2022

COMMUNITY HEALTH NEEDS ASSESSMENT

Providence Saint John's Health Center

Santa Monica, California

To provide feedback on this CHNA or obtain a printed copy free of charge, please email Justin Joe at Justin.Joe@Providence.org.

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MESSAGE TO THE COMMUNITY

For the last 80 years, Providence Saint John's Health Center has remained committed to serving the Westside community, investing in our neighbors and partnering with like-minded organizations to achieve our Vision of Health for a Better World.

Following the traditions set forth by our foundresses, the Sisters of Charity of Leavenworth, Providence Saint John's continues our founding Mission by actively working to transform health care and advocate for vulnerable populations. Through community investments and collaborations, our health center provides housing, food, behavioral health services, health care and other essential and critical services to underserved communities.

For generations, we've worked alongside our local partners to guide investments that are designed to have a lasting impact into the future. Last year alone, Providence Saint John's community benefit totaled $48.9 million to improve the health and well-being of the Westside.

These benefits included offering outpatient mental health services to more than 1,000 families, adolescents and children through Providence Saint John's Child and Family Development Center (CFDC), facilitating warm handoffs between case managers and patients experiencing homelessness through our Homeless Care Navigation Program, and addressing disparities in colorectal screenings among minority communities through partnerships with organizations like Stand Up to Cancer.

Our annual efforts are guided by a Community Health Needs Assessment, a formal evaluation completed every three years that pinpoints the greatest needs in the community and identifies ongoing strategies and solutions to address those needs. This guides our community benefit programs that not only strengthen Providence Saint John's services, but also bolster local resources that meet the diverse needs of our neighbors and make measurable differences in the community.

As we prepare for our next Community Health Needs Assessment, we look forward to upholding the legacy of our foundresses by fulfilling their Mission and embodying their spirit of collaboration so we all can create healthier communities, together.

Thank you and be well,

Michael Ricks
Chief Executive
Providence Saint John's Health Center

ACKNOWLEDGEMENTS

Providence Saint John's Health Center participated in a collaborative CHNA process, which included UCLA Health, Cedars-Sinai Medical Center and Cedars-Sinai Marina del Rey Hospital. We would like to acknowledge the contributions of:

Cindy Levey
Executive Director
Community Benefit and Social Responsibility Systems, Advancement
Cedars-Sinai

Indu Bulbul Sanwal, MBA & MPH
Strategic Development Manager
Office of Health System Strategy and Business Development
UCLA Health

EXECUTIVE SUMMARY

Understanding and Responding to Community Needs

The Community Health Needs Assessment (CHNA) is an opportunity for Providence Saint John's Health Center to engage the community every three years with the goal of better understanding community strengths and needs. At Providence, this process informs our partnerships, programs, and investments. Improving the health of our communities is fundamental to our Mission and deeply rooted in our heritage and purpose. Our Mission calls us to be steadfast in serving all, especially our neighbors who are most economically poor and vulnerable.

The 2022 CHNA was approved by the Board of Directors on November 30, 2022 and made publicly available by December 28, 2022.

Gathering Community Health Data and Community Input

Through a mixed-methods approach, using quantitative and qualitative data, we collected information from several existing data sources. To actively engage the community, we conducted listening sessions with people who have chronic conditions, are from diverse communities, have low-incomes, and/or are medically underserved. We also conducted stakeholder interviews with representatives from organizations that serve these populations, specifically seeking to gain deeper understanding of community strengths and opportunities. Some key findings include the following:

- Homelessness and housing instability was an urgent need identified by both stakeholders and listening session participants who emphasized a need for more affordable housing and homelessness prevention models on the Westside.
- There is a need for more bilingual providers, including mental health providers, as well as a need for coordinated and whole-person care, integrating physical and behavioral health care services.
- Barriers to accessing health care and preventive care include cost of care, health care literacy, transportation, workforce shortages leading to long wait times, and a lack of services outside of regular business hours.
- The high cost of living in Los Angeles County contributes to economic insecurity. Wages have not increased to keep up with rising costs. Economic insecurity is closely related to a lack of affordable housing and difficulty accessing rental assistance.
- Chronic diseases are influenced by the built environment, wealth inequities, and a lack of access to resources. Overcrowded housing and a lack of safe recreational areas contribute to chronic diseases.
- Community safety, including physical and emotional, is important for people's mental health and overall well-being. Stakeholders were concerned about how racism and discrimination contribute to a lack of safety and feeling of belonging in the community.

While care was taken to select and gather data that would tell the story of the hospital's service area, it is important to recognize the limitations and gaps in information that naturally occur.

Identifying Top Health Priorities

Through a collaborative process engaging local community members, external partners, and Providence leadership, the Community Health Needs Assessment Oversight Committee of the Providence Saint John's Health Center Board of Directors identified three priority areas (listed in priority order):

PRIORITY 1: HOMELESSNESS AND HOUSING INSTABILITY

Persons experiencing homelessness is defined as any individual or family who lacks a fixed, regular, and adequate nighttime residence; an individual or family who will imminently lose their primary nighttime residence; and any individual or family who is fleeing, or is attempting to flee, domestic violence, has no other residence, and lacks the resources or support networks to obtain other permanent housing. Health and homelessness are inextricably linked. Health problems can cause a person's homelessness as well as be exacerbated by the experience. Housing is key to addressing the health needs of people experiencing homelessness.

Housing instability encompasses several challenges such as having trouble paying rent, overcrowding, moving frequently, staying with relatives, or spending the bulk of household income on housing. Households are considered "cost burdened" if spending more than 30% of household income on housing, and "severely cost burdened" if spending more than 50% of household income on housing. Cost-burdened households have little left over each month to spend on other necessities such as food, clothing, utilities, and health care.

PRIORITY 2: BEHAVIORAL HEALTH (MENTAL HEALTH AND SUBSTANCE USE/MISUSE)

Mental health is an important part of overall health and well-being. Mental health includes our emotional, psychological, and social well- being. It affects how we think, feel, and act. It also helps determine how we manage stress, relate to others, and make healthy choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood. Mental health programs include the prevention, screening, assessment, and treatment of mental disorders and behavioral conditions.

Substance use/misuse occurs when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and inability to meet major responsibilities at work, school, or home. Substance use/misuse includes the use of illegal drugs and the inappropriate use of legal substances, such as alcohol, prescription drugs and tobacco.

PRIORITY 3: ACCESS TO HEALTH CARE AND PREVENTIVE CARE

Access to care goes beyond medical care, and includes dental, vision, primary care, transportation, culturally appropriate care, and care coordination. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Providence Saint John's Health Center will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs in collaboration with community partners considering resources and community strengths and capacity. The 2023-2025 CHIP will be approved and made publicly available no later than May 15, 2023.

Measuring Our Success: Results from the 2019 CHNA and 2020-2022 CHIP

This report evaluates the impact of the 2020-2022 CHIP. Providence Saint John's Health Center responded to community needs by making investments of direct funding, time, and resources to internal programs and external partners dedicated to addressing the previously prioritized needs using evidence-based and industry leading practices. In addition, we invited written comments on the 2019 CHNA and 2020-2022 CHIP, made widely available to the public. No written comments were received on the 2019 CHNA and 2020-2022 CHIP.

INTRODUCTION

Who We Are

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

Providence Saint John's Health Center is located at 2121 Santa Monica Blvd, Santa Monica, CA 90404. It is an acute care hospital with 266 licensed beds. Providence Saint John's Health Center has been serving Santa Monica and westside Los Angeles County communities since 1942. Providence Saint John's provides the latest in diagnostic technology and specialty care with a strong commitment to its core service lines: heart and vascular care, oncology, orthopedics and women's health. Saint John's also is home to the world-renowned Saint John's Cancer Institute, dedicated to clinical research and medical advancements in cancer care.

Our Commitment to Community

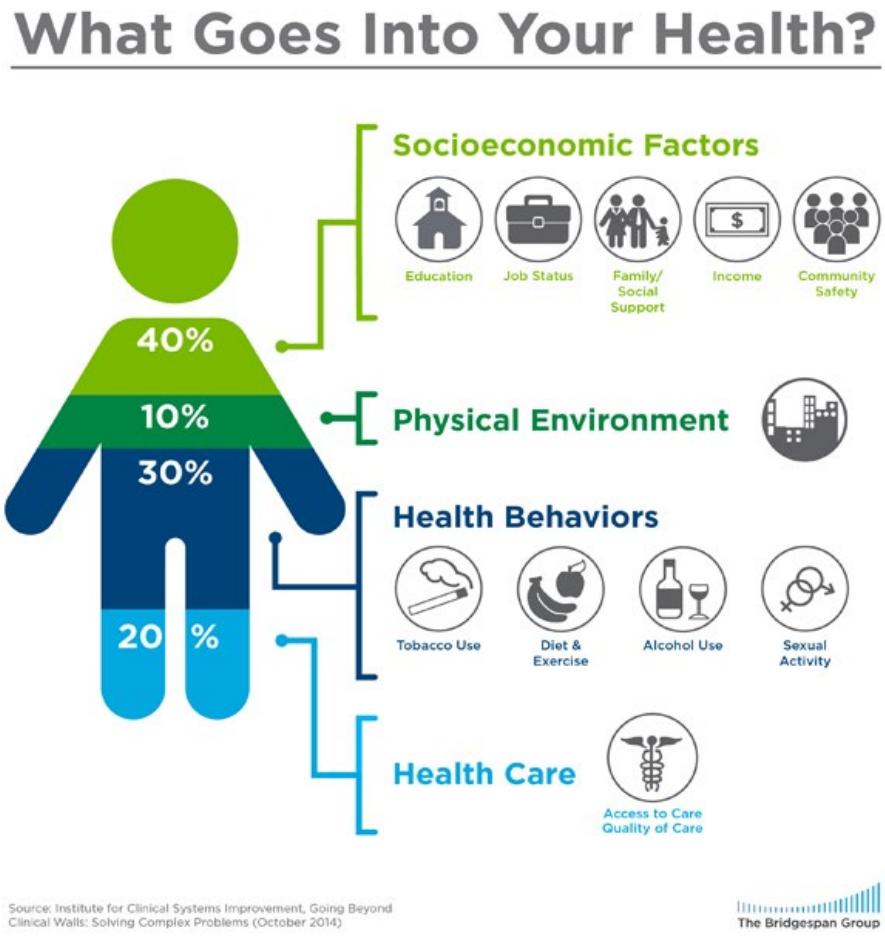
Providence Saint John's Health Center dedicates resources to improve the health and quality of life for the communities we serve. During 2021, the Providence Saint John's Health Center provided $48.9 Million in Community Benefit[1] in response to unmet needs and to improve the health and well-being of those we serve in the west Los Angeles community.

Providence Saint John's Health Center further demonstrates organizational commitment to community health through the allocation of staff time, financial resources, participation, and collaboration to address community identified needs. The hospital's Regional Director, Community Health Investment and the Director, Community Health are responsible for ensuring the compliance of State and Federal 501r requirements. They also ensure community and hospital leaders, physicians, and others work together to plan and implement the resulting Community Health Improvement Plan (CHIP).

[1] Per federal reporting and guidelines from the Catholic Health Association.

Health Equity

At Providence, we acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. Our Vision is "Health for a Better World," and to achieve that we believe we must address not only the clinical care factors that determine a person's length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes (see Figure below[2]).



Factors contributing to overall health and well-being

[2] Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2013)

The CHNA is an important tool we use to better understand health disparities and inequities within the communities we serve, as well as the community strengths and assets (see the figure to the right for definition of terms[3]). Through the literature and our community partners, we know that racism and discrimination have detrimental effects on community health and well-being. We recognize that racism and discrimination prevent equitable access to opportunities and the ability of all community members to thrive. We name racism as contributing to the inequitable access to all the determinants of health that help people live their best lives, such as safe housing, nutritious food, responsive health care, and more.

Health Equity

A principle meaning that "everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups." (Braverman, et al., 2017)

Health Disparities

Preventable differences in the burden of disease or health outcomes as a result of systemic inequities.

To ensure that equity is foundational to our CHNA, we have developed an equity framework that outlines the best practices that each of our hospitals will implement when completing a CHNA. These practices include, but are not limited to the following:

Approach

Explicitly name our commitment to equity

Take an asset-based approach, highlighting community strengths

Use people first and non-stigmatizing language

Community Engagement

Actively seek input from the communities we serve using multiple methods

Implement equitable practices for community participation

Report findings back to communities

Quantitative Data

Report data at the block group level to address masking of needs at county level

Disaggregate data when responsible and appropriate

Acknowledge inherent bias in data and screening tools

For this CHNA, community stakeholders were asked to identify vulnerable populations who were most

[3] Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What is Health Equity? And what Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017.

impacted by the identified significant community needs.

Collaboration

Providence Saint John's Health Center participated in a collaborative process for the stakeholder interviews, which included Cedars-Sinai Medical Center, Cedars-Sinai Marina del Rey Hospital, Providence Saint John's Health Center, Ronald Reagan UCLA Medical Center, UCLA Medical Center, Santa Monica, and Resnick Neuropsychiatric Hospital at UCLA. Given that these partners share an overlapping service area, a collaborative effort increased primary data collection efficiency and reduced redundancies.

Project Oversight

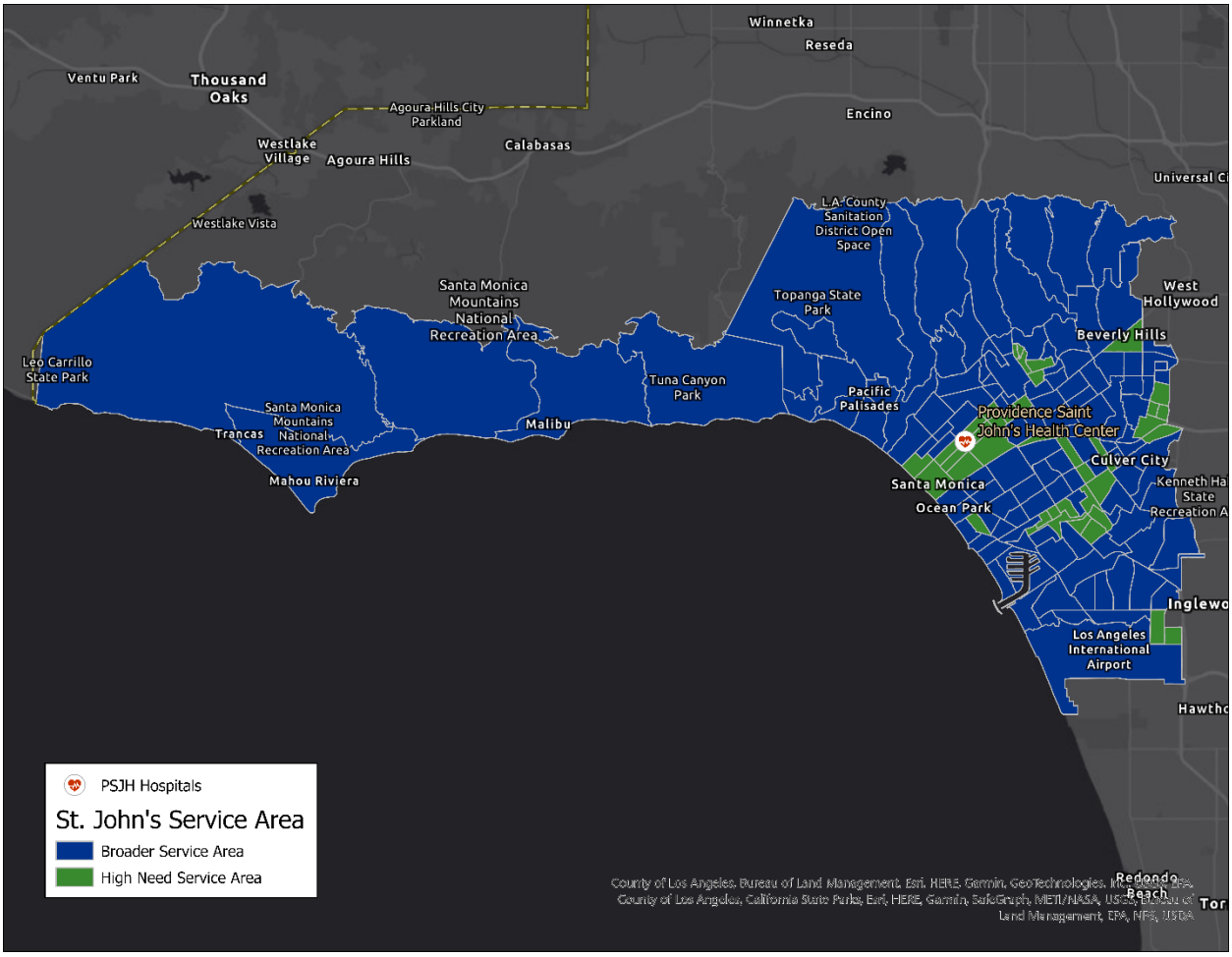
The Community Health Needs Assessment process was overseen by:
Justin Joe, MPH
Director, Community Health
Providence Saint John's Health Center

Consultant

Biel Consulting, Inc. conducted the community stakeholder interviews and wrote the CHNA report. Dr. Melissa Biel was joined by Vanessa Ivie, BS, MSG to complete the primary data collection. Biel Consulting, Inc. is an independent consulting firm that works with hospitals, clinics and community-based nonprofit organizations. Biel Consulting, Inc. has over 25 years of experience conducting CHNAs and working with hospitals on developing, implementing, and evaluating community benefit programs. www.bielconsulting.com

OUR COMMUNITY

Hospital Service Area and Community Served



The service area defined for the Providence Saint John's Health Center (PSJHC) CHNA includes the neighborhoods located within Service Planning Area (SPA) 5 of Los Angeles County. The planning area includes the communities located on the west side of the county (referred to as "the Westside" locally, and in this report), and represents the area where a significant portion of the patients served by the hospital resides. SPA 5 was used as the target geographic area for this CHNA because 1) it closely matched where a majority of PSJHC's patients reside, 2) using the SPA definition aligned data collection to boundaries used by the L.A. County Department of Public Health and other government agencies and 3) it aligned with service areas of other hospitals whom we collaborated with in the needs assessment process. The area includes 20 distinct communities and 30 ZIP codes.

Providence Need Index

For purposes of conducting this CHNA with a health equity framework, within the total Saint John's service area we identified a high need service area based on the social determinants of health specific to the inhabitants of the service area census tracts. Based on work done by the Public Health Alliance of Southern California and their Healthy Places Index (HPI) tool, the following variables were used to calculate a high need census tract:

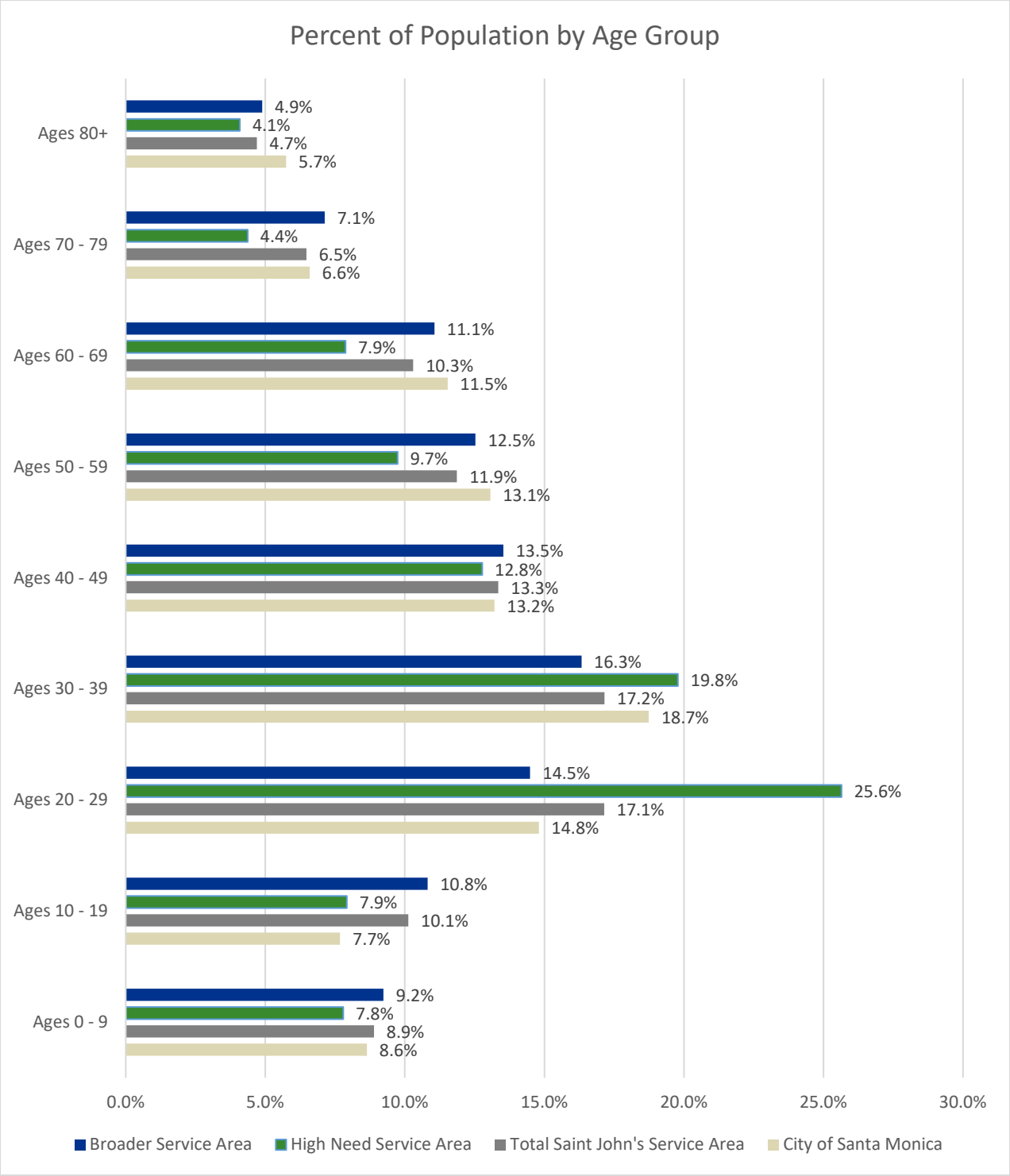
- Population below 200% the Federal Poverty Level (American Community Survey, 2019)
- Percent of population with at least a high school education (American Community Survey, 2019)
- Percent of population, ages 5 Years and older in Limited English Households (American Community Survey, 2020)
- Life expectancy at birth (estimates based on CDC, 2010 – 2015 data)

For this analysis, census tracts with more people below 200% FPL, fewer people with at least a high school education, more people in limited English households and a lower life expectancy at birth were identified as "high need." All variables were weighted equally, and the average value of the population was assigned to census tracts that did not have an estimated life expectancy at birth. Ultimately, the census tracts were given a score between 0 and 100 where 0 represents the best performing census tract and 100 is the worst performing census tract according to the criteria. Census tracts that scored above the 75th percentile and that have strong existing community partnerships were classified as a high need service area and are depicted in green. In the SJHC service area, 40 of 161 census tracts (24.8%) scored above the 75th percentile, indicating a high need.

Community Demographics

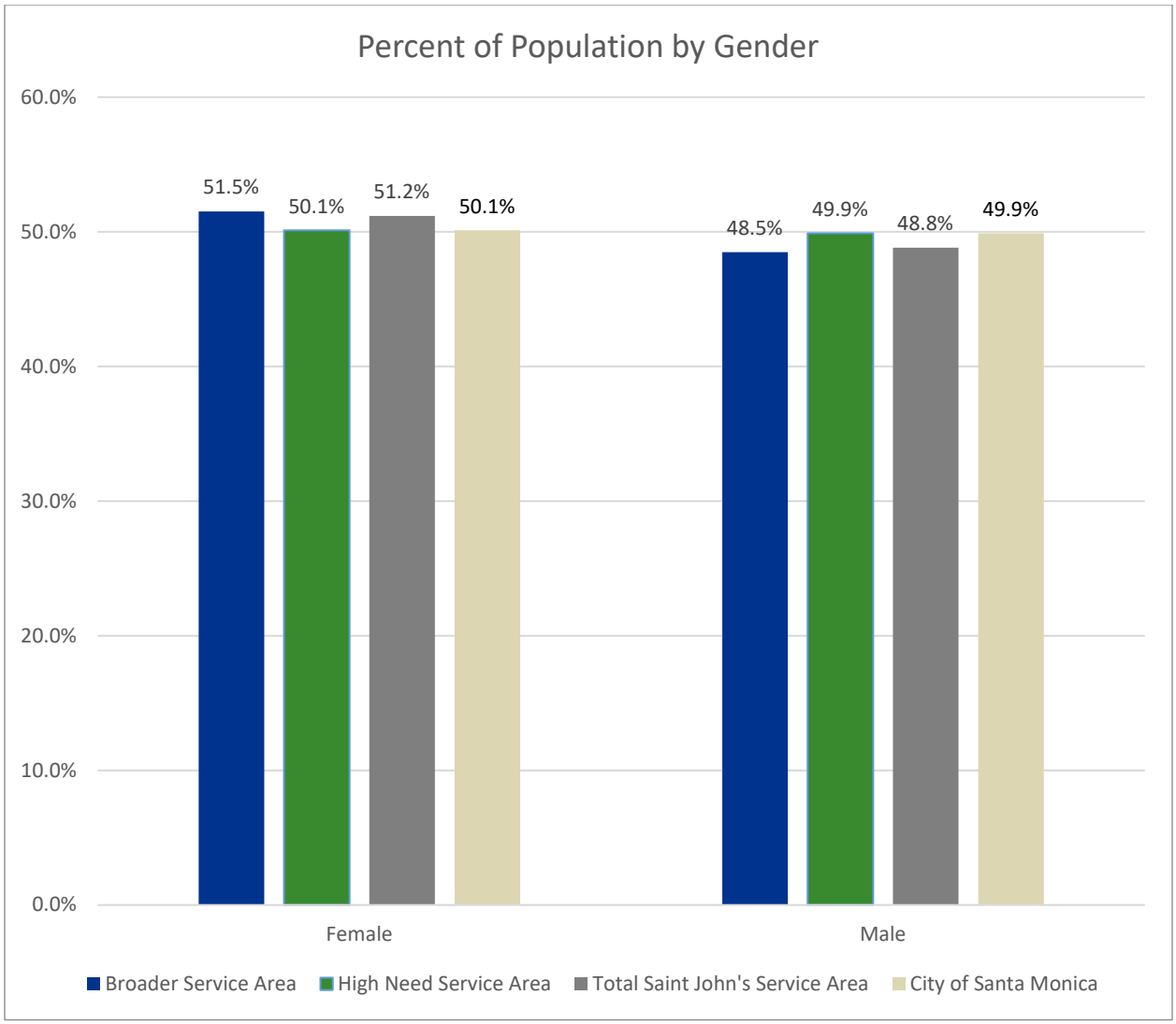
The tables and graphs below provide demographic and socioeconomic information about the service area and how the high need area compares to the broader service area. We have developed a dashboard that maps each CHNA indicator at the census tract level. The dashboard can be found here:

https://experience.arcgis.com/experience/d4bd56ec40a84e2fa865516add50f450/



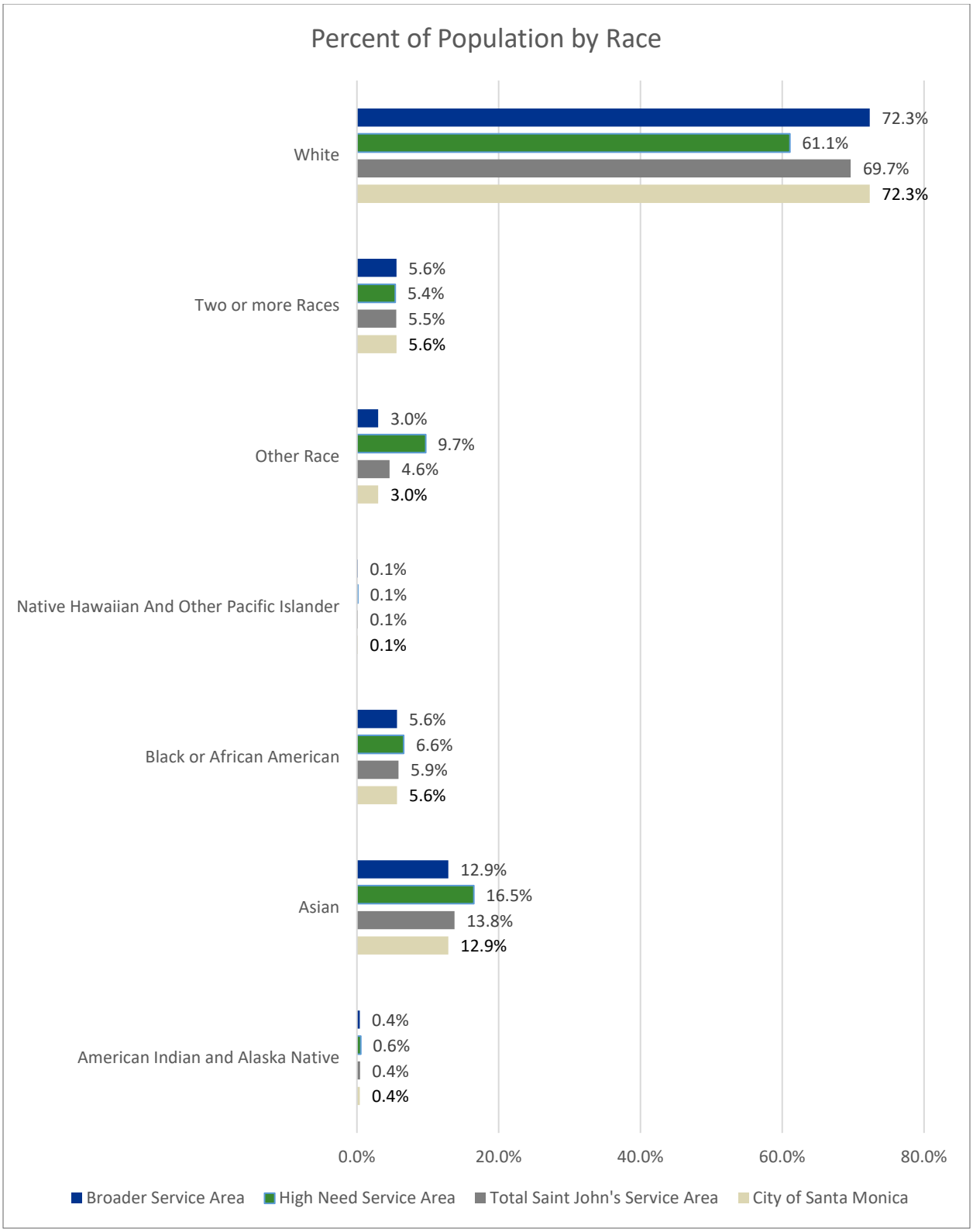
Population by Age Groups by Geography

People aged 20-39 are disproportionately represented in the high need service area, while people aged 50 and older are more likely to live in the broader service area.



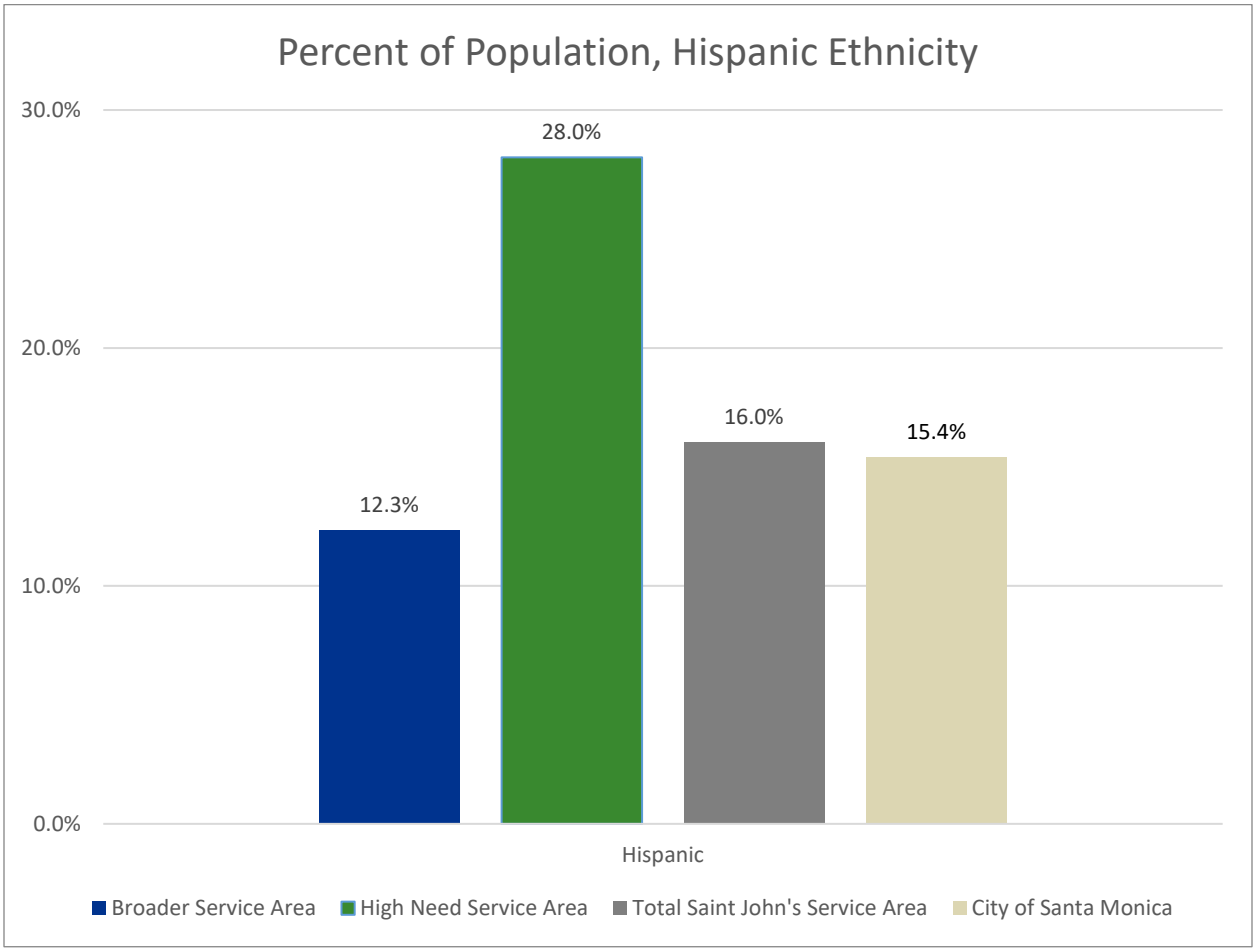
Population by Gender by Geography

The population in the Saint John's service area is split fairly even by sex, with males making up 48.8% and females 51.2%. Females are slightly more represented in the broader service area and males in the high need service area.



Population by Race by Geography

"Other race" and Asian people are disproportionately represented in the high need service area, with white people more likely to live in the broader service area.



Population by Hispanic Ethnicity by Geography

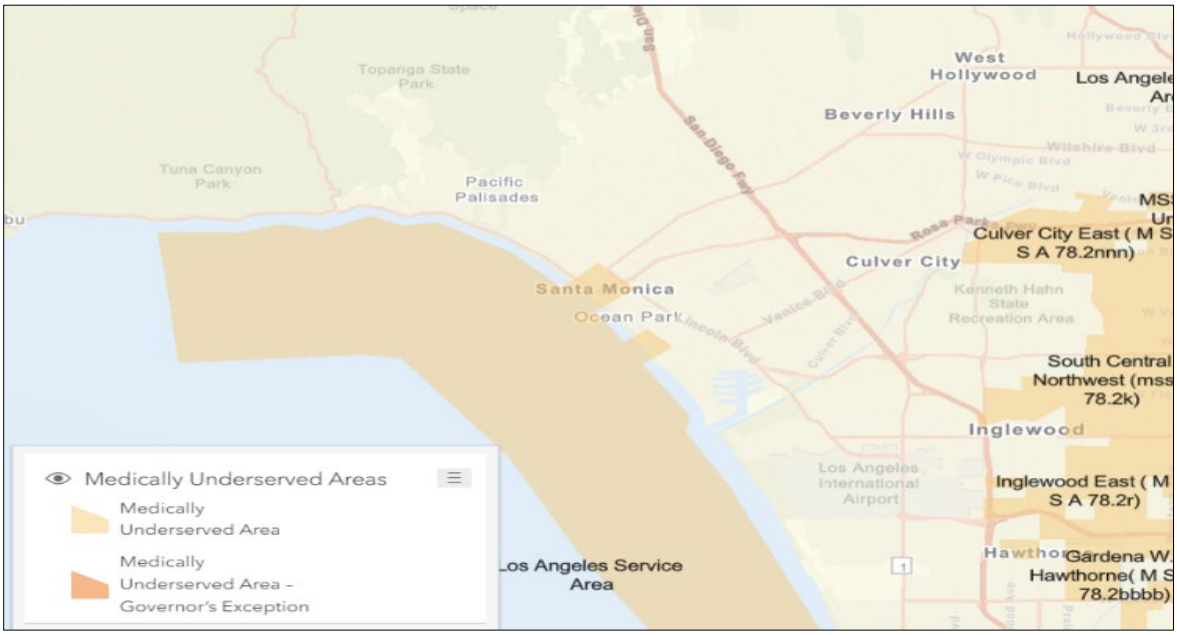
The Hispanic population is over-represented in the high need service area, with 28.0% of the high need service area identifying as Hispanic compared to 12.3% in the broader service area and 16.0% in Saint John's service area overall.

HEALTH PROFESSIONAL SHORTAGE AREA

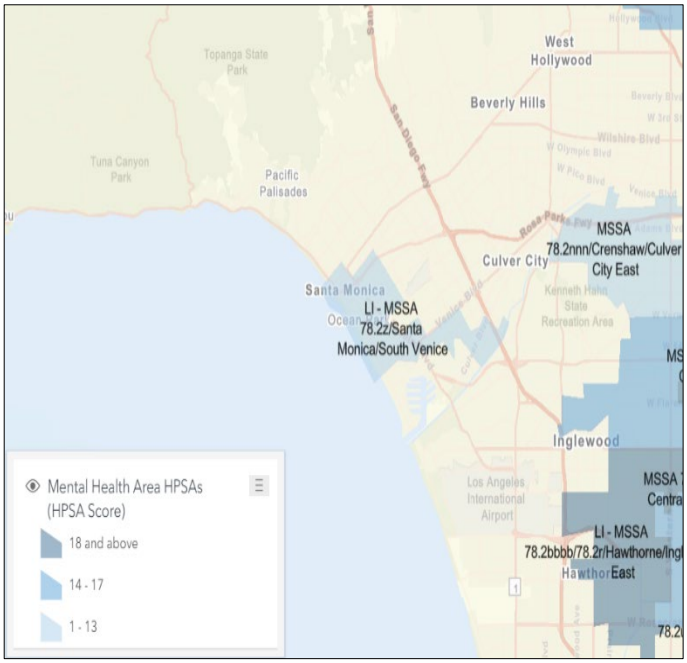
A small portion of the service area is designated as a Medically Underserved Area (MUA) or Health Professional Shortage Areas (HPSAs) for primary care and mental health. See Appendix 1 for additional information related to how MUAs and HPSAs are determined.

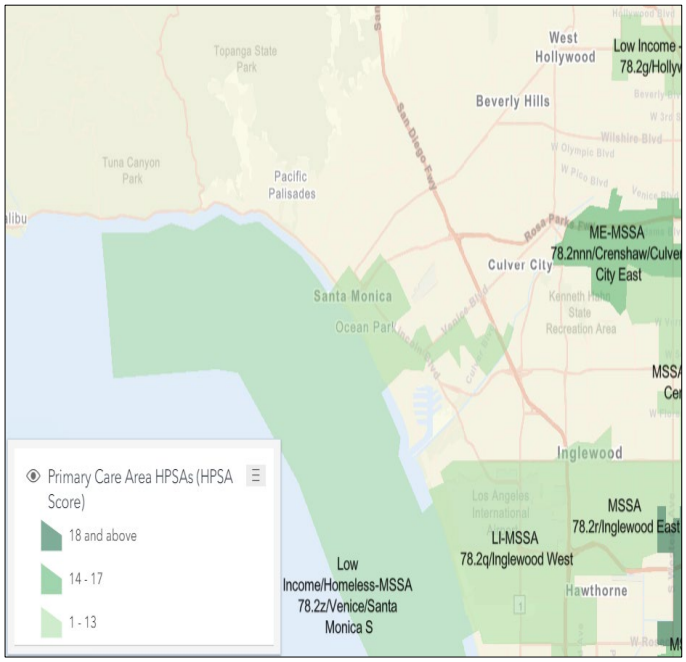
Medical Service Study Areas (MSSAs) are geographic areas viewed at the Census Tract level and used to organize and display population, demographic, and physician data. The MSSAs that are designated as

MUAs, located partially within the service area, are Culver City East, and the portion of the service area that extends inland to Santa Monica.



The three MSSAs that are designated as Mental Health HPSAs, located within or partially within the service area, include: the low-income population of Santa Monica/South Venice, the western-most section of Crenshaw/Culver City East, and the low-income population of the Hawthorne/Inglewood East MSSAs. The four MSSAs that are designated as Primary Care HPSAs, located within or partially within the service area, include: the low-income/homeless population of the Venice/Santa Monica South MSSA, the low-income population of the Inglewood West MSSA, the Inglewood East MSSA, and the Medi-Cal Eligible population of the Crenshaw/Culver City East MSSA.





OVERVIEW OF CHNA FRAMEWORK AND PROCESS

The CHNA process is based on the understanding that health and wellness are influenced by factors within our communities, not only within medical facilities. In gathering information on the communities served by the hospital(s), we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. Additionally, we invited key stakeholders and community members to provide additional context to the quantitative data through qualitative data in the form of interviews and listening sessions. As often as possible, equity is at the forefront of our conversations and presentation of the data, which often have biases based on collection methodology.

In addition, we recognize that there are often geographic areas where the conditions for supporting health are substantially poorer than nearby areas. Whenever possible and reliable, data are reported at the ZIP Code or census tract level. These smaller geographic areas allow us to better understand the neighborhood level needs of our communities and better address inequities within and across communities.

We reviewed data from the American Community Survey, Behavioral Risk Factor Surveillance System, and local public health authorities. In addition, we include hospital utilization data to identify disparities in utilization by income and insurance, geography, and race/ethnicity when reliably collected.

Data Limitations and Information Gaps

While care was taken to select and gather data that would tell the story of the hospital's service area, it is important to recognize the limitations and gaps in information that naturally occur, including the following:

- Not all desired data were readily available, so sometimes we had to rely on tangential or proxy measures or not have any data at all. For example, there is little community-level data on the incidence of mental health or substance use.
- While most indicators are relatively consistent from year to year, other indicators are changing quickly (such as percentage of people uninsured) and the most recent data available are not a good reflection of the current state.
- Reporting data at the county level can mask inequities within communities. This can also be true when reporting data by race, which can mask what is happening within racial and ethnic subgroups. Therefore, when appropriate and available, we disaggregated the data by geography and race.
- Data that are gathered through interviews and surveys may be biased depending on who is willing to respond to the questions and whether they are representative of the population as a whole.

- The accuracy of data gathered through interviews and surveys depends on how consistently the questions are interpreted across all respondents and how honest people are in providing their answers.

Process for Gathering Comments on Previous CHNA and Summary of Comments Received

Written comments were solicited on the 2019 CHNA and 2020-2022 CHIP reports, which were made widely available to the public via posting on the internet in December 2019 (CHNA) and May 2020 (CHIP), as well as through various channels with our community-based organization partners. At this time, no comments have been received.

HEALTH INDICATORS

Please refer to the Providence Saint John's Health Center's Data Hub 2022 to review each of the following health indicators mapped at the census tract level:
https://experience.arcgis.com/experience/d4bd56ec40a84e2fa865516add50f450
The hub provides data on each indicator in the South Bay, high need and broader need service areas, Los Angeles County, and California, as well as information about the importance of each indicator (homelessness data are not included in the hub).

Health Insurance, Uninsured

	Total Saint John's Service Area	High Need Service Area	Broader Service Area	Los Angeles County
Uninsured	4.9%	8.6%	3.7%	9.6%

Source: U.S. Census Bureau, American Community Survey, 2015-2019.

Chronic Diseases

	Total Saint John's Service Area	High Need Service Area	Broader Service Area	Los Angeles County
Asthma prevalence	7.4%	7.8%	7.3%	7.5%
Cancer prevalence	6.2%	4.6%	6.7%	5.0%
Chronic kidney disease prevalence	2.3%	2.3%	2.4%	3.0%
Chronic Obstructive Pulmonary Disease prevalence	3.7%	3.7%	3.7%	4.3%
Coronary heart disease	4.1%	3.6%	4.2%	4.8%
Diabetes prevalence	7.1%	7.2%	7.0%	11.1%

Source: Behavioral Risk Factor Surveillance System Survey, 2019.

Physical Inactivity and Obesity

	Total Saint John's Service Area	High Need Service Area	Broader Service Area	Los Angeles County
Physical inactivity	16.3%	19.8%	15.1%	25.1%
Obesity	22.3%	23.9%	21.8%	27.7%

Source: Behavioral Risk Factor Surveillance System Survey, 2019.

Mental Health

	Total Saint John's Service Area	High Need Service Area	Broader Service Area	Los Angeles County
Mental health distress (14 or more days in past 30 days with poor mental health)	11.0%	13.1%	10.3%	12.4%
Depression	15.4%	15.7%	15.2%	21.6%

Source: Behavioral Risk Factor Surveillance System Survey, 2019.

Substance Use

	Total Saint John's Service Area	High Need	Broader Need	Los Angeles County
Binge drinking	18.8%	19.1%	18.7%	16.8%
Smoking	8.7%	10.7%	8.1%	10.9%

Source: Behavioral Risk Factor Surveillance System Survey, 2019.

Persons Experiencing Homelessness, 2018-2022 Comparison*

	SPA 5			Los Angeles City/County CoC		
	2018	2020	2022	2018	2020	2022
Total homeless count	4,401	6,009	4,604	49,955	63,706	65,111
Sheltered	20.9%	16.0%	24.1%	24.8%	27.7%	29.5%
Unsheltered	79.0%	83.9%	75.8%	75.2%	72.3%	70.4%
Individual adults	80.0%	82.0%	85.0%	84.1%	80.4%	80.5%
Families/family members	14.0%	13.0%	15.0%	15.8%	19.5%	16.3%
Unaccompanied minors (<age 18)	0.1%	0%	0%	0.1%	0.1%	0.1%

*Source: Los Angeles Homeless Service Authority, 2018, 2020, & 2022 Greater Los Angeles Homeless Count. https://www.lahsa.org/homeless-count/ *These data represent the homeless counts from the LA County Continuum of Care, which does not include Glendale, Long Beach and Pasadena homeless counts.*

Persons Experiencing Homelessness, 2022

	City of Santa Monica	
	Persons in 2022	Percent change from 2020
Total homeless count	826	1.8%
Sheltered	132	-21.9%
Unsheltered	694	8%

*Source: Los Angeles Homeless Service Authority, 2022 Greater Los Angeles Homeless Count. https://www.lahsa.org/homeless-count/ *These data represent the homeless counts from the LA County Continuum of Care, which does not include Glendale, Long Beach and Pasadena homeless counts.*

Persons Experiencing Homelessness, Subpopulations*

	SPA 5			Los Angeles City/County CoC		
	2018	2020	2022	2018	2020	2022
Chronically homeless	26%	40%	48%	27%	38%	41%
Physical disability	13%	19%	26%	15%	19%	21%
Developmental disability	6%	13%	13%	6%	9%	10%
Serious mental illness	31%	28%	32%	27%	25%	24%
Substance abuse disorder	12%	25%	30%	15%	27%	26%
Veterans	11%	13%	13%	7%	6%	5%

Source: Los Angeles Homeless Service Authority, 2018 & 2020 Greater Los Angeles Homeless Count. https://www.lahsa.org/homeless-count/
**These data represent the homeless counts from the LA County Continuum of Care, which does not include Glendale, Long Beach and Pasadena homeless counts.*

Additional quantitative data gathered for the service area can be found in Appendix 1.

Hospital Utilization Data

In addition to public health surveillance data, our hospitals can provide timely information regarding access to care and disease burden across the service area. We were particularly interested in studying potentially avoidable Emergency Department visit. Avoidable Emergency Department (AED) use is reported as a percentage of all Emergency Department visits over a given period, which are identified based on an algorithm developed by Providence's Population Health Care Management team based on NYU and Medi-Cal definitions. AED discharges typically contain primary diagnoses that are deemed non-emergent, primary care treatable or preventable/avoidable with better managed care based. AED use serves as proxies for inadequate access to or engagement in primary care. When possible, we look at the data from Providence Saint John's Health Center for total utilization, frequency of diagnosis and demographics to identify disparities.

Avoidable Emergency Department Cases
The percentage of avoidable ED cases at Providence Saint John's Health Center declined from 33.6% in 2019 to 28.7% in 2021. Utilization of the emergency department was significantly impacted at the height of the COVID-19 pandemic.

We reviewed and stratified utilization data by a several factors including self-reported race and ethnicity, patient origin ZIP Code, age, and gender. This analysis helped us identify disparities to better improve our outreach and partnerships. A few key insights from our data included the following:

- There was a higher percentage of avoidable ED visits for patients who self-reported their race as Black or African American (32.6%) compared to the total patient population (28.7%) in 2021.

- There was a higher percentage of avoidable ED visits for patients who self-reported their ethnicity as Hispanic or Latino (31.5%) compared to the total patient population (28.7%) in 2021.

- In looking at total avoidable emergency department visits at Providence Saint John's Health Center in 2021, the top diagnosis groupings were substance use disorder (13.1%), skin infections (7.9%) and urinary tract infections (7.6%).

- Behavioral health related diagnoses groups accounted for three of the top ten diagnoses groups for avoidable emergency department visits: substance use disorder (13.1%), anxiety and personality disorders (4.8%), and psychosis (2.9%).

Behavioral Health Emergency Department Cases

We also reviewed data on Emergency Department utilization specifically for behavioral health conditions. Some of the common diagnoses groupings that fall under behavioral health include substance use disorder, anxiety and personality disorders, mood disorders, psychosis, and poisonings from commonly abused drugs.

- Behavioral health related diagnoses as a portion of all emergency department visits have increased from 8.4% in 2019 to 8.6% in 2021 of all emergency department visits at Providence Saint John's Health Center. Furthermore, Providence Saint John's Health Center had the highest percent of behavioral health related emergency department visits of all the Providence emergency departments in Los Angeles County.

- 45.8% of behavioral health related emergency department visits at Providence Saint John's Health Center were related to substance use disorders in 2021.

COMMUNITY INPUT

Summary of Community Input

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, Providence Saint John's Health Center, in partnership with Cedars-Sinai Medical Center, Cedars-Sinai Marina del Rey Hospital, Providence Saint John's Health Center, Ronald Reagan UCLA Medical Center, UCLA Medical Center, Santa Monica, and Resnick Neuropsychiatric Hospital at UCLA, conducted 33 stakeholder interviews with representatives from community-based organizations during October and November 2021. Additionally, Providence Saint John's Health Center conducted 3 listening sessions with 24 community members in June 2022. During these interviews and listening sessions, community members and nonprofit and government stakeholders discussed the issues and opportunities of the people, neighborhoods, and cities of the service area. Using the notes from the interviews and listening sessions, analysts identified themes related to community needs and the associated gaps in services, barriers, and affected populations. Below is a high-level summary of the findings of these sessions. A listing of the interview and listening session participants are provided in Appendix 2. Full details on the protocols and findings are available in Appendix 3.

Vision for a Healthy Community

Listening session participants were asked to describe their vision of a healthy community. This question is important for understanding what matters to community members and how they define health and wellness for themselves, their families, and their communities. The primary themes shared were the following:

- Safety
- Community connection and pride
- Physical and behavioral health and well-being
- Recreation and green spaces
- Resources to meet basic needs

Community Needs

Listening session participants and stakeholders were asked to identify the most important community needs. Listening session participants most frequently discussed the following needs:

- Homelessness and housing instability
- Behavioral health (mental health and substance use/misuse)
- Chronic diseases
- Safety
- Food insecurity

Feedback from the listening sessions and interviews is summarized below.

The following findings are a summary of the **high-priority health-related needs**, based on community input:

Homelessness and housing instability	Housing is a key component to health, but **NIMBYism**, **politics**, and **zoning** issues impact progress on creating affordable housing units. Understanding **root causes** of homelessness and looking toward **prevention models** are necessary. Listening session participants want more affordable housing. Many community members are **one paycheck** away from their utilities being turned off or not being able to pay rent, which creates **desperation.** People are experiencing **anxiety and hopelessness** around their housing instability. Many feel they have no options, especially **immigrants, BBIPOC individuals, temporary workers, those in the service industry**, and **older adults** living on limited incomes. Stakeholders are worried about evictions and discriminatory targeting of **Black and Brown** and **Asian Pacific Islander communities.** More **tenant rights** are needed and listening session participants want more **protection from rent increases**. They also noted **gentrification** affects their feeling of belonging in their communities. Comprehensive, **wraparound services** are needed to assist the **interim housed**, persons experiencing **homelessness needing self-care supports**, and for **people with a mental health condition,** otherwise housing first models will fail. Listening session participants would like to see more resources for those people who are unhoused.
Behavioral health (mental health and substance use/misuse)	Mental health was impacted by many factors including the transition to online learning, changes in home life, loss of social activities, and loss of jobs. Stakeholders are worried about **school-age children**, **people identifying as LGBTQIA+, BBIPOC, older adults, veterans**, and **foster youth.** Barriers to access include **lack of awareness of services**, a **lack of bilingual clinicians**, **insurance limitations**, and **workforce shortages.** Listening session participants shared a strong need for more mental health resources and spaces where community members can be vulnerable with one another. Stakeholders stress a need for a **whole-person approach** and **integration of services** between mental health and substance use. Funding and payment mechanisms should include screening for depression, anxiety and substance use in **routine primary care** appointments. **Methamphetamine use has escalated** among the population experiencing homelessness since it is cheap, easily accessible, and addictive. Listening session participants would like to see **smoking** banned in public areas to prevent exposure to secondhand smoke.

COVID-19	COVID-19 created **solutions and innovations**, like **telehealth**. **Missed health care appointments decreased** at health clinics, as transportation and childcare barriers were removed because of telehealth. The **technology gap** specific to internet access and hardware, limited access to services for those most in need, including **persons experiencing homelessness and older adults**. Community health workers can help **dispel myths** and **misinformation** around the COVID-19 vaccine through one-on-one conversations. Health care **provider burnout** and high rates of practitioners **leaving the field** will impact care in the future.
Access to health care and preventive care	Diversity of communities leads to a diversity of health care needs. A **lack of bilingual and bicultural providers**, **stigma, and fears over public charge** are barriers to accessing responsive care. Other barriers include **economics, health care knowledge**, **transportation, workforce shortages**, and a **lack of services outside regular business hours**. These barriers disproportionately impact **people with low incomes**, **single parents,** and **BBIPOC populations**. Integrating **whole person care**, one-stop systems of **coordinated health care**, and **linking physical care, mental health and substance use care** will allow people to access care more easily. During the pandemic, some patients **delayed accessing routine primary care**. Patients are overdue for **preventive screenings, flu vaccinations, and childhood immunizations**. These delays in health care may cause significant increases in preventable, treatable, and detectable diseases, especially in BBIPOC communities.
Economic insecurity	The high cost of living in Los Angeles translates to economic insecurity. There is a **lack of affordable housing** developments to support the population. **People paid minimum wage** can no longer afford to live in LA County, even when they **work full-time**. Governmental assistance programs are **bureaucratic** and **cumbersome**. Many persons were **ineligible** for **unemployment and rental relief programs**, including **day laborers and people with undocumented status**. Persons who are vulnerable are those who earn too much to qualify for Medi-Cal and other public assistance programs. But they are still living **paycheck-to-paycheck**. Focusing on prevention strategies including educational advancement, workforce pipelines and linking people to jobs may help individuals find employment that pays a living wage.

Food insecurity	Food insecurity became more pronounced during the pandemic, however, the need has been steadily increasing. Access to healthy and nutritious food on a limited income impacts **BBIPOC communities**, **those working on the front lines**, **people who are unemployed, people with disabilities, older adults, day laborers**, **mixed status families, and veterans reintegrating to civilian life.** Barriers include **stigma and shame**. Many people are not comfortable admitting they are in need, so the numbers of people experiencing food insecurity may be underrepresented. Also, many food banks are not knowledgeable about the **dietary needs of various cultures**. Listening session participants would like to see improved access to **healthier food options**, like those at farmer's markets. Strategically **aligning food with other community resources**, and **food as medicine programs**, may be solutions. The pandemic improved awareness of CalFresh and other economic supports, but more awareness is still needed. There are **too many bureaucratic applications and eligibility requirements** to access food**.** Limited incomes and food choices can exacerbate physical health conditions.
Community safety	**Gangs, police killings, robberies, drive-by shootings**, and the **prevalence of guns** are all contributing to community members feeling unsafe. **Anti-Asian hate attacks, gender-based violence, violence toward trans women and people identifying as LGBTQIA+, and domestic violence** have all increased. Listening session participants want to see reduced crime and increased security. More schools and clinics are embedding **Adverse Childhood Experiences (ACEs**) and **trauma informed care** in their practices, acknowledging these factors can impact mental health, chronic diseases, and overall health outcomes. Racism and discrimination contribute to people not feeling **seen and valued** in the community. There is a need to build **trust** and acknowledge that **systemic racism** prevents families from accessing services. Holistically addressing **community safety** with teams of social workers and mental health practitioners working with police to connect individuals to needed resources may help.
Chronic diseases	The interplay between **chronic disease, the built environment, wealth disparities, and access to resources** underscores how **our environment impacts our health**. Chronic diseases are influenced by exposure to environmental toxins for populations living close to **freeways and high traffic corridors. Overcrowded housing** and having less **infrastructure for safe, active recreation and access to open spaces** impacts chronic diseases. **Transportation, stigma**, and a **lack of specialty care** are barriers to chronic disease management. During the pandemic, many people did not access care, and it is a challenge to re-engage them in their health care. Listening session participants are interested in more **education** related to healthy living, including nutrition and exercise classes.

SIGNIFICANT HEALTH NEEDS

Significant Community Needs

Eight significant community health needs were identified for a prioritization process by the Community Health Needs Assessment Oversight Committee through a review of the secondary health data collected and based on qualitative data collected from interviews and listening sessions.

- Access to Health Care and Preventive Care
- Behavioral Health (Mental Health and Substance Use/Misuse)
- Chronic Diseases
- Community Safety
- COVID-19
- Economic Insecurity
- Food Insecurity
- Homelessness and Housing Instability

Prioritization Process and Criteria

The Community Ministry Board of Directors for Providence Saint John's Health Center Mission authorized an ad hoc Community Health Needs Assessment Committee to provide oversight of the ministry's Community Health Needs assessment and the prioritization of the identified significant community needs. The Committee was chaired by board member, Dr. Kathryn Jeffery, and composed of external stakeholders and Providence Saint John's leadership (see Appendix 5). The Committee met on November 4, 2022 to review key data findings and select the top three Priority Needs.

After a presentation of the key findings from the data on the eight identified significant needs by the Director of Community Health Investment, committee members took an initial vote on their top three needs for Saint John's to prioritize. The Committee was encouraged to take into consideration the following criteria when making their choices:

- Opportunity to Impact: Current PSJHC Community Health Programs/Services
- Opportunity to Impact: Current Community Benefit Investments (operations and grants)
- Partnerships
- Alignment with existing Providence Regional Strategies
- PSJHC service area rates in comparison to County/State/National Benchmarks
- Impact of the problem on vulnerable populations
- Key Stakeholder Survey Prioritization Score

Based on the initial vote, the following needs emerged as the clear top three:

1) Homelessness and Housing Instability
2) Behavioral Health
3) Access to Health Care and Preventive Care

A robust in-depth discussion followed and the Committee unanimously confirmed these needs should be prioritized as the top three for Providence Saint John's Health Center for the 2022 Community Health Needs Assessment.

Potential Resources Available to Address Significant Health Needs

Understanding the potential resources to address significant health needs is fundamental to determining current state capacity and gaps. In addition, there are numerous social service non-profit agencies, faith-based organizations, and private and public-school systems that contribute resources to address these identified needs. For a list of potentially available resources available to address significant health needs see Appendix 4.

EVALUATION OF 2020-2022 CHIP IMPACT

This report evaluates the impact of the 2020-2022 Community Health Improvement Plan (CHIP). Providence Saint John's Health Center responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices.

In 2019, the hospital conducted the previous CHNA. Significant needs were identified from issues supported by primary and secondary data sources gathered for the CHNA. The hospital's 2020-2022 CHIP associated with the 2019 CHNA addressed homelessness and housing insecurity, access to health care, behavioral health, and workforce development through a commitment of community benefit programs and resources. The following tables represent progress made so far during the first two years of the 2020-2022 CHIP.

Initiative 1: Strengthen Continuum of Care Infrastructure for Persons Experiencing Homelessness

Target Population	Strategies	Progress
Persons experiencing homelessness or at risk of becoming homeless	Hospital emergency department-based Community Health Workers assist patients experiencing homelessness with discharge to shelter or homeless service providers.	901 screened for homelessness. 105 linked to homeless services or housing resources. 111 placed in temporary or permanent housing.
	Provide or facilitate funding to homeless service providers. Bring financial support to local organizations either through awarding grants or by facilitating grant awards from external funders.	$300,000 in grants awarded by PSJHC to local homeless service providers. $619,000 in grants awarded by the Saint John's Foundation Community Impact Fund to local homeless service providers.
	Improve the infrastructure of available recuperative care/interim shelter for patients experiencing homelessness who are not medically stable enough to be discharged back to the streets.	Providence participated in the UniHealth Foundation's Recuperative Care Advisory Group to develop recommendations for strengthening the infrastructure of recuperative care in Los Angeles County. Partnerships with recuperative care agencies were strengthened, particularly with the National Health Foundation. $42,940 of expenses were paid to support 14 persons experiencing homelessness who were transferred to recuperative care post-discharge.

Initiative 2: Improve Access to Health Care Services

Target Population	Strategies	Progress
Uninsured and underinsured populations in low-income communities	Provide/facilitate funding and in-kind support for access to care to local community agencies	$550,000 in grants awarded by PSJHC to local organizations for access to care. $245,165 of in-kind lab and diagnostic services provided to local FQHCs. $154,000 in grants awarded by the Saint John's Foundation Community Impact Fund to local organizations to increase access to care.
	Provide testing and vaccinations for COVID-19 and the flu.	In response to the availability of COVID-19 vaccines for the public, PSJHC offered free vaccination clinics at the hospital for community members. 10,068 doses of vaccine were administered from January 2021 through March 2022.

Initiative 3: Improve Access to Behavioral Health Care

Target Population	Strategies	Progress
Children and families who are underinsured or uninsured and have difficulty accessing quality mental health services, as well as those who depend on public assistance and state-funded medical	The Child and Family Development Center (CFCD) will address birth trauma.	Due to the pandemic, staffing and services for women's health had to be modified for social distancing and to respond to COVID-19 surges in the community, which hindered our ability to start up these support service programs for new mothers and their families. Resources for these programs shifted to respond to economic impact of COVID-19 as more effort and time went into delivering basic needs such as food, diapers and wipes, and helping families to access food pantries. In 2021, CFDC provided Warm Line services to 20 families. The Warm Line is for families who have newborns who are at risk for postpartum mental health

Target Population	Strategies	Progress
insurance. Community partners such as local schools who work with vulnerable children.		disorders. Case management and a warm hand off to services is provided. 40 pre/perinatal support groups were held in the community.
	The Child and Family Development Center will engage in capacity building for local organizations through trauma informed trainings.	14 in service trainings to school staff. 4 in service trainings to after school staff. 10 trauma informed trainings at schools to teachers and parents. 8 trauma informed trainings at community centers/after school organizations.
	The Child and Family Development Center will provide programs that support the social emotional functioning of young children.	17 parent support groups were conducted. Each group consisted of 8-10 sessions. Nine mental health education events were held at local libraries. Infant massage services suspended in 2020 due to COVID-19.

Initiative 4: Train and Deploy Community Health Workers to Address Social Determinants of Health

Target Population	Strategies	Progress
Workforce development for persons without a college degree, services for residents of low-income neighborhoods, especially Spanish speaking communities.	Create a CHW Academy In collaboration with Charles Drew University, develop an academy for Community Health Workers that focus on integration into health care organizations.	Recruitment and curriculum design for CHW Academy was completed in 2020. Go-live of the first cohorts training was postponed to January 2021 as adaptations were needed to teach the course online. First cohort in 2021 had 13 Community Health Workers enrolled. 11 of the 13 CHW interns from cohort 1 completed their six-month internships. A second cohort of 16 CHW interns began in August and graduated in February 2022.
	CHWs provide outreach and one-on-one application assistance with CalFresh applications.	Assisted with 26 CalFresh applications.

Target Population	Strategies	Progress
	Health educators and CHWs teach free community-based courses in English and Spanish on mental health awareness and coping skills.	70 people participated in FEAST. 220 participants completed Mental Health First Aid. 75 participants completed Creating Healthier Attitudes Today.

Addressing Identified Needs

The Community Health Improvement Plan developed for the service area will consider the prioritized health needs identified in this CHNA and develop strategies to address needs considering resources, community capacity, and core competencies. Those strategies will be documented in the CHIP, describing how the hospital plans to address the health needs. If the hospital does not intend to address a need or plans to have limited response to the identified need, the CHIP will explain why. The CHIP will not only describe the actions the hospital intends to take, but also the anticipated impact of these actions and the resources the hospital plans to commit to address the health need.

Because partnership is important when addressing health needs, the CHIP will describe any planned collaboration between the hospital and community-based organizations in addressing the health need. The CHIP will be approved and made publicly available no later than May 15, 2023.

2022 CHNA GOVERNANCE APPROVAL

This Community Health Needs Assessment was adopted by the Board of Directors on November 30, 2022. The final report was made widely available by December 28, 2022.

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Michael Ricks
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12/4/2022

Michael Ricks — Date
Chief Executive
Providence Saint John's Health Center

DocuSigned by:
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12/4/2022

Donna Schweers — Date
Chairperson, Community Ministry Board of Directors
Providence Saint John's Health Center

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12/4/2022

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To request a printed copy free of charge, provide comments, or view electronic copies of current and previous Community Health Needs Assessments, please email CHI@providence.org.

APPENDICES

Appendix 1: Quantitative Data

DEMOGRAPHIC DATA

Demographic Profile for the Service Area

Indicator	Broader Service Area	High Need Service Area	Total Saint John's Service Area	City of Santa Monica
Population by Age Groups				
Total Population	495,837	154,726	650,563	91,577
Population Ages 0 - 9	45,796	12,060	57,856	7,912
Population Ages 10 - 19	53,611	12,263	65,874	7,032
Population Ages 20 - 29	71,837	39,679	111,516	13,556
Population Ages 30 - 39	80,970	30,618	111,588	17,163
Population Ages 40 - 49	67,079	19,761	86,840	12,095
Population Ages 50 - 59	62,133	15,071	77,204	11,961
Population Ages 60 - 69	54,833	12,186	67,019	10,560
Population Ages 70 - 79	35,334	6,761	42,095	6,035
Population Ages 80+	24,244	6,327	30,571	5,263
% Population Ages 0 - 9	9.2%	7.8%	8.9%	8.6%
% Population Ages 10 - 19	10.8%	7.9%	10.1%	7.7%
% Population Ages 20 - 29	14.5%	25.6%	17.1%	14.8%
% Population Ages 30 - 39	16.3%	19.8%	17.2%	18.7%
% Population Ages 40 - 49	13.5%	12.8%	13.3%	13.2%
% Population Ages 50 - 59	12.5%	9.7%	11.9%	13.1%
% Population Ages 60 - 69	11.1%	7.9%	10.3%	11.5%
% Population Ages 70 - 79	7.1%	4.4%	6.5%	6.6%
% Population Ages 80+	4.9%	4.1%	4.7%	5.7%

Population by Gender				
Female Population	255,435	77,519	332,954	45,887
Male Population	240,402	77,207	317,609	45,690
% Female Population	51.5%	50.1%	51.2%	50.1%
% Male Population	48.5%	49.9%	48.8%	49.9%
Population by Race				
American Indian and Alaska Native	2,026	859	2,885	284
Asian Population	63,969	25,541	89,510	9,299
Black or African American Population	27,985	10,227	38,212	4,100
Native Hawaiian and Other Pacific Islander Population	573	207	780	101
Other Race Population	14,899	15,019	29,918	2,869
Two or more Races Population	27,674	8,375	36,049	5,385
White Population	358,711	94,498	453,209	69,539
% American Indian and Alaska Native	0.4%	0.6%	0.4%	0.3%
% Asian Population	12.9%	16.5%	13.8%	10.2%
% Black or African American Population	5.6%	6.6%	5.9%	4.5%
% Native Hawaiian and Other Pacific Islander Population	0.1%	0.1%	0.1%	0.1%
% Other Race Population	3.0%	9.7%	4.6%	3.1%
% Two or more Races Population	5.6%	5.4%	5.5%	5.9%
% White Population	72.3%	61.1%	69.7%	75.9%

Population by Ethnicity				
Hispanic Population	61,036	43,342	104,378	14,097
% Hispanic Population	12.3%	28.0%	16.0%	15.4%

Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2015-2019.

POPULATION LEVEL DATA

	Total Saint John's Service Area	High Need Service Area	Broader Service Area	Los Angeles County
Population below 200% of Federal Poverty Level	20.8%	34.8%	16.1%	34.9%
Language proficiency limited English	4.5%	8.0%	3.3%	10.8%
Population with a High School diploma	94.4%	88.7%	96.1%	79.1%
Households without Internet access	6.3%	9.9%	5.1%	12.6%
Labor force, unemployed	5.1%	5.6%	4.9%	6.1%
Households receiving SNAP (Supplemental Nutrition Assistance Program) benefits	2.3%	4.9%	8.7%	8.7%
Household median income	$98,059	$67,046	$118,295	$67,817

Source: U.S. Census Bureau, American Community Survey, 2015-2019.

HEALTH PROFESSIONAL SHORTAGE AREA

The Federal Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas HPSAs) as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers).

MEDICALLY UNDERSERVED AREA/MEDICAL PROFESSIONAL SHORTAGE AREA

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are defined by the Federal Government to include areas or populations that demonstrate a shortage of health care services. This designation process was originally established to assist the government in allocating the Community Health Center Fund to the areas of greatest need. MUAs are identified by calculating a composite index of need indicators compiled and with national averages to determine an area's level of medical "under service." MUPs are identified based on documentation of unusual local conditions that result in access barriers to medical services. MUAs and MUPs are permanently set and no renewal process is necessary.

Appendix 2: Community Input

Listening Session

Community Input Type and Population	Location of Session	Date	Language
Listening session with older adults at WISE & Healthy Aging	Santa Monica, CA	6/14/2022	English
Listening session with adults from health education classes (primarily from Mar Vista Gardens)	Online	6/14/2022	Spanish
Listening session of parents/guardians of children with intellectual and developmental disabilities at Providence Saint John's Child & Family Development Center	Online	6/30/2022	English

Key Community Stakeholder Participants

Name	Title	Organization
Vishesh Anand	Field Deputy	Councilmember Mike Bonin, 11th District, City of Los Angeles
Thomas V. Babayan, MS, LMFT	Director	UCLA/VA Veteran Family Wellness Center
Chris Baca	Executive Director	Meals on Wheels West
Tara Barauskas	Executive Director	Community Corporation of Santa Monica
Grace Cheng Braun, MSPH	President and Chief Executive Officer	WISE & Healthy Aging
Ward Carpenter, MD	Co-Director, Health Services (he)	The Los Angeles LGBT Center
Stephanie Cohen	Health Services Deputy	Office of Supervisor Sheila Kuehl (LA County District 3)
Lucia Diaz	Chief Executive Officer	The Mar Vista Family Center
Sylvia Drew Ivie	Special Assistant to the President for Community Affairs	Charles R. Drew University of Medicine and Science
Connie Chung Joe, JD	Chief Executive Officer	Asian Americans Advancing Justice – Los Angeles
Dr. Va Lecia Adams Kellum	President and Chief Executive Officer	St. Joseph Center
Jan King MD, MPH	Area Health Officer, SPA 5	Los Angeles County Department of Public Health
Alison Klurfeld, MPP, MPH	Director, Safety Net Programs and Partnerships	L.A. Care Health Plan
Chris Ko	Vice President, Impact & Strategy	United Way of Greater Los Angeles
David Lisonbee	President and Chief Executive Officer	Twin Town Treatment Centers
John Maceri	Chief Executive Officer	The People Concern
Lidia Magarian	Chronic Disease Prevention Director	Santa Monica Family YMCA
Smita Malhotra, MD	Medical Director	Los Angeles Unified School District

Name	Title	Organization
Lyn Morris, LMFT	Chief Operating Officer	Didi Hirsch Mental Health Services
Kari Pacheco	Co-Director, Health Services (she/her/hers)	The Los Angeles LGBT Center
Lorri Perreault	Regional Director	Catholic Charities of Los Angeles, Inc.
Daniel Reti	Healthcare Integration Coordinator	Los Angeles Homeless Services Authority
Erin Raftery Ryan	Executive Director	National Alliance on Mental Illness (NAMI) - Westside Los Angeles
Susan Samarge-Powell, EdD	Director of Early Learning	Santa Monica-Malibu Unified School District
Dana Sherrod, MPH	Birth Equity & Racial Justice Manager Lead, Cherished Futures for Black Moms & Babies	Public Health Alliance of Southern California
Michael Tuitasi	Vice President of Student Affairs	Santa Monica College
Nina L. Vaccaro, MPH	Chief Operating Officer	Community Clinic Association of Los Angeles County
Jennifer Vanore	President and Chief Operating Officer	UniHealth Foundation
Rosemary C. Veniegas, PhD	Senior Program Officer, Health	California Community Foundation
Jacquelyn Wilcoxen	Service Area Chief	Los Angeles County Department of Mental Health
Margaret Willis	Housing and Human Services Administrator	City of Santa Monica
Setareh Yavari	Housing and Human Services Manager	City of Santa Monica
Anita Zamora	Deputy Director/Chief Operations Officer	Venice Family Clinic

Appendix 3: Findings from Listening Sessions and Interviews

FINDINGS FROM COMMUNITY LISTENING SESSIONS

Vision for a Healthy Community

Listening session participants were asked to describe their vision of a healthy community. This question is important for understanding what matters to community members and how they define health and wellness for themselves, their families, and their communities. The primary themes shared were the following:

- **Safety**: In a healthy community, people feel safe to walk around the neighborhood and parks. They feel their children are safe playing and they know their neighbors.
- **Community connection and pride:** In a healthy community people know one another and trust their neighbors. They participate in keeping their communities clean and cared for and there is communication and respect among community members.
- **Physical and behavioral health and well-being:** There are local clinics and opportunities for people to be active and learn about nutrition. People are mentally healthy and have access to services to address substance use/misuse challenges.
- **Recreation and green spaces:** People have access to physical activities, including group exercise classes, bike paths, and playgrounds. People are outside being active and social.
- **Resources to meet basic needs:** There are sufficient resources to meet people's basic needs, particularly for older adults. These resources include transportation, support for people with low incomes, education, and housing. In a healthy community there is low-income housing and services for people experiencing homelessness.

Community Needs

High priority community needs identified from listening sessions

- **Homelessness and housing instability:** Participants said there need to be more solutions to address homelessness, including more resources and work programs for people living unhoused. They need more affordable housing and rent protection to avoid their rent continuously increasing. They are also concerned about gentrification and how that affects their feelings of belonging in their community.
- **Behavioral health (mental health and substance use/misuse):** Participants shared there is a strong need for more mental health resources, including spaces where community members can be vulnerable, including children. They noted needing more mental health classes, counseling services, and social connections for people. They would also like to see smoking banned in public areas to prevent exposure to secondhand smoke.
- **Chronic diseases:** Participants are interested in more education related to healthy living, including health fairs, nutrition and exercise classes, and walking opportunities.

- **Safety:** Participants shared a need for increased security and safety on the streets so that people feel safe walking alone. They shared they would like to see less crime and more policing. They would also like more efforts to clean up litter in the streets and more speed bumps to improve safety.
- **Food insecurity:** Participants spoke to wanting to see more food distribution locally at churches and food banks. They also need improved access to healthier food options, like those found at farmer's markets.

Medium priority community needs identified from listening sessions

- **Access to health care and preventive care:** Participants said everyone needs to have access to health care. They would like to see more affordable and accessible health education classes.
- **Economic insecurity:** Participants spoke to needing more services to address poverty, which can contribute to mental health challenges. They specifically shared they would like to see more work programs for people experiencing homelessness.
- **Community building and engagement:** Participants would like to see more community-sponsored social activities like art shows and clubs where people can connect socially and engage in the community. They would also like people to be more engaged in taking care of their community by picking up trash and respecting the environment.

FINDINGS FROM STAKEHOLDER INTERVIEWS

Each interview began by asking participants what are the most significant health issues or needs in your community. Responses included:

- Behavioral health and mental health issues. Now that kids are back to school, teachers are dealing with issues such as anxiety, depression, and post-traumatic stress. There is a stigma around mental health that must be addressed so people will get help, especially with the veteran population.
- The biggest thing is COVID-19 and the changing variants, which is prolonging the pandemic.
- Social isolation and the lack of an adequate support system of family, friends, and trusted individuals.
- Chronic conditions - hypertension, diabetes, cancer, lung disease, colon cancer. For those with deficits in activities of daily living, their chronic conditions require significant management.
- We are waiting to see the overall impact of the pandemic, with lack of face-to-face visits and lost prevention opportunities.
- Access to COVID vaccines and medications, especially in low-income pockets that exist on the Westside; they got lost among the more affluent in that area.
- Access to care in general is difficult for anyone who does not have financial resources. There's a need for timely, quality specialty care and providers compassionate to struggles with mental health, sexually transmitted infections, and substance abuse.
- Easy access to medical professionals in a timely manner; access one month out isn't helpful.
- Accessible health care options for those who are homebound or have limited transportation.

- A “no wrong door” to integrated care is needed, taking into account social determinants and their impacts on health. Case managers work tirelessly to connect patients to health care as, often, there are medication issues, chronic diseases, or they are dying because of untreated ailments.
- The Asian Pacific Islander community is diverse in the range of “haves” and “have nots” with educational attainment and income. Many are front line workers. Mental health issues occur frequently in this community. Pacific Islanders were hit hard with COVID hospitalizations and deaths.
- Homelessness, plus underlying issues, i.e., chronic disease, COVID, lack of affordable housing, access to care and substance abuse treatment. We need street-based medicine to meet people where they are, address complicated health needs, and help them not die on the streets. We see many persons who are homeless near the Santa Monica 3rd Street Promenade. The streets are very dirty in this area, affecting hygiene and presenting a challenge with COVID.
- Inadequate amount of sober or bridge housing.
- Inadequate career preparation, remedial educational resources, and occupation assistance and/or placement for those looking to better their economic stability.
- Birth inequities, specifically affecting black, indigenous mothers.
- Housing and economic security is a crisis impacting black families in the region and older adults who need affordable housing options so they can age in place. There is stress and anxiety tied to unstable housing circumstances, especially with the lifted eviction moratorium and rising housing costs.
- Housing is a key component of health. It's really about having resources or lack of resources, such as in South Los Angeles and pockets of SPA 5. If you don't have access to resources, education, safe places to live, work, and exercise, and you're having challenges - it's impacting your health.
- Food insecurity is significant for low-income and rose to a disturbing high during the pandemic.
- Lack of exercise opportunities for seniors, families, and those without accessible green spaces.
- Lack of transportation. We have great hospitals with great networks, but many can’t access them.

Interview participants were asked about socio-economic, behavioral, or environmental factors or conditions contributing to poor health in the community. Their responses included:

- Many are impacted by the wealth gap in Los Angeles County. People are priced out of their communities, so they are not getting health care resources that meet their needs.
- Structural racism and capitalism are prevalent in Los Angeles. There’s a mix of poverty and structural issues in allocation of resources.
- It’s important to call out structural racism, with disenfranchised black communities in Los Angeles in particular. We call out harmful historical practices, but folks are still pushed into areas we’re largely divested from – where there are underfunded schools, housing insecurity and food insecurity. Living close to freeways exposes families to environmental toxins with negative impacts.
- Structural racism is pervasive. There’s inherent bias present against brown, black, poor people, and women, in the community, the educational system, and health care system. This bias can change how symptoms are heard and types of treatment prescribed, i.e., African American infant mortality is a significant concern, and these women have challenges seeking care and being understood.

- If we could increase pay for medical providers to work in and serve South Los Angeles, maybe more would be willing.
- There are affordability, access, and structural barriers, including structural racism. It almost always comes back to access - lacking health insurance, good schools, good food, primary care, etc.
- Health system structural issues result in lack of specialty care for many due to payer contracts.
- Differences in life span can be attributed to economics, racial/ethnic demographics, and geographic challenges.
- Mental health was impacted by many factors, i.e., the transition to online learning, change in home life, loss of social activities, and loss of jobs.
- There are many literacy issues resulting in knowledge deficits, so transportation becomes an issue.
- High cost of living in Los Angeles translates to income instability. There's a lack of affordable housing developments to support the population, this also carries over to food insecurity issues.
- There's an inability to access care in one's own community with providers who understand cultural beliefs/norms and speak their language. The economic downturn, food insecurity, and homelessness all escalate health issues.
- Families use home remedies or see the doctor too late due to worry about immigration status.
- Housing instability and lost jobs/reduced work hours fuel anxiety. Immigrant populations are significantly impacted; they also have great stress related to what's happening in other countries.
- We see socioeconomic and social diversity factors on the Westside with lower income and ethnic groups who don't have the same resources or familial support systems that others benefit from.
- The Pacific Islander community has high levels of poverty and low-income residents, which are correlated with lower educational attainment rates. Older adults and those who are undocumented and speak limited English have higher vulnerability for safety net support, leading to mental health issues, depression, and anxiety. Anti-Asian hate led to much more fear in our community.
- Certain things like mental health don't get talked about in certain cultures, so people stay silent.
- The LGBTQ and HIV community experience stigma, discrimination, and economic inequity.
- Socio-economic factors affect mental health. If there is not enough money for food, how do individuals who are suffering afford a therapist? There is also a lack of knowledge around mental health prevention and treatment.
- A majority of persons who are homeless are unsheltered so living conditions contribute to poor health. The stigma around mental illness exacerbates the number of those who are unsheltered and who go untreated.
- In Santa Monica, everything is close but it is still challenging to get around without a car. And who can they see for health care after work?

Interview participants were asked who or what groups in the community are most affected by the identified health-related issues. Their responses included:

- Lower income people, specifically black and brown, are at high risk for poor health and have experienced underinvestment.

- Under-resourced families are often not English speaking and lack knowledge about where to seek care. Infants and toddlers are seen for health concerns quickly, but it is harder to get children, ages two to three, in for care.
- Black women who are often heads of households are especially impacted, as well as young people in communities with stigma around mental illness; they go untreated due to lack of access to options/resources.
- Discrimination and racism results in limited job options for brown and black communities, so they're more exposed to COVID as frontline workers. Because of how they've been treated, they are more suspect of interventions, leading to possible hospitalization, maybe death, and family trauma.
- More blacks tend to be overrepresented among those with chronic conditions, driven by intersections with race, income, wealth disparities and access to resources.
- Immigrant communities are impacted especially in areas where FQHCs are not densely located. Trans individuals have hard time accessing appropriate care, as are veterans who aren't able to access VA, possibly due to dishonorable discharge.
- The medical vulnerability index is greatest among blacks, Latinx, and Asian Pacific Islanders. Regions of SPA 5 have pockets with native Hawaiians who are disproportionately impacted by the pandemic, plus they were already suffering with health conditions.
- We see an overall lack of access among seniors and in Hispanic neighborhoods, specifically Del Rey in Los Angeles, which has pockets of housing projects and apartments with working class families.
- LGBTQ and HIV positive clients and youth who are homeless often have every possible barrier.
- For low-income, people of color, and disabled individuals, they are impacted by lack of access to financial, housing, health care, and knowledge resources - a vicious cycle of poverty and oppression.
- Mental health concerns are exceptionally high among school-aged youth, including black and Latinx.
- Hispanic and black clients are impacted at greater level with stigma around mental health issues. Then, factor in worry about law enforcement troubles. With the time change, many clients won't come in for services after dark; it's dangerous to be out.
- Health care workers, first responders, Asian American doctors and nurses were hit hard with mental health issues, depression, and anxiety.
- Mental illness disproportionately impacts seniors and African Americans who are homeless.
- We see mental health issues disproportionately impacting BIPOC, low income, women, older adults, and persons with disabling conditions.
- We see substance abuse issues disproportionately impacting youth and persons who are homeless.
- We see immigrant populations who are stressed about recent hate incidents and what is happening in other countries, i.e., Ethiopia. Cultural norms prevent them asking for help with mental health.
- We're seeing a tremendous issue with homelessness in SPA 5 that looks very different than SPA 6.
- Mental health issues affect older people who are isolated. With the increase in virtual communication, it becomes harder for them to stay connected. Certain pockets of Westside have seniors with great need for assistance and support.
- Older adults in Santa Monica often don't feel safe being outside. They may fear persons who are homeless, exposure to COVID, and safety around increased scooter use on the streets.

- There is a gap in understanding of the veteran experience.
- Mental health needs are seen in Persian, Latinx, Asian American and Pacific Islander, religious, veteran and first responder communities. Needs are also prevalent in affluent communities.
- There's a disproportionate increase in persons who are homeless from previous counts for ages 55 and older, possibly attributed to high rates of elder abuse, predatory property management and illegal evictions.
- With housing, we see the impact of structural racism in an extreme way. Black/African American make up most of homeless – it doesn't get that way by accident.
- Structural issues and racism contribute to homelessness, with blacks being overrepresented.
- Among those who are homeless, there are disproportionate numbers of blacks, veterans, and LGBTQ.
- In schools, wait lists are long for mental health and substance use services.
- Impoverished areas, homeless, and underemployed lack access to substance abuse treatment options, as well as educational/occupational resources to help them improve their living situations.

Interview participants were asked what health inequities they have observed, and the solutions needed to address those inequities. Their responses included:

- Consider supporting/increasing home ownership as a solution to equity and stabilization for low-income persons and persons of color. Persons of color will not get out of this centuries-long disparity without economic growth and protection of home ownership.
- Invest early in communities and infrastructure, targeting communities that are falling behind.
- Black, African American and Latinx are overrepresented with homelessness and most areas of health need. We need community investment into social determinants and community conditions, i.e., affordable housing and healthy food options, transportation, and prioritizing the most vulnerable.
- There's significant income disparity in the Pico neighborhood where the majority are families of color.
- Intervene early and focus on prevention strategies in areas such as education, and access to jobs and educational advancement opportunities so that income can improve.
- Need to focus on developing better workforce pipelines and linking people to jobs and job training.
- There are differences in social supports and care that people receive. Focus on negotiating affordable drug prices, fixing means-testing rules, reinventing care to be less episodic, fixing SSI and Social Security, and ensuring allowances for secure housing.
- Evaluate structural needs and band together to build step-down facilities around inpatient hospitals.
- A long-term issue is negative health care experiences among communities of color. Repeated positive experiences are needed to build trust, such as making institutions more people-friendly with less red tape.
- There is inequity with agencies receiving County Department of Mental Health funding. Agencies can only break even or receive limited extension funding, therefore, we had to turn people away during the pandemic when they needed help the most.

- Housing costs are inequitable. Gentrification is impacting people's ability to stay in their communities.
- Access to care and equitable density of clinics and FQHCs in certain areas is challenging. Need to locate clinics and health access points near where people live, which ensures providers are familiar with the neighborhood and able to provide a more intimate level of care.
- Access to health care is difficult for those who are undocumented. Often, resources aren't available or there are long wait times. Many hesitate to access care through hospital systems, fearing large bills. We need insurance navigators to help people understand benefits and access.
- Lack of universal health care. There are gaps in economics, access, and health care knowledge. Need better campaigns about access to health care and health issues in general.
- Knowledge is key. Many don't understand facts about immunizations and the importance of dental care. We need bilingual liaisons who are part of the community
- Closure of Martin Luther King, Jr. Hospital meant a huge number of beds for the region were lost. We also lost places for physician residents to train, meaning we lost access to these providers as providers often stay in the communities they train in.
- People with diabetes and high blood pressure are at risk of stroke, heart attack, and are more likely to get severely ill from COVID. It's time for health care providers to work together with the communities to address those with chronic diseases to prevent more death and serious illness.
- Many college students lack health care options. Campus health centers provide limited services.
- There's a need for funding to create seamless transitions especially for the frail elderly who otherwise would become hospital patients. Let's help them with make doctor appointments, compliance with medications and coordination of community services to age in place.
- Telehealth and street-based care must continue for physical and mental health. We need access and connectivity, otherwise disparities worsen, negative impacts accelerate, and people get sicker.
- Need large scale policy conversations around free internet access. There are now telehealth reimbursement opportunities, but people need stable internet, which many can't afford.
- Increase health care providers who accept Medi-Cal on a nondiscriminatory basis. Increase services that may not be revenue producing, such as mental health and substance abuse detox.
- Many transitional-age youth enter the mental health system – an important population to emphasize for prevention/early intervention. Low barrier access centers are needed, including sobering centers, where people can walk in to get services. There are not enough on the Westside where NIMBYism exists.
- There's a lack of appropriate facilities; we're losing board and care homes. We all need to come together to fund long-term and skilled nursing beds to meet needs of the population.
- Mental health access, stigma and cost are all barriers. The pandemic shifted all programs online, so transportation and social anxiety were removed as barriers. A solution would be an anti-stigma campaign using high profile ambassadors to share their mental health stories.
- Need mental health support consultants for students who can offer outside counseling and also in-classroom support.

- Focus on more substantial investments in strategies to increase access to food, i.e., food banks, food home delivery (Meals on Wheels), and medically tailored meals.
- Need policy change to expand safety net programs, i.e., food stamps and eviction moratoriums.
- Access to housing is the key to making people healthier. Prioritize affordable housing options and build partnerships to bring shared expertise to the problem.
- Need to consider both language and race/ethnicity in addressing health needs. Draw a map based on the number of languages people speak, then if we only have information in a few of the spoken languages, we're not reaching those who may need it most.
- Community-based organizations are struggling with limited funding and limited ability to change midstream. A solution may be to invest sustained funding in organizations to help them build stability and grow stronger, provide mentorship, and help leaders get advanced degrees or training, particularly with black-led organizations that are often grossly underfunded.
- Invest in legal service providers for low-income residents who are experiencing threat of eviction.
- Invest in navigation, case management, and wrap-around services for those persons who are homeless and who are highly using/mis-utilizing health care systems.
- Need a system of care for those who need long-term support, especially for persons who are homeless with ADL deficits and for mentally ill with wrap-around services.
- Need accessible dental and hearing services. There are dental deserts where children lack access.
- Need more spaces within neighborhoods for exercise, i.e., the Slow Streets program.

Interview participants were asked how the COVID-19 pandemic influenced or changed unmet health-related needs in the community. Responses included:

- The pandemic highlighted the needs, it didn't change them.
- The pandemic ripped the roof off the of the disparities we know. It exposed them for what they are in terms of access to care and resources and ability for people to take care of themselves.
- The focus on COVID took up everyone's bandwidth so other health issues weren't top of mind.
- Fundamental human rights were impacted – access to food and housing, which impacts health. Many agencies' services shifted to addressing these basic needs, even if they didn't before.
- Healthy food distribution was a big need, as well as emergency supplies.
- Agencies needed to get creative in how to provide essential service under public health orders. Still grappling with decisions about reopening using evidence-based or safety-based guidance.
- There is a need for more access to COVID vaccines. There's a lot of delayed care due to fear and hesitancy. It's likely that over the next few years, we'll see an increase in preventable deaths.
- In trying to understand vaccine hesitancy, we need to understand how challenging it must be for an individual who may want to get vaccinated but can't take time off work or get childcare, then add structural racism and distrust of system as a whole – this all affects one's decision.
- How does one decide about the vaccine when information is only in English and Spanish?
- Hospital staffing was a huge challenge. When beds were full, diversion disrupted the system. We need to learn how do we effectively manage emergencies when they are health emergencies?

- If you're unemployed, it's more difficult to purchase healthy foods. Those employed sometimes see an increase in their assets, whether that's housing, securities, investments, but those in low-income communities have difficulty securing that.
- Shutting down schools where children got food, exercise, interaction with peers, and a consistent adult had significant negative effects. Children are returning to school with even more unmet needs.
- The education system was disrupted and there's a ripple effect - getting kids into school and keeping them in school. If they're having problems now, this may affect their ability to finish high school and get a higher education, which has direct impact on employment, wealth, and where they can afford to live. This all has influence on violence in the communities, which impacts health.
- A positive - many schools now require seeing a health care provider for certain symptoms. School nurses are finally highlighted as huge resources due to their liaison role with families and doctors.
- The needs of college students were compounded – stress, food insecurity, and lack of student housing.
- Kids didn't go to the dentist during the pandemic, so we're seeing teeth extractions and root canals.
- Inability to socialize negatively affected mental well-being and physical activity levels. It increased isolation among older generation.
- Seeing tremendous increase in mental and behavioral health issues/crises in adults and children. Many families had loved ones pass away due to COVID. Grief and fears need to be addressed.
- Scapegoating of Asian Americans drove many into hiding so they weren't accessing needed services.
- Many Asian community members were afraid if they tested positive for COVID that they'd be shunned or stigmatized in the community, especially Pacific Islander communities.
- COVID is a disproportionate killer of people of color. This gave Charles R. Drew University (CDU) the opportunity to talk and train with people of color, the largest number being Latinx.
- Increased need but created solutions and innovations, i.e., advancement in infrastructure in community clinics and community access. Telecare and digital visits have improved. What hasn't improved is correlated technology gap around hardware and internet.
- Overall access has improved with remote telehealth services. Missed appointments decreased with work, transportation and childcare barriers removed, but the digital divide is real. Many lack access to smart phones with people of color disproportionately impacted.
- Silver lining is that mental health care was forced to shift to remote work, not a common practice previously. We didn't receive more contract money, but we saw more efficiency.
- Telehealth should continue to be part of the model of care and technology infrastructure.
- The housing crisis plus multiple families living together meant COVID ripped through these families.
- Seeing many foreclosures emerge as an economic effect of the pandemic.
- There's a lot of displacement with unemployment being so high. It's a challenge to maintain secure housing; many have been evicted despite moratoriums. Homelessness has increased.
- Need economic protections among people of color. Anticipating seeing increase in evictions, exacerbating an already tense housing crisis.

- Homelessness was already seen as a public health concern, but we really saw the crisis when persons who were homeless couldn't be safely housed with protections from COVID/illness. Hotels were converted into Project Roomkey housing; we need this to be continuous.
- Underscored need for sustainable street outreach teams for persons who are homeless, providing an ongoing connection to primary care, provision of vaccines and psych meds.
- More substance use and more death on the streets, especially among younger people.
- We see an unemployment crisis, and now a workforce crisis. It's hard to find frontline workers, possibly due to fear of COVID, burnout, low pay. There is homeless services funding so many are hiring, but some may not be looking for work if collecting unemployment.
- Caregiving has very limited systems already; need advocacy in this area. Paid family leave is needed.
- Need to address workers' rights and protections, i.e., paid leave - who has it/who doesn't. Many frontline workers were going into work sick because they couldn't take time off.
  Some lost jobs and then health insurance, which is often tied to employment. Help needs to come from trusted organizations as many are afraid because their immigration status is complicated.

Appendix 4: Community Resources Available to Address Significant Health Needs

Providence Saint John's Health Center cannot address all the significant community health needs. Improving community health requires collaboration with community stakeholders. The table below lists community resources potentially available to address identified community needs. This is not a comprehensive list of all available resources. For additional resources refer to https://www.211la.org/.

Community Resources Available to Address Significant Health Needs

Significant Needs	Community Resources
Access to Health Care and Preventive Care	Asian Pacific Health Care Venture, Black Infant Health Program, Black Infants and Families Los Angeles, Charles R. Drew University of Medicine and Science, Chinatown Service Center, CinnaMoms, Community Clinic Association of Los Angeles, Disability Community Resource Center, Give an Hour, Homeless Health Care Los Angeles, Jewish Family Service LA, KHEIR Center, Los Angeles Christian Health Centers, Los Angeles County Department of Health Services, Mar Vista Family Center, Northeast Valley Health Center, Project Room Key, Refresh Spot, Saban Community Clinic, Santa Monica College Student Health & Wellness Center, St. John's Well Child & Family Center, St. Joseph's Center, The People Concern, UCLA/VA Veteran Family Wellness Center, Venice Family Clinic, Westside Family Health Center, WISE & Healthy Aging
Chronic Diseases	Charles R. Drew University of Medicine and Science, Homeless Health Care Los Angeles, Jewish Family Service LA, Los Angeles Christian Health Centers, Los Angeles County Department of Health Services, Northeast Valley Health Center, Saban Community Clinic, SmartAirLA, St. John's Well Child & Family Center, St. Joseph's Center, UCLA/Alzheimer's and Dementia Care Program, Universal Community Health Center, Venice Family Clinic, Westside Family Health Center, YMCA
Community Safety	Advancing Justice, Asian Pacific Policy and Planning Council (A3PCON), City of West Hollywood Security Ambassador Program, Downtown Women's Center, Homeboy Industries, Jenesse Center, LA vs. Hate, Los Angeles County Department of Mental Health (Veteran Peer Access Network), Sahara, South Asian Network, Southern California Crossroads, Stop the Violence Program, The Los Angeles LGBT Center, The People Concern, The Positive Results Corporation, TransLatina Coalition, U.S. VETS, Westside Infant-Family Network
COVID-19	Charles R. Drew University of Medicine and Science, Connections for Children, Empowering Pacific Islander Communities (EPIC), Kedren Community Health Center, Los Angeles County Department of Health Services, Mar Vista Family Center, Pacific Islander Health Partnership, Search to Involve Pilipino Americans (SIPA), Together Toward Health, Venice Family Clinic
Economic Insecurity	American Legion, Charles R. Drew University of Medicine and Science, Chrysalis, City of Santa Monica, Disability Community Resource Center, Harbor Interfaith Services, HOPICS, Imagine LA, Jewish Vocational Service, Korea Town Youth and Community Center, Korean American Family Services, Lift Los Angeles, LISC Los Angeles, Little

Significant Needs	Community Resources
	Tokyo Service Center, Los Angeles County Department of Public Social Services, Neighborhood Housing Services of Los Angeles County, Pathways Out of Poverty – United Way, Pilipino Workers Center, Special Service for Groups, Inc., St. Joseph's Center, The People Concern, Trans Wellness Center, Upward Bound Study Center, United Way, Village for Vets, WISE & Healthy Aging
Food Insecurity	American Red Cross, CalFresh, Catholic Charities of Los Angeles, Inc., City of Santa Monica, Everytable, Food Forward, H.E.L.P.E.R. Foundation, HOPICS, Los Angeles Regional Food Bank, Los Angeles Unified School District, Meals on Wheels, MOA Wellness Center, Project Angel Food, SEE-LA, St. Joseph Center, St. Mark's Food Pantry, St. Paul's Food Pantry, The Los Angeles LGBT Center, The Mar Vista Family Center, The People Concern, Venice Family Clinic, West Los Angeles VA, Westside Food Bank, WISE & Healthy Aging, World Central Kitchen
Homelessness and Housing Instability	Asian Americans Advancing Justice-Los Angeles, Community Corporation of Santa Monica, Exodus Recovery, Inc., Harbor Interfaith Services, HOPICS, Housing for Health, Inner City Law Center, Legal Aid Foundation of Los Angeles, Los Angeles Homeless Services Authority (LAHSA), People Assisting the Homeless (PATH), Project Roomkey, Saban Community Clinic, Safe House, Safe Place for Youth, Skid Row Housing Trust, St. Joseph Center, Step Up, Students Helping Students, The Mar Vista Family Center, The People Concern, Union Station Homeless Services, Venice Family Clinic, Weingart Center for the Homeless
Mental Health	Airport Marina Counseling Services, Alcott Center, Asian Pacific Counseling and Treatment Centers, California Black Women's Health Project, California Department of Developmental Services (DDS) Regional Centers, Chinatown Service Center, Community Coalition, Didi Hirsch Mental Health Services, Edelman Westside Mental Health Center, Exodus Recovery, Inc., Family Service of Santa Monica, Hathaway-Sycamores Child and Family Services, Korea Town Youth and Community Center, Korean American Family Services, Los Angeles County Department of Mental Health (Veteran Peer Access Network), Maternal Mental Health Now, Mental Health Advocacy Services, Mental Health First Aid, National Alliance on Mental Illness (NAMI), OUR HOUSE Grief Support Center, Pacific Clinics, Painted Brain, Pathways, Rape Treatment Center / Stuart House, Santa Monica-Malibu Unified School District, South Asian Network, Special Service for Groups, Inc., St. John's Well Child & Family Center, St. Joseph Center, Step Up, Strength In Support, The Los Angeles LGBT Center, The People Concern, The Trevor Project, The Village Family Services, UCLA/VA Veteran Family Wellness Center, U.S. VETS, Venice Family Clinic, Westside Infant-Family Network, WISE & Healthy Aging
Substance Use/Misuse	Airport Marina Counseling Services, Alcoholics Anonymous, Asian American Drug Abuse Program, Clare Matrix, Didi Hirsch Mental Health Services, Exodus Recovery, Inc., Homeless Health Care Los Angeles - Center For Harm Reduction, HOPICS, JWCH Institute, Narcotics Anonymous, Pacific Clinics, Special Service for Groups, Inc., St. Joseph Center, Tarzana Treatment Centers, Inc., Twin Town Treatment Centers, UCLA Integrated Substance Abuse Programs, Venice Family Clinic, Vista Del Mar Child and Family Services

Appendix 5: Community Health Needs Assessment Oversight Committee

Community Health Needs Assessment Committee Members

Name	Title	Organization
Kathryn Jeffery, Ph.D. (Committee Chair)	Superintendent/President Board Member	Santa Monica Community College District Providence Saint John's Health Center Board of Directors
Brooke Slusser	Chief Program Officer	The People Concern
Jenny O'Brian	Director of Institutional Giving	Venice Family Clinic
Jim Tehan	Regional Director, Community Health	Providence
Jules Buenabenta	Board Member	Providence Saint John's Health Center Board of Directors
Molly Davies	President & CEO	WISE & Healthy Aging
Paul Makarewicz	Chief Mission Integration Officer	Providence Saint John's Health Center
Ruth Cañas	Executive Director, Child and Family Development Center	Providence Saint John's Health Center
Setareh Yavari	Housing and Human Services Manager	City of Santa Monica
Wendy Merritt	Senior Director	Providence Saint John's Health Center Foundation