immigrants, as groups disproportionately affected by mental health challenges. The percent of children ages 0-17 years who have special health care needs is significantly greater in the Broader Service Area (20%) than the Community Benefit Service Area (12%) or Los Angeles County (14%). • Community members and stakeholders were particularly concerned about substance use, specifically opioids and marijuana, by young people in the San Fernando Valley. • LA County and SPA 2 have both had upward trends in the percentage of adults who saw a healthcare provider for emotional-mental and/or alcohol-drug issues since the year 2012 (from 9.2% to 13.7% in SPA 2, and from 10.6% to 15.1% in Los Angeles County).
Food Insecurity	• Community members shared the factors that make accessing nutritious, fresh foods more challenging: poor quality of fresh foods in local stores, the high cost of nutritious, fresh foods compared to processed foods, time and stress, transportation, and family Influence. • A higher percentage of households in the Community Benefit Service Area are food insecure compared to the Broader Service Area and Los Angeles County: 32.6% of households below 300% FPL in the Community Benefit Service Area are food insecure, compared to only 19.4% in the Broader Service Area and 29.2% in Los Angeles County. • Almost 40,000, or 11.9%, of households in the Community Benefit Service Area were receiving SNAP benefits during the 2013 – 2017 American Community Survey period. This is higher than the 3.4% of households in the Broader Service Area and 8.9% of households in Los Angeles County.

Identified Health-Related Need	Key Findings
	• The highest counts of eligible but unenrolled CalFresh recipients are within the Community Benefit Service Area ZIP codes of 91331 (Pacoima), 91402 (Panorama City) and 91335 (Reseda).
Homelessness and Housing Instability	• Identified as an urgent issue, stakeholders shared the following factors contribute to homelessness and housing instability: siloed services due to funding streams; lack of safety net supports to offset high cost of living; lack of affordable housing options; NIMBYism ("Not in My Backyard"); lack of sufficient supportive services to meet the demand; and economic insecurity and a lack of living wage jobs. • The 2019 Greater Los Angeles Homeless Count shows 58,936 people experiencing homelessness in LA County, a 12% increase in one year. • 7,730 persons are experiencing homelessness in SPA 2 (ranked as 3rd in the county). Individuals make up 88% of the people experiencing homelessness counted and family members make up 12%. • Three out of five people experiencing homelessness are unsheltered in the county. The unsheltered percentage is even higher in SPA 2 (four out of five).
Immunization/School Health	• Fewer children ages 6 months to 17 years have received the flu vaccination in the Community Benefit Service Area (50.7%) than in the Broader Service Area (58.2%) and Los Angeles County (55.2%). • The percent of girls vaccinated for HPV in SPA 2 is less than the County average (43.2% vs. 44.6%).
Senior Care	• Both the Community Benefit Service Area and the Broader Service Area have growing older adult populations (over age 55). • By 2024, the age group 55+ will make up approximately 25% of the population in the Community Benefit Service Area and over 30% of the population in the Broader Service Area. • 15.8% of the Medicare population, age 65 and over, in LA County is affected by Alzheimer's disease or dementia. • More than a third of adults 65+ have fallen in the past year within the Community Benefit Service Area. Percentages for the Broader Service Area (28%) and LA County (27%) are lower.
Violence Prevention	• Most residents feel safe from crime in their neighborhood in both the Community Benefit Service Area (92%) and Broader Service Area (98%). In LA County, the self-reported percentage is significantly lower (84%). • The premature death rate due to homicide—measured in total years of potential life lost (YPLL) – is over four times greater in the Community Benefit Service Area (180.0 YPLL per 100,000 population) than in the Broader Service Area (43.4 YPLL per 100,000 population). Both areas report substantially lower rates than Los Angeles County (240.3 YPLL per 100,000 population).

Prioritization Process and Criteria

The CHNA Oversight Committee met in September 2019 to conduct its work with a clear statement of its role: to recommend to the Community Ministry Board the top identified health needs to be prioritized over the next three years. At the first meeting, on September 10, 2019, the CHNA Oversight Committee considered the CHNA Framework, the definition of the community and the high need areas within the SFV Service Area. The group participated in two panel discussions related to homelessness and food insecurity and utilized some of the secondary data from the high need areas to sharpen the discussion.

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 to be followed in the second panel session.

In advance of the second meeting, Oversight Committee Members received a summary of primary and secondary data collected for nine[2] identified health needs. The second meeting began with each member of the committee submitting a complete email survey of their input for nine specific identified health needs, based upon the collection of primary and secondary data by Providence staff. For each identified health need, committee participants were asked to rate (1) the severity of the identified health need, (2) the change over time, (3) the availability of community resources/assets to address the health need, and (4) the 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 Community Health staff. Half of the meeting time was then set aside to break the Oversight Committee into three groups to address the following 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 Providence 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 email survey and dot counts were combined to calculate the relative priority rank of each of the health needs. The top five prioritized health needs are as follows:

[2] While originally two separate health needs, mental health and substance use were ultimately combined as one health need called "Behavioral Health, including Mental Health and Substance Use." This reflects that community health does not have the capacity to provide treatment services going forward but can provide preventive education related to mental health and substance use through a behavioral health lens.

Table_ES 2. Health-Related Needs in Order of Priority

Rank	Health- Related Need
1	Homelessness and Housing Instability
2	Behavioral Health, including Mental Health and Substance Use
3	Food Insecurity
4	Prevention and Management of Chronic Diseases
5	Access to Health Care and Resources

Evaluation of 2017 - 2019 Community Health Improvement Plan Impact

This section includes a description of the programs and services provided by three Providence medical centers in the San Fernando Valley that support the Community Benefit Plan Strategies and Metrics.

Strategy #1: Improve Access to Healthcare Services. As of 2018, the following has been accomplished.

- Community Health Workers assisted with 786 MediCal applications at various locations in the San Fernando Valley, including school parent centers, churches, health clinics, and community wellness centers. We expect approximately 1,200 medical applications will be submitted by the end of 2019.
- Community Health Workers working in the Emergency Department at Providence Holy Cross Medical Center and Providence St. Joseph Medical Center were able to assist 865 patients applying for Hospital Presumptive Eligibility (HPE), which provided much needed temporary medical coverage for uninsured patients, namely low-income children and adults. In 2019, the Community Health Investment department began to support Providence Cedars-Sinai Tarzana Medical Center Emergency Department. It is projected that approximately 2,547 HPEs will be completed by the end of 2019.
- There were a total of five health clinics that participated in the Access to Care program, including Meet Each Need with Dignity (MEND), All Inclusive Community Health Center, San Fernando Community Health Center, Valley Community Health Center, and El Proyecto del Barrio.
- Community Health Workers in the Emergency Department at Providence Holy Cross Medical Center and Providence St. Joseph Medical Center scheduled 710 primary care appointments to community clinics for follow-up care, with 554 (78%) appointments kept. With service added to Tarzana Medical Center in 2019, appointments are projected to reach 1,345 by the end of 2019.
- Community Health Workers and Faith Community Nurses facilitated 545 follow-up appointments to a medical home for health fair participants who received out-of-range point of care (POCT) test results.

Strategy # 2: Implement Prevention Interventions to Reduce the Prevalence or Progression of Chronic Disease. As of 2018, the following has been accomplished.

- The CSUN/3WINs Wellness program, which includes HbA1c testing, body mass index and body fat percent screenings, as well as goal setting, was conducted at four local sites including St Patrick's Catholic Church (North Hollywood, CA), St. Didacus Catholic Church (Sylmar, CA), Our Lady of Peace Catholic Church (North Hills, CA) and Guardian Angel Church (Pacoima, CA) with 136 participants in 2017 and 235 in 2018 when Lanark Park (Canoga Park, CA) was added as a site.
- Fit Food Fairs/Cardio Carnivals were conducted at three faith-based schools including St. Patrick's, Guardian Angel, and St. Didacus to highlight nutrition education, physical activity, and wellness promotion.
- 457 seniors received services from referrals to local senior agencies such as One Generation and the Joslyn center as a way to improve continuum of services.
- 231 seniors participated in the 3WINS Exercise Program to increase their daily physical activity levels.
- 10 adults completed the FEAST program, a 10 week nutrition support group, including education, cooking demonstrations, and food scholarships. The program showed positive healthy behavior change:
- 10 participants consistently attend weekly sessions for the Attention to Prevention Diabetes Program. Six met their goals and lost an average of 7.7lbs. One individual dropped a total of 21lbs or 10% of their initial weight.

Strategy # 3: Strengthen Community-based Mental Health Infrastructure to Better Align with Hospital-based Mental Health Services (including substance abuse treatment). As of 2018, the following has been accomplished.

- 60 people were referred directly to Tarzana Treatment Center for mental health services from health education workshops provided by Community Health Workers at schools and churches covering topics on mental health awareness and promoting mental wellness.
- Between March 2018 and September 2019, three wellness and activity centers were opened that provided community health navigation and educational services, including mental health classes and physical activity classes: (1) Vaughn Next Century Charter School in the City of Pacoima; (2) the City of Van Nuys (also serves as department administrative office); and (3) the City of Burbank, in partnership with Burbank Housing Corporation.
- 25 Providence Community Health employees received Mental Health First Aid training through a partnership with the National Council for Behavioral Health.
- An Alcohol and Health Research study is being conducted, in partnership with UCLA, with 11 participants to investigate the effectiveness of 3 motivational interviewing sessions on Latinos exhibiting unhealthy drinking behaviors.

Strategy # 4: Align Community Benefit Programs with San Fernando Medical Centers. As of 2018, the following has been accomplished.

- A network of 8 specialty physicians are participating in the Access to Care Program. A total of 341 patients were referred by participating clinics for specialty care consultation services. Referrals are expected to grow to 450 patients by end of 2019.

- 111 students at Sepulveda Middle School completed the Adolescent Coping Education Series (ACES), an 8-week educational series focusing on coping and resiliency skills. An additional 130 students at James Monroe High School will have completed the series by December 2019.
- Community Health staff assisted in providing pre- and post- screenings for 53 participants for the 4 month Live Well Program for seniors in partnership between Providence St. Joseph Medical Center, Providence Community Health Investment and various organizations in Burbank (i.e. YMCA). The program combines exercise, nutritional counseling and disease prevention, and management education.
- In March of 2019, the Specialized Assistance for the Elderly (SAFE) program was implemented at Tarzana Medical Center. It is designed to address avoidable visits by seniors frequently seen in the Emergency Department. It is estimated that Community Health Investment staff will assist over 300 patients by the end of 2019.

Introduction

Who We Are

Providence Holy Cross Medical Center (PHCMC) was founded in 1961 by the Sisters of the Holy Cross to serve a growing population in the northern San Fernando Valley. In 1996, the medical center was purchased by Providence Health & Services, which was founded by the Sisters of Providence who have been serving the western United States since the mid-1800s and, in particular, the San Fernando Valley since 1943. PHCMC, a nonprofit health organization, has expanded its facility to 377 beds, serving the health care needs of residents in San Fernando, Santa Clarita and Simi Valleys. To these communities, PHCMC offers a state-of-the-art Cancer Center, a Heart Center, Orthopedics, Neurosciences, and Rehabilitation Services, Women's and Children's Services, as well as a Level II Trauma Center.

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Our Commitment to Community

As health care continues to evolve, the Providence San Fernando Valley Community 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 (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 the Providence San Fernando Valley Hospital Community to improve the health of entire populations.

During 2018, Providence San Fernando Valley provided $84,414,628 in community benefit in response to unmet needs and to improve the health and well-being of those we serve in the San Fernando Valley.

Our Mission, Vision, Values and Promise

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

Providence St. Joseph Health

Providence St. Joseph Health 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 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 description of the medically underserved, low-income and minority populations.

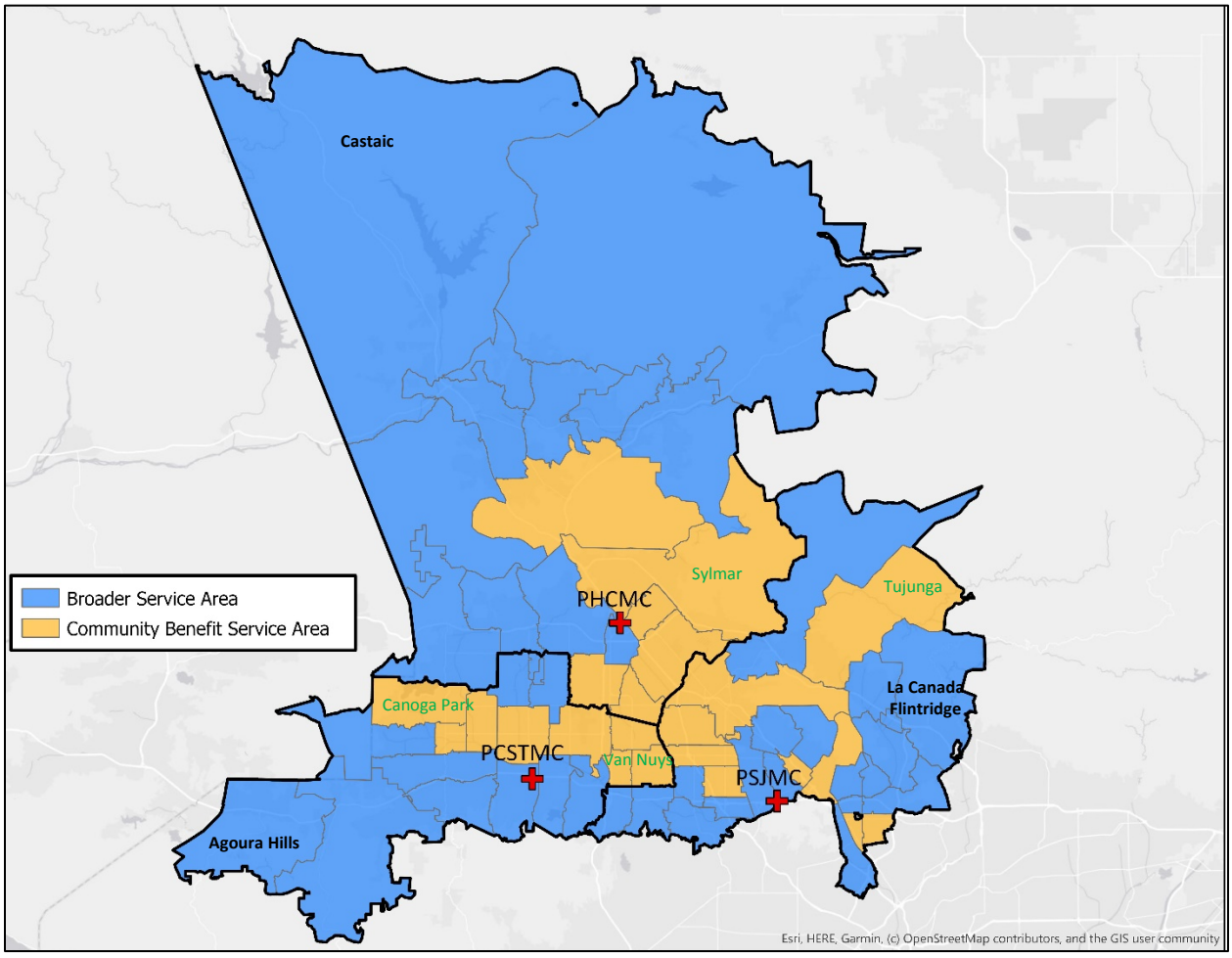
Description of Community Served

The San Fernando Valley (SFV) service area encompasses the San Fernando Valley and Santa Clarita Valley regions of Southern California. This community is a dynamic and diverse area with a population that spans the socioeconomic spectrum. Neighborhoods include resource-rich and affluent areas such as Porter Ranch, Calabasas, and Studio City, as well as many low-income, under-resourced areas including San Fernando, Pacoima, Sylmar, Canoga Park, Reseda, and North Hollywood, among others.

The Providence San Fernando Valley Service Area (SFV Service Area) is comprised of the service areas of three Providence medical centers including Providence Holy Cross Medical Center (PHCMC; Mission Hills); Providence St. Joseph Medical Center (PSJMC; Burbank); and Providence Cedars-Sinai Tarzana Medical Center (PCSTMC; Tarzana). The SFV Service Area geography is represented by both blue and yellow regions in the map below. Within their respective service area boundaries, each medical center has an identified community benefit service area[3] (highlighted yellow in the map below). The Providence San Fernando Valley Community Benefit Service Area consists of all three medical centers' community benefit service areas. Similarly, the Providence San Fernando Valley Broader Service Area (highlighted in blue in the map below) consists of ZIP codes within the SFV Service Area, but outside of the Community Benefit Service Area. Communities in the Broader Service Area are more resource-rich with a population on the higher end of the socioeconomic spectrum. This service area roughly aligns with Los Angeles County Department of Public Health's Service Planning Area (SPA) 2.

[3] The Community Benefit Service Area was defined using the Community Need Index (CNI) mapping tool from Dignity Health and Truven Health Analytics. All zip codes with a score of 4 or greater on the scale were included.

Figure 1. Providence San Fernando Valley Service Area



The ZIP Codes in the SFV Community Benefit Service Area and Broader Service Area for each Hospital are shown below.

Table 1. Zip Codes Included in Providence San Fernando Valley Hospital Community Service Areas

Community Benefit Service Area	Broader Service Area	
PHCMC		
91321	91311	91354
91331	91326	91355
91340	91344	91381
91342	91345	91384
91343	91350	91387
91352	91351	91390
91402		
PSJMC		
91042	90039	91214
91201	91011	91403
91204	91020	91423
91205	91040	91501
91352	91202	91504
91502	91203	91505
91601	91206	91506
91605	91207	91602
91606	91208	91604
		91607
PCSTMC		
91303	91301	91325
91304	91302	91330
91306	91307	91356
91335	91316	91364
91401	91324	91367
91405		91436
91406		
91411		

Community Demographics

Population and Age Demographics

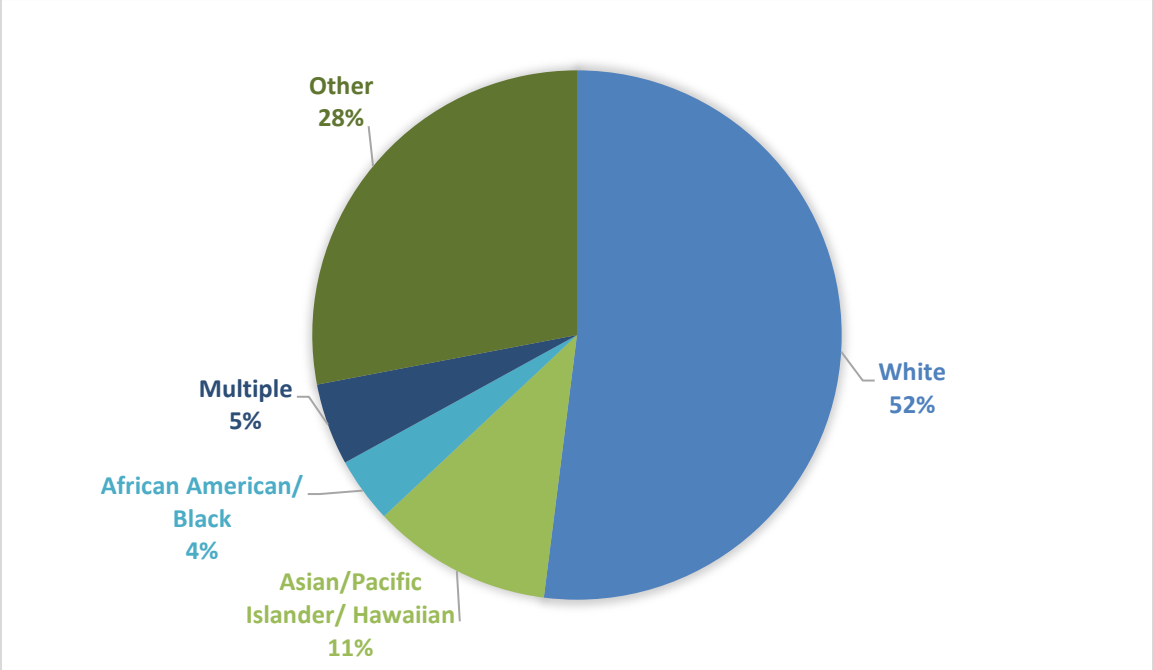
The total population of the Providence San Fernando Valley (SFV) Service Area in 2019 is 2,225,425 people, which represents a 0.2% increase compared to the 2016 population, or approximately 5,000 additional residents living in the area. The total population of the SFV Community Benefit Service Area is just over 52% of the total service area population, with nearly 1.2 million people.

The majority of residents in the SFV Service Area are between 10 and 39 years old. Children under the age of 19 make up 28.2% of the population. This is notable and indicates a greater proportion of youth than elsewhere in the state, where children under the age of 18 make up 22.7% of the population. Adults 60 years of age and older make up 13.9% of the total service area population, compared to the state of California, adults 65 and older make up 14.3% of the population.[4] The SFV Service Area, therefore, is notably younger, on average, than the total population of the state of California.

Population by Race and Ethnicity

Among SFV Community Benefit Service Area residents, in 2019, 52.3% were White, 11.1% were Asian/Pacific Islander/Hawaiian, 0.7% were Alaska Native or American Indian, 3.6% were African American or Black, and 5.0% were of two or more races. Approximately 59.0% of the residents identify as Latino.

Figure 2. Self-Reported Race, SFV Community Benefit Service Area



[4] US Census Bureau 2013-2017 American Community Survey 5-year Estimates.

Table 2. Socioeconomic Data, SFV Community Benefit Service Area

Indicator	SFV Community Benefit Service Area
Families Below 200% FPL	45.4%
Unemployment	4.9%
Adults with No High School Diploma	26.8%
Population Speaking Language Other than English at Home	69.9%

Income Levels

In 2019, the median household income of the SFV Service Area varied significantly from a low of $41,053 for the community of Glendale, to $166,406 for the community of La Cañada Flintridge. The SFV Community Benefit Service Area, compared to Los Angeles County, is home to a higher concentration of low-income residents; approximately 45.4% of families have annual incomes below 200% of the Federal Poverty Level (FPL; $51,500 for a family of 4) compared to 39.6% in Los Angeles County as a whole.

Education Level

While many of the adults living in the SFV Community Benefit Service Area have at least a high school diploma (73.2%), there were several ZIP codes with a high concentration of adults who had not completed high school. These ZIP codes included Pacoima (91331; 44.8%), San Fernando (91340; 39.3%), Panorama City (91402; 36.4%) and Sun Valley (91352; 34.1%).

Economic Indicators

The percent unemployed in the SFV averages 4.9%. Nonetheless, 35.1% of the population is experiencing severe housing cost burden,[5] and 11.3% of the population is enrolled in SNAP, or food assistance programs.

Language Proficiency

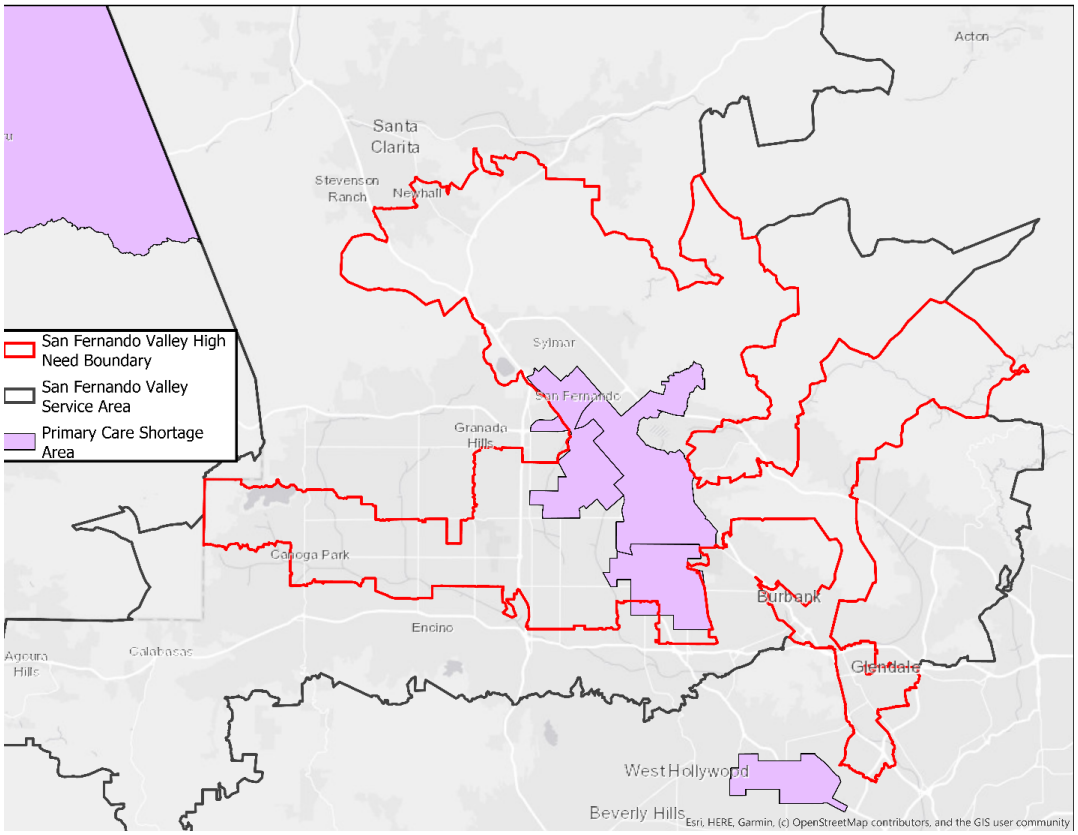
Within Los Angeles County, 56.6% of residents speak a language other than English at home. Far fewer households (an average of 30.1%) in the SFV Service Area speak a language other than English at home, and individuals speaking languages other than English at home are concentrated in Panorama City, Pacoima, Glendale, and San Fernando.

Health Professional Shortage Area

The Health Resources & Services Administration (HRSA) defines a Health Professional Shortage Area (HPSA) as an area of shortage of primary care, dental care or mental health care providers by geographies or populations. The map below shows primary care shortage areas in the San Fernando Valley. The red line indicates the boundary around the SFV Community Benefit Service Area ZIP codes.

[5] Severe housing cost burden is defined as spending more than 50 percent of one's income on rent. https://www.huduser.gov/portal/pdredge/pdr_edge_featd_article_092214.html

Figure 3. Providence SFV Health Professional Shortage Area Map with Community Benefit Service Area Overlay



Overview of CHNA Framework

This section provides a summary of the framework that guided the design of Providence San Fernando Valley Community Health Needs Assessment.

To ensure Providence San Fernando Valley Community continues to stay at the forefront of Community Benefit reporting and programs, the three hospitals in the SFV Service Area engaged in a joint Community Health Needs Assessment (CHNA). The 2019 joint CHNA furthers the commitment to develop regional strategies and increase collaboration on and recognition of shared challenges and solutions across the geography.

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. The goals of this assessment are the following:

- Engage public health and community stakeholders including low-income, minority, and other underserved populations.
- Assess and understand the community's health issues and needs.
- Understand the health behaviors, risk factors and social determinants that impact health.
- Identify community resources and collaborate with community partners.
- Use CHNA findings to develop and implement a 2020-2022 implementation plan based on the prioritized issues.

There is increasing recognition that many other factors beyond the health care system, called the Social Determinants of Health, play an important role in the health of the community. 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. 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 SFV 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 San Fernando Valley Community Health Needs Assessment.

Community Input: Qualitative Data

Providence San Fernando Valley recognizes the value of input from community members and local stakeholders during the Community Health Needs Assessment (CHNA) process. As the people who live and work in the San Fernando Valley, they have first-hand knowledge of the needs and strengths of their community and their opinions help to shape our future direction. For primary data, input was collected from 18 key community leaders via phone interviews. In addition, input was collected from 51 residents during six listening sessions at Vaughn Early Learning Center, San Fernando Elementary School, Blythe Street Elementary School, and Guardian Angel Catholic School. 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, organized by relevant health need.

Solicited CHNA Comments from the Public

The 2016 San Fernando Valley Joint Community Health Needs Assessment is publicly available on each of the three hospital's websites, 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 be considered for the 2019 Community Health Needs Assessment.

Collaborative Partners

As part of the primary data collection process, Providence Holy Cross Medical Center, Providence St. Joseph Medical Center, and Providence Cedars-Sinai Tarzana Medical Center worked in collaboration to collect and analyze information. Together, the three hospital systems collaborated on several components of the CHNA:

- 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.
- Sharing secondary data sources regarding key information available on the targeted area.

With the findings of this CHNA, the hospitals intend to continue collaborative efforts and identify common health needs that they can address through a joint strategy. This includes incorporating one or more prioritized health needs into the implementation strategies of the participating hospitals.

Quantitative Data

Secondary data collection included socio-economic indicators and mortality and morbidity rates from multiple sources. These sources included the U.S. Census American Community Survey, the Community Commons Database, the California Health Interview Survey (UCLA), the L.A. County Department of Public Health, the State of California Department of Public Health, the Public Health Alliance of Southern California, and the Los Angeles Homeless Services Authority.

Additionally, primary quantitative data were collected from the Providence SFV'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 were not always available at the ZIP code level, so Los Angeles County level data as well as Service Planning Area level data were utilized.
- 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 eight key areas were identified as community needs for the Community Health Needs Assessment Oversight Committee to prioritize. Issue briefs that encompassed both primary and secondary data were prepared for each identified health need, listed here in alphabetical order:

- Access to Healthcare and Resources
- Prevention and Management of Chronic Diseases
- Behavioral Health, Including Mental Health and Substance Use
- Food Insecurity
- Homelessness and Housing Instability
- Immunization/School Health
- Senior Care
- Violence Prevention

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 CHNA Oversight Committee met in September 2019 to conduct its work with a clear statement of its role: to recommend to the Community Ministry Board the top identified health needs to be prioritized and addressed over the next three years. At the first meeting, on September 10, 2019, the CHNA Oversight Committee considered the CHNA Framework, the definition of the community and the high need areas within the SFV Service Area. The group participated in two panel discussions related to homelessness and food insecurity and utilized some of the secondary data from the high need areas to sharpen the discussion. 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 panel session.

In advance of the second meeting, Oversight Committee Members received a summary of primary and secondary data collected for nine[6] identified health needs. The second meeting began with each member of the committee submitting a complete email survey of their input for nine specific identified health needs, based upon the collection of primary and secondary data by Providence staff. For each identified health need, committee participants were asked to rate (1) the severity of the identified health need, (2) the change over time, (3) the availability of community resources/assets to address the health need, and (4) the 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 Community Health staff. Half of the meeting time was then set aside to break the Oversight Committee into three groups to address the following 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 Providence 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.

[6] While originally two separate health needs, mental health and substance use were ultimately combined as one health need called “Behavioral Health, including Mental Health and Substance Use.” This reflects that community health does not have the capacity to provide treatment services going forward but can provide preventive education related to mental health and substance use through a behavioral health lens.

2019 Prioritized Health Needs

Results of both the email survey and dot counts were combined to calculate the relative priority rank of each of the health needs. The top five prioritized health needs are as follows:

Table 3. Health-Related Needs in Order of Priority

Rank	Health-Related Need
1	Homelessness and Housing Instability
2	Behavioral Health, including Mental Health and Substance Use
3	Food Insecurity
4	Prevention and Management of Chronic Diseases
5	Access to Healthcare and Resources

Description of Significant Community Health Needs

This section provides primary and secondary data to characterize the significant health needs identified during the Providence San Fernando Valley 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:

- Siloed services due to funding streams
- Lack of safety net supports to offset high cost of living
- Lack of affordable housing options and presence of "NIMBYism" (Not in My Backyard)
- Lack of sufficient homelessness services to meet the demand
- Economic insecurity and a lack of living wage jobs
- Lack of funding for grassroots homelessness service providers
- Lack of full stakeholder engagement in addressing homelessness

Stakeholders named two groups as particularly affected by homelessness/housing instability and lacking support services:

- Young people
- Older adults

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

- Family reconciliation and homeless diversion (helping people identify immediate alternate housing arrangements and connecting them with financial and housing assistance programs)
- Relationship building and improved integration of services
- Community outreach and health education to people experiencing homelessness
- A continuum of housing and supportive services, from transitional to permanent housing

Secondary Data

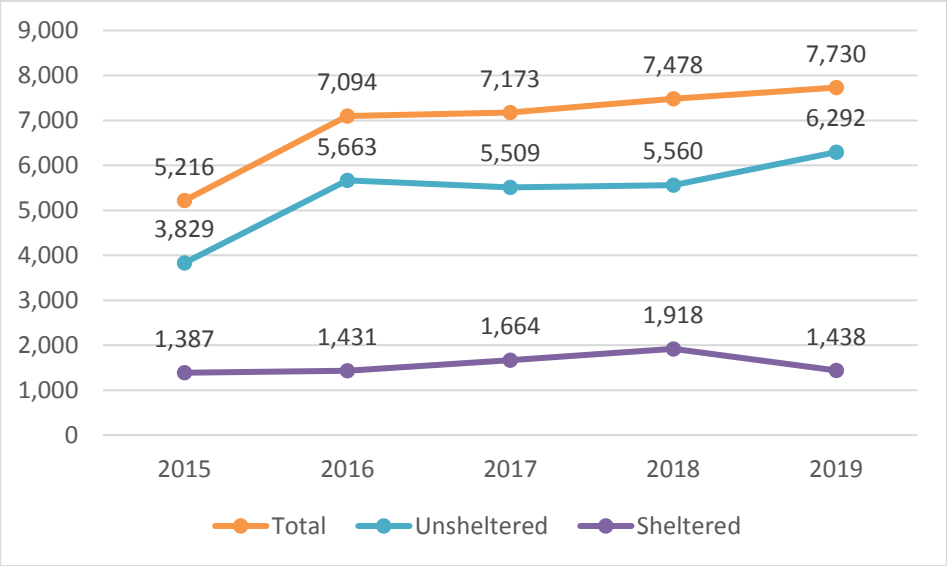
The Los Angeles Homeless Services Authority (LAHSA) conducts a yearly point-in-time count called the Greater Los Angeles Homeless Count. Moderated by the U.S. Department of Housing and Urban Development, LAHSA conducts the nation's largest homeless census count with the help of volunteers over the course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

The table on the next page displays the results of the 2019 Greater Los Angeles Homeless Count with a focused look at the results of Service Planning Area (SPA) 2.

Table 4. 2019 Point-In-Time Homeless Count

Geographic Area	Sheltered	Unsheltered	Total	Percent Change 2018 - 2019
Los Angeles County	14,722	44,214	58,.936	+12%
SPA 2	1,438	6,292	7,730	+3%

Figure 4. Total Number of People Experiencing Homelessness, Sheltered and Unsheltered, in SPA 2, 2015-2019



The total number of individuals experiencing homelessness in SPA 2 has continued to increase since 2015 according to the 2019 Greater Los Angeles Homeless Count. From 2018 to 2019, the number of sheltered individuals experiencing homelessness in SPA 2 has decreased, while the number of unsheltered individuals experiencing homelessness has increased.

Behavioral Health, Including Mental Health and Substance Use

Primary Data— Service Provider and Community Resident Input

Mental Health

Stakeholders shared they are seeing increased incidences of mental health challenges in the community, with increased depression, anxiety, and suicidal ideation, especially in young people. Many stakeholders identified mental health challenges as an urgent issue in the community. Stakeholders named a variety of contributing factors to the community's mental health challenges:

- Poverty and a lack of opportunities
- Trauma and violence
- Fear and racism related to immigration status
- Lack of access to culturally and linguistically appropriate mental health services in the

community and schools

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

- Young people
- Older adults
- Immigrants, particularly undocumented immigrants

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

- Improve access to counseling and mental health services
- Integrate mental health care and primary care
- Utilize health education classes and workshops
- Provide mentorship to young people
- Increase mental health awareness and reduce stigma using social media

Substance Use

Stakeholders were concerned about the increase of substance use, particularly among young people, in the San Fernando Valley. They identified opioids and marijuana as the two substances they are most concerned about, but also identified vaping, methamphetamines, and alcohol as issues. Therefore, addressing substance use is an urgent need. Stakeholders shared the following factors that contribute to substance use:

- Poverty and a lack of opportunities
- Lack of education about risks of substance use
- Increased accessibility of marijuana
- Mental health challenges and use of marijuana as a coping mechanism
- Lack of access to substance use treatment

Stakeholders were concerned about substance use in two populations in particular: young people and people experiencing homelessness. For young people, they were particularly concerned about marijuana use and vaping.

Effective strategies to address substance use shared by stakeholders include:

- Provide health education in local organizations and schools related to substance use risks
- Hub and spoke model of Medication-Assisted Treatment

Secondary Data

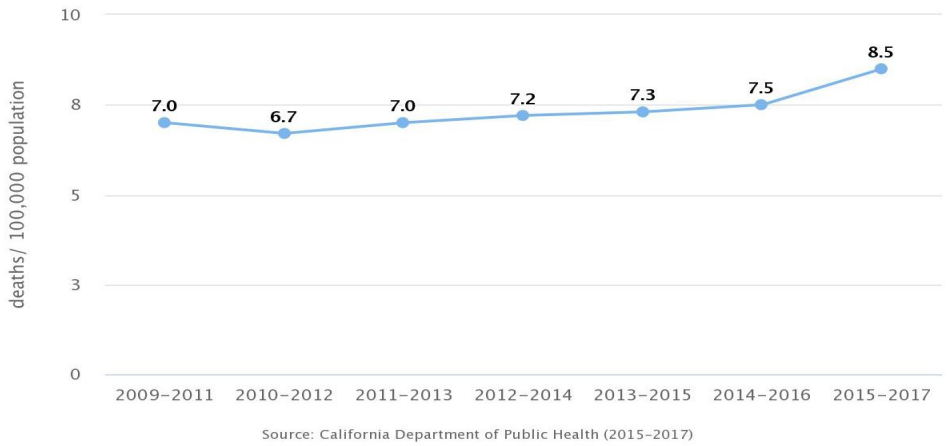
The percent of adults who reported binge drinking in the past 30 days is greater in the Community Benefit Service Area as compared to the Broader Service Area or Los Angeles County. Similarly, the percent of adults who smoke cigarettes is also greatest in the Community Benefit Service Area.

Table 5. Mental Health and Substance Use Data by Geographic Area

Mental Health and Substance Use	Community Benefit Service Area	Broader Service Area	Los Angeles County
Percent of adults at risk for major depression	11.4%	9.3%	11.8%
Alzheimer's disease-specific death rate (per 100,000 population)	33.2	38.8	38.7
Premature death rate due to suicide in total Years of Potential Life Lost (YPLL) per 100,000 population	215.5	238.7	209.0
Percent of adults reporting their health to be fair or poor	23.1%	13.0%	21.5%
Average number of days in past month adults reported regular daily activities were limited due to poor physical/mental health	2.3	2.7	2.3
Percent of children ages 0-17 years who have special health care needs	12.1%	20.0%	14.5%
Percent of adults who binge drink (men who had 5 or more alcoholic drinks, women 4 or more, on at least one occasion in the past 30 days)	16.1%	12.4%	15.9%
Percent of adults who smoke cigarettes	15.2%	10.8%	13.3%
Rate (per 10,000 population) of adult opioid use-related hospitalizations	1.9	2.7	1.9
Premature death rate due to drug overdose in total Years of Potential Life Lost (YPLL) per 100,000 population	196.3	238.2	220.3

There has been an increase in the age-adjusted death rate per 100,000 population due to drug use for Los Angeles County since 2010.

Figure 5. Age-Adjusted Death Rate due to Drug Use in LA County



Food Insecurity

Primary Data—Service Provider and Community Resident Input

Stakeholders discussed how food insecurity is linked to other health-related needs, such as economic insecurity, and contributes to chronic diseases. They shared the following contributing factors to food insecurity:

- Higher cost of nutritious, fresh foods compared to processed foods
- Insufficient SNAP benefits to cover a family's food expenses
- Lack of access to healthy food options and grocery stores

During a listening session on food insecurity, community members identified the barriers they experience to accessing nutritious, high-quality food:

- Poor quality of nutritious, fresh foods in the local grocery stores
- Higher cost of nutritious, fresh foods compared to processed foods,
- Time and stress
- Transportation
- Family influence

Community members shared the following strategies to improve access to nutritious, good quality food:

- Increased information on nutrition from hospitals through health education and resource fairs
- Increased number of government programs to help with grocery expenses or increased financial support from CalFresh
- Lower cost of groceries or increased food specials in stores
- Better signage and information about how to use WIC and CalFresh benefits
- More good-quality grocery stores in food deserts and areas with high amounts of fast food restaurants (food swamps)
- More outreach to students and seniors to share resources and discounts
- More affordable housing options
- Assistance paying for utilities to improve family's financial stability

Secondary Data

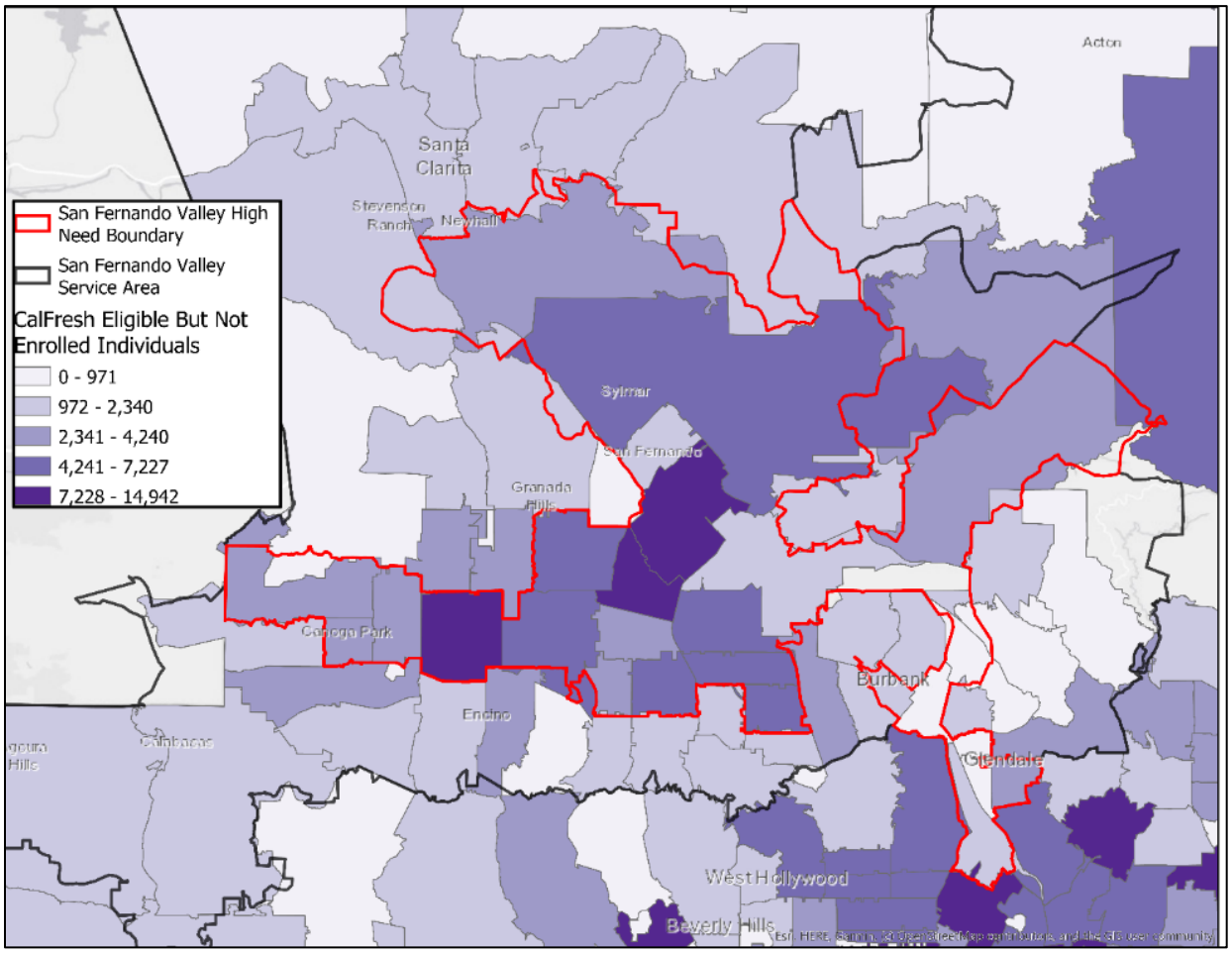
CalFresh/ Food Assistance Enrollment

Table 6. Household Government Assistance by Area

Variable	Community Benefit Service Area	Broader Service Area	Los Angeles County
2013-2017 ACS Households Receiving Food Stamps/SNAP (%)	39,562 (11.19%)	13,245 (3.39%)	294,372 (8.93%)

In 2017, the SFV Community Benefit Service Area had a higher participation rate than Los Angeles County in CalFresh/Food Stamp benefits in 2017.

Figure 6. CalFresh Enrollment in the San Fernando Valley Service Area



According to the Los Angeles Department of Public Social Services, in June of 2018 there were a high concentration of individuals eligible but not enrolled in CalFresh in ZIP codes within the Community Benefit Service Area.

Chronic Diseases

Primary Data—Service Provider and Community Resident Input

Stakeholders shared their concerns about the high numbers of people they serve with chronic diseases, in particular diabetes, obesity, and hypertension. 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:

- Inactive lifestyles
- Food insecurity causing poor nutrition

- Lack of health literacy and knowledge
- Lack of affordable, fresh, good quality foods in many low-income communities

Stakeholders identified the following populations as most affected by chronic diseases:

- Latinos
- Immigrants, particularly new and undocumented immigrants

Stakeholders shared the following strategies for addressing chronic diseases:

- Increase health education and system navigation using patient navigators and closed loop referrals
- Increase screening for chronic diseases and the social determinants of health
- Increase safe and affordable locations for people to be physically active

Secondary Data

Los Angeles County Indicators

Table 7. Chronic disease Indicators by Geographic Area

Health Outcomes	Community Benefit Service Area	Broader Service Area	Los Angeles County
Obesity			
Percent of adults who are obese (BMI≥30.0)	22.5%	17.3%	23.5%
Diabetes			
Percent of adults ever diagnosed with diabetes	9.0%	7.4%	9.8%
Diabetes-related hospital admissions (per 10,000 population)	13.69	8.35	15.74
Diabetes-specific death rate (per 100,000 population)	22.06	14.38	24.21
Cardiovascular Disease			
Hypertension-related hospital admissions (per 10,000 population)	5.68	3.24	5.10
Percent of adults ever diagnosed with hypertension	23.3%	24.8%	23.5%
Coronary heart disease-specific death rate (per 100,000 population population)	120.69	105.48	108.10
Stroke-specific death rate (per 100,000 population)	32.86	28.69	36.20

According the California Health Interview Survey (CHIS), the prevalence of diabetes in Los Angeles County has jumped from 6.9% in 2003 to 12.1% in 2017. Adults who have ever been told

they have pre-diabetes has risen over 10% since 2009. As of 2017, the CHIS reveals that 17.4% of the adult population in Los Angeles has been told they have pre-diabetes.

Access to Health Care

Primary Data—Service Provider and Community Resident Input

Stakeholders identified improved access to health care as high a need in the San Fernando Valley. Stakeholders emphasized that addressing access to care should involve ensuring care is culturally responsive. Stakeholders named a variety of contributing factors to the community's access to health care challenges:

- Lack of necessary knowledge to navigate the complexities of the health care system
- 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

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

- Utilize housing navigators in the Emergency Department
- Improve access to counseling and mental health services by hiring more mental health providers
- Integrate mental health care and primary care
- Increase health education and system navigation using patient navigators and closed loop referrals
- Increase screening for mental health, chronic diseases and the social determinants of health.
- Develop respite care for patients

Secondary Data

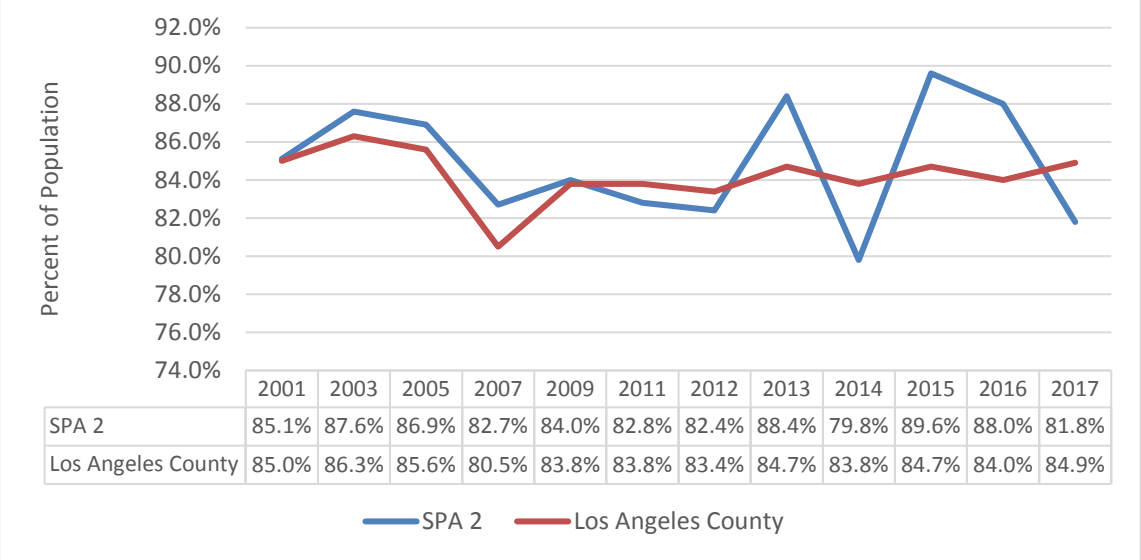
Overall, the Community Benefit Service Area performs less favorably than LA County on a series of access to care indicators, with the exception of the number of adults and children that are not receiving dental care because they could not afford it.

Table 8. Access to Care Data

Indicator	Community Benefit Service Area	Broader Service Area	Los Angeles County
Percent of children ages 0-17 years who are insured	95.6%	99.5%	96.6%
Percent of adults ages 18-64 years who are insured	82.0%	93.9%	88.3%
Percent of children ages 0-17 years with a regular source of health care	93.0%	97.0%	94.3%
Percent of adults 18-64 years with a regular source of health care	77.5%	82.0%	77.7%
Percent of adults who did not see a dentist or go to a dental clinic in the past year	44.8%	26.3%	40.7%
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	12.2%	8.6%	11.5%

Source: 2015 Los Angeles County Health Survey

Figure 7. Population with Usual Source of Care, 2001-2017, SPA 2 and Los Angeles County



	2001	2003	2005	2007	2009	2011	2012	2013	2014	2015	2016	2017
SPA 2	85.1%	87.6%	86.9%	82.7%	84.0%	82.8%	82.4%	88.4%	79.8%	89.6%	88.0%	81.8%
Los Angeles County	85.0%	86.3%	85.6%	80.5%	83.8%	83.8%	83.4%	84.7%	83.8%	84.7%	84.0%	84.9%

Since 2009 Los Angeles County has had an increasing trend in respondents who have a usual source of care. SPA 2 has seen wide fluctuations in those who have a usual source of a care with a recent downward trend beginning in 2015.

Senior Care

Primary Data—Service Provider and Community Resident Input

Stakeholders were concerned about older adults being unable to afford to live in the San Fernando Valley due to increasing housing costs and financial insecurity. Stakeholders shared that the number of seniors in the service area experiencing economic insecurity has increased over the past ten years. Stakeholders identified time, transportation, lack of interest or motivation, literacy/language, awareness of resources, and qualification standards as barriers to accessing resources in the community. Additionally stakeholders were concerned that social isolation among older adults which can contribute to depression.

Secondary Data

Senior Population in Service Planning Area 5

- Both the Community Benefit Service Area and the Broader Service Area have growing 55+ and 65+ age group populations.
- By 2024, the age group 55+ will make up about 25% of the population in the Community Benefit Service Area and over 30% of the population in the Broader Service Area.

Table 9. Older Adult Population by Age in Community Benefit Service Area

Community Benefit Service Area	Census 2019		Census 2024 (projection)	
Population by Age	Number	Percent	Number	Percent
55 - 64	128,584	11.0%	132,506	11.1%
65 - 74	83,576	7.2%	95,995	8.0%
75 - 84	39,894	3.4%	49,693	4.2%
85+	17,867	1.5%	19,191	1.6%
55+	269,921	23.2%	297,385	24.9%
65+	141,337	12.1%	164,879	13.8%

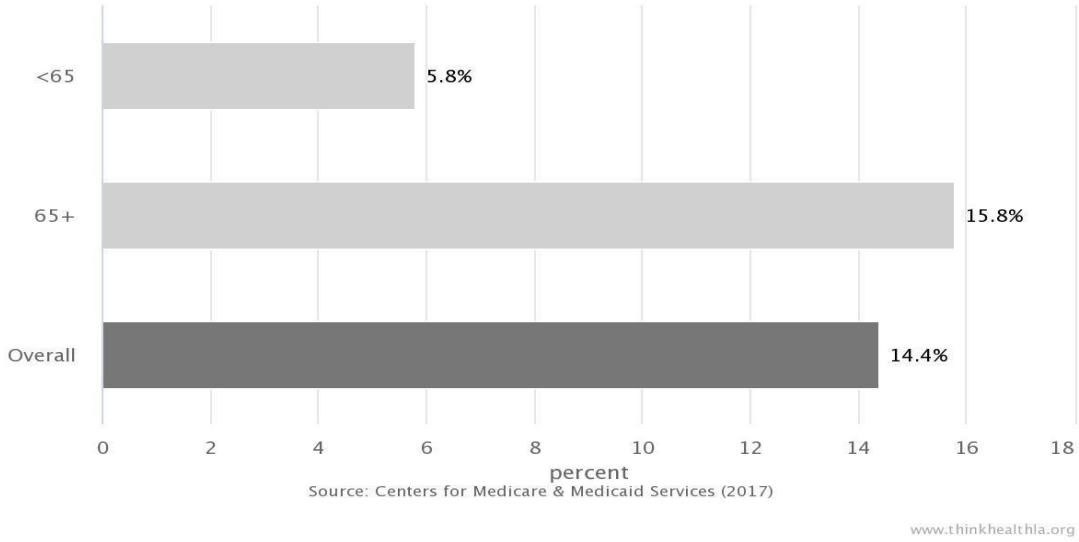
Table 10. Older Adult Population by Age in Broader Service Area

Broader Service Area	Census 2019		Census 2024 (projection)	
Population by Age	Number	Percent	Number	Percent
55 - 64	151,966	14.0%	148,617	13.4%
65 - 74	103,841	9.6%	117,316	10.6%
75 - 84	52,285	4.8%	64,163	5.8%
85+	23,783	2.2%	25,108	2.3%
55+	331,875	30.6%	355,204	32.0%
65+	179,909	16.6%	206,587	18.6%

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, with a 2.3% increase.

Figure 8. Alzheimer's Disease or Dementia in the Medicare Population by Age in LA County



Falls

The percent of adults (ages 65+) who have fallen in the past year is substantially higher in the Community Benefit Service Area than in the Broader Service Area and Los Angeles County.

Table 11. Falls in Adults Ages 65+ by Geographic Area

Indicator	Community Benefit Service Area	Broader Service Area	Los Angeles County
Percent of adults ages 65+ years who have fallen in the past year	35.7%	28.2%	27.1%

Violence Prevention

Primary Data— Service Provider and Community Resident Input

Community members identified public safety, including violence, safety in parks, and inadequate street lighting as one of the biggest health and social issues in their community. Therefore, addressing violence prevention is an urgent need.

Effective violence prevention creates a healthy community:

- A community free of violence and gangs
- A clean community, free of trash on the streets and in the parks

Secondary Data

Table 12. Violence Data by Geographic Area

Violence	Community Benefit Service Area	Broader Service Area	Los Angeles County
Percent of adults who believe their neighborhood is safe from crime	91.8%	97.8%	84.0%
Premature death rate due to homicide in total Years of Potential Life Lost (YPLL) per 100,000 population	180.0	43.4	240.3
Percent of adults who have ever experienced physical (hit, slapped, pushed, kicked, etc.) or sexual (unwanted sex) violence by an intimate partner	14.0%	15.7%	13.4%

The percent of adults who believe their neighborhood is safe from crime is higher in both the Community Benefit and Broader Service Areas than in Los Angeles County. This comparison is the same for the percent of adults who have ever experienced violence from an intimate partner.

The premature death rate due to homicide (measured in total years of potential life lost) is over four times greater in the Community Benefit Service Area than in the Broader Service Area.

Immunizations and School Health

Primary Data—Service Provider and Community Resident Input

Stakeholders shared that addressing immunization and interrelated school health challenges is an urgent need. Stakeholders shared the following factors that contribute to why people may choose not to vaccinate or barriers to child immunization:

- Lack of understanding and misinformation
- Fear of side effects
- Perceived benefits versus risks
- HPV vaccine confusion

Effective strategies to address immunizations and school health by stakeholders include the following:

- Free flu shots
- Free health checks
- Community clinics with affordable care
- Mobile health care clinics

Secondary Data

Immunization/Community Health

Table 13. Child Vaccination Data by Geographic Area

Immunization/School Health	Community Benefit Service Area	Broader Service Area	Los Angeles County
Percent of children ages 6 months - 17 years vaccinated for influenza	50.7%	58.2%	55.2%

The percent of children (ages 6 months to 17 years) who have received the flu vaccination less in the Community Benefit Service Area when compared to the Broader Service Area and to Los Angeles County.

Table 14. Adolescent Vaccination Data by Geographic Area

Immunization/School Health	SPA 2	Los Angeles County	HP 2020 Target
Percent of teen girls (13-17 years) vaccinated for HPV	43.2%	44.6%	80.0%

The percent of girls vaccinated for HPY in SPA 2 1.4% less than the County average. However, 46.8% off from Healthy People 2020 target.

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 San Fernando Valley Community. There are numerous health care providers, social service non-profit agencies, faith-based organizations, private and public-school systems that contribute resources to address these identified needs. For a list of potentially available resources available to address significant health needs go to Appendix 4.

Evaluation of 2017 – 2019 Community Health Improvement Plan Impact

This section includes a description of the programs and services provided by three Providence medical centers in the San Fernando Valley that support the Community Benefit Plan Strategies and Metrics.

In 2016, the San Fernando Valley Service Area adopted a Community Health Improvement Plan designed to address key needs identified in the assessment, which included:

1. Access to Healthcare and Community Resources
2. Prevention and Management of Chronic Diseases
3. Senior Care and Resources
4. Mental Health Services (including Substance Abuse)
5. Poverty and Food Insecurity

The goal of the improvement plan was to measurably improve the health of individuals and families living in the areas served by the three Providence Medical Centers: PHCMC, PSJMC, and PCSTMC. This was the first time the improvement plan was consolidated into one report, representing one San Fernando Valley Service (SFV) Area. The plan included components of education, prevention, disease management, and treatment, as well as a plan to address social determinants of health.

In 2017, the first year of the implementation strategy, the Providence San Fernando Valley Community Investment Department focused on improving access to healthcare, which was the top priority health need identified in the 2016 Community Health Needs Assessment (CHNA). With a new emphasis on building health access programs across the Los Angeles Service Area, the SFV Community Health Department began to expand the scope of services provided by its Community Health Workers. It included providing application assistance for health insurance and CalFresh benefits. All public benefit programs, health insurance (Medi-Cal and Covered California) and CalFresh, require that the Community Health Workers were trained and certified enrollment counselors to assist clients and families enroll for benefits. In addition, Community Health Workers in the Emergency Department began to focus on core responsibilities designed to impact outcomes in support of improving patient access to a medical home, assistance with arranging follow up care at a convenient community clinic, enrolling eligible adults in Emergency Medi-Cal (Hospital Presumptive Eligibility), and navigation to health services.

One of the key relationships developed in 2017 was with Vaughn Next Century Learning Center (Vaughn), which is a private independent K-12 charter school located in Pacoima, California. In March of

2018, the Community Health Department collaborated with Vaughn to open a 1,500 square foot Wellness and Activity Center (the Center). The goal of the Center is to create a place outside the hospital that would give children and adults access to a clean and safe place to play, learn, and come together with their neighbors to improve their own health. The Center offers complementary programs including daily exercise programs: Zumba®, aerobics and walking groups, application assistance for public benefits: Medi-Cal, Covered California and CalFresh, referrals to other local resources and ongoing health and wellness classes. The Center linked Community Health Staff, prevention and management of chronic disease education to a high need Northeast San Fernando Valley community.

Community Health Staff were also able to fulfill the senior care and resources initiatives through collaborative partnerships with senior agencies such as One Generation, the Joslyn Center, and the CSUN Kinesiology Department 3Wins Program that provided much needed mental health, senior specific resources, and/or exercise programs throughout all of the San Fernando Valley as described in the Implementation Strategy. The successful relationships with community partners in the past two years provided new resources to residents in target communities. Additional key partners who contributed to our efforts in improving the health in the community in the San Fernando Valley are MEND, San Fernando Community Health Center, All Inclusive, Los Angeles Unified School District, City of San Fernando, City of Los Angeles, UCLA, Tarzana Treatment Center, and Valley Care Community Consortium.

In July of 2019, the Community Health Investment Department moved its administration office to Van Nuys, California. The new office allowed for more space that now allowed to provide wellness programs for the community. The Van Nuys wellness center includes a 1,250 square foot classroom that is used to provide health education workshops. A future goal is to transform the room into an educational teaching kitchen to allow for health education and cooking classes. Two months later, in September, Community Health Investment established a collaboration with the Burbank Housing Corporation and opened the Providence Wellness Center in Burbank, California. The purpose it to provide services to the clients surrounding our Providence St. Joseph's Hospital. This center offered complementary exercise classes, preventative mental health related classes, health insurance and Cal Fresh enrollment assistance, and referrals or linkage to appropriate resources in the community. Information in English, Spanish and Armenian will be provided to participants visiting the center. These three wellness centers provided the Community Health Investment Department the ability to focus efforts in mental health services and implement food insecurity strategies.

The following is a summary of the five CHNA strategies:

Strategy #1: Improve Access to Healthcare Services. As of 2018, the following has been accomplished.

- Community Health Workers assisted with 786 MediCal applications at various locations in the San Fernando Valley, including school parent centers, churches, health clinics, and community wellness centers. It is projected that approximately 1,200 medical applications will be submitted by the end of 2019.
- Community Health Workers working in the Emergency Department at Providence Holy Cross Medical Center and Providence St. Joseph Medical Center were able to assist 865 patients applying for Hospital Presumptive Eligibility (HPE), which provided much needed temporary medical coverage for uninsured patients, namely low-income children and adults. In 2019, the

Community Health Investment department began to support Providence Tarzana Medical Center Emergency Department. It is projected that approximately 2,547 HPE's will be completed by the end of 2019.

- There were a total of five health clinics that participated in the Access to Care program, including Meet Each Need with Dignity (MEND), All Inclusive Community Health Center, San Fernando Community Health Center, Valley Community Health Center, and El Proyecto del Barrio.
- Community Health Workers in the Emergency Department at Providence Holy Cross Medical Center and Providence St. Joseph Medical Center scheduled 710 primary care appointments to community clinics for follow-up care. 554 (78%) of those appointments were kept. With service added to Tarzana Medical Center in 2019, appointment are projected to reach 1,345 by the end of 2019.
- Community Health Workers and Faith Community Nurses facilitated 545 follow-up appointments to a medical home for health fair participants who received out-of-range point of care (POCT) test results.
- The Mobile Immunization Clinic for free vaccinations to various LAUSD schools, independent charters, and private faith-based schools in partnership with Facey Medical Group is on hold until improvements to the mobile unit pass LA County Immunization Project certification requirements.

Strategy # 2: Implement Prevention Interventions to Reduce the Prevalence or Progression of Chronic Disease. As of 2018, the following has been accomplished.

- The CSUN/3WINs Wellness program, which includes HbA1c testing, body mass index and body fat % screenings, as well as goal setting, was conducted at 4 local sites including St Patrick's Catholic Church (North Hollywood, CA), St. Didacus Catholic Church (Sylmar, CA), Our Lady of Peace Catholic Church (North Hills, CA) and Guardian Angel Church (Pacoima, CA) with 136 participants in 2017, and 235 in 2018 when Lanark Park (Canoga Park, CA) was added as a site.
- Fit Food Fairs/Cardio Carnivals were conducted at three faith-based schools including St. Patrick's, Guardian Angel, and St. Didacus to highlight nutrition education, physical activity, and wellness promotion.
- 457 seniors received services from referrals to local senior agencies, such as One Generation and the Joslyn center as a way to improve continuum of services.
- 231 seniors participated in the 3WINS Exercise Program to increase their daily physical activity levels.
- 10 adults completed the FEAST program- a 10-week nutrition support group, including education, cooking demonstrations, and food scholarships. The program showed positive healthy behavior change.
    - At the beginning of the program, 58% of participants drank soda once a week or more. By the end of the program 91% of participants either drank no soda or only 1 soda a week. (33% change).
    - At the beginning of the program 58% of participants were cooking meals at home once a day. By the end of the program, 75% of participants were cooking meals at home at least once a day (17% change).

- 10 participants consistently attend the Attention to Prevention Diabetes Program has 10 participants who are consistently attending weekly sessions. Six met their goals and lost an average of 7.7lbs. One individual dropped a total of 21lbs or 10% of their initial weight.

Strategy # 3: Strengthen Community-based Mental Health Infrastructure to Better Align with Hospital-based Mental Health Services (including substance abuse treatment). As of 2018, the following has been accomplished.

- 60 people were referred directly to Tarzana Treatment Center for mental health services from health education workshops provided by Community Health Workers at schools and churches covering topics on mental health awareness and how to prevent mental health illnesses.
- Between March, 2018 ad September, 2019, three wellness and activity centers were opened that provided community health navigation and educational services, including mental health classes and physical activity classes: (1) at Vaughn Next Century Charter School in the City of Pacoima; (2) in the City of Van Nuys (also serves as department administrative office); and (3) in the City of Burbank, in partnership with Burbank Housing Corporation.
- 25 Providence Community Health employees received Mental Health First Aid training through a partnership with the National Council for Behavioral Health.
- An Alcohol and Health Research study is being conducted, in partnership with UCLA, with 11 participants to investigate the effectiveness of 3 motivational interviewing sessions on Latinos exhibiting unhealthy drinking behaviors.

Strategy # 4: Align Community Benefit Programs with San Fernando Medical Centers. As of 2018, the following has been accomplished.

- A network of 8 specialty physicians are participating in the Access to Care Program. A total of 341 patients were referred by participating clinics for specialty care consultation services. Referrals are expected to grow to 450 patients by end of 2019.
- 111 students at Sepulveda Middle School completed the Adolescent Coping Education Series (ACES), an 8-week educational series focusing on coping and resiliency skills. An additional 130 students at James Monroe High School will have completed the series by December 2019.
- Community Health staff assisted in providing pre and post screenings for 53 participants for the 4-month Live Well Program for seniors in partnership between Providence St. Joseph Medical Center, Providence Community Health Investment and various organizations in Burbank (i.e. YMCA). The program combines exercise, nutritional counseling and disease prevention & management education.
- In March of 2019 the SAFE program was implemented at Tarzana Medical Center. It is designed to address avoidable visits by seniors frequently seen in the ER. It is estimated that Community Health Investment Staff will assist over 300 patients by the end of 2019.

2019 CHNA Governance Approval

This community health needs assessment was adopted on December 19, 2019 by the Providence Valley Service Area Community Ministry Board and by the Providence Cedars-Sinai Tarzana Board of Managers, on December 17, 2019.

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Chair, Valley Service Area Community Ministry Board

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Providence Holy Cross Medical Center

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Appendix 1: Fact Sheets on Health Indicators

Access to Health Care

Primary Data

Community members and stakeholders both identified access to healthcare as a high health need in the San Fernando Valley. Access to healthcare was a common concern identified across all health needs discussed in listening sessions and stakeholder interviews.

Listening Sessions

- Community members identified low-cost and free health care services as important community assets for addressing health needs. Over half of community members in listening sessions shared that health insurance was one of their biggest financial challenges and wanted improved access to affordable health care.

Community Stakeholder Interviews

- Stakeholders shared that people lack the knowledge to navigate the complexities of the health care system to access the services they need to prevent and manage their chronic diseases.
- Stakeholders shared that there is a lack of mental health providers in the San Fernando Valley, particularly those who are bilingual and from the communities they serve. This lack of access to mental health care is prevalent in community health care settings and in the schools. For young people, there are insufficient counselors in the schools to offer support.
- Stakeholders shared immigrants are disproportionately affected by chronic diseases for a variety of reasons. Undocumented immigrants may not have health insurance and or are afraid to access services due to their immigration status. New immigrants may not know how to navigate the health care system or seek resources, and they may not speak English, making accessing services more challenging.

Opportunities and Effective Strategies for Addressing Access to Care Challenges:

- Utilize housing navigators in the Emergency Department.
- Improve access to counseling and mental health services.
- Integrate mental health care and primary care.
- Increase health education and system navigation using patient navigators and closed loop referrals.
- Increase screening for mental health, chronic diseases and the social determinants of health.
- Develop respite care for patients.

Secondary Data

Los Angeles County Key Indicators of Health

The Los Angeles County Department of Public Health produces reports that present a snapshot of the health of Los Angeles' population. Included are indicators relating to health risk behaviors, access to services, disease, injury, and various social determinants of health that affect the overall well-being of a person. These indicators are used to highlight the disparities between the areas that Providence Saint Joseph Health serves and Los Angeles County.

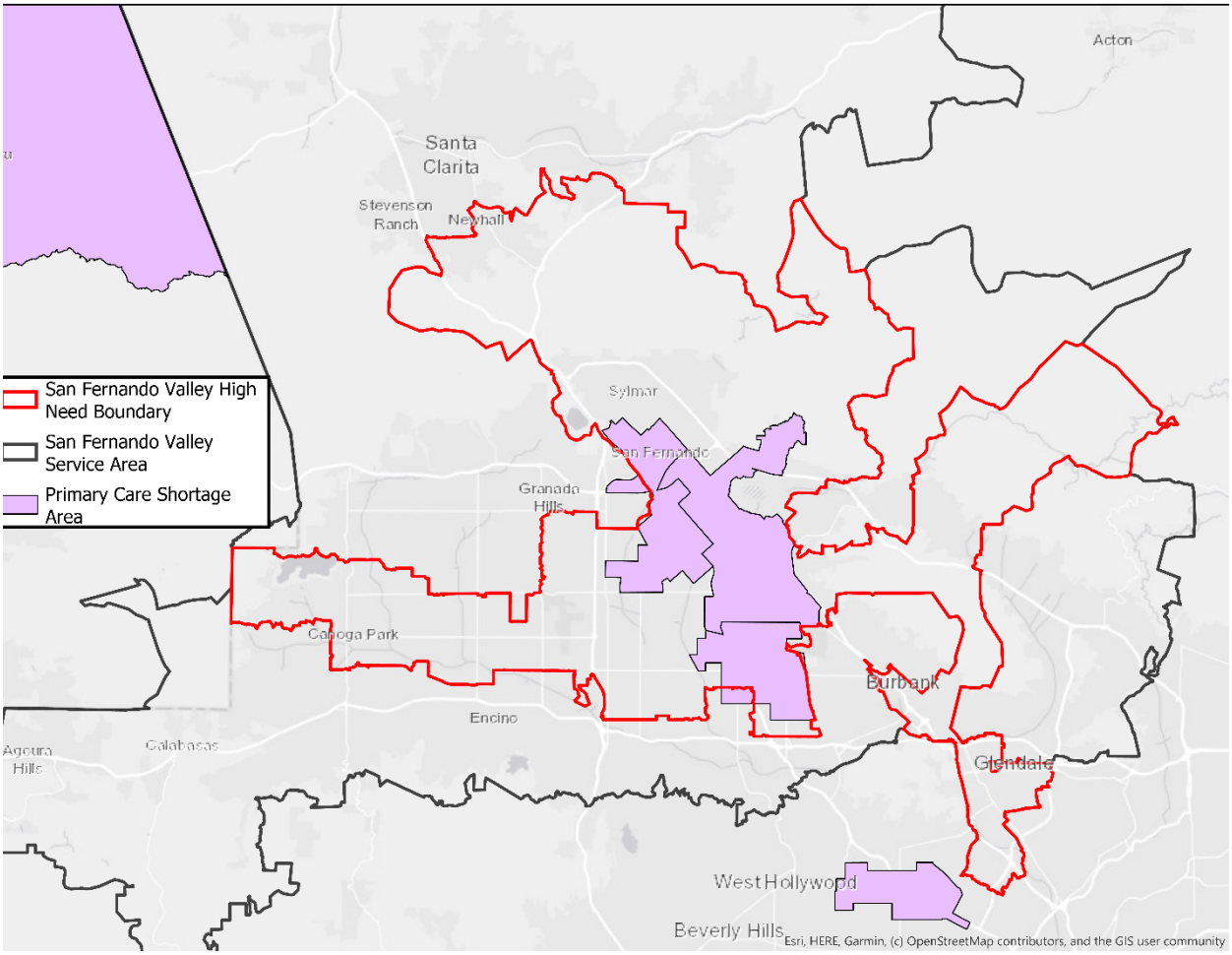
Table_Apx 1. Access to Care Data by Geographic Area

Access to Care	Community Benefit Service Area	Broader Service Area	Los Angeles County
Percent of children ages 0-17 years who are insured	95.6%	99.5%	96.6%
Percent of adults ages 18-64 years who are insured	82.0%	93.9%	88.3%
Percent of children ages 0-17 years with a regular source of health care	93.0%	97.0%	94.3%
Percent of adults 18-64 years with a regular source of health care	77.5%	82.0%	77.7%
Percent of adults who did not see a dentist or go to a dental clinic in the past year	44.8%	26.3%	40.7%
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	12.2%	8.6%	11.5%

- The Community Benefit Service Area has a lower percent of insured children and adults than the Broader Service Area and Los Angeles County. Similarly, the Community Benefit Service area also has a lower rate of children and adults who have a regular source of health care as compared to the Broader Service Area and Los Angeles County.
- Disparities in dental care exist between the Community Benefit Service Area, the Broader Service Area and Los Angeles County. More adults are not receiving dental care and more children could not afford dental care in the Community Benefit Service Area than the Broader Service Area and Los Angeles County.

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 primary care shortage areas in the San Fernando Valley with the boundary of the high need community as defined by the Community Needs Index.

Figure_Apx 1. Primary Care Shortage Area in SFV Service Area



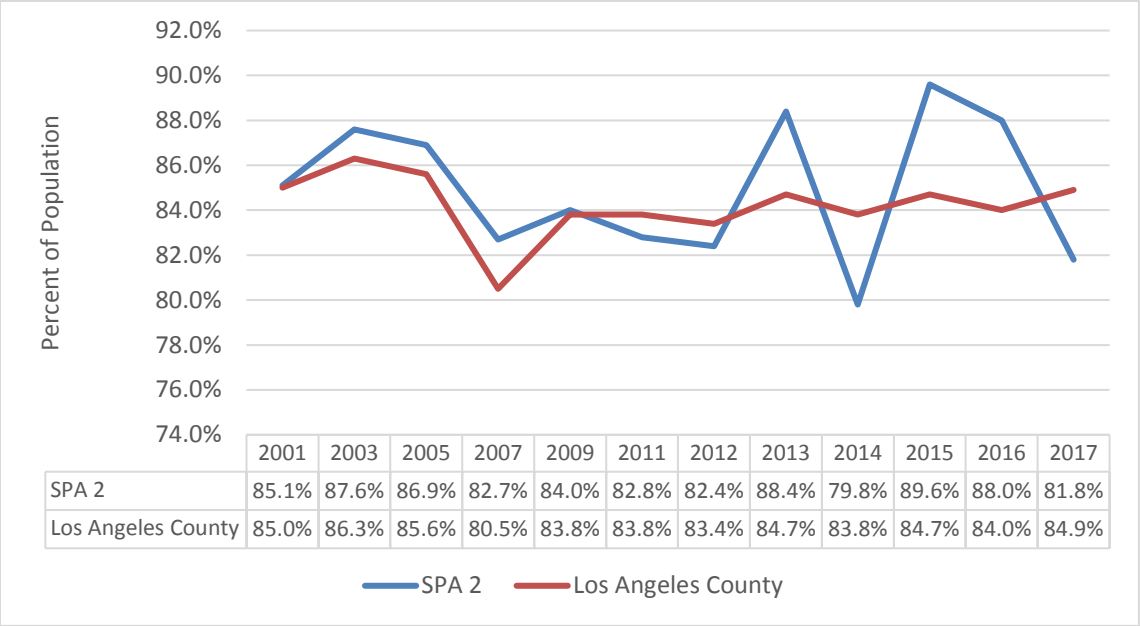
- According to HRSA, all primary care shortage areas lie within the high-need areas in the San Fernando Valley.

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.

CHIS surveys adults, teens and children to determine if have a usual source of care. In the following graph, we see the percent of respondents in SPA 2 and Los Angeles County who have a usual source of care trended by year.

Figure_Apx 2. Population with Usual Source of Care in SPA 2 and LA County



	2001	2003	2005	2007	2009	2011	2012	2013	2014	2015	2016	2017
SPA 2	85.1%	87.6%	86.9%	82.7%	84.0%	82.8%	82.4%	88.4%	79.8%	89.6%	88.0%	81.8%
Los Angeles County	85.0%	86.3%	85.6%	80.5%	83.8%	83.8%	83.4%	84.7%	83.8%	84.7%	84.0%	84.9%

Since 2009 Los Angeles County has had an increasing trend in respondents who have a usual source of care. SPA 2 has seen wide fluctuations in those who have a usual source of a care with a recent downward trend beginning in 2015.

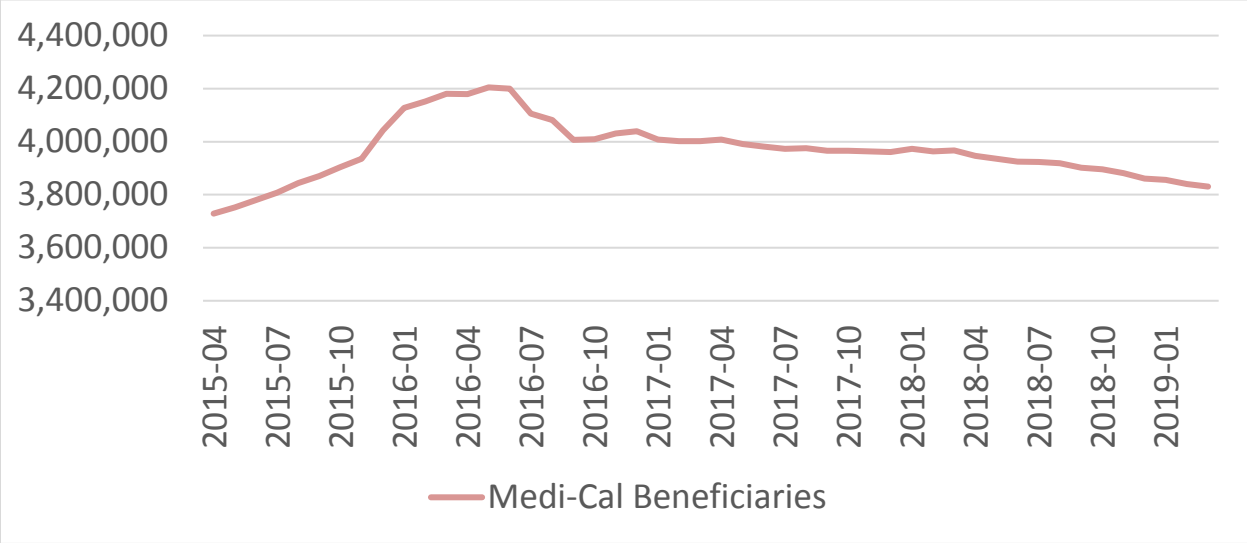
Medi-Cal Eligibility

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. The following tables shows Medi-Cal beneficiaries by the ACA Expansion by race and ethnicity as of March 2019.

Table_Apx 2. ACA Expansions Adult Ages 19- 64 Enrollees as of March 2019

County	AI/AN	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 3. 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.

Chronic Diseases

Primary Data

Stakeholders shared their concerns about the high number of people they serve with chronic diseases. In particular, diabetes, obesity, and hypertension. They named inactive lifestyles, food insecurity causing poor nutrition, and lack of health literacy and knowledge as contributors to the high number of people with chronic diseases. Stakeholders identified Latinx people and immigrants, particularly new and undocumented immigrants, as disproportionately affected by chronic disease. To address chronic diseases in their community, stakeholders shared needing more of the following: health education and system navigation, screening for chronic diseases and social determinants of health, and safe and affordable locations for people to be physically active.

- Community members identified obesity, for both children and adults, linked with poor nutrition as one of the biggest health and social issues in their community.
- Both community members and stakeholders shared a concern for adult and childhood obesity, as well as diabetes and hypertension. They discussed the connection between obesity and food insecurity, particularly the lack of affordable, fresh, good quality foods in many low-income communities, compared to lower cost, unhealthy food options.
- Stakeholders shared they see a lack of understanding about healthy diets and chronic diseases. Additionally, people lack the knowledge to navigate the complexities of the health care system to access the services they need to prevent and manage their chronic diseases.
- Community members identified time, transportation, lack of interest or motivation, literacy/language, awareness of resources, and qualification standards as barriers to accessing resources in the community.

- Stakeholders shared immigrants are disproportionately affected by chronic diseases for a variety of reasons. Undocumented immigrants may not have health insurance and or are afraid to access services due to their immigration status. New immigrants may not know how to navigate the health care system or seek resources, and they may not speak English, making accessing services more challenging.
- Community members identified that the following programs, services, or opportunities would help people lead healthier lifestyles:
    - Affordable classes and educational programs for children: Participants would like to see more affordable recreational opportunities for children such as sports leagues, dance, music, cooking, and art. They also would like more health education programs related to healthy eating, and multiple groups spoke to wanting more frequent classes on the negative effects of substance use.
    - Classes for parents: Participants would like more classes that help parents develop skills and learn how to grocery shop and cook on a budget. Additionally, they would like more affordable exercise classes and programs that focus on food and art for families to participate.
    - Improved access to affordable, healthy food: More markets with healthy food and farmers markets are needed in San Fernando to increase access to organic fruits and vegetables. Additionally, participants would like to see these healthy food options be more affordable in their local grocery stores.
- Community members shared that the following services, programs, and/or resource would be beneficial in improving the health of a community:
    - Healthy cooking classes for diabetes are particularly helpful for managing chronic diseases and adopting healthy habits. Additionally, health fairs at churches and schools and health education classes were named as helpful.
    - Recreational opportunities such as exercise classes and sports leagues: Participants shared sports leagues in the park for youth, as well as adult exercise programs like Zumba are good resources for being active.

Secondary Data

Los Angeles County Key Indicators of Health

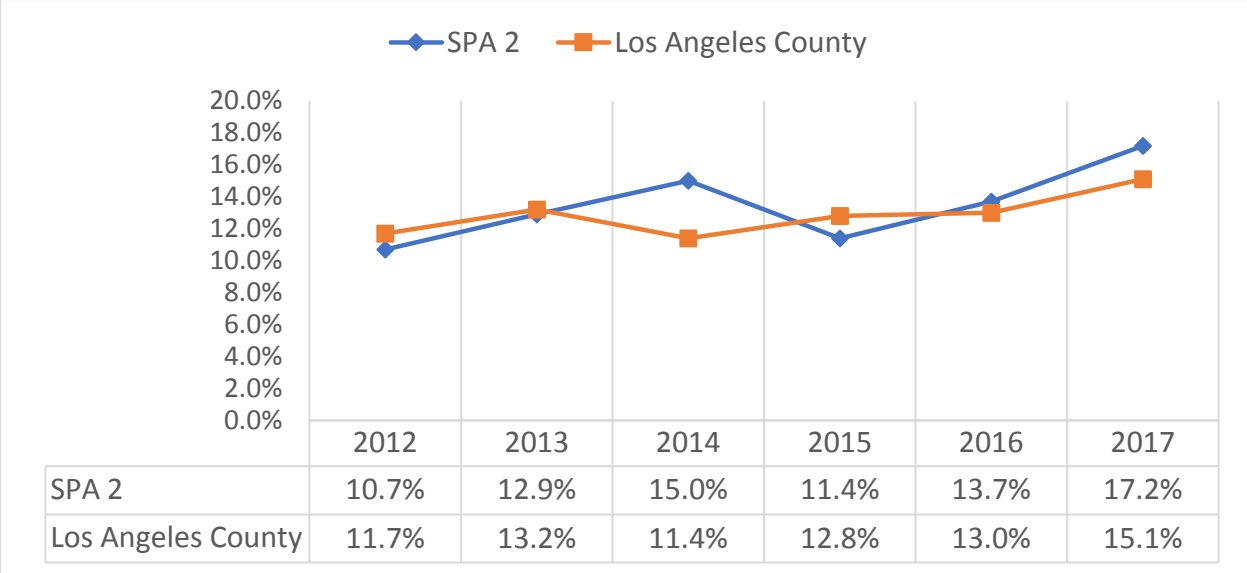
The Los Angeles County Department of Public Health produces reports that present a snapshot of the health of Los Angeles' population. Included are indicators relating to health risk behaviors, access to services, disease, injury, and various social determinants of health that affect the overall well-being of a person. These indicators are used to highlight the disparities between the areas that Providence Saint Joseph Health serves and Los Angeles County.

Table_Apx 3. Chronic Disease Data by Geographic Area

Health Outcomes	Community Benefit Service Area	Broader Service Area	Los Angeles County
Obesity			
Percent of adults who are obese (BMI≥30.0)	22.5%	17.3%	23.5%
Diabetes			
Percent of adults ever diagnosed with diabetes	9.0%	7.4%	9.8%
Diabetes-related hospital admissions (per 10,000 population)	13.69	8.35	15.74
Diabetes-specific death rate (per 100,000 population)	22.06	14.38	24.21
Cardiovascular Disease			
Hypertension-related hospital admissions (per 10,000 population)	5.68	3.24	5.10
Percent of adults ever diagnosed with hypertension	23.3%	24.8%	23.5%
Coronary heart disease-specific death rate (per 100,000 population population)	120.69	105.48	108.10
Stroke-specific death rate (per 100,000 population)	32.86	28.69	36.20

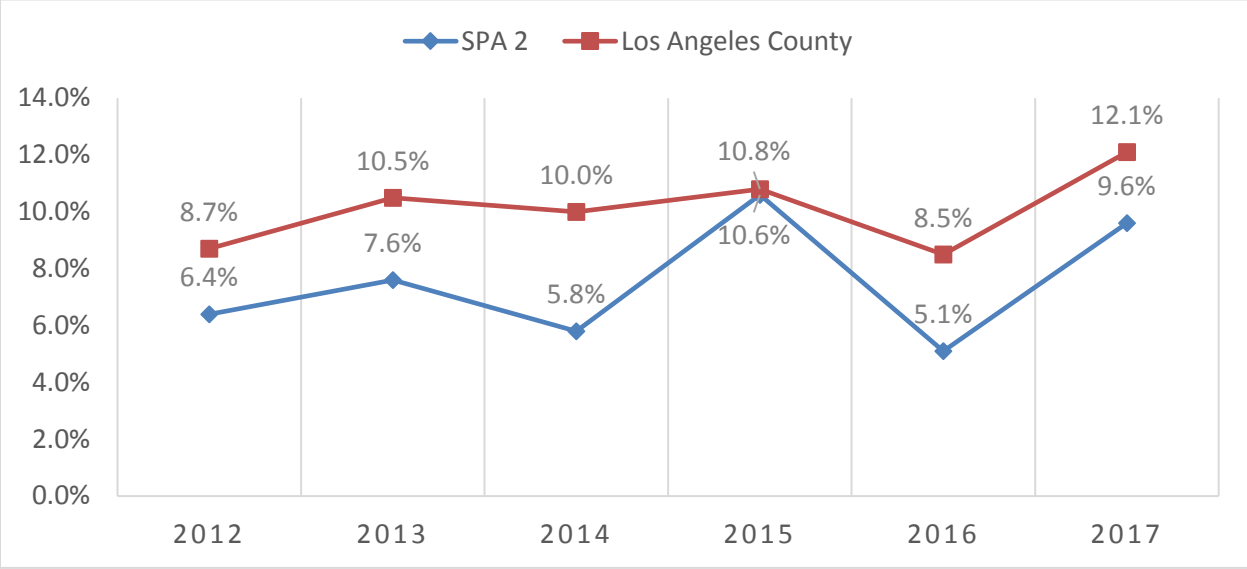
California Health Interview Survey

Figure_Apx 4. Population Diagnosed with Asthma

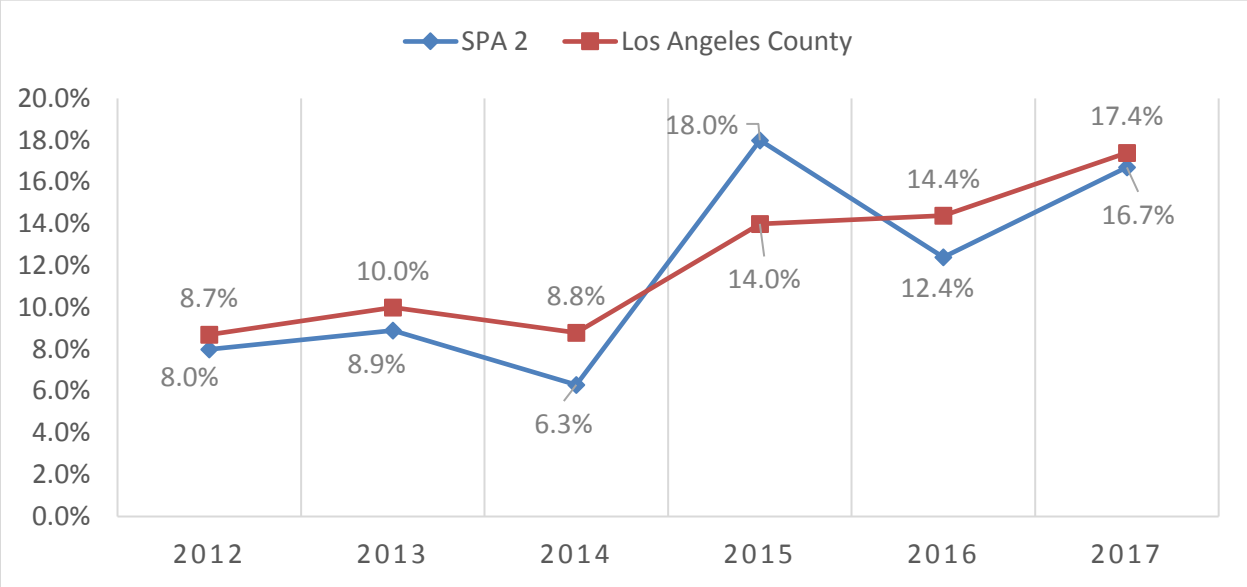


	2012	2013	2014	2015	2016	2017
SPA 2	10.7%	12.9%	15.0%	11.4%	13.7%	17.2%
Los Angeles County	11.7%	13.2%	11.4%	12.8%	13.0%	15.1%

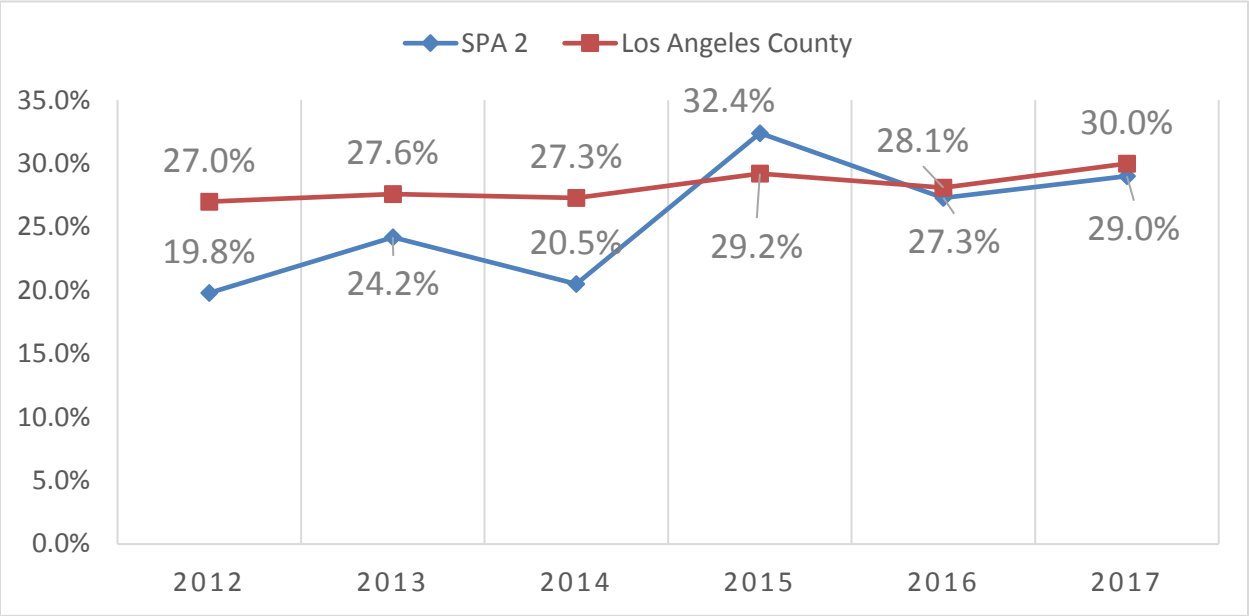
Figure_Apx 5. Adults Diagnosed with Diabetes in SPA 2 and LA County



Figure_Apx 6. Adults Diagnosed with Pre-Diabetes in SPA 2 and LA County



Figure_Apx 7. Adults Diagnosed with High Blood Pressure in SPA 2 and LA County



Food Insecurity

Primary Data

Community members and stakeholders both identified food insecurity as a high health need in the San Fernando Valley. Food insecurity was a common concern identified across all health needs discussed in listening sessions and stakeholder interviews.

- Community members shared they shop at supermarkets, and some said they also get their food at farmers markets or local food banks. Half of the community members said their families do not get enough nutritious, high-quality food and the other half said they do.
- Community members shared there are few resources to help offset the high cost of living in the San Fernando Valley. These safety nets may include help paying bills, affordable transportation, and food assistance. Lack of access to resources in the San Fernando Valley contributes to economic insecurity.
- Stakeholders shared that healthy food is often more expensive than unhealthy alternatives, with cheap, easily accessible fast food often the easier option for families. SNAP benefits are often insufficient to cover all family's food expenses, meaning families cannot always afford to buy fresh, healthy food.
- Community members identified the following barriers to accessing nutritious, high-quality food:
    - Poor quality of nutritious, fresh foods in the stores: Community members shared some of their neighborhood grocery stores do not have good-quality food, in particular produce. Many participants shared they try to buy produce on sale, but often those items are poor-quality or close to expiring. They also shared the food they receive from food banks is often expired or soon to expire.

    - Higher cost of nutritious, fresh foods compared to processed foods: Nutritious, high-quality food is often more expensive than fast food or processed food. For some of the participants who are not working or are trying to support a family, their food budget often does not cover fresh foods.
    - Time and stress: Participants who work full time and take care of a family shared that shopping for and cooking healthy food is a challenge in their busy lives due to time constraints and stressful schedules.
    - Transportation: Getting to a grocery store where fresh produce is available can be a challenge. Eating out or grabbing fast food is easier if it is within walking distance.
    - Family influence: Participants shared it is harder to cook good, nutritious foods when their partners and children do not like healthier food options. Therefore, they end up cooking multiple meals to satisfy everyone or eating unhealthy meals that their family members prefer.
- Community members shared what makes it easier for them to get nutritious, high-quality food:
    - Affordable, healthy options in local stores: The most common theme from the sessions was the cost of nutritious, high-quality food. They shared that they often buy healthy foods when they are on sale at the store. They might even travel outside of their neighborhood to find a more affordable grocery store.
    - Cooking at home instead of eating out: Participants shared the food they cook is usually healthier than the food they eat out. Therefore, going grocery shopping for meals and cooking for their family makes it easier to ensure they are eating nutritious meals.
    - Being intentional about what to buy and planning meals before shopping: Making a list of groceries to buy ahead of time and planning out meals helps participants and their families eat nutritious meals. They shared they need to be intentional about buying only the food they need and sticking to their grocery list.
    - Cooking simple recipes: Participants shared keeping recipes simple, such as making salad or quinoa, ensures the food is healthy and not time consuming to cook.

Community members were asked, “What else can hospitals, businesses, or the government do to help make it easier to get nutritious (healthy), good-quality food?” They shared they need additional support and services to help them afford healthy food. Their ideas for solutions were the following:

- Increased information on nutrition from hospitals through health education and resource fairs
- Increased number of government programs to help with grocery expenses or increased financial support from CalFresh
- Lower cost of groceries or increased food specials in stores
- Better signage and information about how to use WIC and CalFresh benefits
- More good-quality grocery stores in food deserts and places with high amounts of fast food restaurants
- More affordable housing options
- Assistance paying for utilities to improve family’s financial stability
- More outreach to students and seniors to share resources and discounts

Secondary Data

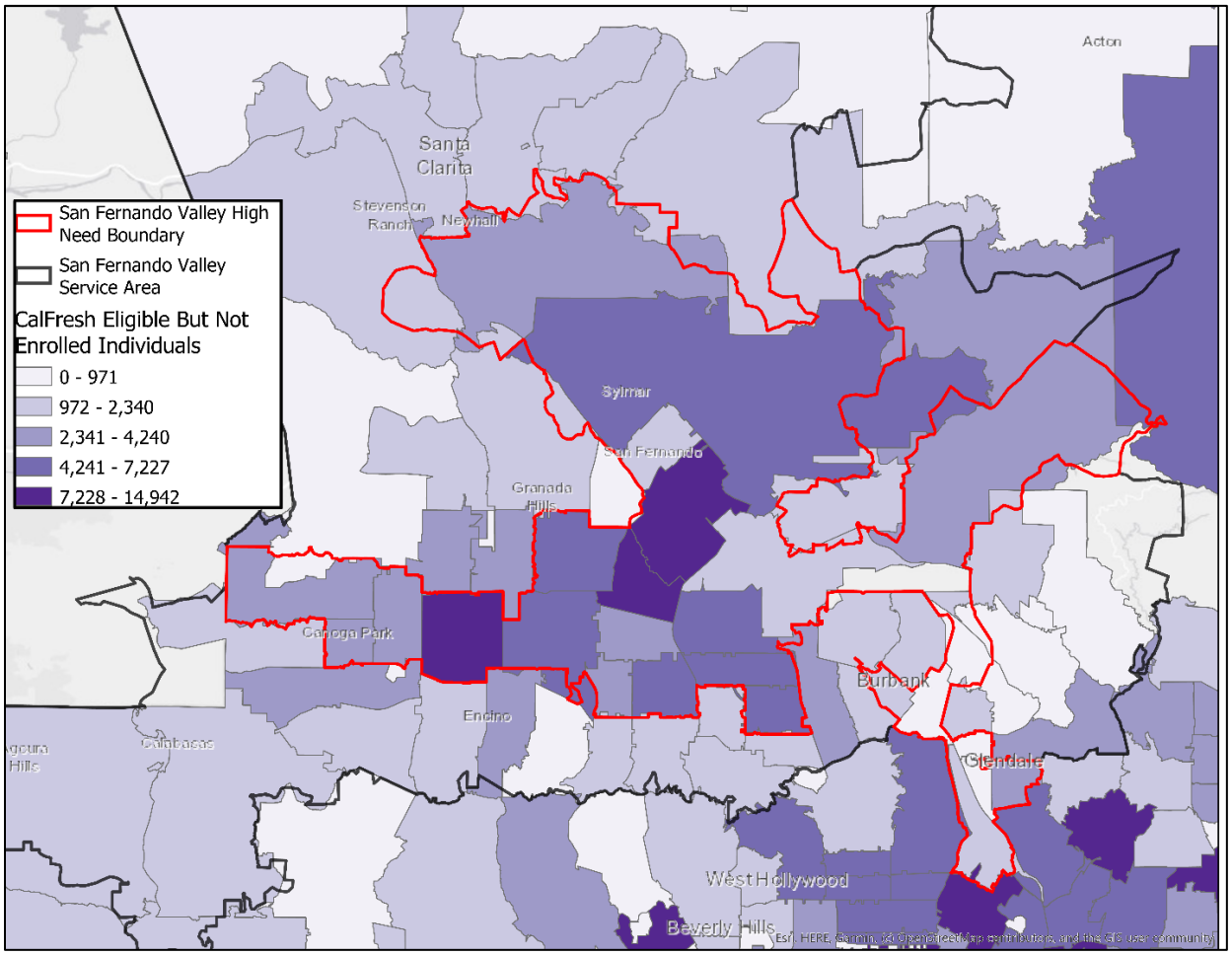
CalFresh/Food Stamp Enrollment

Table_Apx 4. CalFresh/ Food Stamp Enrollment Data by Geographic Area

Variable	Community Benefit Service Area	Broader Service Area	Los Angeles County
2013-2017 ACS Households Receiving Food Stamps/SNAP (%)	39,562 (11.19%)	13,245 (3.39%)	294,372 (8.93%)

- Almost forty thousand households in the Community Benefit Service Area were receiving SNAP benefits during the 2013 – 2017 American Community Survey period. There are higher rates of SNAP participation in the Community Benefit Service Area than the Broader Service Area and there also exists more potential CalFresh enrollees within the Community Benefit Service Area.

Figure_Apx 8. CalFresh Eligible but Not Enrolled Individuals in the San Fernando Valley Service Area



- According to the Los Angeles Department of Public Social Services, in June of 2018 there were a high concentration of eligible CalFresh recipients in zip codes within the Community Benefit Service Area.
- Zip codes 91331, 91402 and 91335 had the highest counts of eligible but unenrolled CalFresh recipients throughout all of Service Planning Area 2. Within these three high-need zip codes there are a total of 24,882 eligible but unenrolled CalFresh recipients.

Los Angeles County Key Indicators of Health

The Los Angeles County Department of Public Health produces reports that present a snapshot of the health of Los Angeles' population. Included are indicators relating to health risk behaviors, access to services, disease, injury, and various social determinants of health that affect the overall well-being of a person. These indicators are used to highlight the disparities between the areas that Providence Saint Joseph Health serves and Los Angeles County.

Table_Apx 5. Food Insecurity and Nutrition Indicators by Geographic Area

Health Indicator	Community Benefit Service Area	Broader Service Area	Los Angeles County
Percent of children with excellent or good access to fresh fruits and vegetables in their community	68.5%	92.9%	75.0%
Percent of households with incomes <300% FPL who are food insecure	32.6%	19.4%	29.2%
Percent of adults who consume five or more servings of fruits & vegetables a day	12.8%	16.3%	14.7%
Percent of children who drink at least one soda or sweetened drink a day	47.6%	28.4%	39.2%

- Overall, the Community Benefit Service Area performs worse in terms of food insecurity, access to fresh produce and healthy eating habits than the Broader Service Area and Los Angeles County. Nearly a third of all households in the Community Benefit Service Area with incomes less than three-hundred percent the Federal Poverty Level are food insecure.
- About 30% of children living in the Community Benefit Service Area do not have excellent or good access to fresh fruits and retables in their community

Homelessness and Housing Instability

Primary Data

Community members and stakeholders identified homelessness and housing instability as an urgent issue in the San Fernando Valley that contributes to a variety of other health-related needs in the community.

They described a reactionary system, struggling to meet the needs of people experiencing homelessness. The themes from the stakeholder interviews related to homelessness and housing instability were the following:

Contributing Factors to Homelessness and Housing Instability

- High cost of housing coupled with a low living wage and a lack of economic opportunities.
- Lack of safety net supports to offset high cost of living.
- Lack of sufficient homelessness services to meet the demand.
- Lack of affordable housing and NIMBYism.
- Siloed services due to funding stream.
- Lack of funding for grassroots homelessness service providers.
- Lack of full stakeholder engagement in addressing homelessness.

Effective Strategies for Addressing Homelessness

- Family reconciliation and homeless diversion.
- Relationship building and increased integration of services.
- Outreach and health education to people experiencing homelessness.
- A continuum of housing, from transitional housing to permanent housing.

Opportunities for Health Care Organizations to Engage in Homelessness Efforts

- Develop respite care for patients.
- Utilize housing navigators in the Emergency Department.
- Train staff in homeless diversion.

Stakeholders identified older adults and young people as disproportionately affected by homelessness and housing instability.

Both community members and stakeholders would like to see more shelters and resources for people experiencing homelessness, although this was more emphasized by stakeholders. Stakeholders highlighted a lack of sufficient funding, capacity, and integrated services as challenges to addressing homelessness in the San Fernando Valley

Secondary Data

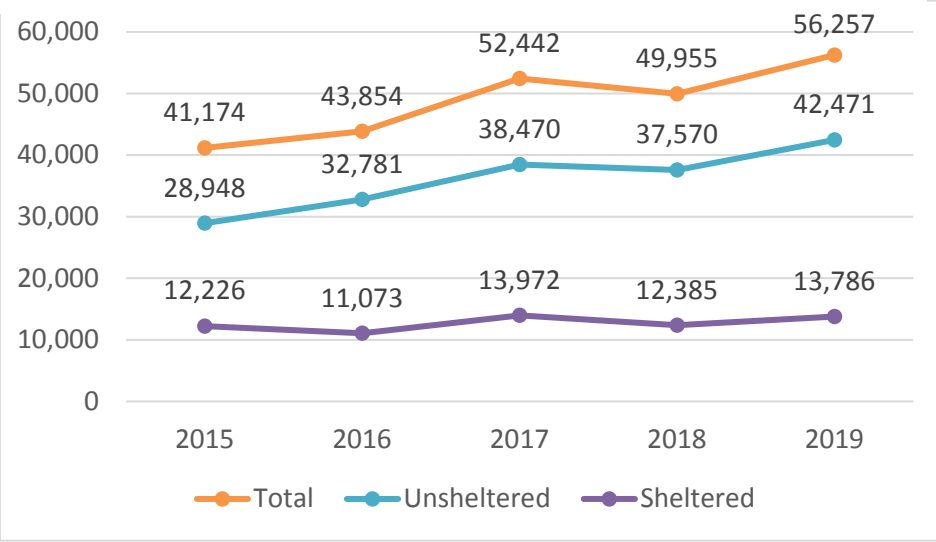
The Los Angeles Homeless Services Authority (LAHSA) conducts a yearly point-in-time count called the Greater Los Angeles Homeless Count. Moderated by the U.S. Department of Housing and Urban Development, LAHSA conducts the nation's largest homeless census count with the help of volunteers over the course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

The table below displays the results of the 2019 Greater Los Angeles Homeless Count with a focused look at the results of Service Planning Area 2.

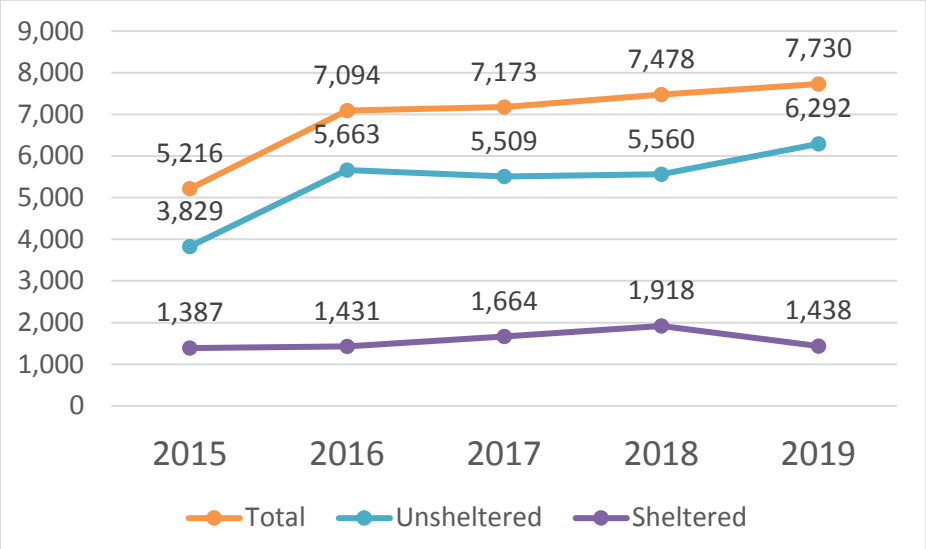
Table_Apx 6. 2019 Point-In-Time Homeless County

Geographic Area	Sheltered	Unsheltered	Total	Percent Change 2018 - 2019
Los Angeles County	14,722	44,214	58,.936	+12%
SPA 2	1,438	6,292	7,730	+3%

Figure_Apx 9. Number of People Experiencing Homelessness, Sheltered and Unsheltered, in LA County



Figure_Apx 10. Number of People Experiencing Homelessness, Sheltered and Unsheltered, in SPA 2



- SPA 2 had the lowest change of all eight SPAs in LA County in total homeless population between 2018 and 2019.
- SPA 2 ranks third in largest count of persons experiencing homeless as of the 2019 PITC count.
- Of all 7,730 persons experiencing homelessness in SPA 2, 88% of those are individuals and 12% are family members.
- There are a total of 332 veterans who are experiencing homelessness in SPA 2 and 1,943 persons who are experiencing chronic homelessness.
- Like Los Angeles County, the unsheltered homeless population for SPA 2 has had an increasing trend between the years 2015 and 2019.
- SPA 2 has seen a decrease in the sheltered homeless population between the years 2018 and 2019. This has been the only year where there has been any decrease between PITCs for sheltered individuals.

Table_Apx 7. 2019 Point-In-Time Homeless Count – Service Planning Area 2

Race/Ethnicity	Sheltered	Unsheltered	Total	Prevalence of Homeless Pop.	Percent Change 2018-2019
American Indian/ Alaska Native	3	94	97	1%	+31%
Asian	5	75	80	1%	-13%
Black/African American	590	733	1,323	17%	+21%
Hispanic/ Latino	557	2,657	3,214	42%	-9%
Native Hawaiian/ Other Pacific Islander	2	0	2	0.0%	-94%
White	257	2,488	2,745	36%	+6%
Multi-Racial/Other	24	245	269	3%	+372%

- 68% of all persons experiencing homelessness are men. By race and ethnicity, the largest groups are Hispanic/Latino (42%), White (36%) and Black/African American at (17%).

Table_Apx 8. 2019 Point-In-Time Homeless Count – Service Planning Area 2

Age Group	Sheltered	Unsheltered	Total	Prevalence of Homeless Population	Total Percent Change 2018 - 2019
Under 18	495	61	556	7%	-42%
18 - 24	156	502	658	9%	+39%
25 - 54	630	3,923	4,553	59%	+2%
55 - 61	89	1,210	1,299	17%	+14%
62 and Over	68	596	664	9%	+44%

- 59% of individuals experiencing homeless are between the ages of 25 and 54.
- The highest change in individuals experiencing homeless by age group are ages 62 and over. This age group saw an increase of 44% since 2018 while individuals between the ages 18 and 24 saw an increase of 39%.

Los Angeles County Department of Public Health Key Indicators

Below is a table of indicators related to homelessness and housing 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 broken out by San Fernando Valley's Community Benefit Service Area and the Broader Service Area.

Table_Apx 9. Housing Insecurity Data by Geographic Area

Los Angeles County Core Indicator	SFV Community Benefit Service Area	SFV Broader Service Area	Los Angeles County
Housing instability (Percent of adults who reported being homeless or not having their own place to live or sleep in the past 5 years)	5.4%	1.0%*	4.8%
Percent of households (owner/renter-occupied) who spend ≥30% of their income on housing	54.4%	45.0%	48.0%

*Statistically unstable

- The percent of adults who reported they are unstably housed in the Community Benefit Service area is higher than that reported for Los Angeles County.
- According to the Los Angeles County Core Indicators, the percent of households in the Community Benefit Service Area who spend at least 30% of the income on housing is about 10% higher than those in the Broader Service Area.

Housing-Cost Burden

Households that pay 30 percent or more of their income on housing costs are "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 10. Housing-Cost Burden Data for Renter Households by Geographic Area

Variable	SFV Community Benefit Service Area	SFV Broader Service Area	Los Angeles County
2013-2017 ACS Households: Renter Households That Are Housing-Cost Burdened	127,829 (61.52%)	86,722 (53.97%)	1,000,400 (56.11%)
2013-2017 ACS Households: Renter Households That Are Severely Housing-Cost Burdened	72,522 (34.90%)	46,686 (29.06%)	536,832 (30.11%)

- The Community Benefit Service area has a greater percent of renter households who suffer from housing-cost burden and severe housing-cost burden as compared to the Broader Service Area and Los Angeles County.

Immunization/School Health

Primary Data

- Community members shared mobile health care clinics would be beneficial for accessing care and would help them and their child/ student live a healthier lifestyle. They also would like more low-cost clinics in their community to reduce the length of time they wait for appointments.

- Community members identified that free flu shots, mammogram tests, and health checks were helpful resources. They also liked community clinics where they can receive affordable care.
- Community members identified time, transportation, lack of interest or motivation, literacy/language, awareness of resources, and qualification standards as barriers to accessing resources in the community.
- Community members shared some reasons why people may choose not to vaccinate or barriers to child immunization. The themes from their responses were the following:
    - Lack of understanding and misinformation: Participants shared there is a lack of understanding around what vaccines do and why they are needed. Additionally, when vaccines are needed and specifically which vaccines their children have already received is confusing. They shared they need easy to understand information (without abbreviations and acronyms) regarding vaccines. Typically, appointments with providers are rushed and there is little time to ask questions or receive any education about vaccines.
    - Fear of side effects: Some parents may be afraid vaccines could have negative side effects or make their children sick. False information that vaccines cause autism can also scare parents.
    - Perceived benefits versus risks: Parents do not always understand how vaccines will benefit their child and family. Education on the importance of disease prevention is important to help people understand how the benefits outweigh any risks of vaccination. Additionally, parents are unsure if newer vaccines have been proven successful and therefore do not want their children to receive them.
    - HPV vaccine confusion: Participants spoke specifically about the HPV vaccine, expressing doubts about the need for and effectiveness of this vaccine. They shared they have little information about this vaccine and they see it as more controversial for a couple of reasons. They have heard rumors that the vaccine makes children mature at a faster rate and they believe it is in an experimental phase since it is newer.
- When community members were asked what the role of a hospital should be, they shared that hospitals should care about the people they serve and educate people, particularly on understanding the causes of disease. They should notify people of disease outbreaks and prevention methods, as well as provide vaccines and programs to help people be healthy.
- Stakeholders shared having public health nurses do outreach to patients experiencing homelessness is helpful for vaccinating people. This outreach paired with health education by community health workers is effective for sharing health messages and connecting people to resources.
- Stakeholders shared they would welcome a partnership with a health care organization to provide on-site health care services at their organizations. These services could include health education classes, health screenings, or specialty care and take place as locations such as senior centers, transitional housing buildings, or faith based organizations.

Secondary Data

Los Angeles County Key Indicators of Health

The Los Angeles County Department of Public Health produces reports that present a snapshot of the health of Los Angeles' population. Included are indicators relating to health risk behaviors, access to

services, disease, injury, and various social determinants of health that affect the overall well-being of a person. These indicators are used to highlight the disparities between the areas that Providence Saint Joseph Health serves and Los Angeles County.

Table_Apx 11. Youth Immunization Data by Geographic Area

Immunization/School Health	Community Benefit Service Area	Broader Service Area	Los Angeles County
Percent of children ages 6 months - 17 years vaccinated for influenza	50.7%	58.2%	55.2%

- The percent of children (ages 6 months to 17 years) who have received the flu vaccination less in the Community Benefit Service Area when compared to the Broader Service Area and to Los Angeles County.

Table_Apx 12. HPV Vaccination Data by Geographic Area

Immunization/School Health	SPA 2	Los Angeles County	HP 2020 Target
Percent of teen girls (13-17 Years) vaccinated for HPV	43.2%	44.6%	80.0%

- The percent of girls vaccinated for HPY in SPA 2 1.4% less than the County average. However, 46.8% off from Healthy People 2020 target.

Mental Health

Primary Data

Stakeholders shared they are seeing increased incidences of mental health challenges in the community, with increased depression, anxiety, and suicidal ideation, especially in young people. They identified trauma and violence in the community as contributors to poor mental health, as well as lack of access to culturally and linguistically appropriate mental health services in the community and schools. Stakeholder shared young people, older adults, and immigrants, particularly those undocumented, are disproportionately affected by mental health challenges. Health care organizations can engage in efforts to address mental health needs in the community by providing mental health education, supporting efforts to increase the number of mental health professionals, and partnering with community-based organizations to support mental health referrals.

Community members identified mental health challenges, including depression, anxiety, and stress, as one of the biggest health and social issues in their community.

Stakeholders shared the following insight related to mental health:

Contributing Factors to Mental Health Challenges

- Poverty and a lack of opportunities

- Trauma and violence
- Fear and racism related to immigration status
- Lack of access to culturally and linguistically appropriate mental health services in the community and schools

Effective Strategies for Addressing Mental Health Needs

- Improve access to counseling and mental health services
- Integrate mental health care and primary care
- Utilize health education classes and workshops
- Provide mentorship to young people
- Increase mental health awareness and reduce stigma using social media

Opportunities for Health Care Organizations to Engage in Mental Health Efforts

- Provide education to new parents on mental health for children ages zero to five
- Support efforts to increase the number of psychiatrists in the community, particularly bilingual ones
- Provide support for referrals from community-based organizations for mental health care, particularly needed is medication support for children under 12 years
- Partner with schools and community-based organizations to prevent youth suicide and support community efforts in preventing mental health challenges.

Groups disproportionately affected by mental health challenges:

- Older Adults: stakeholders were concerned about social isolation for older adults contributing to depression.
- Young People: many stakeholders were concerned about the increasing number of young people they see who are experiencing depression, anxiety, and suicidal ideation at younger and younger ages. They shared that social media, lack of engaged parents and family dysfunction, and lack of counselors in schools contribute to mental health challenges.
- Immigrants, particularly undocumented immigrants: Immigrants were identified as disproportionately affected by mental health challenges for a variety of reasons. They may have a harder time finding a bilingual, culturally sensitive mental health provider due to the mental health provider shortage. Undocumented immigrants especially may have less access to mental health services if they are uninsured because organizations typically have limited funding for serving undocumented immigrants. Additionally, fear related to immigration status, racism and xenophobia, and new public charge laws all contribute to poor mental health and wellbeing.

Both Community members and stakeholders identified trauma and violence as contributors to people's depression and anxiety. They identified stressful schedules as contributing to people's insufficient time to care for themselves. Stakeholders emphasized a need for more mental health providers in the San Fernando Valley

Secondary Data

Los Angeles County Key Indicators of Health

The Los Angeles County Department of Public Health produces reports that present a snapshot of the health of Los Angeles' population. Included are indicators relating to health risk behaviors, access to services, disease, injury, and various social determinants of health that affect the overall well-being of a person. These indicators are used to highlight the disparities between the areas that Providence Saint Joseph Health serves and Los Angeles County.

Table_Apx 13. Mental Health Data by Geographic Area

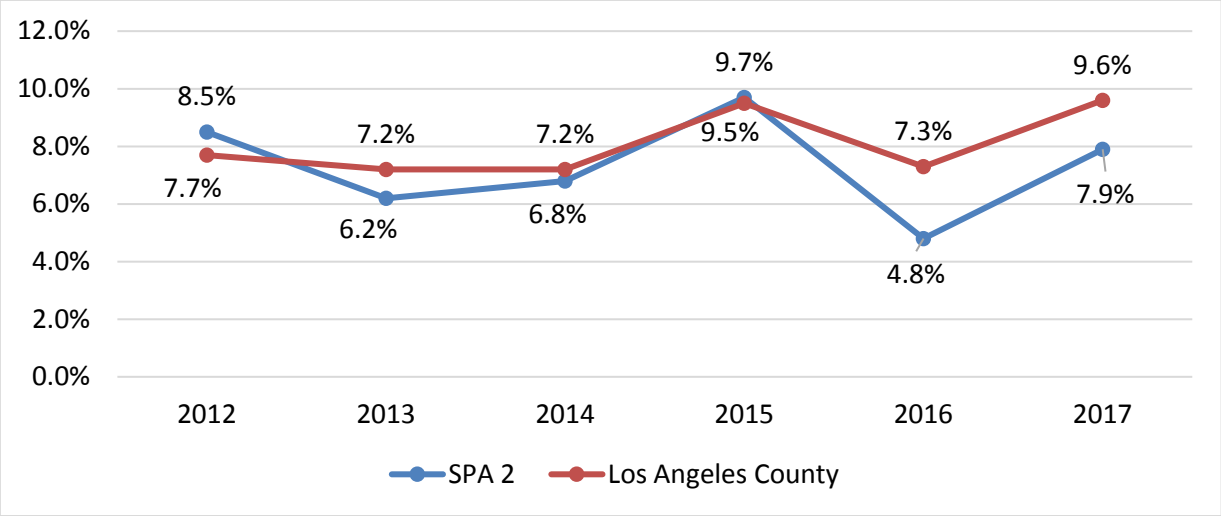
Mental Health	Community Benefit Service Area	Broader Service Area	Los Angeles County
Percent of adults at risk for major depression	11.4%	9.3%	11.8%
Alzheimer's disease-specific death rate (per 100,000 population)	33.2	38.8	38.7
Premature death rate due to suicide in total Years of Potential Life Lost (YPLL) per 100,000 population	215.5	238.7	209.0
Percent of adults reporting their health to be fair or poor	23.1%	13.0%	21.5%
Average number of days in past month adults reported regular daily activities were limited due to poor physical/mental health	2.3	2.7	2.3
Percent of children ages 0-17 years who have special health care needs	12.1%	20.0%	14.5%

- The Community Benefit Service Area has a greater percent of adults at risk for major depression as compared to the Broader Service Area. Additionally, the Community Benefit Service Area has a higher percent of adults reporting their health to be fair or poor when compared to both the Broader Service Area and Los Angeles County.
- The premature death rate due to suicide (measured in total years of potential life lost) is greater in both the Community Benefit Service Area and Broader Service area than in Los Angeles County.

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

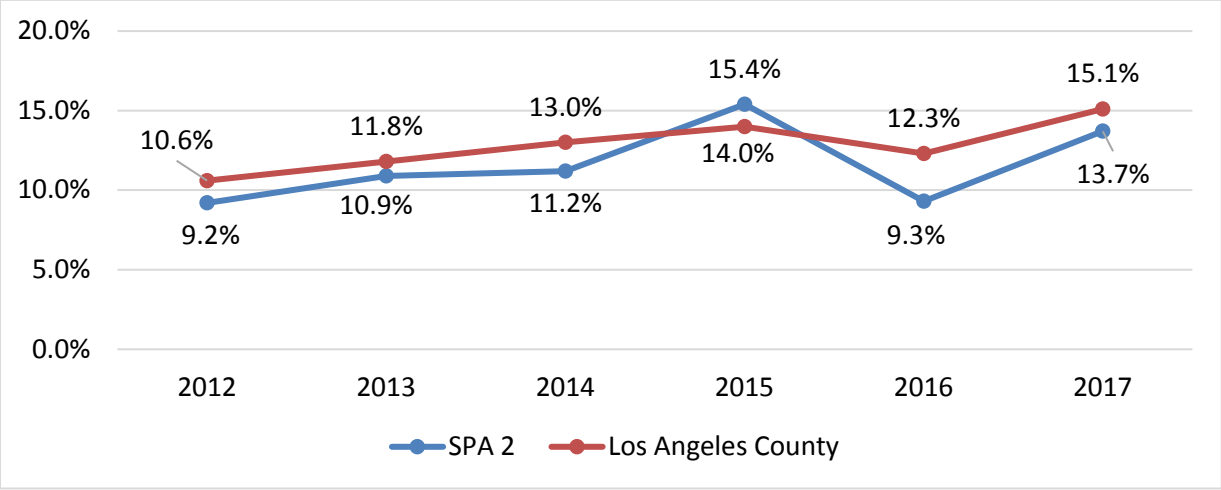
Figure_Apx 11. Percent of Adults Who Have Considered Committing Suicide in SPA 2 and LA County



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.

- Service Planning Area 2 and Los Angeles County have similar trends in percent of adults who have considered committing suicide. Recently there was a drop in percent of adults by both geographies between the years 2015 and 2016 followed by an increase between the years 2016 and 2017.

Figure_Apx 12. Percent of Adults Who Saw a Healthcare Provider for Emotional-Mental and/or Alcohol-Drug Issues in Past Year in SPA 2 and LA County



- Los Angeles County and Service Planning Area 2 have both had upward trends in percent of adults who saw a healthcare provider for emotional-mental and/or alcohol-drug issues since the year 2012. SPA 2 has risen by 4.5% while Los Angeles County has risen by 5.5%.
- Similar to the percent of adults who have considered suicide, there was a dip in percent of adults who saw a healthcare provider between the years 2015 and 2016 followed by large increase between the years 2016 and 2017.

Senior Care Services

Primary Data

Stakeholders identified access to senior care services were a high health need in the San Fernando Valley. Senior care services were a common concern identified across many health needs discussed in stakeholder interviews conducted for 2019 CHNA.

- Stakeholders were particularly concerned about older adults who may be unable to afford to live in the San Fernando Valley. They shared that some of their clients have lived their entire lives there and do not want to move to Los Angeles or another area where there may be more resources. They described a shift towards late baby boomers, those in their mid-sixties, who are seeking support services and experiencing housing instability or homelessness.

- Groups disproportionately affected by mental health challenges:
    - Older Adults: stakeholders were concerned about social isolation for older adults contributing to depression.

Secondary Data

Table_Apx 14. Senior Population by Age in the Community Benefit Service Area

Community Benefit Service Area	Census 2019		Census 2024	
Population by Age	Number	Percent	Number	Percent
0 - 4	75,860	6.5%	77,187	6.5%
5 - 9	74,750	6.4%	71,476	6.0%
10 - 14	75,193	6.5%	73,420	6.2%

15 - 19	75,238	6.5%	72,192	6.1%
20 - 24	86,068	7.4%	80,461	6.7%
25 - 34	196,574	16.9%	196,558	16.5%
35 - 44	163,535	14.0%	178,400	15.0%
45 - 54	147,662	12.7%	145,838	12.2%
55 - 64	128,584	11.0%	132,506	11.1%
65 - 74	83,576	7.2%	95,995	8.0%
75 - 84	39,894	3.4%	49,693	4.2%
85+	17,867	1.5%	19,191	1.6%
55+	269,921	23.2%	297,385	24.9%
65+	141,337	12.1%	164,879	13.8%

Table_Apx 15. Senior Population by Age in the Broader Service Area

Broader Service Area	Census 2019		Census 2024	
Population by Age	Number	Percent	Number	Percent
0 - 4	52,112	4.8%	54,169	4.9%
5 - 9	57,215	5.3%	56,157	5.1%
10 - 14	64,351	5.9%	60,587	5.5%
15 - 19	64,783	6.0%	61,603	5.6%
20 - 24	63,552	5.9%	58,342	5.3%
25 - 34	150,524	13.9%	157,362	14.2%
35 - 44	146,502	13.5%	162,012	14.6%
45 - 54	153,606	14.2%	144,505	13.0%
55 - 64	151,966	14.0%	148,617	13.4%
65 - 74	103,841	9.6%	117,316	10.6%
75 - 84	52,285	4.8%	64,163	5.8%
85+	23,783	2.2%	25,108	2.3%
55+	331,875	30.6%	355,204	32.0%
65+	179,909	16.6%	206,587	18.6%

- Both the Community Benefit Service Area and the Broader Service Area have a growing 55+ and 65+ age group populations.
- By 2024, the age group 55+ will make up about a quarter of the population in the Community Benefit Service Area and about a third of the population in the Broader Service Area.

Los Angeles County Key Indicators of Health

The Los Angeles County Department of Public Health produces reports that present a snapshot of the health of Los Angeles' population. Included are indicators relating to health risk behaviors, access to services, disease, injury, and various social determinants of health that affect the overall well-being of a person. These indicators are used to highlight the disparities between the areas that Providence Saint Joseph Health serves and Los Angeles County.

Table. Apx 16. Senior Related Data by Geographic Area

Senior Care	Community Benefit Service Area	Broader Service Area	Los Angeles County
Percent of adults ages 65+ years who have fallen in the past year	35.7%	28.2%	27.1%
Alzheimer's disease-specific death rate (per 100,000 population)	33.2	38.8	38.7
Percent of women ages 50- 74 years who had a mammogram within the past 2 years	77.4%	78.2%	77.3%

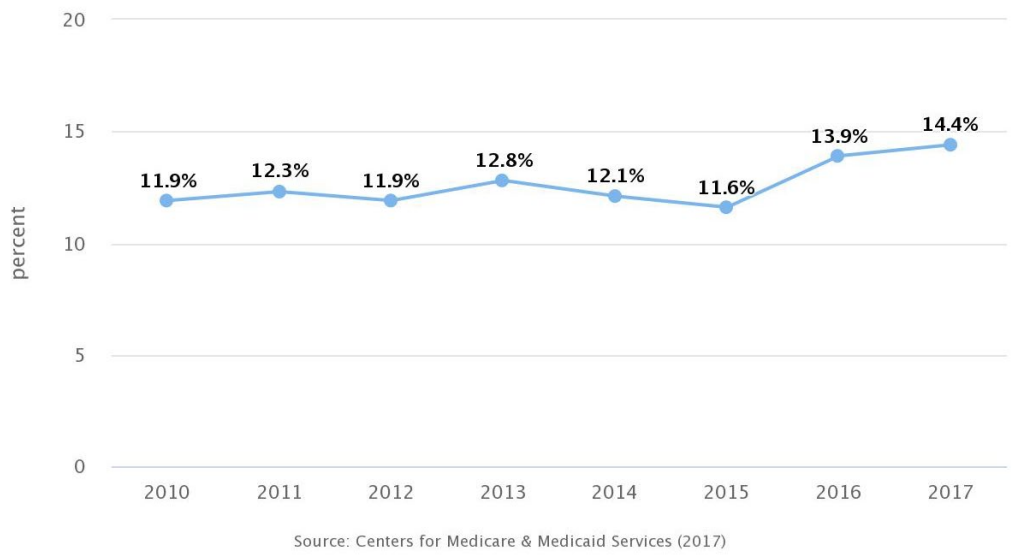
- The percent of adults (ages 65+) who have fallen in the past year is significantly higher in the Community Benefit Service Area as compared to the rates in the Broader Service Area and Los Angeles County.

Alzheimer's disease and dementia

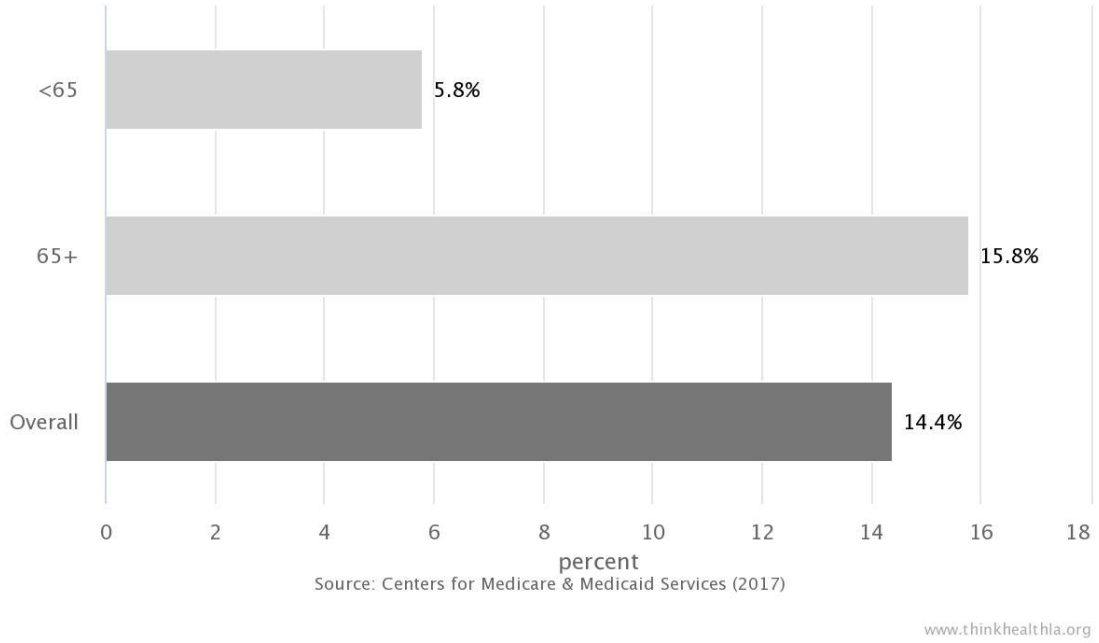
The Centers for Medicare and Medicaid Services show that the percentage of Medicare beneficiaries who were treated for Alzheimer's disease or dementia has seen an increasing trend in Los Angeles County with the largest spike between the years 2015 and 2016 where the rate increased by 2.3%.

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

Figure_Apx 13. Alzheimer's Disease or Dementia in the Medicare Population in LA County



Figure_Apx 14. Alzherimer's Disease or Dementia in Medicare Population by Age in LA County



Substance Use

Primary Data

Stakeholders were concerned about the increase of substance use, particularly in young people, in the San Fernando Valley. They identified opioids and marijuana as the two substances they are most

concerned about, but also identified vaping, methamphetamines, and alcohol as issues. Stakeholders identified poverty, lack of understanding of the risks of substance use, increased access to marijuana, mental health challenges, and lack of access to substance use disorder treatment as contributors to substance use being a prioritized need. Stakeholders named young people and people experiencing homelessness as being disproportionately affected by substance use. They shared using the "hub and spoke model" of Medication-Assisted Treatment (MAT) program for opioid use disorder. Local health care organizations can engage in addressing substance use challenges by providing health education at community-based organizations and schools related to substance use risks.

Both community members and stakeholders were concerned about substance use in young people, particularly marijuana and vaping, and easy access to these substances. Community members identified substance use and the selling of substances, particularly in young people as one of the biggest health and social issues in your community. Stakeholders shared it is challenging to get people into substance use treatment programs. There are few beds, people sit on long waiting lists, and then often must travel long distances to the treatment center. This means that once a person is ready to receive substance use treatment they often must wait for an available bed. By the time it becomes available, the person may no longer be willing to go.

Stakeholders shared the following information:

Contributing Factors to Substance Use

- Poverty and lack of opportunities
- Lack of education about risks of substance use
- Increased accessibility of marijuana
- Mental health challenges and use of marijuana as a coping mechanism
- Lack of access to substance use treatment

Opportunities for Health Care Organizations to Engage in Addressing Substance Use

- Provide health education in local organizations and schools related to substance use risks.
- Provide health education classes and healthcare services onsite at community-based organizations.
- Endorse work of grassroots agencies and formalize partnerships.
- Implement b-directional referrals and health information exchanges.
- Develop career pathways into healthcare.
- Stakeholders noted health care organizations could support local organizations and schools in providing more health education related to the risks of substance use and information about addiction.

Secondary Data

Los Angeles County Key Indicators of Health

The Los Angeles County Department of Public Health produces reports that present a snapshot of the health of Los Angeles' population. Included are indicators relating to health risk behaviors, access to

services, disease, injury, and various social determinants of health that affect the overall well-being of a person. These indicators are used to highlight the disparities between the areas that Providence Saint Joseph Health serves and Los Angeles County.

Table_Apx 17. Substance Use Data by Geographic Area

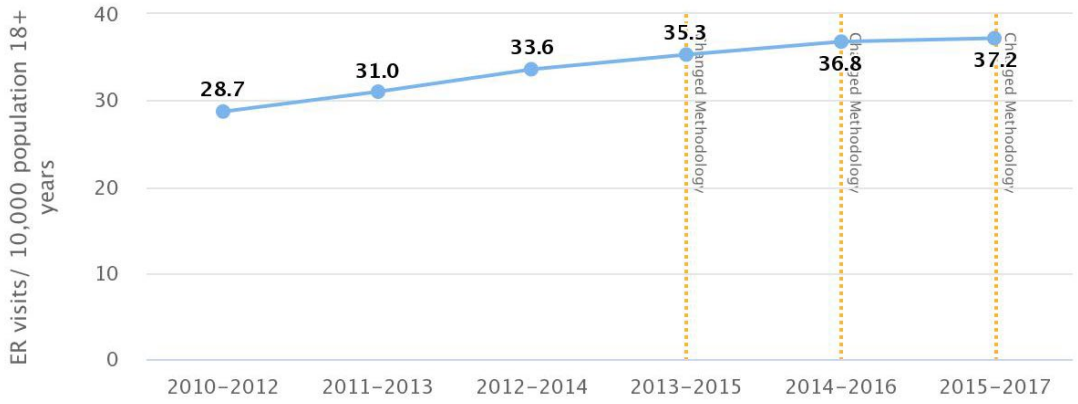
Substance Use	Community Benefit Service Area	Broader Service Area	Los Angeles County
Percent of adults who binge drink (men who had 5 or more alcoholic drinks, women 4 or more, on at least one occasion in the past 30 days)	16.1%	12.4%	15.9%
Percent of adults who smoke cigarettes	15.2%	10.8%	13.3%
Rate (per 10,000 population) of adult opioid use-related hospitalizations	1.9	2.7	1.9
Premature death rate due to drug overdose in total Years of Potential Life Lost (YPLL) per 100,000 population	196.3	238.2	220.3

- The percent of adults who reported binge drinking in the past 30 days is greater in the Community Benefit Service Area as compared to the Broader Service Area or Los Angeles County. Similarly, the percent of adults who smoke cigarettes is also greatest in the Community Benefit Service Area.

Alcohol Use

The following indicator shows the average annual age-adjusted emergency room visit due to acute or chronic alcohol abuse per 10,000 population aged 18 years and older in Los Angeles County. Population are further segmented into age groups, gender and ethnicity. This data is taken from the California Office of Statewide Health Planning and Development at several points in time.

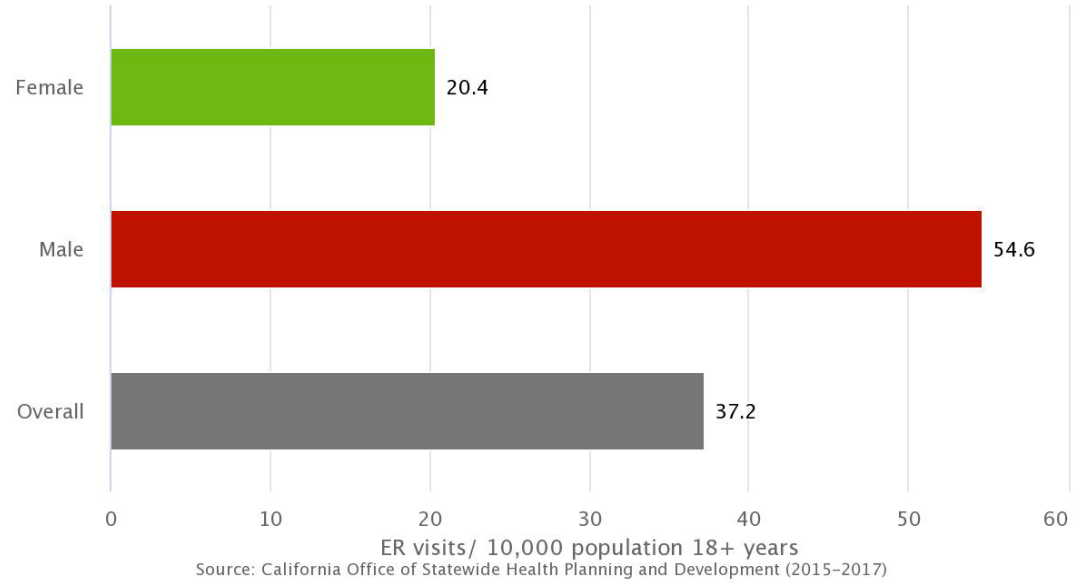
Figure_Apx 15. Age-Adjusted ER Rate due to Alcohol Use in LA County



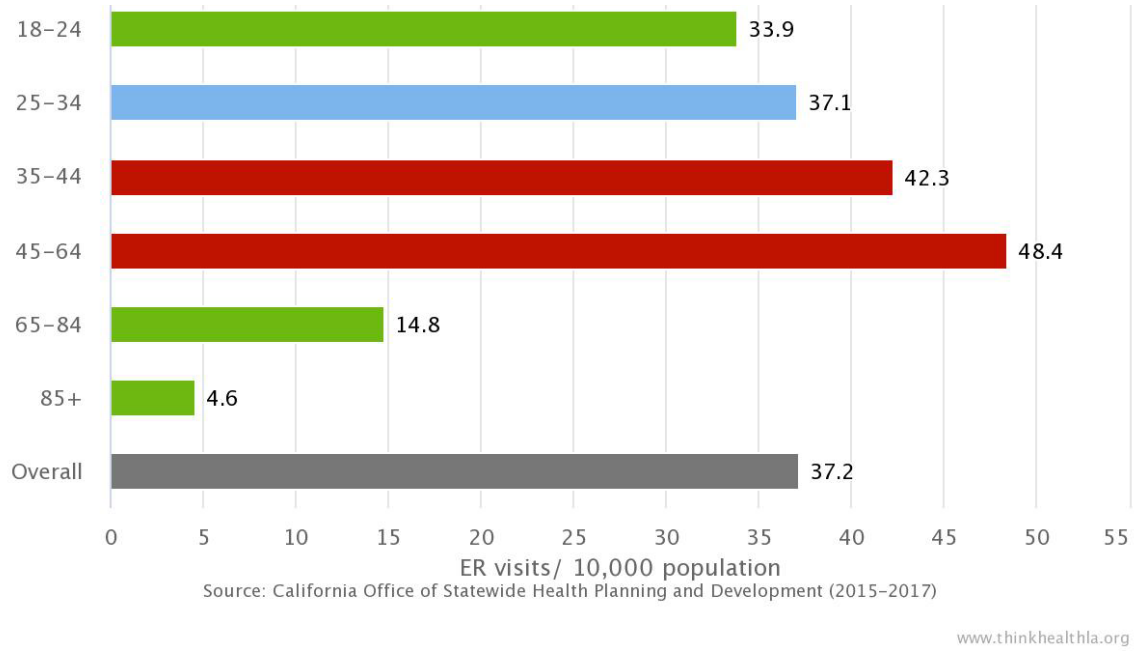
Source: California Office of Statewide Health Planning and Development (2015–2017)
Due to a change in methodology with the introduction of ICD–10, 2013–2015 is not directly comparable to previous or following time periods.
2014–2016 values are not directly comparable to previous time periods due to the increased number of records coded with ICD–10.
2015–2017 values are not directly comparable to previous time periods due to the increased number of records coded with ICD–10.

In the following charts for subpopulations of Los Angeles County adults, green is used to denote values that are significantly better than the overall rate, red is used to denote values that are significantly worse than the overall rate and blue shows no significant difference from the overall value.

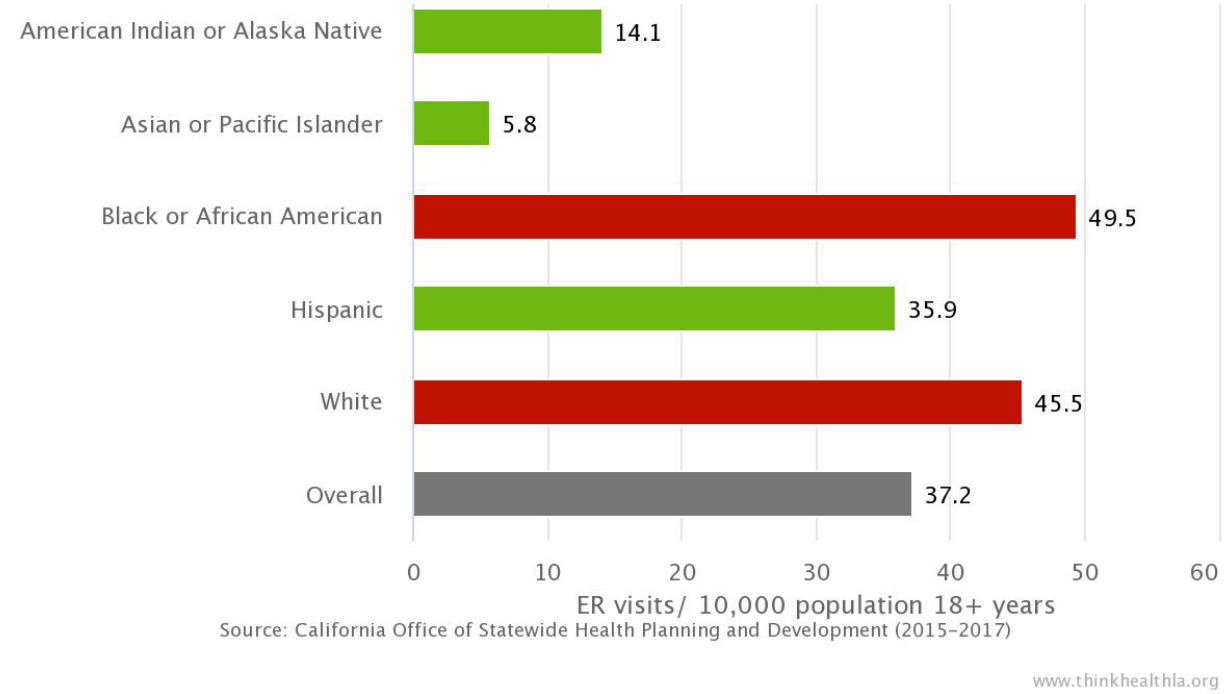
Figure_Apx 16. Age-Adjusted ER Rate due to Alcohol Use by Gender in LA County



Figure_Apx 17. ER Rate due to Alcohol Use by Age in LA County



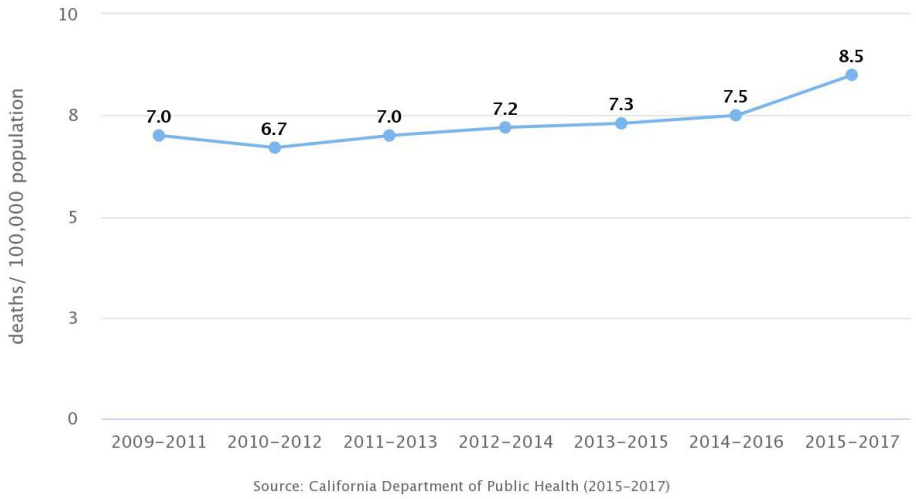
Figure_Apx 18. Age-Adjusted ER Rate due to Alcohol Use by Race/Ethnicity in LA County



Drug Use Death Rates

The following indicator shoes the age-adjusted death rate per 100,000 population due to drug use for Los Angeles County. This data is sourced from the California Department of Public Health. Drug-induced deaths included both legal and illegal use and also poisoning from medically prescribed drugs.

Figure_Apx 19. Ade-Adjusted Death Rate due to Drug Use in LA County



Violence Prevention

Primary Data

Community members identified Public safety, including violence, safety in parks, and inadequate street lighting as one of the biggest health and social issues in their community.

When Community members were asked, “What is your vision/definition of a healthy community?” Two themes in particular emerged from the responses with at least half of the participants naming the following:

- A place where all people, especially children, feel safe: Participants described a community free of violence and gangs, where their family could walk outside and feel safe. In a healthy community, people are not afraid for their child’s safety.
- Clean streets and parks: Participants described a clean community, free of trash on the streets and in the parks.

Secondary Data

Los Angeles County Key Indicators of Health

The Los Angeles County Department of Public Health produces reports that present a snapshot of the health of Los Angeles’ population. Included are indicators relating to health risk behaviors, access to services, disease, injury, and various social determinants of health that affect the overall well-being of a

person. These indicators are used to highlight the disparities between the areas that Providence Saint Joseph Health serves and Los Angeles County.

Table_Apx 18. Violence and Safety Data by Geographic Area

Violence Prevention	Community Benefit Service Area	Broader Service Area	Los Angeles County
Percent of adults who believe their neighborhood is safe from crime	91.8%	97.8%	84.0%
Premature death rate due to homicide in total Years of Potential Life Lost (YPLL) per 100,000 population	180.0	43.4	240.3
Percent of adults who have ever experienced physical (hit, slapped, pushed, kicked, etc.) or sexual (unwanted sex) violence by an intimate partner	14.0%	15.7%	13.4%

- The percent of adults who believe their neighborhood is safe from crime is higher in both the Community Benefit and Broader Service Areas as compared to Los Angeles County. This comparison is the same for the percent of adults who have ever experienced violence from an intimate partner.
- The premature death rate due to homicide (measured in total years of potential life lost) is over four times greater in the Community Benefit Service Area when compared to the Broader Service Area

Appendix 2: Additional Quantitative Data

2019 Common Metrics San Fernando Valley

Variable

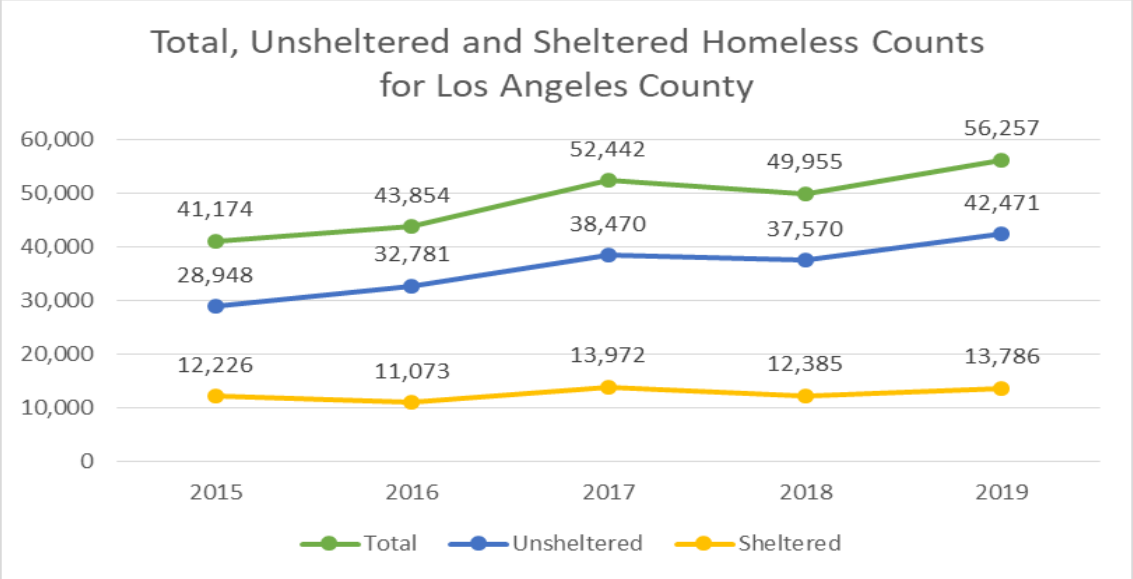
Social Determinants, Poverty, and Environment

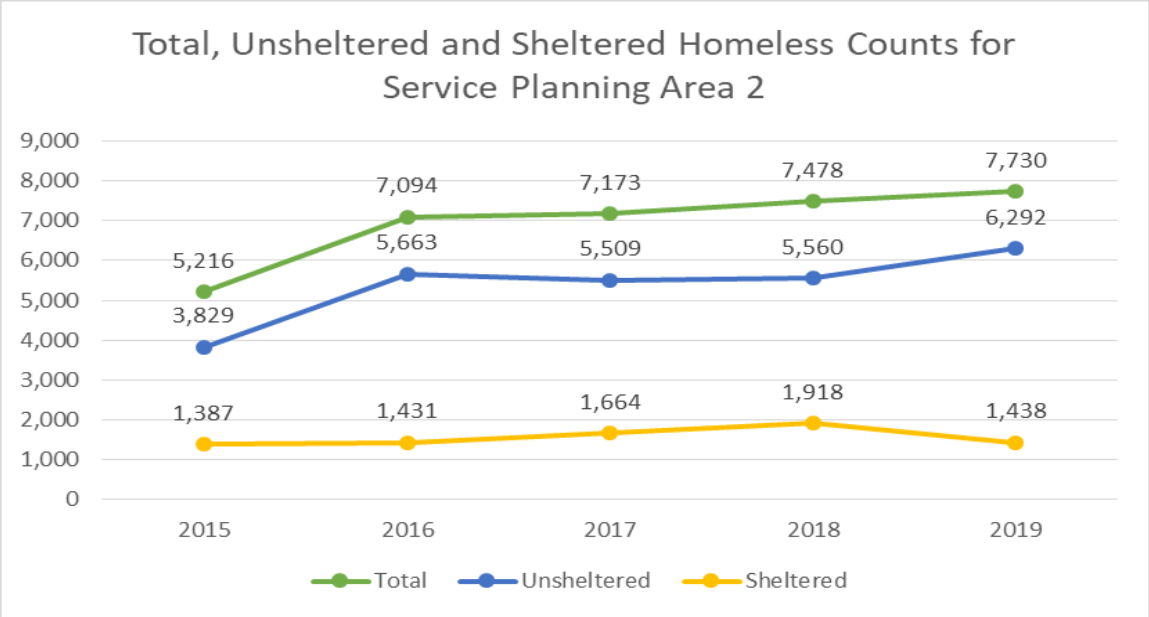
	San Fernando Valley Community Benefit Service Area	San Fernando Valley Broader Service Area	Los Angeles County	California	United States
% Population below 200% FPL	**45.4%**	**20.8%**	**39.6%**	**35.2%**	**33.6%**
Language spoken at home other than English	**69.9%**	**39.8%**	**56.7%**	**44.0%**	**21.2%**
Top 5 Zip Codes					
91402	85.2%				
91331	83.6%				
91203	81.3%				
91340	80.1%				
91204	78.7%				
Bottom 5 Zip Codes					
91350	23.7%				
91355	22.9%				
91604	21.8%				
91301	21.0%				
91390	20.9%				
Median HH income	$54,981	$94,228	$62,751	$69,051	$58,100
Top 5 Zip Codes					
91011	$166,406				
91436	$156,230				
91302	$153,182				
91301	$126,420				
91381	$124,735				
Bottom 5 Zip Codes					
91402	$44,627				
91502	$43,390				
91204	$41,804				
91205	$41,053				
91330	$7,500				

% Population with at least a HS diploma	**73.2%**	**92.4%**	**78.4%**	**82.6%**	**87.7%**
Top 5 Zip Codes					
91330	98.7%				
91302	97.9%				
91011	97.6%				
91604	97.4%				
91423	96.8%				
Bottom 5 Zip Codes					
91605	69.4%				
91352	65.9%				
91402	63.6%				
91340	60.7%				
91331	55.2%				
% Labor force employed	**95.1%**	**96.2%**	**95.5%**	**95.3%**	**95.2%**
Top 5 Zip Codes					
91208	97.8%				
91011	97.6%				
91020	97.5%				
91214	97.5%				
91302	97.4%				
Bottom 5 Zip Codes					
91606	94.3%				
91402	94.1%				
91331	94.0%				
91205	93.9%				
91330	85.2%				
Severe Housing Cost Burden	**35.1%**	**28.9%**	**30.6%**	**27.9%**	**24.1%**
Top 5 Zip Codes					
91330	66.7%				
91605	41.5%				
91436	40.0%				
91352	39.9%				
91207	39.3%				
Bottom 5 Zip Codes					
91011	21.1%				
91384	21.1%				
91307	20.0%				
91390	19.3%				
91355	18.8%				

Food insecurity/HH on SNAP	**11.3%**	**3.4%**	**9.0%**	**9.4%**	**13.1%**
Top 5 Zip Codes					
91330	33.3%				
91402	16.9%				
91204	16.5%				
91331	15.9%				
91405	14.8%				
Bottom 5 Zip Codes					
91403	1.2%				
91604	1.2%				
91214	1.1%				
91436	0.7%				
91011	0.6%				
Chronic Homelessness					

2019 Point-In-Time Homeless Count				
Geographic Area	**Sheltered**	**Unsheltered**	**Total**	**Percent Change 2018 - 2019**
Los Angeles County	14,722	44,214	58,.936	+12%
SPA 2	1,438	6,292	7,730	+3%



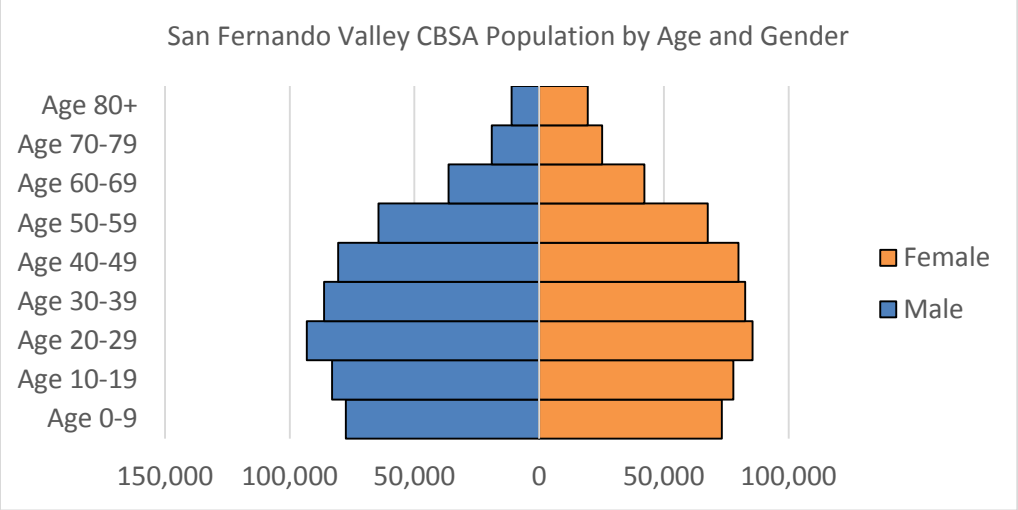


2019 Point-In-Time Homeless Count – Service Planning Area 2 Race and Ethnicity Table					
Race/Ethnicity	**Sheltered**	**Unsheltered**	**Total**	**Prevalence of Homeless Pop.**	**Percent Change 2018-2019**
American Indian/ Alaska Native	3	94	97	1%	31%
Asian	5	75	80	1%	-13%
Black/African American	590	733	1,323	17%	21%
Hispanic/ Latino	557	2,657	3,214	42%	-9%
Native Hawaiian/ Other Pacific Islander	2	0	2	0.00%	-94%
White	257	2,488	2,745	36%	6%
Multi-Racial/Other	24	245	269	3%	372%

2019 Point-In-Time Homeless Count – Service Planning Area 2 Age Table					
Age Group	**Sheltered**	**Unsheltered**	**Total**	**Prevalence of Homeless Population**	**Total Percent Change 2018 - 2019**
Under 18	495	61	556	7%	-42%
18 - 24	156	502	658	9%	39%
25 - 54	630	3,923	4,553	59%	2%
55 - 61	89	1,210	1,299	17%	14%
62 and Over	68	596	664	9%	44%

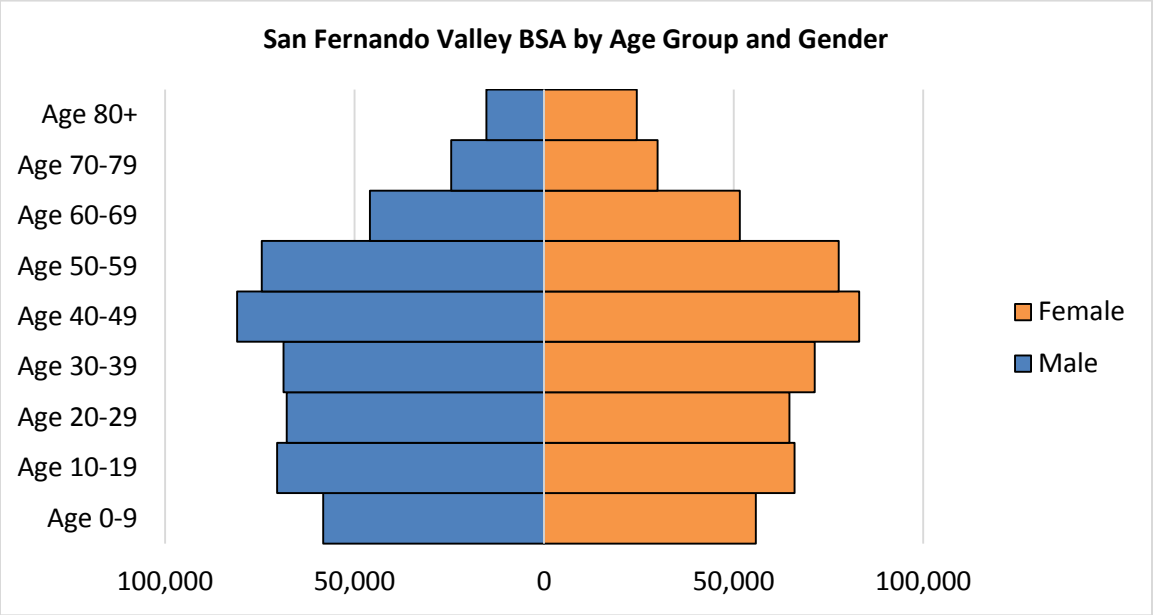
San Fernando Valley Community Benefit Service Area Population by Race

Race	Population Count	Population %
White	608,290	52.31%
Black	42,207	3.63%
American Indian	8,246	0.71%
Asian	120,877	10.39%
Pacific Islander	1,459	0.13%
Other Race	323,953	27.86%
Mulitple Races	57,899	4.98%
Total Population	**1,162,931**	**100%**
Hispanic Population	685,737	58.97%
Minority Population	871,423	74.93%



San Fernando Valley Broader Service Area Population by Race		
Race	**Population Count**	**Population %**
White	745,457	68.23%
Black	38,753	3.55%
American Indian	4,325	0.40%
Asian	157,485	14.42%
Pacific Islander	1,281	0.12%
Other Race	87,785	8.04%
Mulitple Races	57,408	5.25%
Total Population	**1,092,494**	**100%**

Hispanic Population	236,451	21.64%
Minority Population	473,630	43.35%



		Prevention Quality Inidcators (Per 1,000 Inpatient Discharges) 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 Compli-cations 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 Birth Weight Rate	PQI #10 Dehydration Admission Rate	PQI #11 Community Acquired Pneumonia Admission Rate	PQI #12 Urinary Tract Infection Admission Rate	PQI #14 Uncon-trolled Diabetes Admission Rate	PQI #15 Asthma in Younger Adults Admission Rate	PQI #16 Lower-Extremity Amputation Among Patients with Diabetes Rate
710 - PROVIDENCE ST JOSEPH MEDICAL CENTER	Facility Level	6.95	4.87	9.1	23.13	3.48	38.48	53.13	3.73	14.6	13.59	4.17	6.05	1.45
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER	Facility Level	5.66	3.48	9.63	15.57	3.81	40.36	42.01	2.45	9.79	9.57	4.08	3.22	2.12
725 - PROVIDENCE TARZANA MEDICAL CENTER	Facility Level	3.6	3.25	4.57	19.02	1.76	39.82	50.33	11.78	13.19	9.76	3.6	1.28	1.32
Southern California Average	Facility Level	4.95	3.82	6.62	17.47	2.94	35.09	38.89	5.2	13.22	12.71	4.03	3.32	1.17

Facility	Age Group													
710 - PROVIDENCE ST JOSEPH MEDICAL CENTER	18 to 39 years	15.67	9.69	2.28	-	1.14	3.13	46.3	2.28	4.27	4.27	2.85	6.06	-
710 - PROVIDENCE ST JOSEPH MEDICAL CENTER	40 to 64 years	9.21	5.99	17.96	18.4	4.6	29.24	61.07	3.22	10.82	7.37	5.06	-	2.99
710 - PROVIDENCE ST JOSEPH MEDICAL CENTER	65 to 74 years	4.27	3.92	14.24	23.97	6.05	49.13	-	3.2	17.8	12.46	7.12	-	3.56
710 - PROVIDENCE ST JOSEPH MEDICAL CENTER	75+ years	0.58	1.16	3.49	27.09	2.72	64.78	-	5.43	22.89	25.8	2.72	-	-
710 - PROVIDENCE ST JOSEPH MEDICAL CENTER Total		6.95	4.87	9.1	23.23	3.48	38.56	47.23	3.73	14.54	13.59	4.17	6.06	1.45
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER	18 to 39 years	8.2	5.27	1.76	-	1.17	4.1	40.27	0.2	2.93	4.68	2.34	3.22	-
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER	40 to 64 years	8.78	4.84	15.59	10.1	6.81	37.09	46.51	3.05	9.14	7.17	7.17	-	3.23
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER	65 to 74 years	1.96	2.61	15.99	21.56	2.94	62.97	-	1.96	12.4	11.42	4.57	-	2.94
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER	75+ years	1.52	0.43	6.93	18.13	3.68	69.56	-	4.55	16.25	16.47	1.95	-	2.6
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER Total		5.66	3.48	9.63	15.49	3.81	40.36	40.53	2.45	9.74	9.52	4.08	3.22	2.12
725 - PROVIDENCE TARZANA MEDICAL CENTER	18 to 39 years	3.98	3.32	-	-	0.33	1.66	41.32	2.65	1.33	1.66	1.33	1.28	-
725 - PROVIDENCE TARZANA MEDICAL CENTER	40 to 64 years	6.09	4.19	9.52	16.85	3.81	21.7	71.01	3.43	8.76	3.81	8.37	-	0.38
725 - PROVIDENCE TARZANA MEDICAL CENTER	65 to 74 years	4	5.71	10.27	23.1	1.14	50.23	-	7.99	17.69	10.27	5.71	-	5.71
725 - PROVIDENCE TARZANA MEDICAL CENTER	75+ years	1.51	1.51	2.27	18.66	1.76	76.3	-	10.32	23.17	19.64	1.26	-	1.01
725 - PROVIDENCE TARZANA MEDICAL CENTER Total		3.61	3.26	4.58	19.04	1.76	39.86	43.23	6.34	13.2	9.77	3.61	1.28	1.32

Facility	Gender													
710 - PROVIDENCE ST JOSEPH MEDICAL CENTER	FEMALE	4.27	3.42	5.44	24.83	3.63	34.37	60.02	3.31	13.98	16.12	2.56	3.76	6.4
710 - PROVIDENCE ST JOSEPH MEDICAL CENTER	MALE	10.85	6.98	14.42	21.42	3.26	44.66	47.3	4.34	15.35	9.92	6.51	15.58	26.36
710 - PROVIDENCE ST JOSEPH MEDICAL CENTER Total		6.95	4.87	9.1	23.23	3.48	38.56	53.13	3.73	14.54	13.59	4.17	6.06	14.54
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER	FEMALE	5.11	3.47	6.39	16.49	3.93	30.67	43.97	2.37	8.4	12.41	2.46	2.37	16.43
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER	MALE	6.46	3.5	14.4	14.43	3.63	54.64	40.05	2.56	11.71	5.25	6.46	6.64	28.26
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER Total		5.66	3.48	9.63	15.49	3.81	40.36	42.01	2.45	9.74	9.52	4.08	3.22	21.21
725 - PROVIDENCE TARZANA MEDICAL CENTER	FEMALE	2.77	2.36	2.77	24.75	2.22	29.52	47.73	4.99	10.67	10.4	3.05	0.71	2.77
725 - PROVIDENCE TARZANA MEDICAL CENTER	MALE	5.06	4.82	7.71	12.5	0.96	57.83	52.92	8.67	17.59	8.67	4.58	6.47	31.33
725 - PROVIDENCE TARZANA MEDICAL CENTER Total		3.61	3.26	4.58	19.04	1.76	39.86	50.33	6.34	13.2	9.77	3.61	1.28	13.2

Facility	Gender													
710 - PROVIDENCE ST JOSEPH MEDICAL CENTER	CAPITATION	6.76	-	13.51	6.8	-	54.05	-	-	27.03	-	6.76	1000	-
710 - PROVIDENCE ST JOSEPH MEDICAL CENTER	COMMERCIAL	10.6	8.14	7.4	6.91	2.22	9.37	45.05	3.45	8.88	5.43	3.21	4.39	1.23
710 - PROVIDENCE ST JOSEPH MEDICAL CENTER	MEDICAID	11.14	6.96	8.08	29.75	5.29	27.29	61.28	1.95	7.8	6.96	4.73	7.6	1.67
710 - PROVIDENCE ST JOSEPH MEDICAL CENTER	MEDICARE	3.09	2.19	10.44	26.81	3.48	59.45	-	4.9	20.63	21.53	4.26	-	1.55
710 - PROVIDENCE ST JOSEPH MEDICAL CENTER	OTHER	-	-	-	-	-	-	-	-	-	-	-	-	-
710 - PROVIDENCE ST JOSEPH MEDICAL CENTER	OTHER GOVERNME	13.33	-	26.67	37.74	-	-	71.43	-	26.67	-	-	-	-
710 - PROVIDENCE ST JOSEPH MEDICAL CENTER	SELF PAY	4.95	9.9	-	39.22	-	19.8	19.61	-	4.95	4.95	9.9	-	-
710 - PROVIDENCE ST JOSEPH MEDICAL CENTER Total	All Payors	6.95	4.87	9.1	23.13	3.48	38.48	53.13	3.73	14.6	13.59	4.17	6.05	1.45
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER	CAPITATION	3.42	1.71	13.11	15.53	1.71	51.85	-	1.71	9.12	12.54	1.14	-	2.28
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER	COMMERCIAL	7.01	5.08	8.22	7.32	2.18	12.09	28.4	1.69	5.32	4.11	4.35	3.58	1.93
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER	MEDICAID	7.96	4.85	6.06	17.7	5.02	23.03	49.56	1.9	6.93	7.1	4.85	2.47	1.04
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER	MEDICARE	3.16	1.27	12.82	18.05	3.96	71.52	-	3.8	15.51	14.87	3.8	26.09	3.32
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER	OTHER	-	-	-	-	-	-	-	-	-	111.11	-	-	-
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER	OTHER GOVERNME	-	-	-	22.99	-	75	26.32	-	25	-	-	-	-
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER	SELF PAY	13.04	17.39	17.39	7.46	17.39	17.39	44.78	-	-	4.35	13.04	-	-
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER Total	All Payors	5.66	3.48	9.63	15.57	3.81	40.36	42.01	2.45	9.79	9.57	4.08	3.22	2.12
725 - PROVIDENCE TARZANA MEDICAL CENTER	CAPITATION	-	-	13.16	13.25	6.58	26.32	-	39.47	13.16	6.58	6.58	-	-
725 - PROVIDENCE TARZANA MEDICAL CENTER	COMMERCIAL	3.68	4.81	2.27	8.89	1.7	5.38	52	14.16	4.81	1.98	2.27	1.08	0.28
725 - PROVIDENCE TARZANA MEDICAL CENTER	MEDICAID	5.41	3.94	5.91	28.12	1.97	19.69	50.81	14.27	4.92	3.94	4.92	1.75	0.49
725 - PROVIDENCE TARZANA MEDICAL CENTER	MEDICARE	2.74	2.19	5.49	21.13	1.46	71.14	-	8.96	22.13	16.83	3.66	-	2.38
725 - PROVIDENCE TARZANA MEDICAL CENTER	OTHER	-	-	-	-	-	-	-	-	-	-	-	-	-
725 - PROVIDENCE TARZANA MEDICAL CENTER	OTHER GOVERNME	20.83	-	-	-	-	-	-	-	-	20.83	20.83	-	-
725 - PROVIDENCE TARZANA MEDICAL CENTER	SELF PAY	6.94	-	-	-	6.94	6.94	23.53	-	-	13.89	6.94	-	-
725 - PROVIDENCE TARZANA MEDICAL CENTER Total	All Payors	3.6	3.25	4.57	19.02	1.76	39.82	50.33	11.78	13.19	9.76	3.6	1.28	1.32

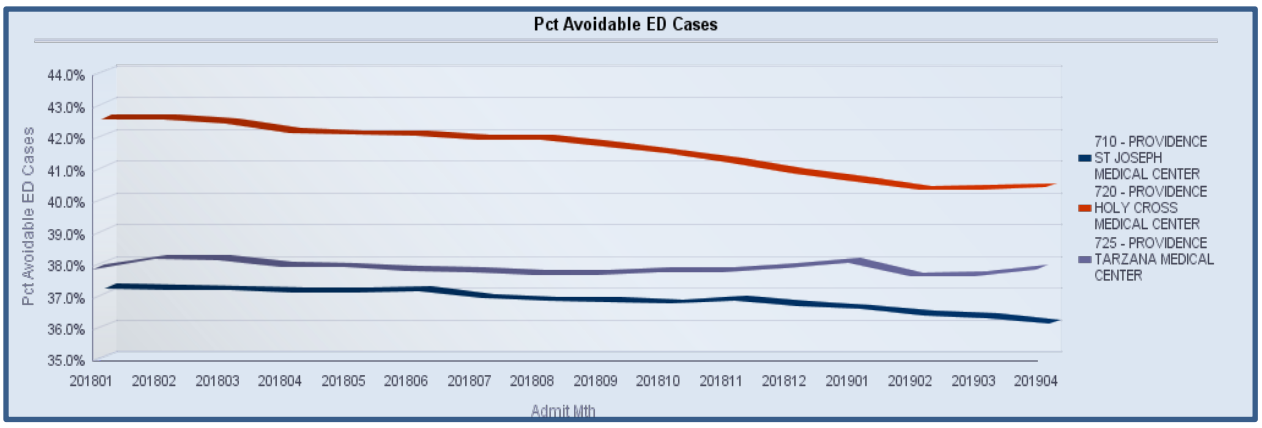
Avoidable ED Visits Detail Tables (May 2018 - April 2019)

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 JOHNS 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

The Avoidable Emergency Visit (AED) Tables show the rolling year number of Avoidable ED Cases and Total ED Cases along with the percentage of Avoidable ED Cases. The AED trended tables and graph show a rolling year AED percentage calculated at the indicated month and year.



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
710 - PROVIDENCE ST JOSEPH MEDICAL CENTER	37.1%	37.1%	37.1%	37.0%	37.0%	37.0%	36.8%	36.7%	36.7%	36.6%	36.7%	36.6%
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER	42.5%	42.5%	42.4%	42.1%	42.0%	42.0%	41.9%	41.9%	41.6%	41.4%	41.2%	40.8%
725 - PROVIDENCE TARZANA MEDICAL CENTER	37.9%	38.2%	38.2%	38.0%	37.9%	37.8%	37.8%	37.7%	37.7%	37.8%	37.8%	37.9%
Grand Total	**39.9%**	**40.0%**	**39.9%**	**39.7%**	**39.6%**	**39.6%**	**39.5%**	**39.4%**	**39.3%**	**39.2%**	**39.1%**	38.9%

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
710 - PROVIDENCE ST JOSEPH MEDICAL CENTER	20,991	21,065	20,950	20,872	20,763	20,788	20,664	20,656	20,662	20,638	20,676	20,346
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER	39,879	40,326	40,055	39,502	39,072	38,918	38,692	38,701	38,357	37,861	37,464	36,633
725 - PROVIDENCE TARZANA MEDICAL CENTER	16,127	16,520	16,532	16,386	16,293	16,158	16,095	16,046	16,010	16,011	16,056	15,838
Grand Total	**76,997**	**77,911**	**77,537**	**76,760**	**76,128**	**75,864**	**75,451**	**75,403**	**75,029**	**74,510**	**74,196**	**72,817**

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
710 - PROVIDENCE ST JOSEPH	56,564	56,810	56,531	56,394	56,144	56,141	56,152	56,259	56,317	56,332	56,287	55,619

MEDICAL CENTER												
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER	93,786	94,886	94,483	93,856	92,994	92,698	92,388	92,465	92,104	91,413	91,035	89,776
725 - PROVIDENCE TARZANA MEDICAL CENTER	42,561	43,241	43,308	43,157	42,940	42,716	42,596	42,551	42,454	42,379	42,476	41,776
Grand Total	**192,911.0**	**194,937.0**	**194,322.0**	**193,407.0**	**192,078.0**	**191,555.0**	**191,136.0**	**191,275.0**	**190,875.0**	**190,124.0**	**189,798.0**	**187,171.0**

Pct Avoidable ED Cases	2019			
Enc Facility Desc	2019 JAN	2019 FEB	2019 MAR	2019 APR
710 - PROVIDENCE ST JOSEPH MEDICAL CENTER	36.5%	36.3%	36.2%	36.0%
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER	40.6%	40.3%	40.3%	40.4%
725 - PROVIDENCE TARZANA MEDICAL CENTER	38.1%	37.6%	37.7%	37.9%
Grand Total	**38.8%**	**38.5%**	**38.5%**	**38.5%**

Avoidable ED Cases	2019			
Enc Facility Desc	2019 JAN	2019 FEB	2019 MAR	2019 APR
710 - PROVIDENCE ST JOSEPH MEDICAL CENTER	20,146	19,932	19,949	19,887
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER	35,539	34,701	34,886	35,012
725 - PROVIDENCE TARZANA MEDICAL CENTER	15,657	15,319	15,396	15,498
Grand Total	**71,342**	**69,952**	**70,231**	**70,397**

Total ED Cases	2019			
Enc Facility Desc	2019 JAN	2019 FEB	2019 MAR	2019 APR
710 - PROVIDENCE ST JOSEPH MEDICAL CENTER	55,256	54,956	55,138	55,245
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER	87,633	86,171	86,619	86,763
725 - PROVIDENCE TARZANA MEDICAL CENTER	41,110	40,694	40,874	40,896
Grand Total	**183,999.0**	**181,821.0**	**182,631.0**	**182,904.0**

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

Providence St. Joseph Medical Center			
Rank	**MSDRG Code Desc**	**Cases**	**% of Total Cases**
1	153 - OTITIS MEDIA & URI W/O MCC	3,546	17.8%
2	690 - KIDNEY & URINARY TRACT INFECTIONS W/O MCC	1,526	7.7%
3	603 - CELLULITIS W/O MCC	1,310	6.6%
4	203 - BRONCHITIS & ASTHMA W/O CC/MCC	1,283	6.5%
5	392 - ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	1,138	5.7%
6	897 - ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	956	4.8%
7	552 - MEDICAL BACK PROBLEMS W/O MCC	917	4.6%
8	103 - HEADACHES W/O MCC	899	4.5%
9	607 - MINOR SKIN DISORDERS W/O MCC	846	4.3%
10	880 - ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	629	3.2%
11	556 - SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	607	3.1%
12	149 - DYSEQUILIBRIUM	603	3.0%
13	951 - OTHER FACTORS INFLUENCING HEALTH STATUS	587	3.0%
14	305 - HYPERTENSION W/O MCC	422	2.1%
14	950 - AFTERCARE W/O CC/MCC	422	2.1%
16	125 - OTHER DISORDERS OF THE EYE W/O MCC	401	2.0%
17	885 - PSYCHOSES	301	1.5%
18	761 - MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC	250	1.3%
19	195 - SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	222	1.1%
20	159 - DENTAL & ORAL DISEASES W/O CC/MCC	200	1.0%
	Top 20 MSDRGs Grand Total	17,065	85.8%

Providence Holy Cross Medical Center

Rank	MSDRG Code Desc	Cases	% of Total Cases
1	153 - OTITIS MEDIA & URI W/O MCC	9,179	26.2%
2	690 - KIDNEY & URINARY TRACT INFECTIONS W/O MCC	3,535	10.1%
3	103 - HEADACHES W/O MCC	2,287	6.5%
4	203 - BRONCHITIS & ASTHMA W/O CC/MCC	2,051	5.9%
5	607 - MINOR SKIN DISORDERS W/O MCC	1,876	5.4%
6	603 - CELLULITIS W/O MCC	1,789	5.1%
7	392 - ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	1,638	4.7%
8	552 - MEDICAL BACK PROBLEMS W/O MCC	1,515	4.3%
9	556 - SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	1,308	3.7%
10	149 - DYSEQUILIBRIUM	918	2.6%
11	880 - ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	899	2.6%
12	125 - OTHER DISORDERS OF THE EYE W/O MCC	814	2.3%
13	950 - AFTERCARE W/O CC/MCC	571	1.6%
14	897 - ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	536	1.5%
15	951 - OTHER FACTORS INFLUENCING HEALTH STATUS	391	1.1%
16	195 - SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	385	1.1%
17	761 - MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC	358	1.0%
18	305 - HYPERTENSION W/O MCC	346	1.0%
19	639 - DIABETES W/O CC/MCC	341	1.0%
20	866 - VIRAL ILLNESS W/O MCC	277	0.8%
	Top 20 MSDRGs Grand Total	31,014	88.6%

Providence Tarzana Medical Center

Rank	MSDRG Code Desc	Cases	% of Total Cases
1	153 - OTITIS MEDIA & URI W/O MCC	3,415	22.0%
2	203 - BRONCHITIS & ASTHMA W/O CC/MCC	1,231	7.9%
3	690 - KIDNEY & URINARY TRACT INFECTIONS W/O MCC	1,050	6.8%
4	603 - CELLULITIS W/O MCC	1,028	6.6%
5	607 - MINOR SKIN DISORDERS W/O MCC	964	6.2%
6	392 - ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	774	5.0%
7	552 - MEDICAL BACK PROBLEMS W/O MCC	721	4.7%
8	103 - HEADACHES W/O MCC	625	4.0%

9	556 - SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	574	3.7%
10	950 - AFTERCARE W/O CC/MCC	472	3.0%
11	125 - OTHER DISORDERS OF THE EYE W/O MCC	443	2.9%
12	897 - ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	438	2.8%
13	149 - DYSEQUILIBRIUM	417	2.7%
14	880 - ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	396	2.6%
15	951 - OTHER FACTORS INFLUENCING HEALTH STATUS	279	1.8%
16	305 - HYPERTENSION W/O MCC	229	1.5%
17	195 - SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	184	1.2%
18	761 - MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC	173	1.1%
19	156 - OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W/O CC/MCC	148	1.0%
20	885 - PSYCHOSES	133	0.9%
	Top 20 MSDRGs Grand Total	13,694	88.4%

Providence St. Joseph Medical Center

Rank	Principal ICD Dx Sub Categorization	Cases	% of Total Cases
1	Acute upper respiratory infections	2,621	13.2%
2	Infections of the skin and subcutaneous tissue	1,318	6.6%
3	Other diseases of the urinary system	1,199	6.0%
4	Chronic lower respiratory diseases	1,113	5.6%
5	General symptoms and signs	1,089	5.5%
6	Mental and behavioral disorders due to psychoactive substance use	992	5.0%
7	Other dorsopathies	921	4.6%
8	Diseases of middle ear and mastoid	818	4.1%
9	Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	671	3.4%
10	Other joint disorders	630	3.2%
11	Symptoms and signs involving cognition, perception, emotional state and behavior	623	3.1%
12	Noninfective enteritis and colitis	610	3.1%
13	Hypertensive diseases	438	2.2%
14	Persons encountering health services for examinations	426	2.1%
15	Symptoms and signs involving the skin and subcutaneous tissue	384	1.9%

16	Renal tubulo-interstitial diseases	349	1.8%
17	Other acute lower respiratory infections	316	1.6%
18	Viral infections characterized by skin and mucous membrane lesions	274	1.4%
19	Symptoms and signs involving the digestive system and abdomen	269	1.4%
20	Influenza and pneumonia	267	1.3%
	Top 20 ICD-10 Sub Categorizations Grand Total	15,328	77.1%

Providence Holy Cross Medical Center

Rank	Principal ICD Dx Sub Categorization	Cases	% of Total Cases
1	Acute upper respiratory infections	6,860	19.6%
2	Other diseases of the urinary system	2,922	8.3%
3	General symptoms and signs	2,602	7.4%
4	Diseases of middle ear and mastoid	2,206	6.3%
5	Infections of the skin and subcutaneous tissue	1,813	5.2%
6	Chronic lower respiratory diseases	1,474	4.2%
7	Other dorsopathies	1,438	4.1%
8	Other joint disorders	1,328	3.8%
9	Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	942	2.7%
10	Symptoms and signs involving cognition, perception, emotional state and behavior	924	2.6%
11	Noninfective enteritis and colitis	910	2.6%
12	Other acute lower respiratory infections	844	2.4%
13	Symptoms and signs involving the skin and subcutaneous tissue	708	2.0%
14	Renal tubulo-interstitial diseases	662	1.9%
15	Disorders of conjunctiva	586	1.7%
16	Mental and behavioral disorders due to psychoactive substance use	556	1.6%
17	Viral infections characterized by skin and mucous membrane lesions	534	1.5%
18	Symptoms and signs involving the digestive system and abdomen	507	1.4%
19	Dermatitis and eczema	485	1.4%
20	Diabetes mellitus	444	1.3%
	Top 20 ICD-10 Sub Categorizations Grand Total	28,745	82.1%

Providence Tarzana Medical Center

Rank	Principal ICD Dx Sub Categorization	Cases	% of Total Cases
1	Acute upper respiratory infections	2,608	16.8%
2	Infections of the skin and subcutaneous tissue	1030	6.6%

3	Chronic lower respiratory diseases	889	5.7%
4	Other diseases of the urinary system	882	5.7%
5	Diseases of middle ear and mastoid	741	4.8%
6	General symptoms and signs	739	4.8%
7	Other dorsopathies	723	4.7%
8	Other joint disorders	594	3.8%
9	Other acute lower respiratory infections	471	3.0%
10	Mental and behavioral disorders due to psychoactive substance use	463	3.0%
11	Symptoms and signs involving the skin and subcutaneous tissue	455	2.9%
12	Symptoms and signs involving cognition, perception, emotional state and behavior	425	2.7%
13	Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	404	2.6%
14	Symptoms and signs involving the digestive system and abdomen	372	2.4%
15	Dermatitis and eczema	271	1.7%
16	Disorders of conjunctiva	267	1.7%
17	Noninfective enteritis and colitis	247	1.6%
18	Hypertensive diseases	235	1.5%
19	Influenza and pneumonia	202	1.3%
20	Viral infections characterized by skin and mucous membrane lesions	183	1.2%
	Top 20 ICD-10 Sub Categorizations Grand Total	12,201	78.7%

Providence St. Joseph Medical Center

Rank	Principal ICD Dx Code Desc	Cases	% of Total Cases
1	J06.9 - Acute upper respiratory infection, unspecified	1,649	8.3%
2	R51 - Headache	867	4.4%
3	K52.9 - Noninfective gastroenteritis and colitis, unspecified	608	3.1%
4	R42 - Dizziness and giddiness	599	3.0%
5	N39.0 - Urinary tract infection, site not specified	566	2.8%
6	J02.9 - Acute pharyngitis, unspecified	565	2.8%
7	M54.5 - Low back pain	473	2.4%
8	F41.9 - Anxiety disorder, unspecified	442	2.2%

9	I10 - Essential (primary) hypertension	424	2.1%
10	J40 - Bronchitis, not specified as acute or chronic	395	2.0%
11	N30.00 - Acute cystitis without hematuria	354	1.8%
12	J20.9 - Acute bronchitis, unspecified	286	1.4%
13	J45.901 - Unspecified asthma with (acute) exacerbation	274	1.4%
14	Z02.89 - Encounter for other administrative examinations	266	1.3%
15	F10.120 - Alcohol abuse with intoxication, uncomplicated	258	1.3%
15	N12 - Tubulo-interstitial nephritis, not specified as acute or chronic	258	1.3%
17	H66.91 - Otitis media, unspecified, right ear	257	1.3%
18	H66.92 - Otitis media, unspecified, left ear	233	1.2%
19	R19.7 - Diarrhea, unspecified	232	1.2%
20	J02.0 - Streptococcal pharyngitis	204	1.0%
	Top 20 ICD-10 Codes Grand Total	9210	46.3%

Providence Holy Cross Medical Center

Rank	Principal ICD Dx Code Desc	Cases	% of Total Cases
1	J06.9 - Acute upper respiratory infection, unspecified	4,678	13.4%
2	R51 - Headache	2,298	6.6%
3	N39.0 - Urinary tract infection, site not specified	1,764	5.0%
4	J02.9 - Acute pharyngitis, unspecified	1,589	4.5%
5	R42 - Dizziness and giddiness	918	2.6%
6	M54.5 - Low back pain	902	2.6%
7	K52.9 - Noninfective gastroenteritis and colitis, unspecified	901	2.6%
8	H66.91 - Otitis media, unspecified, right ear	814	2.3%
9	J20.9 - Acute bronchitis, unspecified	795	2.3%
10	N30.00 - Acute cystitis without hematuria	699	2.0%
11	H66.92 - Otitis media, unspecified, left ear	685	2.0%
12	J45.901 - Unspecified asthma with (acute) exacerbation	581	1.7%
13	F41.9 - Anxiety disorder, unspecified	511	1.5%
14	R19.7 - Diarrhea, unspecified	482	1.4%
15	R21 - Rash and other nonspecific skin eruption	391	1.1%

16	N12 - Tubulo-interstitial nephritis, not specified as acute or chronic	357	1.0%
17	I10 - Essential (primary) hypertension	348	1.0%
18	H66.93 - Otitis media, unspecified, bilateral	336	1.0%
19	L50.9 - Urticaria, unspecified	323	0.9%
20	F41.1 - Generalized anxiety disorder	313	0.9%
	Top 20 ICD-10 Codes Grand Total	19685	56.2%

Providence Tarzana Medical Center

Rank	Principal ICD Dx Code Desc	Cases	% of Total Cases
1	J06.9 - Acute upper respiratory infection, unspecified	1,726	11.1%
2	J02.9 - Acute pharyngitis, unspecified	596	3.8%
3	R51 - Headache	587	3.8%
4	J20.9 - Acute bronchitis, unspecified	433	2.8%
5	R42 - Dizziness and giddiness	409	2.6%
6	J40 - Bronchitis, not specified as acute or chronic	360	2.3%
6	R19.7 - Diarrhea, unspecified	360	2.3%
8	R21 - Rash and other nonspecific skin eruption	326	2.1%
9	N39.0 - Urinary tract infection, site not specified	313	2.0%
10	N30.00 - Acute cystitis without hematuria	312	2.0%
11	M54.5 - Low back pain	302	1.9%
12	F41.9 - Anxiety disorder, unspecified	257	1.7%
13	K52.9 - Noninfective gastroenteritis and colitis, unspecified	247	1.6%
14	I10 - Essential (primary) hypertension	230	1.5%
15	H66.91 - Otitis media, unspecified, right ear	202	1.3%
16	J45.901 - Unspecified asthma with (acute) exacerbation	194	1.3%
17	H66.92 - Otitis media, unspecified, left ear	173	1.1%
17	L50.9 - Urticaria, unspecified	173	1.1%
19	F10.120 - Alcohol abuse with intoxication, uncomplicated	159	1.0%
20	M54.9 - Dorsalgia, unspecified	145	0.9%
	Top 20 ICD-10 Codes Grand Total	7,504	48.4%

Appendix 3: Additional Qualitative Data--Community Input

Listening Session Participants

Location	Topic/Population	Date	Language	Number of Participants
Vaughn Early Learning Center	Parents	5/31/19	Spanish	10
San Fernando Elementary School	Parents	6/3/19	Spanish	6
Blythe Street Elementary School	Parents	6/4/19	Spanish	10
Guardian Angel Catholic School	Parents	6/7/19	English	10
Vaughn Early Learning Center	Food Insecurity	6/26/19	Spanish	10
Vaughn Early Learning Center	Food Insecurity	6/26/19	English	5
			Total Participants	**51**

Stakeholder Interview Participants

Organization	Name	Title	Sector
3WINS Fitness	Steven Loy, Ph.D.	Founder	Program, physical activity
Cal State University, Northridge		Professor of Kinesiology	University, physical activity
Alliance for Community Empowerment	Michelle Miranda	President and Chief Executive Officer	Community based organization, community programming and empowerment
All-Inclusive Community Health Center	Marine Dzhgalyan	Chief Executive Officer	Community based organization, health care
Burbank Housing Corporation	Judith Arandes*	Executive Director	Community based organization, housing/homelessness
City of Burbank	Judie Wilke	Acting Assistant City Manager	Government
El Centro de Amistad	Tania Fallert-Del Gatto, MA, LMFT	Associate Director	Community based organization, behavioral health
El Proyecto Del Barrio	Karmen Tatulian, MD	Medical Director	Community based organization, health care
LA Family Housing	Alynn Gausvik*	Sr. Director of Engagement	Community based organization, housing/homelessness
Los Angeles County Department of Public Health	Grace Tan, MPH, CHES	Senior Public Health Analyst	Government, public health
North Valley Caring Services	Manny Flores*	Executive Director	Community based organization, housing/homelessness

Northeast Valley Health Corporation	Eddie Sanders*	Associate Director of Grants	Community based organization, health care
San Fernando and Santa Clarita Valley Homeless Coalition		Co-Chair	Coalition, housing/homelessness
Northeast Valley Health Corporation	Jessica King, MPH, RDN	Associate Director, Health Education	Community based organization, health care
ONEgeneration	Jenna Hauss, MSW	Director of Strategic Initiatives and Community Based Services	Community based organization, aging services
San Fernando Community Health Center	Heidi Lennartz, LCSW, FACHE	Chief Operating Officer	Community based organization, health care
The Office of LAUSD School Board Member Kelly Gonez	Esmeralda Marcial	Director of Community Engagement and Advocacy	Government, education
Valley Crossroads Seventh-day Adventist Church	Sali Butler, MPH PM	Health Ministries Program Director	Faith based organization
West Valley YMCA	Brent Finlay	Executive Director	National organization, healthy living and youth development
	Scott Brumer	Regional Mission Advancement Director of Development	
*Stakeholder asked question set related to housing/homelessness			

Parent Listening Session Findings

Four listening sessions were conducted with a total of 36 participants at schools and early learning centers on the topic of their community's wellbeing and health. Three sessions were conducted in Spanish and one in English. The goal of the listening sessions was to better understand how community members define a healthy community, what issues they want to see addressed, and what resources they think are working well.

Demographics

Twenty-six of the participants were primarily Spanish speaking and ten were primarily English speaking. A third of the participants lived in Pacoima, a quarter in Reseda, and a quarter in San Fernando. The others lived in neighboring cities: Northridge, North Hollywood, Lake View Terrace, Arleta, Sylmar, and Sun Valley.

Vision for a healthy community

Participants were asked, "What is your vision/definition of a healthy community?" Two themes in particular emerged from the responses with at least half of the participants naming the following:

A place where all people, especially children, feel safe
Participants described a community free of violence and gangs, where their family could walk outside and feel safe. In a healthy community, people are not afraid for their child's safety.

Clean streets and parks
Participants described a clean community, free of trash on the streets and in the parks.

Other dominant themes from the sessions include the following:

Green space for children to play and families to spend time
Related to the theme of clean streets and parks, participants shared a healthy community has green space where kids can play and families can be together outside.

Free and low-cost programs for children available year round
In a healthy community, there are programs for children year round that are free or low-cost. Examples of these programs include educational summer classes, sports and exercise opportunities, and cooking and music classes.

Services and supports to address homelessness
Participants shared a healthy community would have fewer people experiencing homelessness than they currently see and would have more shelters and services to address homelessness.

Role of parent, school, and hospital

Participants were asked, "What do you think is the role of the parent, school, and local hospital in creating this vision/definition of a healthy community?" They shared that parents should teach their children **good values and habits**, such as healthy eating. Parents should be **role models** to help their children be good people. Schools are responsible for providing an **academic education** and providing some **health education** information to families. They should communicate with parents, particularly if their children are having problems. Participants shared hospitals should care about the people they serve and **educate people**, particularly on understanding the causes of disease. They should notify people of **disease outbreaks** and prevention methods, as well as provide **vaccines** and **programs** to help people be healthy.

Health-related issues

Participants were asked, "From your perspective what are the biggest health and social issues in your community?" While participants named a variety of issues, the following are the most prevalent themes, presented in order based on the number of times identified by participants:

- Public safety, including violence, safety in parks, and inadequate street lighting
- Homelessness, particularly increased trash and perceived substance use
- Obesity, for both children and adults, linked with poor nutrition
- Cancer
- Mental health challenges, including depression, anxiety, and stress
- Substance use and the selling of substances, particularly in young people

Other concerns included diabetes, community cleanliness, and a lack of programming to keep kids engaged.

Participants were asked, “What do you feel you struggle the most with financially?” All listening session groups said paying **rent** is a challenge. Over half of the groups also said they struggle to pay for **food** and **insurance**, such as health insurance.

Community needs

Participants were asked, “What types of educational programs, services, or opportunities do you think would help you and your child/ student live a healthier lifestyle?” Each listening session group shared different ideas, although resources for youth were a common theme. Participants shared the following needs for their community:

Affordable classes and educational programs for children
Participants would like to see more affordable recreational opportunities for children such as sports leagues, dance, music, cooking, and art. They also would like more health education programs related to healthy eating, and multiple groups spoke to wanting more frequent classes on the negative effects of substance use.

Classes for parents
Participants would like more classes that help parents develop skills and learn how to grocery shop and cook on a budget. Additionally, they would like more affordable exercise classes and programs around food and art for families to participate.

Improved access to affordable, healthy food
More markets with healthy food and farmers markets are needed in San Fernando to increase access to organic fruits and vegetables. Additionally, participants would like to see these healthy foods be more affordable in local grocery stores.

Mobile clinics and increased access to care
Participants shared mobile health care clinics would be beneficial for accessing care. They also would like more low-cost clinics in their community to reduce the length of time they wait for appointments.

Community assets

Participants were asked, “What resources exist in the community to help address these health needs?” Participants shared the following themes:

Low-cost and free health care services
Free flu shots, mammogram tests, and health checks were identified as helpful resources. Participants like community clinics where they can receive affordable care.

Health education classes and wellness fairs
Participants shared LA Care diabetes and cooking classes are particularly helpful for managing chronic diseases and adopting healthy habits. Additionally, health fairs at churches and schools and health education classes, such as those at North East Valley Health Center, were named as helpful.

Recreational opportunities such as exercise classes and sports leagues
Participants shared sports leagues in the park for youth, as well as adult exercise programs like Zumba are good resources for being active. They also shared the 3 WINS Fitness Program from California State University, Northridge as a helpful resource for preventing diabetes and living a healthy lifestyle.

Support accessing basic needs

Food banks and fruit distributions help participants access food for their family. Meeting Each Need with Dignity (MEND) is another organization that addresses food insecurity, homelessness, and poverty.

Barriers to services

Participants were asked, "What are the barriers to accessing resources in your community?" The following are the themes from their responses:

- **Time**: Being busy and caring for other children makes accessing resources more challenging, especially in the summer when kids are at home.
- **Transportation**: For people without cars, getting to classes or programs might be more challenging and take more time.
- **Lack of interest or motivation**: People may not prioritize their health or think they will get sick. They may not be motivated because they do not think the resources will really help.
- **Literacy and language**: Information is not always understandable and clear or in people's preferred languages. Even if the information is translated, people may not understand the terms or the information might not be accessible.
- **Awareness of resources:** While there are many resources, participants shared they are not always aware of those resources and do not always know where to get the information they need.
- **Qualification standards:** Many of the resources have qualification requirements that people may not qualify for based on address and income.

Barriers to vaccinations

While participants said their children were vaccinated, they shared some reasons why people may choose not to vaccinate or barriers to child immunization. The themes from their responses were the following:

Lack of understanding and misinformation
Participants shared there is a lack of understanding around what vaccines do and why they are needed. Additionally, when vaccines are needed and specifically which vaccines their children have already received is confusing. They shared they need easy to understand information (without abbreviations and acronyms) regarding vaccines. Typically, appointments with providers are rushed and there is little time to ask questions or receive any education about vaccines.

Fear of side effects
Some parents may be afraid vaccines could have negative side effects or make their children sick. False information that vaccines cause autism can also scare parents.

Perceived benefits versus risks
Parents do not always understand how vaccines will benefit their child and family. Education on the importance of disease prevention is important to help people understand how the benefits outweigh any risks of vaccination. Additionally, parents are unsure if newer vaccines have been proven successful and therefore do not want their children to receive them.

HPV vaccine confusion
Participants spoke specifically about the HPV vaccine, expressing doubts about the need for and effectiveness of this vaccine. They shared they have little information about this vaccine and they see it

as more controversial for a couple of reasons. They have heard rumors that the vaccine makes children mature at a faster rate and they believe it is in an experimental phase since it is newer.

Food Insecurity Listening Session Findings

Two listening sessions were conducted at the Vaughn Early Learning Center on the topic of food insecurity. One session was conducted in English with five participants and one in Spanish with ten participants. The goal of the sessions was to better understand what makes it easier or harder for families to get nutritious, high-quality food in their neighborhoods.

Demographics

Ten of the participants were primarily Spanish speaking and five were primarily English speaking. Half of the participants lived in Pacoima, while the others lived in neighboring cities: San Fernando, Sun Valley, Sylmar, Burbank, and Los Angeles.

Access to nutritious, high-quality food

Participants were asked, “Where do you get most of your family’s food on a weekly basis?” All of the participants said they shop at **super markets**. A third said they shop at **farmers markets** and a few said they get food from local **food banks**. Participants who utilize food banks shared they typically only seek assistance if they cannot afford groceries, typically once a month. One or two people said they get their food from the following places: 99 Cent Store, fast food restaurants, and liquor stores.

Participants were asked, “Do you get enough nutritious, high-quality, good food every week for your family?” All of the participants said they try to ensure their family has enough good food each week. **Half the participants said they do not get enough nutritious, high-quality food and the other half said they do.** Those that said they do not primarily said that they cannot afford high-quality foods and have to buy cheaper options, which sometimes means choosing fast food.

Support accessing nutritious, high-quality food

Participants were asked, “What makes it easier to get nutritious, high-quality, and good food?” The most common themes were the following (ranked in order based on number of related comments):

Affordable, healthy options in local stores
The most common theme from the sessions was the cost of nutritious, high-quality food. They shared that they often buy healthy foods when they are on sale at the store. They might even travel outside of their neighborhood to find a more affordable grocery store.

Cooking at home instead of eating out
Participants shared the food they cook is usually healthier than the food they eat out. Therefore, going grocery shopping for meals and cooking for their family makes it easier to ensure they are eating nutritious meals.

Being intentional about what to buy and planning meals before shopping
Making a list of groceries to buy ahead of time and planning out meals helps participants and their families eat nutritious meals. They shared they need to be intentional about buying only the food they need and sticking to their grocery list.

Cooking simple recipes

Participants shared keeping recipes simple, such as making salad or quinoa, ensures the food is healthy and not time consuming to cook.

Participants were asked about which programs help them get nutritious, good quality food. They shared the following resources:

- Meet Each Need with Dignity's (MEND) emergency food bank
- Women, Infant and Children (WIC) nutrition program
- CalFresh: California's food assistance program
- UCLA Food Closet
- Food banks and churches
- Providence Health and Services: referrals to food banks and CalFresh

Participants agreed CalFresh does help their families afford nutritious, high-quality food, although the amount of money they receive is not sufficient to cover all of their needs. They shared they still shop carefully and utilize sales. One person shared they only receive $15 a month in CalFresh benefits. Additionally, accessing phone assistance related to CalFresh benefits is very time consuming and sometimes they make people wait long lengths of time for an interpreter.

Barriers accessing nutritious, high-quality food

Participants were asked, "What are the challenges to getting nutritious, high-quality, and good food?" The most common themes were the following (ranked in order based on number of related comments):

Poor quality of nutritious, fresh foods in the stores
Community members shared some of their neighborhood grocery stores do not have good-quality food, in particular produce. Many participants shared they try to buy produce on sale, but often those items are poor-quality or close to expiring. They also shared the food they receive from food banks is often expired or soon to expire.

Higher cost of nutritious, fresh foods compared to processed foods
Nutritious, high-quality food is often more expensive than fast food or processed food. For some of the participants who are not working or are trying to support a family, their food budget does not cover fresh foods.

Time and stress
Participants who work full time and take care of a family shared that shopping for and cooking healthy food is a challenge in their busy lives due to time constraints and stressful schedules.

Transportation
Getting to a grocery store where fresh produce is available can be a challenge. Eating out or grabbing fast food is easier if it is within walking distance.

Family influence
Participants shared it is harder to cook good, nutritious foods when their partners and children do not like those foods. Therefore, they end up cooking multiple meals to satisfy everyone or eating unhealthy meals that their family members prefer.

Health effects

Participants agreed not having nutritious and healthy food affects their health in negative ways. They discussed the importance of healthy food for children, particularly to keep them **focused in school** and give them the **energy to play sports**. They shared an unhealthy diet leads to **weight gain** and **chronic diseases**, such as **high blood pressure** and **diabetes**. Participants recognized that healthy, nutritious foods contribute to overall wellbeing and are important for managing diseases/disorders, such as diabetes and ADHD.

Solutions

Participants were asked, "What else can hospitals, businesses, or the government do to help make it easier to get nutritious (healthy), good-quality food?" They shared they need additional supports and services to help them afford healthy food. Their ideas for solutions were the following:

- Increased information on nutrition from hospitals through health education and resource fairs
- Increased number of government programs to help with grocery expenses or increased financial support from CalFresh
- Lower cost of groceries or increased food specials in stores
- Better signage and information about how to use WIC and CalFresh benefits
- More good-quality grocery stores in food deserts and places with high amounts of fast food restaurants
- More affordable housing options
- Assistance paying for utilities to improve family's financial stability
- More outreach to students and seniors to share resources and discounts

Limitations Related to Community Listening Sessions

Community-based organizations recruited the people they serve to participate in listening sessions and those interested and available attended. 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 they were 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. Additionally, because the note-takers were quickly documenting the themes, their own perspectives and biases may have influenced their interpretation of certain comments. 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-taker's understanding of a comment or personal bias. Translation after the session may have lacked context.

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

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

Stakeholder Individual 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. Following is their prioritization based on urgency and need:

Homelessness and housing instability

Stakeholders identified homelessness and housing instability as an urgent issue in the San Fernando Valley that contributes to a variety of other health-related needs in the community. They described a reactionary system, struggling to meet the needs of people experiencing homelessness.

Factors contributing to homelessness

Stakeholders identified the following factors as contributing to the number of individuals experiencing homelessness and housing instability in the San Fernando Valley:

High cost of housing coupled with a lack of a living wage and economic opportunities
Stakeholders agreed the cost of housing in the San Fernando Valley is high and wages are typically not sufficient to cover the cost of living. Particularly for people without a high school diploma or higher education, there are a lack of employment opportunities that pay people enough to cover their needs. Stakeholders agreed poverty contributes to housing instability and homelessness.

Lack of safety net supports to offset high cost of living
Participants shared there are few resources to help offset the high cost of living in the San Fernando Valley. These safety nets may include help paying bills, affordable transportation, and food assistance. Lack of access to resources in the San Fernando Valley contributes to economic insecurity.

> *"Cost of living is very high and the jobs that are typically held in our community are usually lower paying jobs. And so that's a huge pressure and, [not] enough support systems within the community to be able to offset some of those pressures. There's just not enough access to services." – Community stakeholder*

Once people become unstably housed or are living homeless, there are a variety of factors that make it challenging to move people into stable housing:

Lack of sufficient homelessness services to meet the demand
Participants overwhelmingly shared a lack of resources to support the number of people experiencing homelessness in the San Fernando Valley. All participants noted the services that do exist are over capacity. LA Family Housing has 250 shelter beds for 8,000 people experiencing homelessness. Village Family Services for youth is over capacity. There are currently zero shelters in Burbank and Glendale. Stakeholders described serving only the highest need clients while other people are left without services. They worry that trying to serve this many people will ultimately compromise the quality of services they are able to provide.

"It's the inflow. We don't have enough to serve every single person coming to us. Last year we were contracted to serve a thousand people and 10,000 people came through our doors that were served in some way, which the more people you have and the more you're trying to serve everyone, the more they lose all of what you're trying to do. It makes it harder to really focus in on people who need a lot of help. And so we're at a place right now where we are literally having to prioritize at the front door and say, you know, like this level of acuity is going to get help, but everyone beyond that is not. Like everyone who's not at a high enough need is not going to get served by us because we can't serve everyone." – Community stakeholder

"There are very few affordable housing options up here in San Fernando. And we're coming across people who've lived here their whole lives. They don't want to go down to Los Angeles. So it kind of leaves them stuck with like, 'I don't want to move, pick up my life and move down there where all the resources are.'" – Community stakeholder

Lack of affordable housing and NIMBYism

The San Fernando Valley lacks sufficient housing stock for the people in the community. Residents who have lived there for years are now unable to afford the cost of living. NIMBYism, or the "not in my backyard" attitude, has made developing more affordable housing challenging. Additionally, the cost of property, zoning requirements, and development fees all contribute to the challenges housing service providers face in developing affordable housing properties.

"I think first and foremost there's the lack of affordable housing stock. It's the biggest, it's the premier challenge. I mean you can just turn on the news and you know, it's pretty obvious that there is just a dearth of housing. You know, the demand for housing way outweighs the available supply. And so in order to sort of really make a dent in the homeless crisis, we really need to see more housing." – Community stakeholder

"When the economy wasn't great, people weren't wanting to build housing. So that's a part of it. But now the fact that the economy's better, people are wanting to build housing. You have residents in your community who say, 'no way, I don't want that five unit apartment building to turn into 40 units.' Yeah. So you have NIMBYism going on in communities where people are like, 'not in my backyard. That's not going to happen.' So it's been difficult." – Community stakeholder

Siloed services due to funding streams

Stakeholders described a fragmented system in the San Fernando Valley and a general lack of coordination among agencies working with individuals experiencing homelessness. Due to funding streams, organizations are responsible for specific services, but lack line of sight to the other services being provided. They described it as one organization is funded to do A and B, while another is funded to do C and D, but neither organization is aware of what the other is doing, making coordination difficult.

Lack of funding for grassroots homelessness service providers

While there is additional funding for homelessness services, stakeholders described tapping into that funding as challenging. They shared that typically funding for homelessness services is distributed to

certain organizations that are charged with addressing the housing crisis and smaller, grassroots agencies have very limited opportunities to tap into the funding.

> *"We have a handful of agencies that are typically tapped into the most significant amount of funding and then everything else gets rationed out to a very small community center where that funding becomes actually a life line. It's very hard to tap into that funding and it's very hard to be able to bring grassroots models to people who are building more complex systems and departmentalizing homeless services." – Community stakeholder*

Lack of full stakeholder engagement in addressing homelessness

All stakeholders agreed homelessness is not a problem that can be solved by one or a few organizations. The needs of people experiencing homelessness are so complex that every organization needs to be engaged in solutions and coordinate to maximize efforts. Currently, not enough organizations are stepping up to engage meaningfully. Specifically, the Housing First model is being misinterpreted to mean that before service providers can engage with a person experiencing homelessness they need to have their housing needs met. Unfortunately, with the lack of shelter beds and supportive housing available, this is an unrealistic expectation. Stakeholders called for all organizations to see it as their role to step up in addressing homelessness.

> *"The idea [of Housing First] is that housing is the first step to having good health care. But it doesn't mean you don't provide [services] because someone is homeless. And so I feel like it's become a lot of, like the minute someone's homeless all of the housing and homeless agencies need to do their part before anybody else sees it as their job to step in. And that becomes really challenging." – Community stakeholder*

> *"So if I can qualify the biggest challenges, I would say that it takes a village to tackle this situation and unfortunately we don't have all of our community stakeholders involved in serving the homeless." – Community stakeholder*

Groups disproportionately affected by homelessness and housing instability

Stakeholders shared the lack of affordable housing in the San Fernando Valley is a challenge for all people, but they named two groups as particularly affected by homelessness and lacking support services:

Older adults

Stakeholders were particularly concerned about older adults who may be unable to afford to live in the San Fernando Valley. They shared some of their clients have lived their entire lives there and do not want to move to Los Angeles or another area where there may be more resources. They described a shift towards late baby boomers, those in their mid-sixties, who are seeking support services and experiencing housing instability or homelessness.

> *"So these are individuals that maybe can't work because of a disability or they're not able to find work or they've just thought they were able to retire and live a sustainable life and now they can't. So now they're desperately trying to find more work or finding roommates to come live with them or vice versa." – Community stakeholder*

Young people

Stakeholders identified a lack of services for youth experiencing homelessness, stating that those that exist are already over capacity. While there has been a 34% increase in youth experiencing homelessness in the San Fernando Valley they have not seen an increase in funding for services for youth. Stakeholders typically see youth living homeless due to negative family dynamics, violence in the home, and poverty.

"The families we work with, many are living in poverty and so the stress in the home environment that often erupts violence and people are trying to get away from that." – Community stakeholder

Effective strategies for addressing homelessness

Stakeholders shared a variety of strategies they have found to be effective at addressing homelessness:

Family reconciliation and homeless diversion
Considering the lack of shelters and affordable housing units, service providers are doing their best to move people from living unsheltered to staying with family and friends. Homeless diversion or system diversion is a strategy that works with people who are experiencing homelessness to rebuild relationships and leverage their social networks to have them stay with family and friends instead of sleeping unsheltered. While stakeholders acknowledged this is not an ideal solution, it is often the only option available to keep people from sleeping on the street.

"So diversion is this effort to look at someone's networks who's experiencing homelessness or about to become homeless and say, 'okay, I'm going to paint a reality for you if you have not been homeless for 10 years, the reality of you getting anything beyond just a deposit and employment assistance is very rare. And so let's talk about who else you have, because the more you're on the streets, the worse it's going to get. And so who else do you have? How do we like, negotiate/mediate? How do we rebuild relationships with family and friends who are currently housed and can provide assistance?'" – Community stakeholder

Relationship building and increased integration of services
Stakeholders shared their greatest outcomes come when they are able to develop relationships with the people they serve and work with people consistently throughout their experience with homelessness. The current system of services is fragmented, requiring numerous handoffs and missing the opportunity to build trust between service providers and people experiencing homelessness. The opportunity for more integration of services, relationship building, and fewer handoffs is potentially a more effective model.

"The bottom line is that the way we deal with homelessness is more of an engagement. It's relational and it's really walking somebody through their homelessness and it's leveraging services that we provide and asking as a requirement that people would invest in their own homeless situation." – Community stakeholder

Community outreach and health education to people experiencing homelessness
Stakeholders shared having public health nurses do outreach to patients experiencing homelessness is helpful for vaccinating people. This outreach paired with health education by community health workers is effective for sharing health messages and connecting people to resources.

A continuum of housing, from transitional to permanent housing

Stakeholders spoke to the effectiveness of having the option for people living in transitional housing to move into permanent housing afterwards. While transitional housing is important and may help people stabilize, people still may have low-incomes and experience challenges finding an apartment once their time in transitional housing ends. Therefore, giving them preference for permanent housing units supports this transition and prevents people from returning to being unstably housed.

Opportunities for health care organizations to engage in homelessness efforts

A few stakeholders from organizations specifically related to homelessness were asked how their agency is coordinating with primary care providers like hospitals and clinics. They shared few formal collaborations, stating that most of their interactions are from referring patients with health care needs. There are some collaborations around street outreach using mobile health units, but most stakeholders shared a desire for more formal and thoughtful collaboration. Stakeholders identified a few opportunities for health care organizations to better engage in efforts to address homelessness in the San Fernando Valley:

Develop respite care for patients
Stakeholders agreed there are simply not enough beds for people experiencing homelessness, especially those who are recently discharged from the hospital and with health challenges. They suggested hospitals build or develop interim housing for people with health care needs to prevent discharging people into homelessness.

Utilize housing navigators in the Emergency Department
To address high utilization of the Emergency Department (ED) by patients experiencing homelessness, stakeholders suggested implementing a housing navigator in the ED to facilitate coordination between housing and health care organizations. This navigator could help connect patients experiencing homelessness to appropriate services, such as follow-up care, and navigate housing resources.

Train staff in homeless diversion
While ultimately moving people into housing is the goal, there is a lack of housing available. Therefore, stakeholders asked that health care organizations are realistic in their support of patients experiencing homelessness and creative in their solutions. Hospital staff can be trained in homeless diversion, which is a strategy that works with people who are experiencing homelessness to rebuild relationships and leverage their social networks to have them stay with family and friends instead of sleeping unsheltered. This strategy, while not ideal, is one method for keeping people sheltered.

Mental health

Stakeholders shared they are seeing increased incidences of mental health challenges in the community, with increased depression, anxiety, and suicidal ideation, especially in young people.

Factors contributing to mental health challenges

Stakeholders shared the following contributing factors to poor mental health in the populations they serve:

Poverty and a lack of opportunities
The stress of living paycheck to paycheck and lack of opportunities for improved economic situations contribute to feelings of hopelessness and depression.

Trauma and violence
Stakeholders shared they see a lot of domestic violence, gang violence, and crime in the communities they work with. The lack of safety and experiences with violence contribute to their clients' mental health challenges caused by trauma.

"I feel like trauma and mental health [are] kind of rising to the top and I know you can't really move forward with a lot of these other health issues until we really address that need." – Community stakeholder

Fear and racism related to immigration status

Often included in comments about trauma, stakeholders shared fear related to immigration status is affecting their clients' mental health. Stakeholders described people who are undocumented or have family members who are undocumented as being afraid to go outside, feeling like they lack control over their situations, and suffering from the racism and xenophobia they experience.

"I feel like the current administration is really contributing to a lot of fear within our communities. For example a couple of weeks ago there were ICE vans surrounding our communities and people saying, 'don't leave your homes at this particular time. Don't go to the grocery store.' So I can only imagine, you know, how are we going to reach out to patients to come to their medical appointments when they're afraid of, you know, whatever deportation or those types of scenarios?" – Community stakeholder

Lack of access to culturally and linguistically appropriate mental health services in the community and schools
There is a lack of mental health providers in the San Fernando Valley, particularly those who are bilingual and from the communities they serve. This lack of access to mental health care is prevalent in community health care settings and in the schools. For young people, there are insufficient counselors in the schools to offer support.

"Whenever there's budget cuts that happen there isn't policy to protect counseling in schools… because you look at other statistics with divorce rates high and all these other stressors that young people experience, but yet there isn't this avenue to help young people work through those issues." – Community stakeholder

Groups disproportionately affected by mental health challenges

Young people
Many stakeholders were concerned about the increasing number of young people they see who are experiencing depression, anxiety, and suicidal ideation at younger and younger ages. They shared that social media, lack of engaged parents and family dysfunction, and lack of counselors in schools contribute to mental health challenges.

"We have had a lot of issues with our youth and mental illness, suicides and things like that. I know the hospital has seen that because a lot of them have, you know, gone through their doors." – Community stakeholder

Older adults
Stakeholders were concerned about social isolation for older adults contributing to depression.

Immigrants, particularly undocumented immigrants
Immigrants were identified as disproportionately affected by mental health challenges for a variety of reasons. They may have a harder time finding a bilingual, culturally sensitive mental health provider due to the mental health provider shortage. Undocumented immigrants especially may have less access to mental health services if they are uninsured because organizations typically have limited funding for serving undocumented immigrants. Additionally, fear related to immigration status, racism and xenophobia, and new public charge laws all contribute to poor mental health and wellbeing.

> *"The funding is low so we can't provide services for every person who is uninsured or is undocumented because we have a certain like allocation for uninsured and immigrant population[s]." – Community stakeholder*

Effective strategies for addressing mental health needs

Stakeholders shared the following strategies for addressing mental health needs:

Improve access to counseling and mental health services
To better meet the needs of their community, stakeholders shared their organizations are trying to hire more mental health providers. They are also utilizing supervised graduate student volunteers to support patients who are uninsured. In this way, they can offer free mental health services in the community and support professional training.

Integrate mental health care and primary care
To identify individuals who may need mental health support, providers are screening for mental health challenges in a primary care setting and making appropriate referrals to an onsite social worker or other mental health professional.

> *"And regarding depression, we screen all older patients the age of 12 and above, during their annual visit, for depression. And if the screening process was a positive, we have right now a LCSW who their primary care providers can refer those patients to this LCSW who will meet with them right away on that day." – Community stakeholder*

Utilize health education classes and workshops
Stakeholders noted the importance of utilizing health education classes and workshops, particularly with young people, around social skills and mental health. These classes could be for either the young person coping with mental health challenges or for the parent of a young person struggling.

Provide mentorship to young people
Specifically to better support young people, stakeholders discussed the importance of mentorship and relationship-building. This is especially important for young people experiencing homelessness or with disengaged parents.

Increase mental health awareness and reduce stigma using social media
Stakeholders discussed utilizing social media to raise awareness around mental health challenges. The information includes events related to mental wellbeing as well as stories about mental illness to reduce stigma around the topic.

> *"Social media too, like posting different kinds of success stories and also current issues that are going on within the mental health community. We also have annual mental health awareness*

events to bring mental health awareness and to decrease the stigma associated with mental health." – Community stakeholder

Opportunities for health care organizations to engage in mental health efforts

Organizations engaged in providing mental health support noted the following opportunities for health care organizations to engage:

- Provide education to new parents on mental health for children ages zero to five
- Support efforts to increase the number of psychiatrists in the community, particularly bilingual ones
- Provide support for referrals from community-based organizations for mental health care, particularly needed is medication support for children under 12 years
- Partner with schools and community-based organizations to prevent youth suicide and support community efforts in preventing mental health challenges

Chronic diseases, particularly obesity, diabetes, and hypertension

Stakeholders shared their concerns about the high number of people they serve with chronic diseases, in particular diabetes, obesity, and hypertension.

Contributing factors to chronic diseases

They named the following contributing factors to diabetes, obesity, and hypertension:

Inactive lifestyles due to busy schedules and lack of safe places for exercise
Stakeholders shared many of their patients are physically inactive, taking few steps a day and not exercising. For youth, high amounts of screen time keeps them sedentary. For adults, busy and stressful schedules prevent them from having time to exercise. Gyms may be unaffordable for families and parks are not seen as safe for exercising, therefore people do not have safe places to be active.

"I believe that poor eating, due to very, very busy, inactive lifestyles creates the situation where health patterns are chronic and never improving. Lack of external safe places for exercise, be it parks, be it a safe facility, safe organizations that individuals can trust. Outside walking spaces are very limited, you know, busy, busy streets. So there's really no galvanizing hub for the masses to come to and be a part of." – Community stakeholder

Poor diets due to food insecurity
Healthy food is often more expensive than unhealthy alternatives, with cheap, easily-accessible fast food often the easier option for families. SNAP benefits are often insufficient to cover all of a family's food expenses, meaning families cannot always afford to buy fresh, healthy food.

"Obesity, that's a very complex issue. Definitely food insecurity and the lack of access to resources, right? Like a flood of food injustice where, you know, you might see a plethora of fast food restaurants, but not as much access to healthy fruits or vegetables." – Community stakeholder

Lack of health literacy and knowledge about healthy lifestyles
Stakeholders shared they see a lack of understanding about healthy diets and chronic diseases. Additionally, people lack the knowledge to navigate the complexities of the health care system to access the services they need to prevent and manage their chronic diseases.

"We still see people not really understanding the health system and where and how to access preventive health care. Many, many issues with early health education. So understanding how diet affects your teeth, as an example, or that diet can lead to kidney problems and kidney problems can lead to diabetes. There's still a great deal of need for health education and health system navigation." – Community stakeholder

Groups disproportionately affected by chronic diseases

Stakeholders identified the following groups as disproportionately affected by chronic diseases:

Latinx
A majority of the patients served by stakeholders' organizations are Latinx. Stakeholders shared they see a high number of their Latinx patients affected by obesity, diabetes, and hypertension.

Immigrants, particularly new immigrants or those who are undocumented
Stakeholders shared immigrants are disproportionately affected by chronic diseases for a variety of reasons. Undocumented immigrants may not have health insurance or be afraid to access services due to immigration status. New immigrants may not know how to navigate the health care system or seek resources, and they may not speak English, making accessing services more challenging.

Effective strategies for addressing chronic diseases

Stakeholders shared the following strategies for addressing chronic diseases:

Increase health education and system navigation using patient navigators and closed loop referrals
Stakeholders shared improving patients' health literacy is crucial for addressing chronic diseases. Included in health literacy is how to navigate the health system to improve access to care, as well as health education, related to nutrition. Stakeholders shared one strategy is to utilize health navigators in health homes who can connect patients with chronic diseases to health education programs. Closed loop referrals to food banks or exercise programs are another way to ensure people are connected to the resources they need.

"So health homes I hope is like the answer to really taking the best care of our patients that we can. Our patient navigators have the ability to actually accompany patients to different medical appointments and social service appointments." – Community stakeholder

Increase screening for chronic diseases and the social determinants of health
Stakeholders shared identifying patients who may be at risk for chronic diseases due to food insecurity or lack of access to health care is a way to address contributing factors to chronic diseases. They suggested screening for the social determinants of health (using the PRAPARE tool) in the primary care setting and making appropriate referrals. They also suggested screening for chronic diseases in community settings, such as faith-based centers as a way to engage with patients and ensure they are connected to health care services.

"We're also implementing what's called the PRAPARE tool. So it's the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences. And so this was a social determinant of health survey that was developed by the National Association of Community Health Centers. So what we're doing is we're starting to implement it or conduct it more and more amongst

different patient populations… so that we can better understand their underlying social needs and hopefully when we address the social needs, we can also make improvements and move the dial on their medical or health outcomes." – Community stakeholder

Increase safe and affordable locations for people to be physically active
Stakeholders shared many of their patients feel unsafe exercising outside in parks due to crime and violence. Additionally, people do not always know how to exercise properly. Therefore, they noted a need for affordable and safe places for people to exercise and receive guidance.

"I wish we could have more training places where people can go and exercise and see how other people are exercising and get more advice. You know gyms, like a membership is pretty expensive and not everybody can afford that." – Community stakeholder

Opportunities for health care organizations to engage in addressing chronic diseases

"Walk with a doc" program
The "walk with a doc" program, or walk with a health professional, is an opportunity for health care professionals to spend time in a community and go for a walk with a patient while providing health care consultation.

"That individual is able to look out there and see that these people look like them, you know, that it's their community… Now you're bringing that education to the people. They don't have to seek it out. They can get their physical activity in at the same time they have the opportunity to ask questions". – Community stakeholder

Substance use

Stakeholders were concerned about the increase of substance use, particularly in young people, in the San Fernando Valley. They identified opioids and marijuana as the two substances they are most concerned about, but also identified vaping, methamphetamines, and alcohol as issues. They have particularly seen an uptake of people abusing prescription medications.

Contributing factors to substance use

Stakeholders shared the following contributing factors to substance use:

Poverty and lack of opportunities
Similar to that seen with poor mental health, stakeholders identified a lack of opportunities and hopelessness as contributors to substance use. Financial stressors and inability to change one's economic situation were also contributors.

"Just the frustration of being in these environments and feeling hopeless and you know, young people then, well people just in general, turn to violence. They're short fused, they turn to substances to numb out." – Community stakeholder

Lack of education about risks of substance use
Stakeholders shared they do not think people fully understand the risks of using substances and their addictive properties. They noted a lack of health education around substance use, particularly marijuana and alcohol.

"There's a lack of education about addictive behaviors and the dangers of the misuse of alcohol and other substances that we're looking at how to address that more proactively." – Community stakeholder

Increased accessibility of marijuana

With the legalization of marijuana, stakeholders believe it is too accessible. Young people in particular are able to get marijuana without challenge and in a variety of forms.

"We're starting to see more of an increase in marijuana, especially since now it's provided in all different forms. It's a candy, chips. Young people understanding that taking one cookie is one thing, but then when you take two cookies or three cookies, we're seeing people start to OD just on like the edibles. So there's still a lack of education around it and just the access, it's just too accessible for young people especially." – Community stakeholder

Mental health challenges and use of marijuana as a coping mechanism

Stakeholders have seen young people use marijuana as a method of coping with their feelings of depression and isolation.

"I mean probably every third, every fourth teenager who comes to see us for preventative visits and stuff they are mentioning about their depression and are mentioning that marijuana use is for their depression, which is kind of scary because it means we are going to deal in the future for marijuana being a gateway for other kinds of drugs." – Community stakeholder

Lack of access to substance use treatment

Stakeholders shared it is challenging to get people into substance use treatment programs. There are few beds, people sit on long waiting lists, and then often have to travel long distances to the treatment center. This means that once a person is ready to receive substance use treatment they often have to wait for an available bed. By the time it becomes available, the person may no longer be willing to go.

"Just lack of access. No access to being able to get into a treatment bed. Great example is that, you know, we had someone who wanted to go to treatment and it can take us months to get someone to even say yes. And if we don't have access that day, it's really difficult to keep that momentum. We spent five hours yesterday, like three staff time, spent five hours driving someone out to Pomona to a treatment bed because that was the only treatment bed that we could get. And when that person is released and out of that treatment bed, they'll have to get to us so that we can continue services, which just the kind of cycle of it, of not having housing, needing to get into treatment, not having access same day and having to wait and hope that that person still wants to go by the time we get a bed. And then having them exit into street homelessness where the situation isn't any better and the reasons they were using prior are still very much present." – Community stakeholder

Groups disproportionately affected by substance use

Stakeholders shared the following groups as being disproportionately affected by substance use:

Young people

Stakeholders shared concerns about young people using marijuana and vaping starting from young ages. They discussed an increasing number of young people using marijuana to cope with depression and feelings of hopelessness. They were also concerned about how easily accessible marijuana is.

People experiencing homelessness
Participants discussed seeing substance use and homelessness as two issues that are linked with both making the other worse. Substance use may contribute to homelessness or people may develop substance use disorder as a way to cope with homelessness.

Effective strategies for addressing substance use

Stakeholders identified the following effective strategies they are using to address substance use:

Hub and spoke model of Medication-Assisted Treatment
One stakeholder described a Medication-Assisted Treatment (MAT) program for opioid use disorder. They use a "hub and spoke model" for their program, which is an evidence-based model in which a regional "hub" or expert in the field of substance use provides support to the "spokes" or community clinic providers. In this instance, the "hub" or expert, is a regional treatment center that can provide inpatient services for people with more intensive needs.

The "spokes" are regional health centers that can provide outpatient MAT services to individuals who may need less intensive support. This two-way referral system based on severity of the disorder utilizes the expertise of each agency and connects patients with an appropriate level of support.

Opportunities for health care organizations to engage in addressing substance use

Stakeholders shared the following suggestion for how health care organizations could engage in addressing substance use:

Provide health education in local organizations and schools related to substance use risks
Stakeholders noted health care organizations could support local organizations and schools in providing more health education related to the risks of substance use and information about addiction.

Other opportunities for health care organizations to engage in community health

Specific opportunities for health care organizations to engage in efforts to address each of the prioritized health needs are listed above in their respective sections. Stakeholders also shared more general opportunities for collaboration and supporting one another such as the following:

Provide health education classes and health care services onsite at community-based organizations
Stakeholders shared they would welcome a partnership with a health care organization to provide on-site health care services at their organizations. These services could include health education classes, health screenings, or specialty care and take place as locations such as senior centers, transitional housing buildings, or faith based organizations.

> *"Providing onsite classes [at community based organizations] themed around maybe current issues, whether it's nutrition, parenting, health, but providing them on site. I often get the newsletters of different classes and workshops that you have [at the hospitals] but some of our young people don't have transportation or access, to attend to those workshops is a challenge." – Community stakeholder*

Endorse work of grassroots agencies and formalize partnerships

Stakeholders appreciate the resources and breadth of large health care organizations and would like to see them better utilize their power to intentionally partner with and support grassroots agencies. These on the ground organizations see opportunities to partner in advocacy opportunities on community needs and apply for grants together. Organizations could even co-locate services to meet patients' needs for health and social services in one location.

"Having the medical community really endorse the work that's being done in these grassroots agencies and, and, uh, you know, create these partnerships that we hope to have. That'll be a great support for [us]." – Community stakeholder

Implement bi-directional referrals and health information exchanges

Stakeholders shared their organizations often need help connecting patients to health care, specifically specialty care. They would appreciate a more streamlined referrals system between their agencies to ensure patients' needs are not overlooked. To support these efforts, improved sharing of health information, such as shared records between health centers and hospitals could improve the continuum of care and communication between providers.

"Definitely expediting services. You know, I have to call in favors for a bed. I have to beg a friend of mine from an outreach team to come see a client, who's got a major health situation going on. Expediting services would be something that would be a really positive thing for us. But also making sure that services that we're, we're talking about like food security and the outreach that we do, it's really associated to a medical treatment." – Community stakeholder

Develop career pathways into health care

To address poverty and lack of opportunities for economic and educational growth, stakeholders suggested health care organizations develop career pathways into health care.

Limitations Related to Stakeholder Interviews

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.

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

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

Summary and Data Blending

The following figure is a high-level summary of the needs prioritized by community members and community stakeholders:

Community Member Prioritized Issues	Public safety, including violence, safety in parks, and inadequate street lighting
	Homelessness, particularly increased trash and perceived substance use
	Obesity, for both children and adults
	Cancer
	Mental health challenges, including depression, anxiety, and stress
	Substance use and the selling of substances, particularly in young people
Community Stakeholder Prioritized Issues	Homelessness and housing instability, particularly a lack of affordable housing in the San Fernando Valley and insufficient capacity to meet the needs of people experiencing homelessness
	Mental health challenges, related to a lack of mental health professionals in the community and high levels of trauma and violence
	Chronic diseases, specifically obesity, diabetes, and hypertension due to lack of safe places to exercise, food insecurity, and lack of health literacy
	Substance use, particularly in young people, and a lack of education about the risks of substance use

Both community members and stakeholders identified the following health-related needs as priorities. There were many overlaps in their comments and some differences, which are noted below:

Homelessness and housing instability

Overlap	Differences
•High cost of housing is the primary financial struggle for families •A lack of affordable housing in the San Fernando Valley •Concern for the number of people living unsheltered •A need for more shelters and resources for people experiencing homelessness	•Stakeholders highlighted a lack of sufficient funding, capacity, and integrated services as challenges •Community members focused on the perception that increased homelessness in their communities increases the amount of trash and substance use, leading to decreased safety

Mental health

Overlap	Differences
•Trauma and violence contributing to people's depression and anxiety •Stressful schedules contributing to insufficient time to care for oneself	•Stakeholders emphasized a need for more mental health providers

Chronic diseases, particularly obesity, diabetes, and hypertension

Overlap	Differences
•Concern for high amounts of childhood and adult obesity, leading to other diseases such as diabetes and hypertension •Connection between obesity and food insecurity, particularly the lack of affordable, fresh, good-quality foods in many low-income communities •Lack of safety in parks for people to walk and exercise outside •Desire for more health education classes related to nutrition and cooking and shopping on a budget •Desire for improved access to health care through mobile medical vans and community-based health services	•Stakeholders emphasized a need for improved health literacy for patients to help them access health care services and better understand the advice from their health care provider

Substance use

Overlap	Differences
•Concern for substance use in young people, particularly marijuana and vaping •Concern for easy access to substances •Need for increased education regarding the risks of substance use	•Stakeholders shared a need for increased substance use disorder treatment centers •Stakeholders have seen high amounts of use of opioids and methamphetamines

Protocols

Listening Session Facilitation Guides

The facilitation guide was developed by Valley Care Community Consortium and included 10 questions for the sessions with parents and nine questions for the food insecurity sessions. Participants were asked the following questions:

Parent Listening Sessions

1. What is your vision/definition of a healthy community?
2. From your perspective, what are the biggest health and social issues in your community? Why? Which populations are disproportionately affected?
3. What do you feel that you struggle the most with financially?
4. What do you think is the role of the parent, school, and local hospital in creating a vision/ definition of a healthy community?
5. What else is important for us to know about significant health needs in the community?
6. What resources exist in the community to help address these needs? (e.g. people, organizations or agencies, programs, or other community resources)
7. What are the barriers to accessing resources in your community?
8. What types of educational programs, services, or opportunities do you think would help you and your child/student live a healthier lifestyle?
9. Are your children vaccinated?
10. What are some barriers to child immunization?

Food Insecurity Listening Sessions

1. Where do you get most of your family's food on a weekly basis? Please list your top three places.
2. Do you get enough nutritious, high-quality, good food every week for your family?
3. What makes it easy to get nutritious, high-quality, and good food?
4. What are the challenges to getting nutritious, high-quality, and good food?
5. Does not having nutritious, healthy food affect your health? Please describe.
6. What programs, organizations/agencies and/or groups have helped you get nutritious, healthy, good-quality food?
7. How often do you receive food from a food bank or food pantry?
8. What else can hospitals, businesses, or the government do to help make it easier to get nutritious, healthy, good quality food?

9. Does CalFresh make it easier for your family to get nutritious, high-quality, and good food? Please explain why or why not.

Stakeholder Interview Questions

General Interview Questions

1. What is your name, title, organization and role in your organization?
2. What are the most significant health issues or needs in the community, considering both their importance and urgency? Please rank your top three.
3. What factors or conditions cause or contribute to these health needs?
4. Please describe environmental or social factors/conditions that contribute to these health needs.
5. Is the population you serve disproportionately exposed to air pollution, have inadequate access to safe, accessible parks, etc.?
6. Who or what groups in the community are most affected by these needs? (e.g., youth, older residents, racial/ethnic groups, specific neighborhoods)
7. What do you think are effective strategies or actions for addressing these needs?
8. What resources exist in the community to help address these health needs? (e.g., people, organizations or agencies, programs, or other community resources)
9. Where do you see the most significant opportunity for the medical and healthcare community in helping to support your organization's efforts?

Homelessness Interview Questions

1. What is your name, title, organization and role in your organization?
2. What are the most significant health issues or needs in the community, considering both their importance and urgency? Please rank your top three.
3. What factors or conditions cause or contribute to these health needs?
4. Please describe your organization's role in addressing homelessness in SPA2.
5. What are the biggest issues and challenges facing homeless services providers in SPA 2?
6. Is your agency coordinating or collaborating with primary care providers like hospitals/community clinics in helping the target population?
7. Where do you see the most significant opportunity for the medical and healthcare community in helping to support your organization's efforts?

Appendix 4: Available Resources to Address Identified Needs

This section includes a description of the programs and services available in the Providence San Fernando Valley Service Area and that may be included in future Community Benefit Plan strategies or hospital partnerships and collaborations.

Community Assets including Existing Health Care Facilities, Organized by Health Need

Community need	Resource
Access to health care services	El Proyecto Del Barrio Mission City Community Network Partners in Care Foundation Providence Saint Joseph Medical Center Samuel Dixon Family Health Center, Inc.
Aging services	ONEgeneration
Chronic diseases and physical inactivity	3 Wins Fitness Central Day Diabetes Organization YMCA (Achievers Program)
Education	Vaughn Next Century Learning Center
Employment and job training	Chrysalis Goodwill Los Angeles Pierce College Los Angeles Valley College South San Fernando Valley WorkSource Center
Food insecurity	CalFresh Food Forward Local food banks MEND WIC
Health education	L.A. Care's Family Resource Centers
Homelessness	LA Family Housing Los Angeles Homeless Services Authority MEND Salvation Army The Village Family Services
Immigration support	Coalition for Humane Immigrant Rights (CHIRLA)
Mental health	Burbank Police Department Didi Hirsch Mental Health Services El Centro de Amistad Hillview Mental Health Center Strength United
Poverty and basic needs	Maravilla Foundation (utilities assistance) Meet Each Need with Dignity (MEND)

	NEW Economics for Women (transportation assistance, economic empowerment, skills training)
Substance use	BRIDGES Inc. Phoenix House Tarzana Treatment Centers
Youth programming and family support	Boys & Girls Club of San Fernando Valley Child Development Institute El Nido Family Centers First 5 LA New Directions for Youth

Appendix 5: Evaluation of 2016 Community Health Improvement Plan Impact

This section outlines the investments made in priority health needs in response to the 2016 Community Health Needs Assessment process.

In 2016, the San Fernando Valley Service Area adopted a Community Health Improvement Plan designed to address key needs identified in the assessment, which included:

6. Access to Healthcare and Community Resources
7. Prevention and Management of Chronic Diseases
8. Senior Care and Resources
9. Mental Health Services (including Substance Abuse)
10. Poverty and Food Insecurity

The goal of the improvement plan was to measurably improve the health of individuals and families living in the areas served by the three Providence Medical Centers; PHCMC, PSJMC, and PCSTMC. This was the first time the improvement plan was consolidated into one report, representing one San Fernando Valley Service (SFV) Area. The plan included components of education, prevention, disease management, and treatment, as well as a plan to address social determinants of health.

In 2017, the first year of the implementation strategy, the Providence San Fernando Valley Community Investment Department focused on improving access to healthcare, which was the top priority health need identified in the 2016 Community Health Needs Assessment (CHNA). With a new emphasis on building health access programs across the Los Angeles Service Area, the SFV Community Health Department began to expand the scope of services provided by its Community Health Workers. It included providing application assistance for health insurance and CalFresh benefits. All public benefit programs, health insurance (Medi-Cal and Covered California) and CalFresh, require that the Community Health Workers were trained and certified enrollment counselors to assist clients and families enroll for benefits. In addition, Community Health Workers in the Emergency Department began to focus on core responsibilities designed to impact outcomes in support of improving patient access to a medical home, assistance with arranging follow up care at a convenient community clinic, enrolling eligible adults in Emergency Medi-Cal (Hospital Presumptive Eligibility), and navigation to health services.

One of the key relationships developed in 2017 was with Vaughn Next Century Learning Center (Vaughn), which is a private independent K-12 charter school located in Pacoima, California. In March of 2018, the Community Health Department collaborated with Vaughn to open a 1,500 square foot Wellness and Activity Center (Center). The goal of the Center is to create a place outside the hospital that would give children and adults access to a clean and safe place to play, learn, and come together with their neighbors to improve their own health. The Center offers complementary programs including daily exercise programs: Zumba®, aerobics and walking groups, application assistance for public benefits: Medi-Cal, Covered California and CalFresh, referrals to other local resources and ongoing health and wellness classes. The Center linked Community Health Staff, prevention and management of chronic disease education to a high need Northeast San Fernando Valley community.

Community Health Staff were also able to fulfill the senior care and resources initiatives through collaborative partnerships with senior agencies such as One Generation, the Joslyn Center, and the CSUN Kinesiology Department 3Wins Program that provided much needed mental health, senior specific resources, and/or exercise programs throughout all of the San Fernando Valley as described in the Implementation Strategy. The successful relationships with community partners in the past two years provided new resources to residents in target communities. Additional key partners who contributed to our efforts in improving the health in the community in the San Fernando Valley are MEND, San Fernando Community Health Center, All Inclusive, Los Angeles Unified School District, City of San Fernando, City of Los Angeles, UCLA, Tarzana Treatment Center, and Valley Care Community Consortium.

In July of 2019, the Community Health Investment Department moved its administration office to Van Nuys, California. The new office allowed for more space that now allowed to provide wellness programs for the community. The wellness center includes a 1,250 square foot classroom that is used to provide health education workshops. A future goal is to transform the room into an educational teaching kitchen to allow for health education and cooking classes. Two months later, in September, the Community Health Investment established a collaboration with the Burbank Housing Corporation and opened the Providence Wellness Center in Burbank, California. The purpose was to provide services to the clients surrounding our Providence St. Joseph's Hospital. This center offered complementary exercise classes, preventative mental health related classes, health insurance and Cal Fresh enrollment assistance, and referrals or linkage to appropriate resources in the community. Information in English, Spanish and Armenian will be provided to participants visiting the center. These three wellness centers provided the Community Health Investment Department the ability to focus efforts in mental health services and implement food insecurity strategies. The following is a summary of the five CHNA strategies:

Strategy #1: Improving Access to Healthcare and Resources

Action Plan: Health Insurance

Tactic: Community Health Insurance Program

- Community Health Workers assisted with 786 MediCal applications at various locations in the San Fernando Valley, including school parent centers, churches, health clinics, and community wellness centers. It is projected that approximately 1,200 medical applications will be submitted by the end of 2019.

Tactic: Emergency Dept. Community Health Workers

- Community Health Workers working in the Emergency Department at Providence Holy Cross Medical Center and Providence St. Joseph Medical Center were able to assist 865 patients applying for Hospital Presumptive Eligibility (HPE), which provided much needed temporary medical coverage for uninsured patients, namely low-income children and adults. In 2019, the Community Health Investment department began to support Providence Tarzana Medical Center Emergency Department. It is projected that approximately 2,547 HPE's will be completed by the end of 2019.

Action Plan: Primary Care

Tactic: Access to Care

- Total of five health clinics that participated in the Access to Care program, including Meet Each Need with Dignity (MEND), All Inclusive Community Health Center, San Fernando Community Health Center, Valley Community Health Center, and El Proyecto del Barrio.

Tactic: Emergency Dept. Community Health Workers

- Community Health Workers in the Emergency Department at Providence Holy Cross Medical Center and Providence St. Joseph Medical Center scheduled 710 primary care appointments to community clinics for follow-up care. 554 (78%) of those appointments were kept. With service added to Tarzana Medical Center in 2019, appointment are projected to reach 1,345 by the end of 2019.

Tactic: Health Fair Follow-ups

- Community Health Workers and Faith Community Nurses facilitated 545 follow-up appointments to a medical home for health fair participants who received out-of-range point of care (POCT) test results.

Action Plan: Immunization

- Mobile Immunization Clinic for free vaccinations to various LAUSD schools, independent charters, and private faith-based schools in partnership with Facey Medical Group is on hold until improvements to the mobile unit pass LA County Immunization Project certification requirements.

Strategy # 2: Implement Prevention Interventions to Reduce the Prevalence or Progression of Chronic Disease

Action Plan: Increase Physical Activity

Tactic: Conduct wellness visits as part of the Faith Community Health Partnership and CSUN/3WINs Programs.

- CSUN/3WINs Wellness program, which includes HbA1c testing, body mass index and body fat % screenings, as well as goal setting, was conducted at 4 local sites including St Patrick's Catholic Church (North Hollywood, CA), St. Didacus Catholic Church (Sylmar, CA), Our Lady of Peace Catholic Church (North Hills, CA) and Guardian Angel Church (Pacoima, CA) with 136 participants in 2017, and 235 in 2018 when Lanark Park (Canoga Park, CA) was added as a site.

Action Plan: Increase Access to Healthier Foods

Tactic: Fit Food Fairs

- Fit Food Fairs/Cardio Carnivals were conducted at three faith-based schools including St. Patrick's, Guardian Angel, and St. Didacus to highlight nutrition education, physical activity, and wellness promotion.

Action Plan: Strengthen Senior Outreach Program

Tactics: Partner with SFV Senior Services Agencies

- Community Health Staff partnered with local senior agencies, such as One Generation and the Joslyn center, to improve continuum of services, including seeking funding to fill identified gaps. It is estimated that approximately 457 seniors were provided services from referrals from the Community Health Investment Senior Program.

Tactics: Improve documentation on sources of referrals to program

- Community Health Staff have reviewed and improved the documentation on sources of referrals to program scope of referrals, and confirmation of partner services provided.

Tactics: Plan, design and implement a physical activity program for seniors

- 231 seniors participated in a physical activity program through 3WINS Exercise Program for Seniors.

Tactic: Pilot Groceryships (FEAST)

- The FEAST program includes a 10-week nutrition support group, including nutrition education, cooking demonstrations, and food scholarships. The program showed positive healthy behavior change.
    - 10 adults completed the course.
    - At the beginning of the program, 58% of participants drank soda once a week or more. By the end of the program 91% of participants either drank no soda or only 1 soda a week. (33% change).
    - At the beginning of the program 58% of participants were cooking meals at home once a day. By the end of the program, 75% of participants were cooking meals at home at least once a day (17% change).

Tactic: CalFresh Enrollment in Community Settings

- Community Health Workers were placed a various locations weekly, including churches, parks, community-based organizations, health fairs, etc. to conduct outreach to increase enrollment.

Action Plan: Diabetes Self-Management Education

Tactic: Adopt an evidence-based curriculum for pre-diabetic adults

- 10 participants consistently attend the Attention to Prevention Diabetes Program has 10 participants who are consistently attending weekly sessions. Six met their goals and lost an average of 7.7lbs. One individual dropped a total of 21lbs or 10% of their initial weight.

Strategy #3: Strengthen Community Based Mental Health Infrastructure to Better Align with Hospital-Based Mental Health Services

Action Plan: Improve Access

Tactic: Coordinate linkage of participants in health promoter classes to mental health providers.

- 60 people were referred directly to Tarzana Treatment Center for mental health services from health education workshops provided by Community Health Workers at schools and churches covering topics on mental health awareness and how to prevent mental health illnesses.

Action Plan: Treatment

Tactic: Explore the feasibility of a wellness and activity center

- In March of 2018 a wellness and activity center was opened on the property of Vaughn Next Century Charter School in the City of Pacoima, which is in the Holy Cross Community Benefit service Area. This location allows for the community health department to enhance its footprint in the Northeast San Fernando Valley. The location is being used to conduct community health navigation and educational services, including mental health classes.

- In July of 2019, a wellness and activity center was opened in Van Nuys, California, which is in the Tarzana and St. Joseph Medical Center Community Benefit service areas. The location is being used as the primary administration office for Community Health Investment and also to conduct community health navigation and educational services, including mental health classes.
- In September of 2019, a wellness and activity center was opened on the property of Burbank Housing Corporation, which is in the St. Joseph Medical Center Community Benefit service area. The location is being used to conduct community health navigation and educational services, including mental health classes.

Tactic: Implement Mental Health First Aid Training

- In partnership with the National Council for Behavioral Health, our new Wellness Center at Vaughn Next Century Learning Center conducted a *Mental Health First Aid* training to 25 Providence Community Health employees.
- To address mental health needs in the San Fernando Service Area, Community Health Investment Department partnered with UCLA to conduct an Alcohol & Health Research Study. In 2018, 11 participants, out of 346 approached, were recruited and consented to participate in the study. The research study is intended to investigate the effectiveness of 3 motivational interviewing sessions performed by community health workers on Latino's exhibiting unhealthy drinking behaviors.

Strategy # 4: Align Community Benefit Programs with San Fernando Medical Centers

<u>Action Plan: Providence Holy Cross & Saint Joseph Medical Centers</u>

Tactic: Develop Network of Physicians

- A total of 8 specialty physicians are participating in the Access to Care Program and specialize in the field of orthopedics, cardiovascular health, urology, ophthalmology, dermatology, gastroenterology, podiatry, and otolaryngology (ENT). As of 2018, there was a total of 341 patients referred by participating clinics for specialty care consultation services. It is estimated that Community Health Investment staff will assist over 450 patients by the end of 2019.

Tactic: Develop Mental Health/Resiliency Skill Program.

- The Adolescent Coping Education Series (ACES), an 8-week educational series focusing on coping and resiliency skills, was piloted at Sepulveda Middle School in the spring of 2017. A total of 111 students completed the educational series. It is estimated that an additional 130 students from James Monroe High School will have completed the series by December 2019.

<u>Action Plan: Providence Saint Joseph Medical Center</u>

Tactic: Support "Live Well" program

- The Live Well Program is a partnership between Providence St. Joseph Medical Center, Providence Community Health Investment and various organizations in the Burbank community, including the YMCA. The 4-month evidence-based program is free to seniors and combines exercise, nutritional counseling and disease prevention & management education to help at-risk people improve their quality of life. In 2018, Community Health Dept. Staff assisted in providing pre and post screenings for 53 participants.

<u>Action Plan: Providence Tarzana Medical Center</u>

Tactic: Pilot Senior Program

- In March of 2019 the SAFE program was implemented at Tarzana Medical Center. It is designed to address avoidable visits by seniors frequently seen in the ER. It is estimated that Community Health Investment Staff will assist over 300 patients by the end of 2019.

Appendix 6: CHNA GOVERNANCE

Assessment Oversight Committee

The Valley Service Area Community Ministry Board authorized the Community Health Needs Assessment Oversight Committee to consider primary and secondary data collected by Providence staff and prioritize the identified community health needs for the 2020-2022 cycle. The following is a roster of Committee Members.

Name	Organization	Title
Judith Arandes	Burbank Housing Corporation	Executive Director
Anette Besnillian, MPH	California State University, Northridge	Executive Director of the Marilynn Magaram Center
Sandra Yanez, MA Psych	Catholic Charities of Los Angeles, Inc.	San Fernando Regional Director
Tamika Farr, MBA	El Centro de Amistad	Executive Director
Dr. Frank Alvarez, MD, MPH	LA County Dept. of Public Health	Regional Area Health Officer
Janet Marinaccio, MA Psych	MEND	Executive Director
Jenna Hauss, MSW	ONEgeneration	Director, Strategic Initiatives & Community Based Services
Audrey Simons, RDH, MSHA	San Fernando Community Health Center	Chief Executive Officer
Dr. Jose Salazar, PhD, MPH	Tarzana Treatment Center	Director of Program Development
Dr. Huey Donald, MD	Facey Medical Group	Specialist, Internal Medicine
Suzanne Silva, RN MSN CEN	Providence Holy Cross Medical Center	Director of Emergency Services
Debbie Buffham, BSN, RN	Providence Saint Joseph Medical Center	Director of Emergency Dept. & Critical Care Services
Carol Granados, MNutr	Providence Saint Joseph Medical Center	Director, Dietary Patient Services
Terry Walker	Providence Saint Joseph Medical Center	Director, Provider Relations
Brian Wren, LCSW	Providence Saint Joseph Medical Center	Manager, Clinical Social Work
Danny Fajardo	Providence St. Joseph Foundations, SoCal Region	Associate Director, Corporate and Foundation Relations
Estelle Schwarz, RN, BSN, MBA	Providence Tarzana Medical Center	Director of Nursing
Jeanne Sulka	Providence Tarzana Medical Center	Director, Business Development

Valley Service Area Community Ministry Board

2019 Valley Service Area Community Ministry Board

Name	TITLE/COMPANY
Omaran Abdeen, MD	Past Chief of Staff, Providence Holy Cross Medical Center
Thomas L. Bruehl	Retired
Norman Coulson	Past Chair, VSA Foundation Board of Directors
Ed Feinstein	Senior Rabbi, Valley Beth Shalom
Sue Georgino	Adjunct Professor
Sr. Mary Hawkins, SP	Sister of Providence
Sarah Karzel, Esq.	Past Chair, VSA Community Ministry Board
Bernie Klein, MD	Chief Executive, Providence Holy Cross Medical Center
Boris Larreta, MD	Foothill Cardiology/ California Heart Medical Group, Inc.
Carrie Leonard	Vice President, American Homes 4 Rent
Peter J. Lynch	Chair, PH&S Foundations, Board of Directors
Richard Marciniak	CA State Knights of Columbus - Culture of Life Chairman
Gerald Puchlik	Principal, Puchlik Design Associates, Inc.
Howard J. Reinstein, MD	Pediatrician, Zimble & Reinstein
Peter Richman, MD	Vice President, Administration, Meissner Manufacturing Company, Inc.
Bill Wiggins	Owner, Automation Plating Corp

Providence Cedars-Sinai Tarzana Medical Center, Board of Managers

2019 Providence Cedars-Sinai Tarzana Medical Center, Board of Managers

Name	Title	Organization
Tom Priselac	President and Chief Executive Officer	Cedars-Sinai Medical Center
Erik Wexler	Chief Executive, Providence St. Joseph Health	Southern California Region
Lisa Weaver	Chief Integration & External Relations Officer	Providence St. Joseph Health
Jeff Smith, MD, JD, MMM	Executive VP, Hospital Operations and COO	Cedars-Sinai Medical Center
Victor Jordan	Chief Operating Officer	Providence St. Joseph Health, Southern California Region
Ed Prunchunas	Executive VP, Finance and CFO	Executive Director
Jeff Work, MD	Physician	Providence Cedars-Sinai Tarzana Medical Center