PROVIDENCE
Little Company of Mary
Medical Center
Torrance

PROVIDENCE
Little Company of Mary
Medical Center
San Pedro

Providence South Bay Community
Joint Community Health Needs Assessment 2016

Providence Little Company of Mary Medical Center San Pedro
San Pedro, Calif.

Providence Little Company of Mary Medical Center Torrance
Torrance, Calif.

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Creating healthier communities, together

As health care continues to evolve and systems of care become more complex, Providence is responding with dedication to its Mission and a core strategy to *create healthier communities, together*. Partnering with many community organizations, we are committed to addressing the most pressing health needs in our community.

Defining the community

For purposes of this CHNA, the Total Service Area for Little Company of Mary San Pedro and Torrance is divided into the "Broader South Bay Service Area" and the "Community Benefit Service Area". The Total Service Area of the two Providence Little Company of Mary Medical Centers encompasses the South Bay region of Los Angeles County. South Bay is a demographically and geographically diverse area stretching from El Segundo and Inglewood in the north, Carson to the East, the Los Angeles port to the South, and the Pacific Ocean in the west.

The Community Benefit Service Area was defined using the Community Need Index (CNI) mapping tool from Dignity Health and Truven Health Analytics. All communities with a score of 4 or greater on the scale were included. Communities identified as having higher need using the scale experience greater barriers to health care including income, cultural, educational, health insurance, and housing barriers. Areas identified as "Community Benefit Service Areas" include the neighborhoods and surrounding areas of Inglewood, Hawthorne, Lawndale, Gardena, Harbor City, San Pedro (90731), and Wilmington.

The Broader South Bay Service Area are the communities within the Total Service Area of the two Medical Centers remaining after application of the Community Need Index. These areas are more resource rich with a population on the higher end of the socioeconomic spectrum.

Our starting point: Gathering community health data and input

Gathering data for this CHNA involved systematic collection of both primary and secondary data relevant to our South Bay community. In 2016, Providence Health and Services provided leadership that resulted in the formation of a regional coalition of hospitals working to devise standard core indicators for community health to be used in community health needs assessments, implementation plans, and program planning. The efforts of the coalition resulted in an enhanced custom report furnished by the Epidemiology Unit at the Los Angeles County Department of Public Health (LAC DPH). Based on the results of the 2015 LA County Health Survey and multiple other data sources available to LAC DPH, the report covered 65 core indicators related to community health status, the majority of which are reported in the body of this document. A full list of indicators can be found in the appendix.

We also conducted key informant interviews, focus groups, and an online survey to gather more insightful data that further describe the community. Key informants were selected based on their expertise in working with low-income, medically underserved, minority, or otherwise vulnerable populations.

Other secondary data sources included publicly available state and nationally recognized data

sources such as the US Census Bureau, Centers for Disease Control and Prevention, Community Commons, Nielsen, and various other state and federal databases. When feasible, health metrics have been further compared to national benchmarks, such as Healthy People 2020 objectives to better gauge health in our community.

Identified Community Health Needs in 2016

Priority Health Issue	Rationale/contributing factors
Access to healthcare and resources • **Enrollment services** • **Specialty services** • **Medical home**	• Even after ACA, the Community Benefit Service Area has lower percentages of insured adults and children, adults and children receiving dental care services in the past year, and mothers receiving prenatal care in the first trimester in comparison to the Broader Service Area. • Issues with access to care, navigating the system, or other social resources were among the top barriers mentioned by key informants, focus group participants, and community based organizations • Key informants consistently cited a need for more health and physical education and outreach to ensure client access to and use of services. The need for health navigator type services in combination with medical care was also expressed.
Affordable housing and homelessness	• SPA 8 has the 5th largest homeless population among the SPAs with a growing population of those in need. From 2015 to 2016, the homeless population in SPA increased by 22 percent, to 3,663 people, according to the Los Angeles Homeless Services Authority. • Key informants mentioned homelessness as an inevitable consequence of housing cost burden, low-income, and lack of economic opportunities. Participants also noted a growing number of homeless persons served in the past year.
Low educational attainment and unemployment	• Unemployment is as high as 21 percent in neighborhoods in the Community Benefit Service Areas. These areas also have higher rates of people employed full time, yet still living below the poverty level • Economic opportunities and job growth were consistently mentioned by focus group participants. Participants expressed a need for occupational training and availability of jobs paying a living wage.
Mental health (services including substance abuse)	• Mental health was one of the most frequently mentioned health need by key informants, focus group participants, and community based organizations. All participants noted a need for more specialty (substance, trauma, coping skills) and integrated services for all age levels. • 13 percent of adults in the Community Benefit Service Area are at risk for major depression, in comparison to 7 percent in the Broader Service Area and 12 percent in Los Angeles County.
Poverty and food insecurity	• Poverty was consistently mentioned as a key driver of health across key informant interviews and focus groups and was the top ranked health or social determinant mentioned.

Priority Health Issue	Rationale/contributing factors
	• 21 percent of households in the Community Benefit Service Areas are living in poverty in comparison to 8 percent in the Broader Service Area. • In the Community Benefit Service Area, about 35 percent of households with annual incomes less than 300 percent of the federal poverty level are food insecure. Comparatively, 15 percent of households in the Broader Service Area and 30 percent in LA County are experiencing food insecurity.
Prevention and management of chronic diseases • **Obesity** • **Diabetes** • **Physical activity**	• Secondary data showed lower rates of adults diagnosed with diabetes in the Community Benefit Service Area in comparison to other areas, but higher hospital admissions rates. This suggests issues in connecting to primary care providers and/or screening services. • Obesity and diabetes rates among children was one of the most frequently mentioned health issues among key informants and focus group participants. Participants expressed a need for more opportunities for physical activity in a safe environment for all members of the family.
Senior care and resources	• The Alzheimer's disease-specific death rate for the Broader South Bay Service Area (26.2 per 100,000) is greater than the Community Benefit Service Area (22.0 per 100,000).and LA County (25.1 per 100,000) estimates. • 27 percent of adults age 65 and older in the Broader South Bay Service Area have fallen in the past year in comparison to 25 percent in the Community Benefit Service Area.
Violence	• Violence was the top health or social issue noted by focus group participants. Key informants also mentioned violence as having a significant impact on health in our communities. • 17 percent of adults living in the Community Benefit Service Area have experienced physical or intimate partner violence in the past year in comparison to 9 percent in the Broader South Bay Service Area.

Identifying top health priorities, together

The Oversight Committee for Providence Little Company of Mary Medical Centers met two times in 2016 to learn about the key findings from the CHNA and determine the priority health needs for the 2017-2019 cycle. The first meeting provided an in depth walk through of methods used to define the Community Benefit Service Area and core indicators related to social determinants of health in our communities. In the second meeting, Board members reviewed the list of top identified health needs and associated CHNA results to determine the final list of priority health needs for 2017-2019. Committee members used a priority matrix to determine the final list of needs. The matrix consisted of a list of criteria based on IRS regulations and developed in partnership with experts at PLCM and HC^2 Strategies, Inc:

- Attorney General requirements regarding the effect of the change in control and governance of St. Joseph Health System and Providence Health and Services on the availability and accessibility of healthcare services to the communities served by Providence Little Company of Mary Medical Center-Torrance and Providence Little Company of Mary Medical Center-San Pedro

- Input from community
- Mission alignment and resources of hospital
- Severity and magnitude
- Addresses disparities of subgroups
- Existing resources and programs
- Opportunity for partnership

On November 1, 2016, Oversight Committee members authorized by the Community Ministry Board for PLCM met to debrief on the findings of the CHNA and prioritize the identified needs. Members used a priority matrix with pre-determined weights and criteria to determine the final prioritized list of needs for the 2017-2019 cycle. Committee members were provided the rankings for input from the community (primary data), severity and magnitude (secondary data), and programs required by the Attorney General. Committee members were broken into two separate groups and asked to rank the remaining four criteria based on their expertise, using a scale of 1 (low need) to 4 (high need). Two facilitators helped participants reach a ranking for each of the eight identified priority issues. The rankings for each group were scored and the scores were tallied for each priority health need. The final ranked list: (1) Access to healthcare and resources, (2) Prevention and management of chronic diseases, (3) Mental health services (including substance abuse treatment), (4) Violence, (5) Affordable housing and homelessness, (6) Poverty and food insecurity, (7) Low educational attainment and unemployment, (8) Senior care and resources.

Providence top priority health needs for 2017-2019

1. **Access to healthcare and resources**
2. **Prevention and management of chronic diseases**
3. **Mental health services (including substance abuse treatment)**
4. **Violence**
5. **Affordable housing and homelessness**

Measuring our success: Results from our 2014 CHNA

This report also evaluates results from our most recent CHNA in 2014. Identified prioritized needs were: increased access to health care, primary and secondary prevention services, capacity building with external community partners, and program development in new priority areas of need identified by the CHNA. PLCM responded by making investments of time, resources and funding to programs that were most likely to have an impact on these needs.

In this third cycle from 2014 through 2016, 6 of 21 benchmarks set for our community benefit programming were accomplished in 2014 for a success rate of 29 percent. This figure increased in 2015 to a rate of 71 percent (15 of 21 benchmarks completed). In 2016, 16 of 21 benchmarks were accomplished at the time of writing this report (76 percent success rate) and 18 benchmarks have either been accomplished or are on track/in progress to be completed by the end of 2016 (86 percent success rate). A full report of the activities for each priority need and trends can be found later in this document and a final report that includes all of 2016 will be prepared and reported to regulatory agencies.

Acknowledgements
Summary of community input

We express our sincere gratitude to participants who provided feedback during the community health needs assessment and for our subsequent health implementation plan. Many attendees may have participated more than once in various meetings and community presentations.

From July to September of 2016, on behalf of PLCM, HC2 Strategies, Inc. conducted multiple focus groups, key informant interviews, and an internet based survey for community partners. 84 people were surveyed to obtain input from the community in the form of 14 key informant interviews, five focus groups, and 24 people responded to the online community based organization survey.

Summary of Key Informant Interviews

Key informant interviews comprised key leaders in our community from an array of agencies, including social service agencies, local government, funders, not-for-profits, researchers, and public health practitioners.

Summary of Focus Groups

Participants in the focus groups were end-users who are currently receiving programming and services from Little Company of Mary Medical Centers, San Pedro and Torrance. Focus group types included those participating in the coping skills, resilience, and Wellness Center classes, insurance assistance program, and Welcome Baby program.

Summary of Community-Based Organization Survey

Participants in the online community based organization survey included safety-net providers that have a current working relationship with PLCM and serve the broader social and health needs in our community, including but not limited to housing, homelessness, asthma, and children's health. Participants had the opportunity to respond by either an online survey or paper copy.

Summary of Written Comments

Little Company of Mary Medical Centers of San Pedro and Torrance solicited written comments on the latest CHNA through a link on both hospital's websites; however, neither hospital received feedback.

Providence Little Company of Mary Medical Center San Pedro
1300 W. 7th Street
San Pedro, CA 90732

Providence of Little Company of Mary Medical Center Torrance
4101 Torrance Blvd,
Torrance, CA 90503

Introduction

Creating healthier communities, together

As health care continues to evolve, Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance are responding with dedication to their Mission and a desire to *create healthier communities, together*. Partnering with others of goodwill, we conduct a formal community health needs assessment to learn about the greatest needs and assets in our community, especially considering members of medically underserved, low-income, and minority populations.

This assessment helps us develop collaborative solutions to fulfill unmet needs while continuing to strengthen local resources. It guides our community benefit investments, not only for our own programs but also for many partners, toward improving the health of entire populations. Through strategic programs and donations, health education, charity care, medical research and more, Providence Health and Services provided $951 million in community benefit across Alaska, California, Montana, Oregon and Washington during 2015.

Serving South Bay Community

The Mission of the Little Company of Mary Sisters is reflected in the historical significance of their name: that small group of women who stood with Mary at the foot of the cross as her son Jesus lay dying. From the beginning, the Sisters' commitment to the poor and vulnerable has manifested itself through outreach to underserved communities and care of the sick and dying. In 1982, Little Company of Mary Hospital voluntarily adopted a social accountability budget and, when the organization expanded during the 1990's to include San Pedro Hospital, the commitment continued. Today, these two nonprofit Medical Centers:

Providence Little Company of Mary Medical Center, San Pedro
Providence Little Company of Mary Medical Center, Torrance

have agreed to jointly sponsor this Community Health Needs Assessment (hereafter CHNA), as part of the continuing commitment to live out the Mission.

During the 1990's, the Sisters of Little Company of Mary recognized that across the American Province, their diminishing numbers threatened to undo core mission commitments and, following a period of discernment in 1998, entered into a joint sponsor agreement with the Providence Health System. During the transition years, the Sisters retained their Mission statement and, when Providence Health System merged with Providence Services in 2006, the Sisters finalized the transfer of assets and joined in the creation of Providence Health and Services. Today, the two Little Company of Mary Medical Centers are part of Providence Health and Services, Southern California and are fully aligned with both the Mission and Core Values of the Renton-based Providence Health and Services:

MISSION
As People of Providence,
we reveal God's love for all,
especially the poor and vulnerable,
through our compassionate service.

The Providence Mission statement's emphasis on special attention for the poor and vulnerable

reinforced the original portion of the Mission of the Sisters of Little Company of Mary that spoke to meeting the health care needs of our communities. In a world of interest groups and separateness, the Providence Mission statement is more inclusive because it does not discriminate on a social level (As people of Providence we reveal God's love for all) and specifically directs attention to the care of the poor and vulnerable. This statement of organizational purpose reaffirms the organization's commitment to underserved communities. During 2015, the Providence Little Company of Mary Medical Centers provided $53,900,793 in community benefit in response to unmet needs and to improve the health and well-being of those we serve in the South Bay. This includes $7.3 million in Charity Care, $15.9 million in Community Benefit Services, and $30.6 million in Medi-Cal Shortfall. For 2015, the California region provided $169,027,860 in community benefit. Centers that are sponsored by the South Bay Community include:

- 2 Hospitals:
  - Providence Little Company of Mary Medical Center San Pedro
  - Providence Little Company of Mary Medical Center Torrance

- 1 Home health provider:
  Providence Little Company of Mary Home Health

- 2 Long-term care, assisted living and adult day centers:
  - Providence Little Company of Mary Transitional Care Center
  - Providence Little Company of Mary Sub Acute Care Center

- 1 Hospice for Adults
  - Providence TrinityCare Hospice

- 1 Hospice for Children
  - Providence TrinityKids Care

About us

Providence Health & Services is a not-for-profit Catholic health care ministry committed to providing for the needs of the communities it serves – especially for those who are poor and vulnerable. Providence's combined scope of services includes 34 hospitals, 475 physician clinics, senior services, supportive housing and many other health and educational services. The health system and its affiliates employs more than 76,000 people across five states – Alaska, California, Montana, Oregon and Washington – with its system office located in Renton, Washington. Our community health activities are rooted in the charitable work the Sisters of Providence started nearly 160 years ago, when they answered a call for help from a new pioneer community in the West.

Our Mission
As people of Providence, we reveal God’s love for all, especially the poor and vulnerable, through our compassionate service.

Our Values
Respect, Compassion, Justice, Excellence, Stewardship

Our Vision
Simplify health for everyone

Our Promise
Together, we answer the call of every person we serve: Know me, Care for me, Ease my way. ®

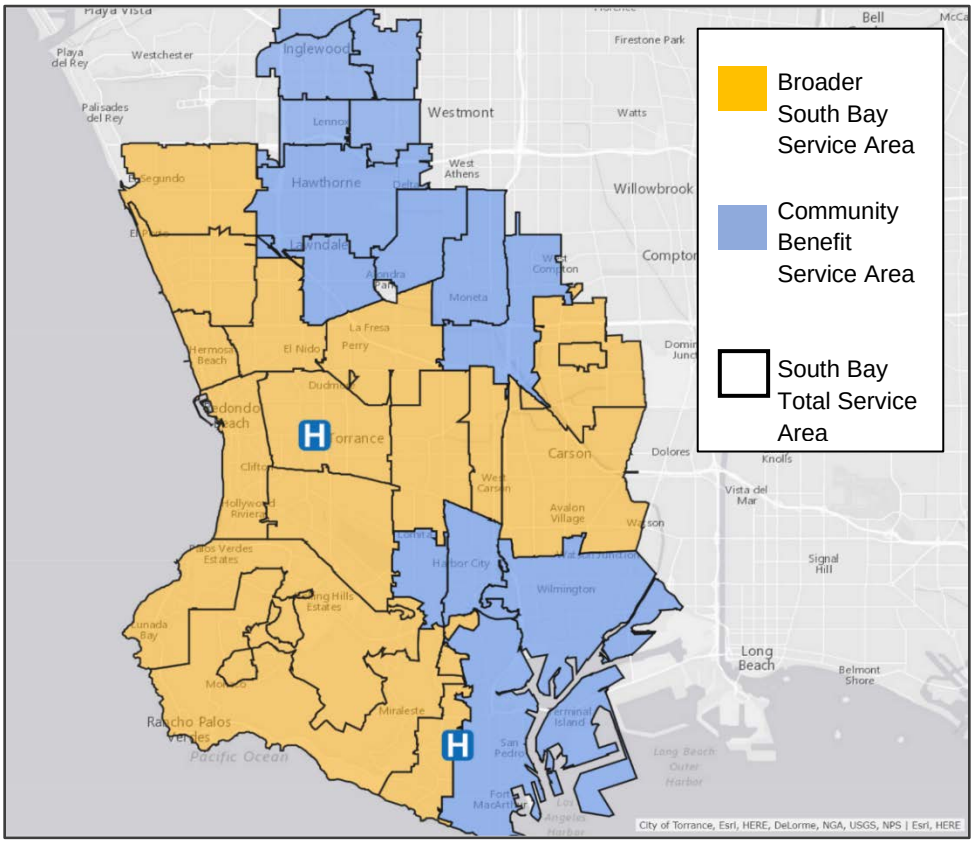
Description of community

This section provides a definition of the community served by the hospital, and how it was determined. It also includes a description of the medically underserved, low-income and minority populations.

For purposes of this CHNA, the Total Service Area for Little Company of Mary San Pedro and Torrance is divided into the “Broader South Bay Service Area” and the “Community Benefit Service Area”. The Total Service Area of the two Providence Little Company of Mary Medical Centers encompasses the South Bay region of Los Angeles County. South Bay is a demographically and geographically diverse area stretching from El Segundo and Inglewood in the north, Carson to the East, the Los Angeles port to the South, and the Pacific Ocean in the west.

The Community Benefit Service Area was defined using the Community Need Index (CNI) mapping tool from Dignity Health and Truven Health Analytics. All communities with a score of 4 or greater on the scale were included. Communities identified as having higher need using the scale experience greater barriers to health care including income, cultural, educational, health insurance, and housing barriers. Areas identified as “Community Benefit Service Areas” include the neighborhoods and surrounding areas of Inglewood, Hawthorne, Lawndale, Gardena, Harbor City, San Pedro (90731), and Wilmington.

The Broader South Bay Service Area are the communities within the Total Service Area of the two Medical Centers remaining after application of the Community Need Index. These areas are more resource rich with a population on the higher end of the socioeconomic spectrum.



The CNI score is an average of five different barrier scores that measure various socio-economic indicators of each community using the 2015 source data. The five barriers are listed below along with the individual 2015 statistics that are analyzed for each barrier. These barriers, and the statistics that comprise them, were carefully chosen and tested individually in a partnership between Dignity Health and Truven Health:

1. Income Barrier
    - Percentage of households below poverty line, with head of household age 65 or more
    - Percentage of families with children under 18 below poverty line
    - Percentage of single female-headed families, with children under 18, below poverty line

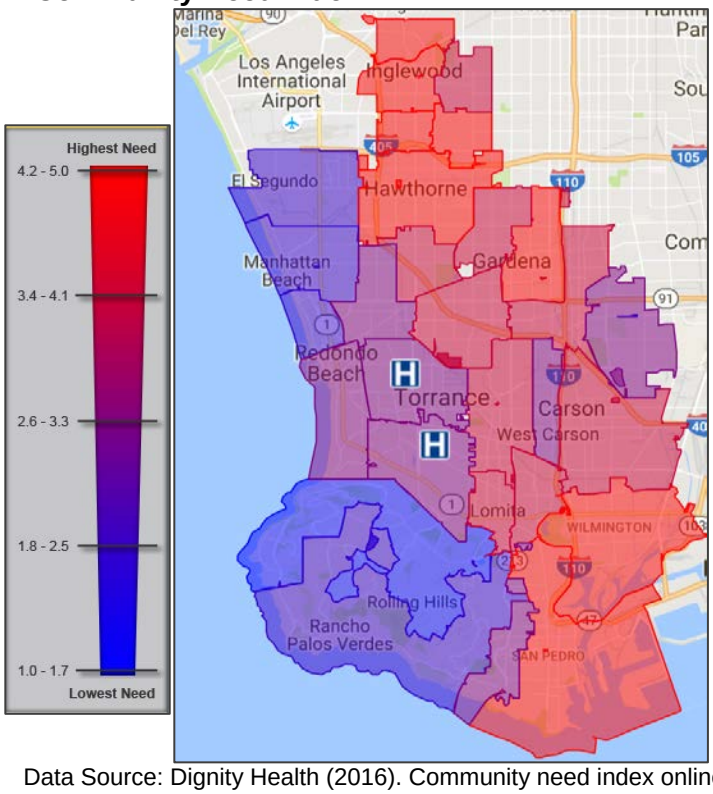
2. Cultural Barrier
    - Percentage of population that is minority (including Hispanic ethnicity)
    - Percentage of population over age 5 that speaks English poorly or not at all

3. Education Barrier
    - Percentage of population over 25 without a high school diploma

4. Insurance Barrier
    - Percentage of population in the labor force, aged 16 or more, without employment
    - Percentage of population without health insurance

5. Housing Barrier
    - Percentage of households renting their home

Community Need Index



Data Source: Dignity Health (2016). Community need index online mapping tool. Retrieved from http://cni.chw-interactive.org/.

Every populated ZIP code in the United States is assigned a barrier score of 1, 2, 3, 4, or 5 depending upon the ZIP code national rank (quintile). A score of 1 represents the lowest rank nationally for the statistics listed, while a score of 5 indicates the highest rank nationally. For example, ZIP codes that score a 1 for the Education Barrier contain highly educated populations; ZIP codes with a score of 5 have a much lower percentage of high school graduates.

For the two barriers with only one statistic each (education and housing), Truven Health used only the single statistic listed to calculate the barrier score. For the three barriers with more than one component statistic (income, cultural and insurance), Truven Health analyzed the variation and contribution of each statistic for its barrier; Truven Health then weighted each component statistic appropriately when calculating the barrier score.

Community Benefit Service Area Zip Codes and CNI Score		
Zip Code	**CNI Score**	**City**
90305	3.6	Inglewood
90717	3.6	Lomita
90248	3.6	Gardena
90710	3.8	Harbor City
90249	4	Gardena
90260	4	Lawndale
90302	4.2	Inglewood
90250	4.2	Hawthorne
90301	4.4	Inglewood
90247	4.4	Gardena
90303	4.6	Inglewood
90304	4.6	Inglewood
90731	4.6	San Pedro
90744	4.6	Wilmington

Broader South Bay Service Area Zip Codes and CNI Score		
Zip Code	**CNI Score**	**City**
90274	1.6	Palos Verdes Peninsula
90266	2.2	Manhattan Beach
90747	2.4	Carson
90245	2.4	El Segundo
90254	2.4	Hermosa Beach
90275	2.4	Rancho Palos Verdes
90277	2.6	Redondo Beach
90505	2.8	Torrance
90746	2.8	Carson
90278	2.8	Redondo Beach
90503	3	Torrance
90502	3.2	Torrance
90732	3.2	San Pedro
90504	3.4	Torrance
90745	3.8	Carson
90501	4	Torrance

Once each ZIP code is assigned its barrier scores from 1 to 5, all five barrier scores for each ZIP code are averaged together to yield the CNI score. Each of the five barrier scores receives equal weight (20 percent each) in the CNI score. A score of 1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with the most need.

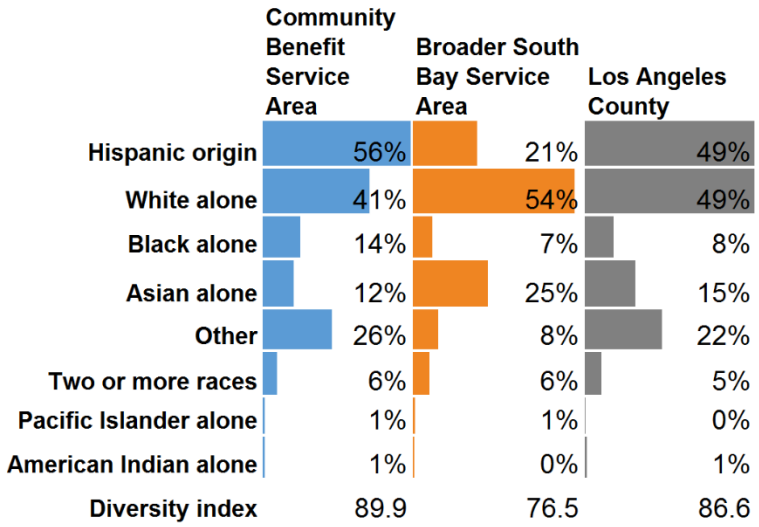
Population and age demographics

According to the 2010-2014 American Community Survey 5-year estimate, the population for the Total Service Area is 1,028,238 with an annual growth rate of about 0.46 percent annually. Age demographics are 77 percent of the population is aged 18 years or older. The median age in this area is 37.8, compared to U.S. median age of 38.0. In 2016 the population comprised:

- 19 percent youth (0-14 years)
- 13.6 percent adolescent and young adults (15-24)
- 27.1 percent adults (25-44 years)
- 26.4 percent older adults (45-64 years)
- 14 percent seniors (65 years and older)

Ethnicity

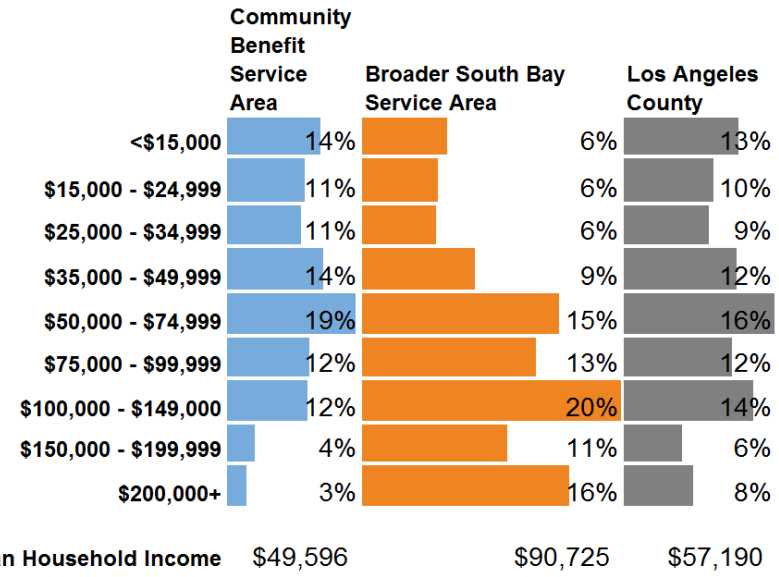
Among residents in the Total Service Area in 2016, 45.1 percent were White, 16.8 percent Asian, 39.5 percent were Hispanic or Latino, 0.6 percent were Alaska Native or American Indian, 13.2 percent were African American or Black, 0.7 percent were Native Hawaiian or other Pacific Islander, and 5.4 percent were of two or more races.



Source: Esri, Inc. (2016). US Census Bureau, American Community Survey 5-year estimates, 2010-2014. Custom community profiles created using Esri Community Analyst®. Geography: zip code.

Income levels and housing

In 2016, the median household income in the Total Service Area was $65,240, compared to $54,149 for all U.S. households. Median household income is projected to be $75,368 in five years, compared to $59,476 for all U.S. households. 47 percent of the 375,048 housing units in the area are owner occupied; 47.9 percent, renter occupied; and 5.1 percent are vacant. Comparatively, in the U.S., 55.4 percent of the housing units in the area are owner occupied; 32.9 percent are renter occupied; and 11.7 percent are vacant.

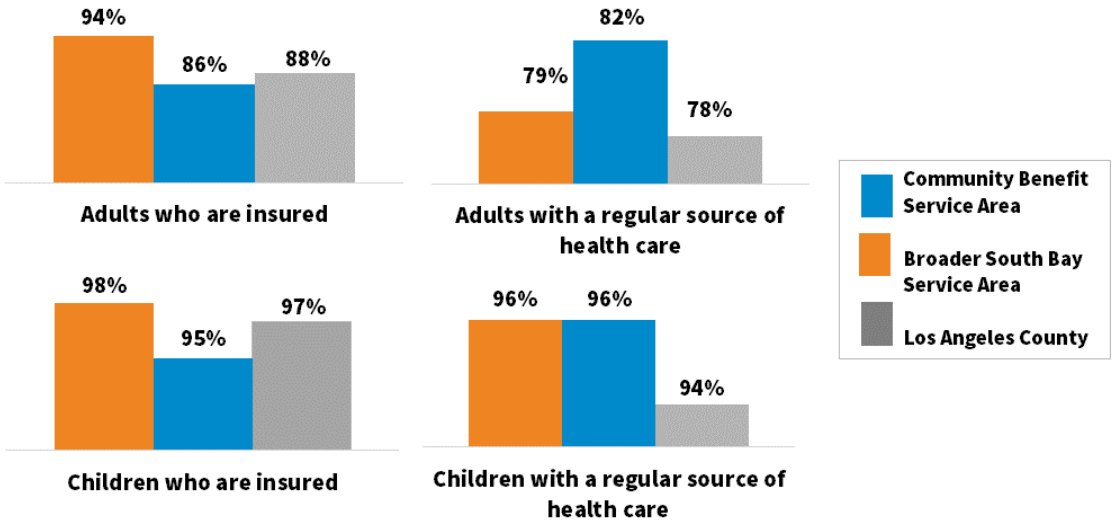


Source: Esri, Inc. (2016). US Census Bureau, American Community Survey 5-year estimates, 2010-2014. Custom community profiles created using Esri Community Analyst®. Geography: zip code.

When looking at income by service area, one can see that half of the households in the Community Benefit Service Area could be considered low-income, earning $50,000 or less per year (50 percent). Comparatively, 27 percent of households in the Broader South Bay Service Area have a household income of $50,000 and 47 percent earn $100,000 or more per year.

Health care and coverage

The share of adults ages 18 to 64 years in the Total Service Area who are uninsured was 15.2 percent in 2014. The figure below shows the percentages of adults and children with insurance and a regular source of care. The Community Benefit Service Area under performed in comparison to the Broader South Bay Service Area in all areas except, “adults with a regular source of care”. In this area, the Community Benefit Service Area out performed both the broader service area and the county.



Source: Core Health Indicators: Little Company of Mary Medical Center. Custom report of results from the 2015 Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

In 2015, 43 percent of adults in the community benefit area had not seen a dentist or gone to a dental clinic in the past year. Comparatively, 30 percent of adults throughout the Broader South Bay Service Area and 41 percent of adults throughout Los Angeles County did not receive dental care in the past year. 20 percent of children ages three to 17 years did not obtain dental care, including checkups, in the past year because they could not afford it. Comparatively, 5[1] percent of children in the Broader South Bay service and 12 percent of children in LA County did not receive dental care in the past year.

Health and wellbeing

In 2015, 20 percent of adults in the Community Benefit Service Area reported their health to be fair or poor. Comparatively, 19 percent of adults in the Broader South Bay Service Area and 22 percent of adults in LA County reported fair or poor health. The percentages of children living with special needs are 17 percent in the Community Benefit Service Area, 16 percent in the Broader South Bay Service Area and 15 percent throughout LA County.

[1] The Epidemiology Unit at the Los Angeles County Department of Public Health advices that this is a statistically unstable estimate that should be interpreted with caution.

Process, participants and health indicators

This section provides a description of the processes and methods used to conduct the assessment; this section describes data and other information used in the assessment, the methods of collecting and analyzing the information, and any parties with whom we collaborated or contracted with for assistance. This section also provides a summary of how we solicited and considered input received from persons who represent the broad interests of the community. This description includes the process and criteria used in identifying the health needs as significant.

Assessment process

Every three years, Providence Little Company of Mary Medical Centers, San Pedro and Torrance conduct a community health needs assessment (CHNA) for the communities in South Bay. The CHNA is conducted to satisfy our annual community benefit obligations by meeting requirements that are outlined in section 501(r)(3) of the Federal IRS Code and to create partnerships that address identified needs. The goals of this assessment are to:

- Engage public health and community stakeholders including low-income, minority, and other underserved populations
- Assess and understand the community's health issues and needs
- Understand the health behaviors, risk factors and social determinants that impact health
- Identify community resources and collaborate with community partners
- Use Assessment findings to develop and implement a 2017-2019 implementation plan based on the prioritized issues

Beginning with the 2013 CHNA, the Hospitals agreed to conduct a Joint CHNA in accordance with §1.501(r)-3(b)(6)(v) of the Federal IRS code 26 CFR Parts 1, 53, and 602 ("Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return; Final Rule"). Accordingly, representatives of both medical centers agreed to participate on an Oversight Committee authorized by the Community Ministry Board. In collaboration with community representatives, the oversight group considered primary and secondary data collected and prioritized community needs as described hereinbelow.

Participants

The organizations listed below represent the key informants that contributed to this CHNA. These individuals represent a variety of low-income, medically underserved, and minority populations throughout South Bay.

Community participants in 2016 community health needs assessment

Key Informant and Title	Organization	Community Representation
Barbara Andrade Dubransky. Director of Program Development	First 5 LA	First 5 LA is a leading early childhood advocate working collaboratively across L.A. County. They were created in 1998 to invest L.A. County's allocation of funds from California's Proposition 10 tobacco tax. Since then, First 5 LA has invested more than $1.2 billion in efforts aimed at providing the best start for children from prenatal to age 5 and their families.

Key Informant and Title	Organization	Community Representation
Ben Schirmer, Executive Director	Harbor Community Benefit Foundation	The Harbor Community Benefit Foundation assesses, protects, and improves the health, quality of life, aesthetics, and physical environment of the harbor communities of San Pedro and Wilmington, California, which have been impacted by the Port of Los Angeles. Their vision is that the harbor communities of San Pedro and Wilmington become safe, healthy, and beautiful places in which to live, learn, work, play, and enjoy the physical environment. The formation of HCBF demonstrates a historic collaboration between the Port of Los Angeles and the organized efforts of 17 environmental and community groups.
Brian Cole, Dr.PH	UCLA Fielding School of Public Health	For more than 55 years, UCLA Fielding School of Public Health has played an instrumental role in advancing the field of public health in the areas of research, training and service. Their world class faculty in collaboration with students have made research discoveries that have improved the health of communities large and small around the world.
Brian Markarian, Assistant Superintendent	Hawthorne School District	Hawthorne School District educates close to 10,000 pre-kindergarten through twelfth grade students in the diverse urban community of Hawthorne. Founded in 1907, the District is proud of its long tradition of academic excellence.
Jann Hamilton Lee, CEO	South Bay Family HealthCare	Leading community clinic system and one of Los Angeles County's largest safety net providers, offering high-quality, low-and-no cost health care in a warm and supportive environment to economically disadvantaged and uninsured populations throughout Los Angeles County's South Bay and Harbor Gateway communities.
Linda Aragon, Acting Director	Division of Maternal, Child, and Adolescent Health; Los Angeles County Department of Public Health	The Maternal, Child, and Adolescent Health (MCAH) Programs is a division of the Department of Public Health in Los Angeles County. It is responsible for the planning, implementing and evaluating of services that address the health priorities and primary needs of infants, mothers, fathers, children and adolescents, and their families in Los Angeles County through ongoing assessment, policy development and quality assurance.
Michael Ballue, Chief Strategy Officer	Behavioral Health Services	Not-for-profit community-based healthcare organization providing substance abuse, mental health, drug-free transitional living, older adult services, HIV/AIDS education and prevention, and other related health services to the residents of Southern California.

Key Informant and Title	Organization	Community Representation
Rosemary Veniegas, Senior Program Officer	California Community Foundation	Philanthropic organization driven by a desire to find long-term, systemic solutions addressing the root causes of the most pressing issues facing Los Angeles County. Since 2000, they have granted more than $200 million, impacting hundreds of thousands of lives and helping to transform entire communities.
Sandra Gonzalez, Ed. D., Executive Director	Training and Research Foundation	Non-profit Head Start organization that serves low-income preschool children and families by providing comprehensive child development and school readiness services including education, health, nutrition, and mental health.
Silvia Prieto, MD, Area Health Officer	SPA 7 and 8; Los Angeles County Department of Public Health	The Los Angeles County Department of Public Health works to improve the lives of residents through our many diverse programs, Public Health Centers, and community partners. Our mission is to protect health, prevent disease, and promote health and well-being for all persons in Los Angeles County.
Tahia Hayslet, Executive Director	Harbor Interfaith Services	Provides services to the homeless and working poor in the South Bay area of Los Angeles. Services include food, 90-day emergency shelter for families, transitional housing, children's services for kids 6 weeks to school age, rental assistance, moving costs.
Tamra King, Executive Director	Harbor Community Clinic	Trusted provider of state-of-the-art health services for men, women and children throughout San Pedro, CA, and the surrounding Los Angeles and South Bay areas. The clinic provides low-cost and no-cost health services to residents with low incomes and those whose employers do not provide health insurance coverage.
Yolanda Becerra, Chair, Health Committee	St. Joseph Catholic Church	St. Joseph Parish is in Hawthorne, CA. This is a thriving Catholic Parish located in the South Bay. The heart of this parish is a lovely, classic church building where generations of people have prayed together and celebrated God's enduring love. The soul of this Parish is the Lord, who gathers us to share His life and love in word and sacrament, and who then sends us out to be His witnesses in our world. The people of St. Joseph's love their Church and are proud of its history going back to 1913.
Yolanda Vera, Senior Deputy for Health and Advocacy and Chief Counsel Office of Supervisor Mark Ridley-Thomas	Board of Supervisors, County of Los Angeles, Office of Supervisor Mark Ridley	The five-member Board of Supervisors is the governing body of the County of Los Angeles. Created by the state Legislature in 1852, the Board has executive, legislative and quasi-judicial roles. Members are elected by voters in their respective districts and are limited to three four-year terms.

Board Committee on Community Benefit

The following individuals reviewed the data collected and helped us prioritize the top health needs for 2017 – 19:

Name	Title	Organization	Sector
Jorge Arroyo	Director, Student Support Services	Lawndale Elementary School District	Academics
Michael Ballue	Chief Strategy Officer	Behavioral Health Services	Federally Qualified Health Center
Jan Brandmeyer	Board Member	Providence Little Company of Mary, Community Ministry Board	Hospital
Gary Carnes, BSN, RN	Assistant Nurse Manager, CDOU	Providence Little Company of Mary, Torrance	Hospital
Lori Eastman, MSW, LCSW	Manager, Clinical Social Work	Providence Little Company of Mary, Torrance	Hospital
Mary Ann Green, BS, RT(R)(T)	Director of Specialty Services	Providence Little Company of Mary, San Pedro and Torrance	Hospital
Tahia Hayslet	Executive Director	Harbor Interfaith Services	Community Based Organization
Robin Hughes	CEO	Abode Communities	Affordable Housing Provider
Sr. Nancy Jurecki	Chief Mission Integration Officer	Providence Health and Services, Southern CA	Hospital
Allison Partridge, RN, BSN	Director, Emergency Services and Critical Care	Providence Little Company of Mary, San Pedro	Hospital
Silvia Prieto, MD, MPH/ Eloísa Gonzalez, MD, MPH	Area Health Officer, SPA 8/ Director, Physical Activity & Cardiovascular Health	Los Angeles County Department of Public Health	Public Health
Elizabeth Sander, MD, FACP	President	Providence Medical Associates	Medical Group
Ben Schirmer, MBA, JD	Executive Director	Harbor Community Benefit Foundation	Grant-making agency

Outside Consultant: HC^2 Strategies, Inc.

Little Company of Mary Medical Centers, San Pedro and Torrance contracted HC^2 Strategies, Inc. to conduct and document this community health needs assessment. HC^2 Strategies, Inc. is a healthcare consulting firm with expertise in health care systems, strategy and innovation, community health needs assessments, and program evaluation. Research and development of the final written product was led by HC^2's Healthcare Intelligence Director, Jessica L.A. Jackson, MA, MPH.

Data collection

CHNA Framework

Developing metrics for population health interventions are imperative for continued success in elevating the health status of our community. The CHNA ensures that we can target our community investments into interventions that best address the needs of our community. Our hospital is transitioning from process evaluation based system to a more inclusive and regional focus of metrics. This requires being in alignment with statewide and national indicators, such as Healthy People 2020 and The County Health Rankings & Roadmaps. The domains used in this assessment encompass the same type of national and state community health indicators. We recognize that health status is a product of multiple factors. Each domain influences the next, and through systematic and collective action, improved health can be achieved.

Primary Data

Little Company of Mary Medical Centers conducted key informant interviews, focus groups, and an online survey with community based organizations to gather more insightful data and aid in describing the community. Key informants were selected based on their expertise in working with low-income, medically underserved, minority, or otherwise vulnerable populations. Focus groups focused on end-user experiences and needs. The online survey was targeted to community based safety net organizations and focused on service needs among clients. The full results of the qualitative analysis and description of groups and process can be found later in this document.

Secondary Data

In 2016, Providence Health and Services provided leadership that resulted in the formation of a regional coalition of hospitals working to devise standard core indicators for community health to be used in community health needs assessments, implementation plans, and program planning. The efforts of the coalition resulted in an enhanced custom report furnished by the Epidemiology Unit at the Los Angeles Public Health Department. Based on the results of the 2015 LA County Health Survey, the report covers 65 indicators related to community health status, the majority of which are reported here.

The custom report presented data grouped by zip code to further breakout and define communities of greater and lower need in the Total Service Area and identify disparities between communities. For each of the 65 core indicators, data was obtained for the Community Benefit Service Area (areas of greater need), the Broader South Bay Service Area (remaining zip codes after application of the Community Need Index), and Los Angeles County.

Other secondary data sources included publicly available state and nationally recognized data sources

such as the US Census Bureau, Centers for Disease Control and Prevention, Community Commons, Nielsen, and various other state and federal databases. When feasible, health metrics have been further compared to national benchmarks, such as Healthy People 2020 objectives to better gauge health in our community.

Data Limitations and Gaps

It should be noted that the community based organization survey results are not based on a stratified random sample of community based safety net organizations throughout Los Angeles County. The perspectives captured in this data simply represent the partners who agreed to participate. In addition, this assessment relies on several local, national, and state entities with publicly available data. All limitations inherent in these sources remain present for this assessment.

Identification of significant health needs

The criteria selected for determining significant health needs were chosen per the IRS 501(r) regulations for conducting community health needs assessments and developing implementation plans. The Oversight Committee used these criteria in a prioritization matrix to determine the final list of prioritized needs by the Oversight Committee.

The Prioritization Matrix uses a mathematical process whereby participants assign a priority ranking to issues based on how they measure against established criteria. Weighting of each criteria was selected based on input from the panel of experts at HC2 Strategies, Inc. that included public health professionals, persons with expertise in hospital administration, and persons with expertise in conducting community health needs assessments from the Providence Medical Centers in Los Angeles County. More information on the criteria used and identified priority areas will be presented later in this document.

Health indicators and trends

Social and Economic Factors

Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Our health is also determined in part by access to social and economic opportunities; the resources and support available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans generally are not as healthy as they could be.

Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as “place.” In addition to the more material attributes of “place,” the patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins. This section will detail indicators related to social and economic factors in our community that play a role in maintaining good health.

Education

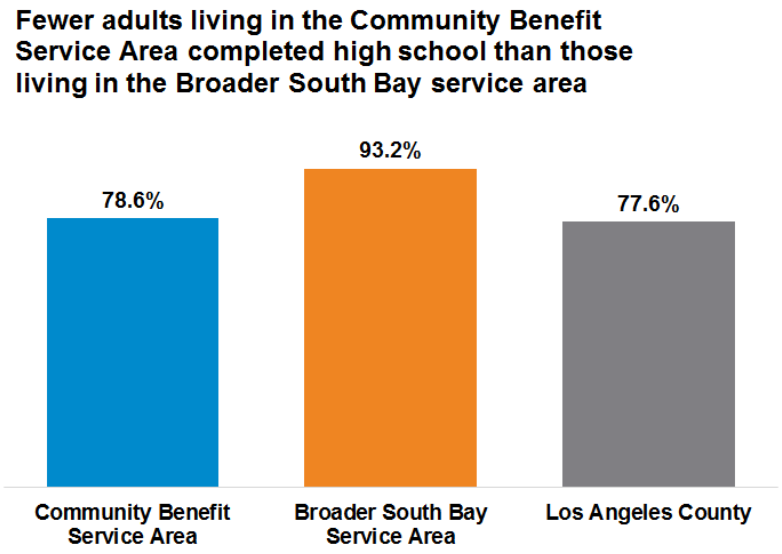
Education is an important factor in health status. Independent of its relation to behavior, education influences a person’s ability to access and understand health information. Education is also correlated with a host of preventable poor health outcomes including increased rates of childhood illness, respiratory illness, renal and liver disease, and diabetes, to name a few. Higher educational levels are associated with lower morbidity and mortality.

Beginning early is particularly important, because the early years provide a window of opportunity to shape a child’s brain during the most rapid period of development. Study after study proves that smart investments made in the early years can lead to profoundly better outcomes for our children, families, and economy. In fact, the National Center for Education Statistics found that children who are read to more frequently at home recognized all of the letters of the alphabet compared to those who were read to less frequently. Children who were read to frequently were also more likely to count to 20 or higher, write their own names, and read or pretend to read. 39 percent of children age 0 to 5 years, living in the community beneift service area are read to daily by a parent or family member. In comparison, 80 percent of children living in the Broader South Bay Service Area and 56 percent of children in LA County are read to daily, at home.

39% *of children age 0 to 5 years, in the community benefit service area are read to daily by a parent or family member*

Graduation from high school is also associated with better health outcomes and lifetime earning potential. In the Community Benefit Service Area, fewer adults have completed high school than those living in the Broader South Bay service

area. In comparison to LA County, the rate for the completion was slightly higher.



Data Source: Core Health Indicators: Little Company of Mary Medical Center. Custom report of results from the Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

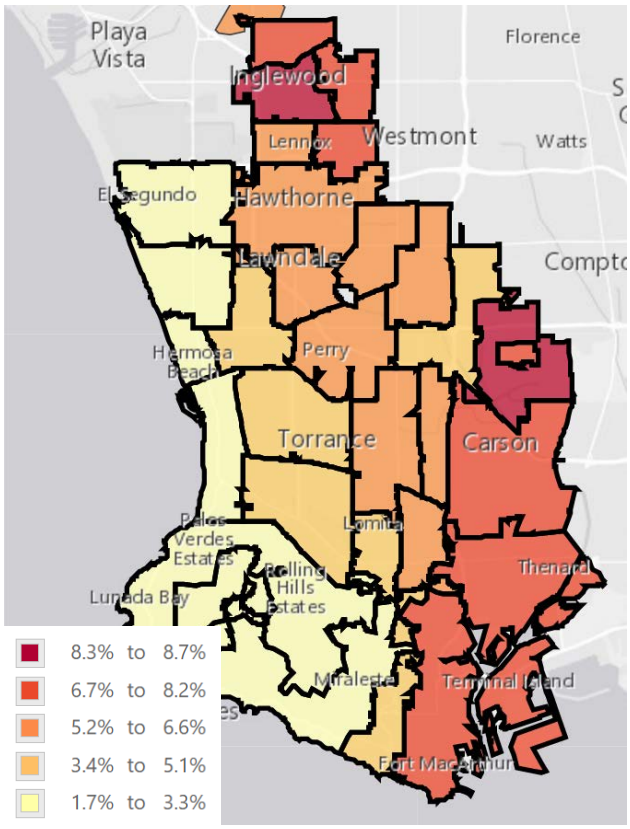
Employment

Addressing unemployment levels is important to community development, because unemployment can lead to financial instability and serve as a barrier to healthcare access and utilization. Many people secure health insurance through an employer; however, even with Medicaid expansion, without gainful employment some may not be able to afford deductibles certain office visits, procedures, or medications.

As of June 2016, the unemployment rate for LA County was 5.2 percent. This was slightly higher than the rate for the United States (5.1 percent) and slightly lower than the state (5.7 percent). Notably, unemployment estimates for LA County have steadily decreased in the past year from a high of 7.9 percent in January 2015, with the lowest rate (5.7 percent) occurring in December 2015. Analysis at the zip code level reveals deep pockets of unemployment throughout South Bay. For example, the unemployment rate is estimated to be as high as 8.6% in the Carson area (zip code 90746).

Equally important to health, are the concepts of underemployment and earning a living wage. Underemployment is the condition in which people in a labor force are employed at less than full-time or at inadequate jobs with respect to their training or economic needs. Being in a state of underemployment may force some workers to work multiple jobs and increased hours throughout the week, while still not receiving the full benefits associated with full-time employment. Workers in a state of underemployment may also suffer from lack of a living wage. Families working in low-wage jobs make insufficient income to live locally given the local cost of living. As such, a working family's income would not be high enough to maintain a normal standard of living.

Unemployment rate by zip code, 2016



Data Source: Esri, Inc. (2016). Map created using ArcGIS online. Data from US Census Bureau's American Community Survey 5-year estimates.

Analysis of median income demonstrates that having a job, is not sufficient to afford the cost of living and healthcare services. For example, the median income in the community benefit area is $49,596 annually and the average income is $64,810 annually. Using the living wage calculator from MIT, it was found that a household with one adult and one child would need to earn $56,264 to maintain a normal standard of living. For a family with one adult and three children this figure skyrockets to $81,203.

When looking at occupational trends across the Total Service Area, careers in management, business, science, and arts occupations are the most common type of employment for the overall population, men, and women. Within this category, management, business, and financial occupations are the most common for men (50.2 percent) and women (47.3 percent).

For women, careers in management, business, science, and arts, sales and office occupations, and service occupations are the most common. Within the sales and office occupational field, jobs within the office and administrative support field are most common (69.6 percent). Within the service occupational field, personal care and service occupations are the most common (31.1 percent).

For men, careers in management, business, science, and arts, sales and service occupations, and production, transportation, and material moving occupations are the most common. Within the services and sales occupational field, sales and related occupations are most common (56.1 percent). Within the production, transportation, and material moving occupational field,

production occupations are most common (43.1 percent).

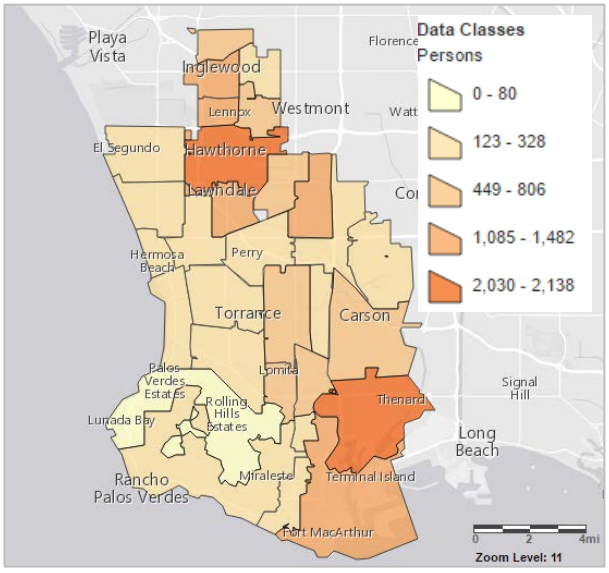
Occupational trends for the total service area

	Overall	Men	Women
1 Management, business, science, and arts occupations	40.40%	37.90%	43.84%
2 Service Occupations	14.78%	14.23%	15.52%
3 Sales and office occupations	24.88%	18.49%	33.64%
4 Natural resources, construction, and maintenance occupations	7.07%	11.79%	0.60%
5 Production, transportation, and material moving occupations	12.88%	17.60%	6.40%

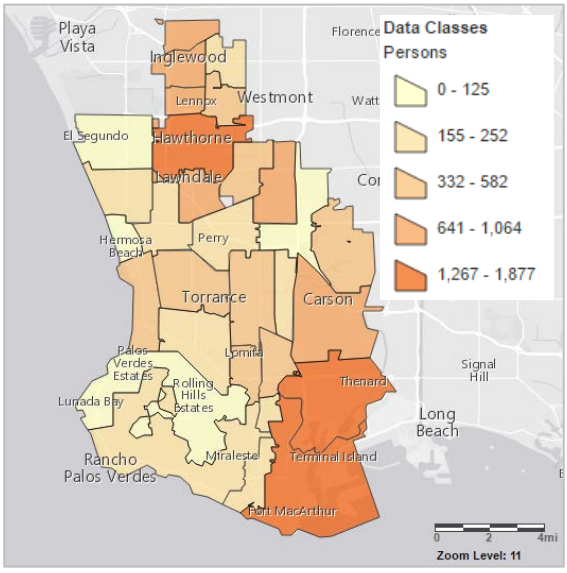
Data Source: US Census Bureau (2016). American Community Survey 5-year estimates, 2010-2014. Retrieved from https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

The next two maps depict adults throughout the Total Service Area who are employed full-time, yet still living below the federal poverty level. By gender, adult females have higher rates of being employed but living below the federal poverty level (26 percent) than males (17.3 percent).

Males with full-time jobs who are living below the federal poverty level



Females with full-time jobs who are living below the federal poverty level



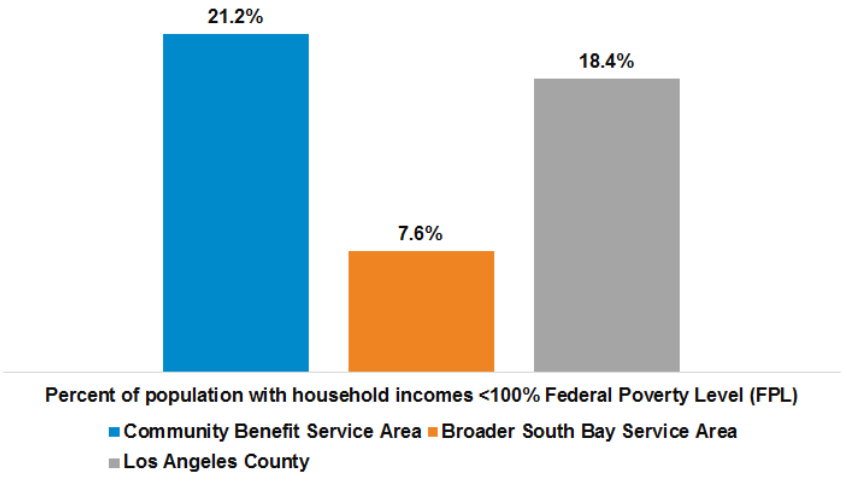
Data Source: US Census Bureau (2016). American Community Survey 5-year estimates, 2010-2014. Retrieved from https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

Poverty

Poverty is a particularly strong risk factor for disease and death, especially among children. Children who grow up in poverty are eight times more likely to die from homicide, five times more likely to have a physical or mental health problem, and twice as likely to be killed in an accident. Family poverty is relentlessly correlated with high rates of teenage pregnancy, failure to earn a high school diploma, and violent crimes.

21 percent of the population in the Community Benefit Service Area have household incomes that are living below the federal poverty level. In comparison, 8 percent of households in the Broader South Bay Service Area and 18 percent of households throughout LA County are living below the federal poverty level.

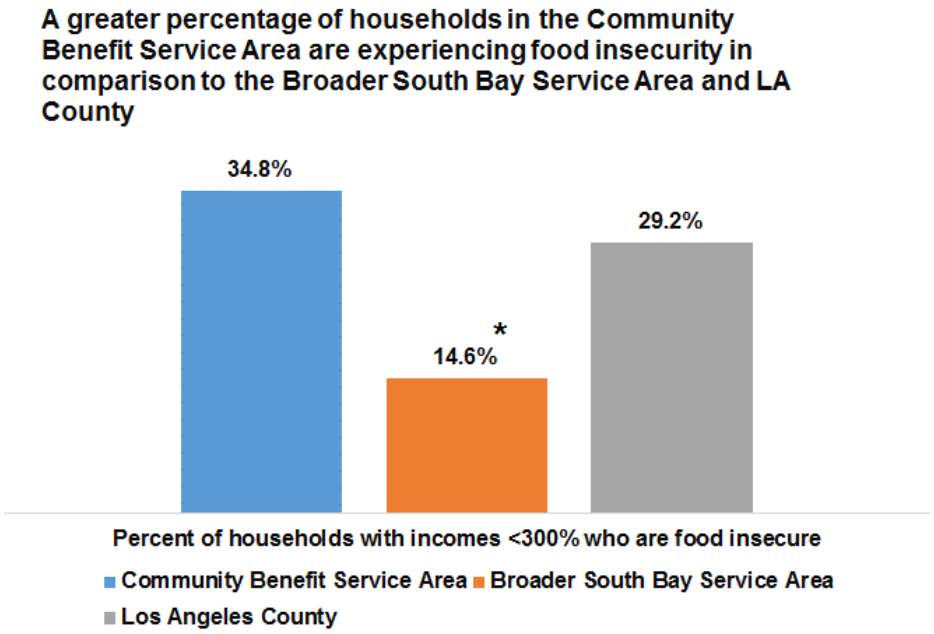
A greater percentage of households in the Community Benefit Service Area have household incomes that are living below the federal poverty level, in comparison to the Broader South Bay Service Area and LA County



Data Source: Core Health Indicators: Little Company of Mary Medical Center. Custom report of results from the Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

Food insecurity

Food security refers to access by all people, at all times, to enough food for an active, healthy life. Food insecurity is a lack of consistent access to food resulting in reduced quality, variety, or desirability of diet or multiple indications of disrupted eating patterns and reduced food intake. In the Community Benefit Service Area, about 35 percent of households with annual incomes less than 300 percent of the federal poverty level are food insecure. Comparatively, 15 percent[2] of households in the South Bay service area and 29 percent in LA County are experiencing food insecurity.

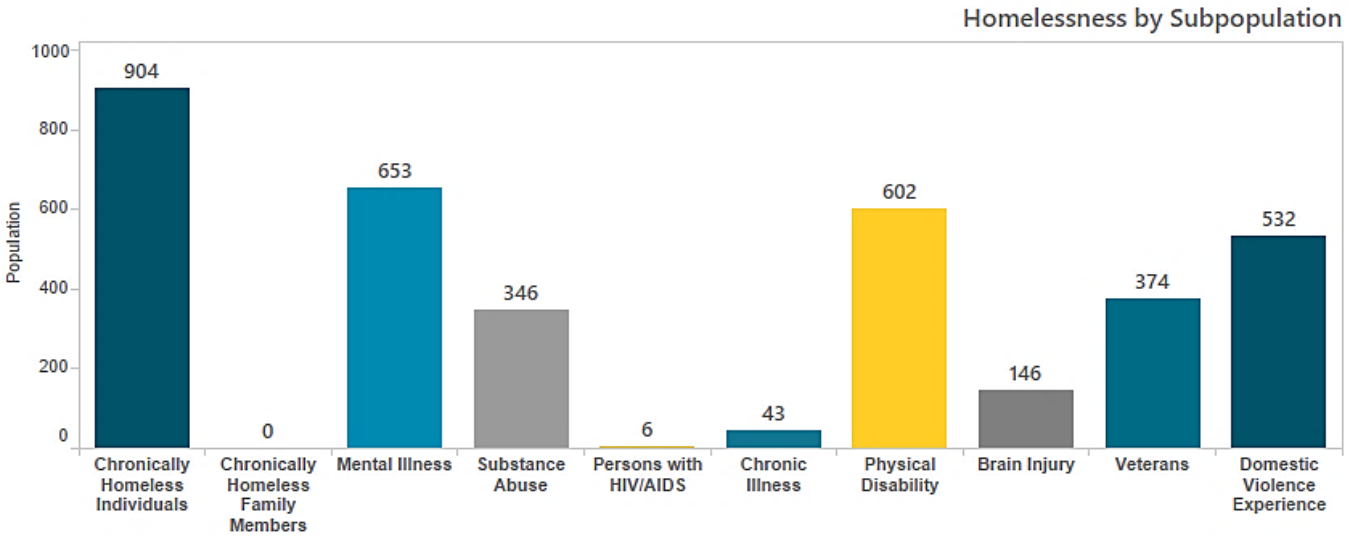


Data Source: Core Health Indicators: Little Company of Mary Medical Center. Custom report of results from the Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

Homelessness

A lack of affordable housing and the limited scale of housing assistance programs have contributed to the current housing crisis and to homelessness. The lack of affordable housing leads to high rent burdens (rents which absorb a high proportion of income), overcrowding, and substandard housing. These phenomena, in turn, have not only forced many people to become homeless, they have put a large and growing number of people at risk of becoming homeless. SPA 8 has the 5th largest homeless population among the eight SPAs with a growing population of those in need. From 2015 to 2016, the homeless population in SPA 8 increased by 22 percent. The 2016 point in time homelessness count estimates a total of 3,663 people who are homeless in South Bay. Of that 695 are sheltered and 2,968 are unsheltered. The next graph, “Homelessness by subpopulation” shows the various conditions and experiences of the homeless population in SPA 8.

[2] The Epidemiology Unit at the Los Angeles County Department of Public Health advises that this is a statistically unstable estimate that should be interpreted with caution.



Data Source: Los Angeles Homeless Services Authority. 2016 Greater Los Angeles Homeless Counts Results. Retrieved from https://www.lahsa.org/homeless-count/

When looking at the homeless population by various conditions and experiences, one finds that the largest portions suffer from chronic homelessness, mental illness, and/or have a physical disability. A smaller portion have experienced domestic violence/intimate partner violence or have a physical disability or are veterans.

Housing affordability

Recognizing that basic needs consume a higher fraction of income for lower income households, the US Department of Housing and Urban Development uses a definition of affordability that applies specifically to households with incomes at or below 80 percent of the area median family income. It currently calls housing affordable if housing for that income group costs no more than 30 percent of the household's income. Families with cost burden may have difficulty affording necessities such as food, clothing, transportation, and medical care.

In the Community Benefit Service Area, 51.6 percent of households spend 30 percent or more of their income on housing. In comparison, 39.8 percent of households in the Broader South Bay Service Area and 49.9 percent of households in Los Angeles County are experiencing housing burden.

The average rent for an apartment in Los Angeles County is about $ 1,728 per month. A working family needs to earn nearly $33 per hour – or $69,120 per year – to afford the average rent in Los Angeles. At $10.50 per hour, one minimum wage worker supporting a family would have to work 127 hours per week to afford the average 2-bedroom, 1-bathroom rent. With an annual median renter household income of $39,081, families in the region are unable to afford current rental pricing and are doubling up or becoming homeless.

Home prices in several traditionally working-class cities in Los Angeles County have risen dramatically in the past year. Home prices in the South Bay and adjacent communities have increased by 13 percent in Gardena, 25 percent in Lynwood and 14 percent in Compton. In April 2016, the median-priced single family home in Los Angeles County sold for the approximately $520,000. The monthly mortgage payment required to buy the median-priced Los Angeles home is $3,532 per month. A family would need to earn $128,443 per year to support this mortgage, assuming they spend no more than 33 percent of the family's income on housing.

Health system

Birth

Rate of births to teens are an indication of population growth and demand on a community's existing resources, infrastructure, schools, and the healthcare system/services. It is critical to understand current birth trends to ensure adequate availability of needed resources, particularly among low-income families and young mothers. This rate is calculated by dividing total number of births in a given year by the total population, in this case teenage girls age 15 to 19 years of age. The Community Benefit Service Area has a much higher teen birth rate than both the Broader South Bay Service Area and LA County.

Birth indicators for Community Benefit Service Area, Broader South Bay Service Area, and LA County

	CB	Broader South Bay	LA County
Rate of births (per 1,000 females) to teens	58.8	19.5	53.4
Percent of low birth weight (<2,500 grams) births (per 100 live births)	7%	6%	6.9%
Infant death rate	5.8	3.1	4.4
Children who were exclusively breastfed for at least 3 months (0-2)	29%	57%	38%

Data Source: Core Health Indicators: Little Company of Mary Medical Center. Custom report of results from the Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

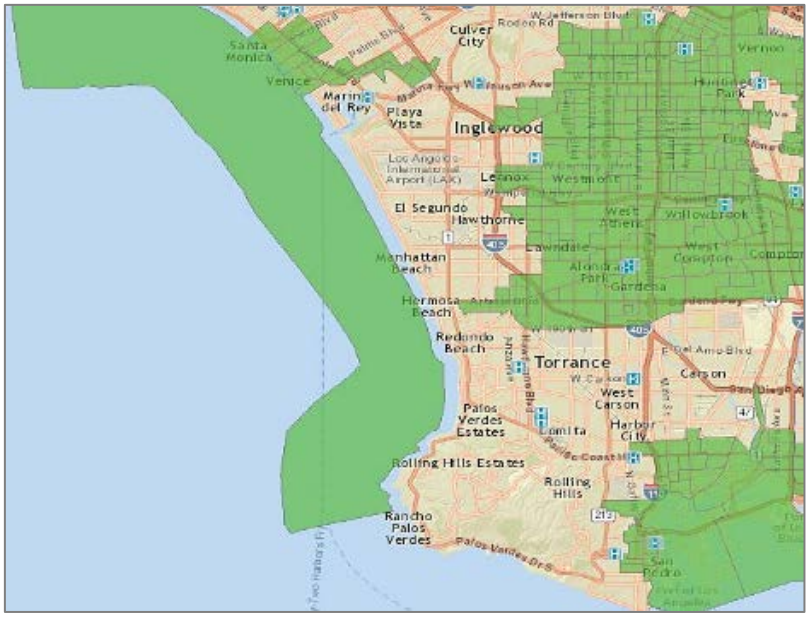
Low birth weight is indicative of the general health of newborns and often a key determinant of survival, health, and development. Understanding such data is critical as infants born at low birth weights are at a heightened risk of complications, including infections, neurological disorders, Sudden Infant Death Syndrome, breathing problems, learning disabilities, and even chronic diseases. The Healthy People 2020 goal is for 7.8 percent or less of infants to be born with weights below 2,500 grams. All three areas of comparison meet this goal. Healthy People 2020 also strives for 95 percent of all infants to be breastfed exclusively for the first six months. All three areas fell short of this goal within the first three months.

Finally, the infant mortality rate (IMR) is critical as it is indicative of the existence of broader issues pertaining to access to care and maternal child health. Such rates can further provide us metrics of community health outcomes and areas of needed services and interventions. The infant mortality rate in the community beneftit area is nearly twice that of the Broader South Bay Service Area.

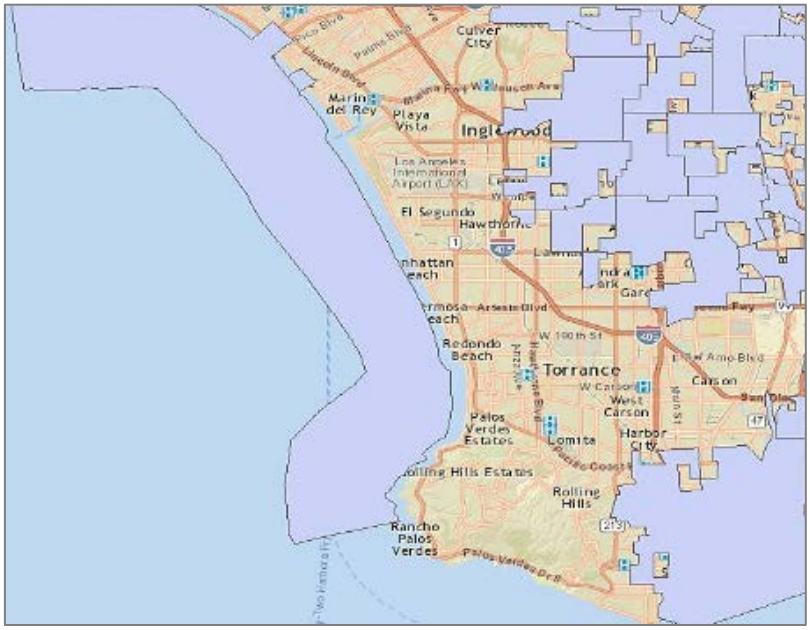
Health professional shortage areas

A health professional shortage area is a geographic area, population group, or health care facility that has been designated by the Federal government as having a shortage of health professionals. There are three categories of HPSAs: primary care (shortage of primary care clinicians), dental (shortage of oral health professionals), and mental health (shortage of mental health professionals). The South Bay area around the Los Angeles Port (Wilmington and San Pedro-90731) and the communities on the northeastern boundary of the Total Service Area (Inglewood, Hawthorne, Lawndale and Gardena) are most affected by a shortage of primary care health professionals and are defined as medically underserved populations or areas.

Primary care health professional shortage area



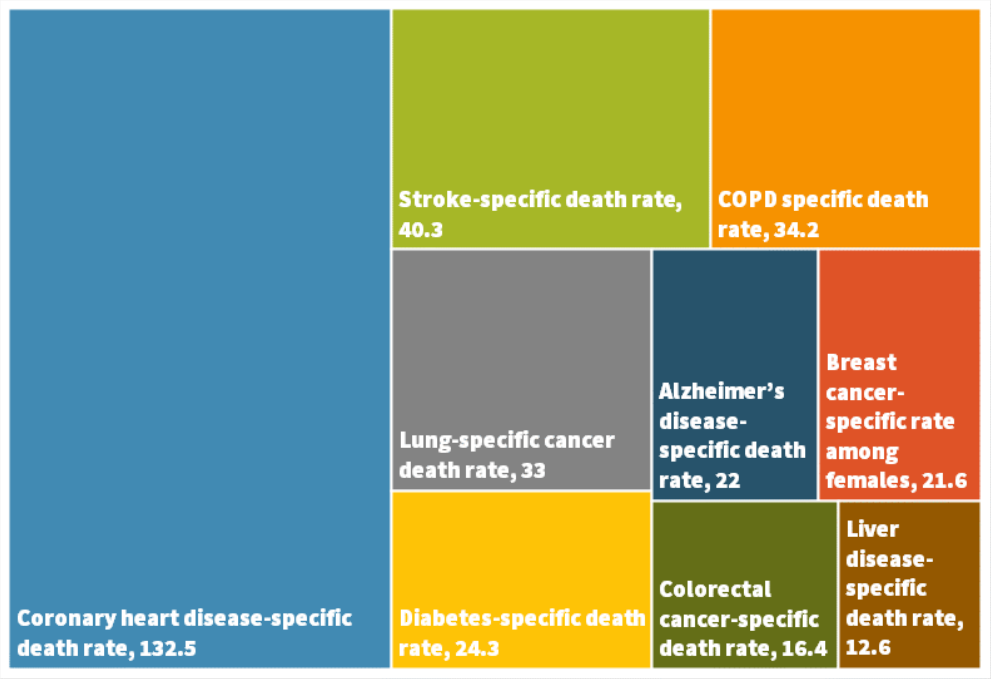
Medically underserved population/area



Data Source: Health Resources and Services Administration (2016). Data warehouse, map tool. Retrieved from http://datawarehouse.hrsa.gov/Tools/MapTool.aspx?tl=HPSA&gt=State&cd=&dp=

Leading causes of death

The leading causes of death in the United States are overwhelmingly the result of chronic and preventable diseases. The Community Benefit Service Area had lower mortality rates than the Broader South Bay Service Area for Alzheimer's Disease and higher mortality rates for all other causes listed in the figure below. For comparison, a table is also provided with rates for the Broader South Bay Service Area and Los Angeles County.



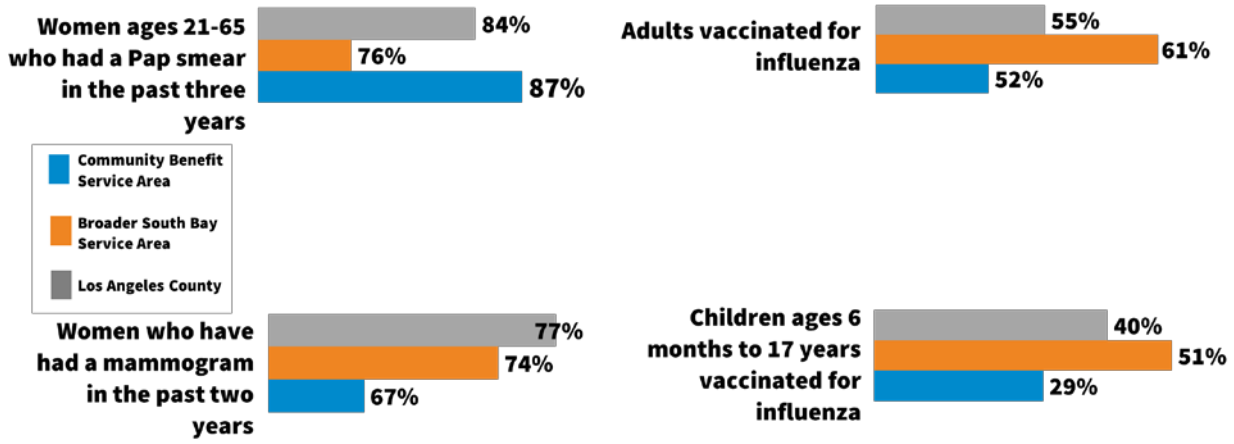
Leading Causes of Death	Broader South Bay Service Area	Los Angeles County
Alzheimer's disease-specific death rate (per 100,000 population)	26.2	25.1
Breast cancer-specific death rate among females (per 100,000 females)	19.3	20.5
Colorectal cancer-specific death rate (per 100,000 population)	11.7	13.8
COPD specific mortality rate (per 100,000 population)	28.1	29.2
Coronary heart disease-specific death rate (per 100,000 population population)	99.9	116.7
Diabetes-specific death rate (per 100,000 population)	15.5	21.9
Liver disease-specific death rate (per 100,000 population)	8.3	12.8
Lung-specific cancer death rate (per 100,000 population)	24.5	27.5
Stroke-specific death rate (per 100,000 population)	29.6	32.8

Data Source: Core Health Indicators: Little Company of Mary Medical Center. Custom report of results from the Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

Public Health and Prevention

Preventive practices

Access to primary care prevention care and screenings can help individuals treat and manage chronic diseases at early onset and prevent complications. Successfully managing risk factors for chronic diseases is important for preventing unnecessary hospitalizations. The next figure shows rates for preventive screenings for women and influenza vaccination for adults and children. For the four indicators presented, the Community Benefit Service Area had higher percentages of women ages 21-65 who had a Pap smear in the past three years. Higher percentages of adults and children in the Broader South Bay Service Area have received vaccination for influenza in the past year.



Data Source: Core Health Indicators: Little Company of Mary Medical Center. Custom report of results from the Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

Alcohol, drug, and tobacco use

Alcohol and/or substance abuse has a major impact on individuals, families and communities. The effects of abuse are cumulative, contributing to costly social, physical, mental, and public health problems. Binge drinking is the most common pattern of excessive alcohol use in the United States. The National Institute on Alcohol Abuse and Alcoholism defines binge drinking as a pattern of drinking that brings a person's blood alcohol concentration (BAC) to 0.08 percent or above. For men, this typically occurs with 5 or more drinks in about 2 hours; and for women, 4 or more drinks, in about 2 hours.

20 percent of adults living in the Community Benefit Service Area reported binge drinking in the past 30 days when surveyed by the LA County Health Survey. In comparison, 16 percent of adults in the Broader South Bay Service Area and Los Angeles County reported engaging in binge drinking.

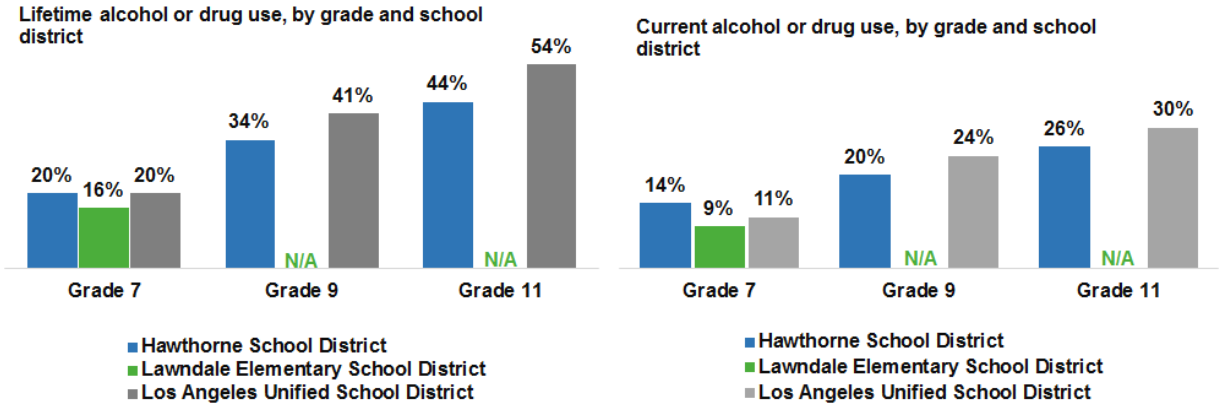
Additionally, 16 percent of adults living in the Community Benefit Service Area reported smoking cigarettes. Comparatively, 13 percent of adults in the Broader South Bay Service Area and LA County reported current smoking.

	Grade 5 (percent); Hawthorne School District	Grade 5 (percent); Lawndale Elementary School District
Alcohol, one or two sips	11	14
Alcohol, a full glass	1	0
Inhalants (to get high)	4	1
Marijuana	1	0
None of the above	86	84
Any of the above	14	16

Data Sources: 1). Hawthorne School District. California Healthy Kids Survey, 2014-15: Main Report. San Francisco: WestEd Health & Human Development Program for the California Department of Education. 2). Lawndale Elementary School District. California Healthy Kids Survey, 2014-15: Main Report. San Francisco: WestEd Health & Human Development Program for the California Department of Education.

Per estimates from the California Healthy Youth Survey, the majority of grade 5 students surveyed reported not engaging in alcohol, inhalant, or marijuana used. (Hawthorne School District and Lawndale Elementary School District) The table to the right provides additional information on alcohol or drug use among grade 5 students surveyed.

Alcohol and substance use among adolescents and teens



Data Sources: 1). Hawthorne School District. California Healthy Kids Survey, 2014-15: Main Report. San Francisco: WestEd Health & Human Development Program for the California Department of Education.
2). Lawndale Elementary School District. California Healthy Kids Survey, 2014-15: Main Report. San Francisco: WestEd Health & Human Development Program for the California Department of Education.
3). Los Angeles Unified School District. California Healthy Kids Survey, 2014-15: Main Report. San Francisco: WestEd Health & Human Development Program for the California Department of Education.

Injury

Injuries and violence affect everyone, regardless of age, race, or economic status. In the first half of life, more Americans die from violence and injuries — such as motor vehicle crashes, falls, or homicides — than from any other cause, including cancer, HIV, or the flu. The CDC estimates the total lifetime medical and work loss costs of injuries and violence in the United States was $671 billion in 2013. The costs associated with fatal injuries was $214 billion while nonfatal injuries accounted for over $457 billion. Almost double the amount of adults living in the Community Benefit Service Area have experienced physical or intimate partner violence than those in the South Bay service area (17 percent in comparison to 9 percent). 25 percent of adults living in the Community Benefit Service Area age 65 and older have fallen in the past year. In comparison, 27 percent in the Broader South Bay Service Area and Los Angeles county fell in the past year.

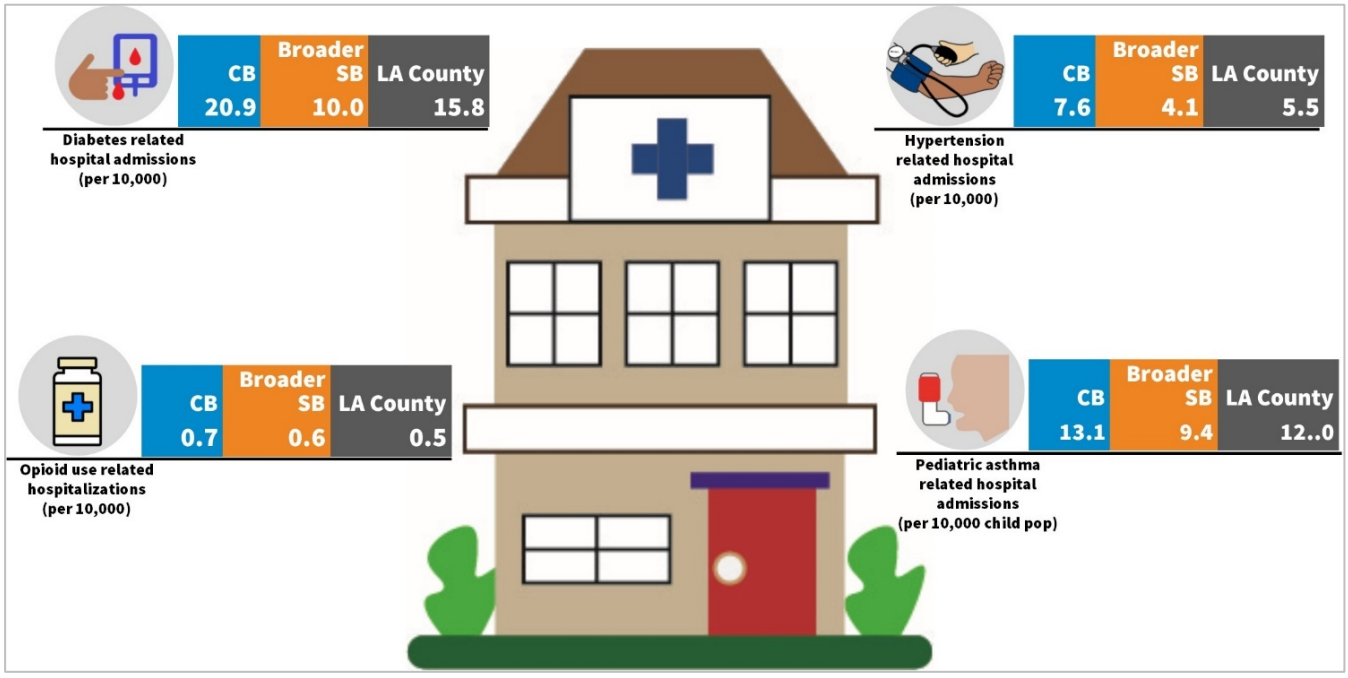
Chronic disease

Chronic diseases and conditions—such as heart disease, stroke, cancer, type 2 diabetes, obesity, and arthritis—are among the most common, costly, and preventable of all health problems. The Centers for Disease Control and Prevention estimate that as of 2012, about half of all adults—117 million people—had one or more chronic health conditions and one of four adults had two or more chronic health conditions. Additionally, seven of the top 10 causes of death in 2010 were chronic diseases. Two of these chronic diseases—heart disease and cancer—together accounted for nearly 48 percent of all deaths. Of note, there is a much higher rate of diabetes-related admissions in the Community Benefit Service Area in comparison to other areas, however, lower percent of people have been diagnosed, suggesting a lack of access to or use of primary care or screening services (see preceding table).

	CB	Broader South Bay	Los Angeles County
Adults ever diagnosed with diabetes	8%	10%	10%
Adults ever diagnosed with hypertension	18%	25%	24%

Data Source: Core Health Indicators: Little Company of Mary Medical Center. Custom report of results from the Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

Rates of preventable hospitalizations per 10,000 population



Data Source: Core Health Indicators: Little Company of Mary Medical Center. Custom report of results from the Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

Sexually transmitted infections

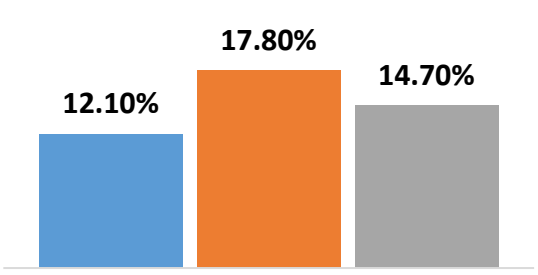
Sexually transmitted infections (STIs) are infections that are passed from one person to another through sexual contact. The causes of STIs are bacteria, parasites, yeast, and viruses. There are more than 20 types of STIs, including chlamydia, genital herpes, gonorrhea, HIV/AIDS, HPV, syphilis, and trichomoniasis. Most STIs affect both men and women, but in many cases the health problems they cause can be more severe for women. If a pregnant woman has an STI, it can cause serious health problems for the baby. Rates for sexually transmitted infections are significantly higher (in two cases) in the Community Benefit Service Area in comparison to the Broader South Bay Service Area and Los Angeles County.

	CB	Broader South Bay	Los Angeles County
Incidence of HIV among adolescents and adults (annual new cases per 100,000 population)	20.5	5.6	20.7
Incidence of primary and secondary syphilis (annual new cases per 100,000 population)	10.7	6.5	14.3
Incidence of gonorrhea (annual new cases per 100,000 population)	177.5	79.5	165.1
Incidence of chlamydia (annual new cases per 100,000 population)	622.6	298.9	532.1

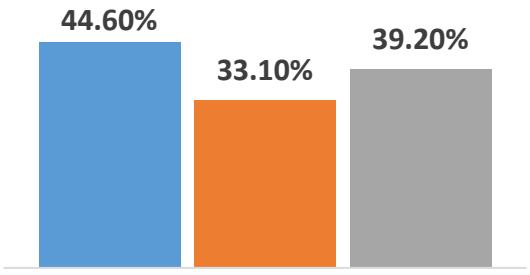
Data Source: Core Health Indicators: Little Company of Mary Medical Center. Custom report of results from the Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

Physical activity and nutrition

Making healthy food choices is important to losing or maintaining weight and fueling physical activity. About 15 percent of children and 34 percent of adults living in the community benefit area are currently meeting aerobic and muscle-strengthening exercise guidelines per week. In comparison, about 22 percent of children and about 29 percent of adults living in the Broader



Adults who consume five or more servings of fruits & vegetables a day



Children who drink at least one soda or sweetened drink a day

Community Benefit Service Area
Broader South Bay Service Area
Los Angeles County

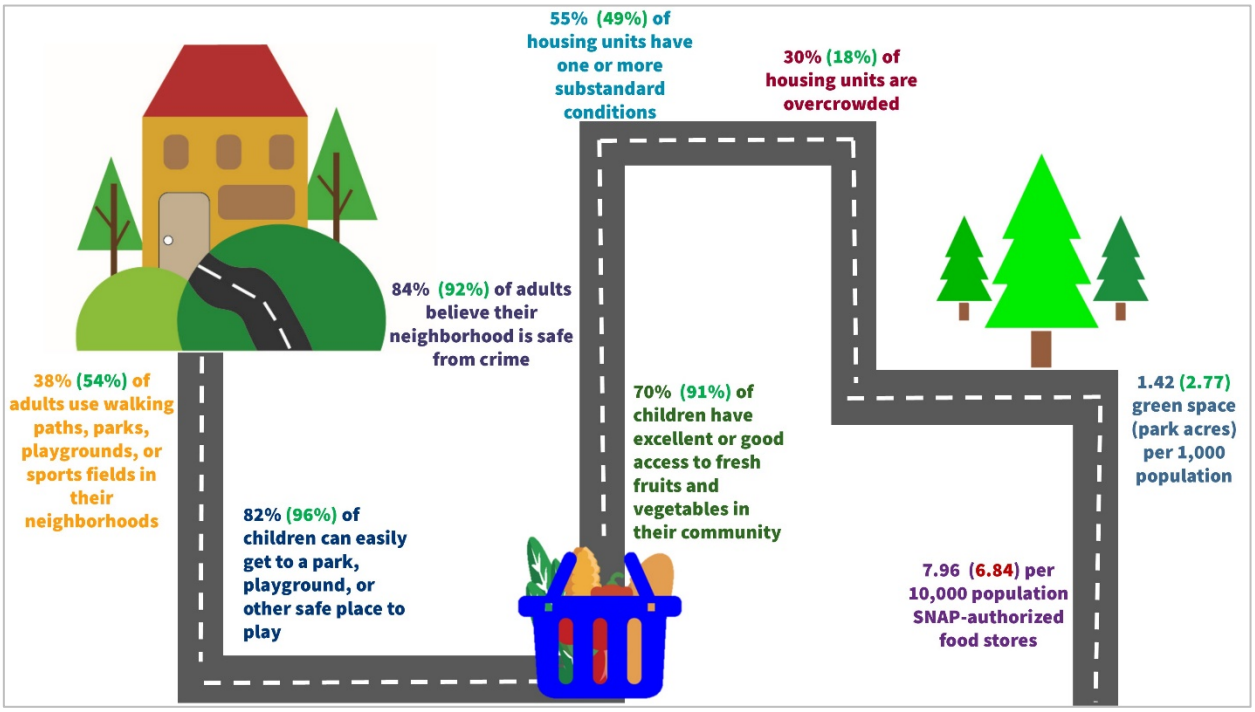
Data Source: Core Health Indicators: Little Company of Mary Medical Center. Custom report of results from the Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

South Bay Service Area are currently meeting guidelines. The Community Benefit Service Area also has a lower percentage of adults consuming five or more fruits and vegetables per day and a higher perentage of children who drink at least one soda per day than the Broader Service Bay Service Area and LA County.

Physical environment

We interact with the environment constantly, as such, our physical environment can affect our health behaviors, quality of life, years of healthy life lived, and health disparities. The World Health Organization (WHO) defines environment, as it relates to health, as “all the physical, chemical, and biological factors external to a person, and all the related behaviors.” This can include air quality and exposure to toxic substances, as well as, factors such as the built environment and housing.

Physical Environment Indicators



Note: Percentages in parentheses are for the Broader South Bay service area. Green coloring indicates a better outcome on the indicator in comparison to the CBSA. Red coloring indicates a worse outcome. Data Source: Core Health Indicators: Little Company of Mary Medical Center. Custom report of results from the Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department. Custom community health needs assessment report courtesy of Community Commons, www.communitycommons.org.

In comparison to the figures presented above, those living in the Broader South Bay Service Area reported the following:

- 54 percent of adults use walking paths
- 96 percent of children can get to park
- 92 percent of adults believe neighborhood is safe
- 49 percent of housing units have substandard conditions. Substandard conditions include at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities

- 91 percent of children have excellent or good access to fresh fruits and vegetables in their community
- 18 percent of housing units are overcrowded
- 2.77 green space (park acres) per 1,000 population
- 6.84 per 10,000 SNAP authorized stores (Of note, this is less than the Community Benefit Service Area and reflective of the more “upscale” nature of grocery offerings)

Primary data

A CHNA would not be complete without hearing from the population of concern; the local community. Those chosen to provide input, represent the diversity of our community and those who are medically underserved or low-income minority populations. As professionals at a health institution, we reside in the unique position, which allows for the modeling of health programming, initiatives, and agendas capable of addressing local social determinants and inequalities in our surrounding community. Through inclusion of our community partners and end-users we intend to build upon the work already done, refine or develop new programming to meet emerging needs, and support our partners in creating a healthier community.

Overview

From July to September of 2016, on behalf of PLCM, HC^2 Strategies, Inc. conducted multiple focus groups, key informant interviews, and an internet based survey for community partners. 84 people were surveyed to obtain input from the community in the form of 14 key informant interviews, five focus groups (46 participants), and 24 people responded to the online community based organization survey.

Key informant interviews comprised key leaders in our community from an array of current partner agencies, including social service agencies, local government, funders, not-for-profits, researchers, and public health practitioners. Participants in the online community based organization survey included organizations that have a current working relationship with PLCM and serve the broader social and health needs in our community, including but not limited to housing, homelessness, asthma, and children’s health. Participants had the opportunity to respond by either an online survey or paper copy. Participants in the focus groups were end-users who are currently receiving programming and services at PLCM. A full description of each focus group can be found in the table below.

Focus Group Name	Number of participants	Description	Location	Language
CHAT Program - July 20	11	Participants of coping skills and resilience workshop series	St. Joseph's Catholic Church. 11901 Acacia Ave, Hawthorne, CA 90250	Spanish
CHAT Program - August 6	6	Participants of coping skills and resilience workshop series	470 N Hawaiian Avenue, Wilmington CA	Spanish
Wellness Center - August 10	11	Community members who have used the Wellness Center in Wilmington	470 N Hawaiian Avenue, Wilmington CA	Spanish
Insurance Assistance Program - August 6	3	Clients who were assisted with health insurance enrollment	470 N Hawaiian Avenue, Wilmington CA	Spanish
Welcome Baby (Early Childhood Development) - August 10	15	Mothers who have received services from Welcome Baby	470 N Hawaiian Avenue, Wilmington CA	Spanish/ English

Objectives

Our main objective for each conversation and survey was to discover strategies in which PLCM can better collaborate to serve the needs of our community. To ensure more rich data collection, a technique was implemented by which three common questions were asked of all key informants and focus group participants and three (or four) tailored questions were asked depending on the focus group type. The entire set of questions remained constant for all key informant interviews. The goal being to find commonality in themes across all participants and dive deeper in the nuance of each focus group and participant's specific needs. Questions asked of all focus group participants and key informants included:

- What is your vision of a healthy community?
- From your perspective, what are the biggest health and social issues in your community? Why? Any populations disproportionately affected?
- What are the barriers to accessing resources in your community? What resources are missing?

PLCM also conducted community based organization surveys that asked about health status, health/social issues, and service needs in our community. The full list of questions used for each group type (focus group, key informant, CBO) can be found later, in the appendix of this document.

Findings by Themes

The codebooks for the focus groups, key informant interviews and surveys were instrumental in combining themes for comparison and analysis. The three sources were synchronized to provide a richer analysis when applicable. In addition, the quantitative data from the surveys were used to support the qualitative data for a more comprehensive analysis where applicable.

Background and Service Area

The focus groups started with an introduction of the participants, which included city or town of residence and one things that causes pride in the community. Many participants were from Wilmington, Hawthorne and Torrance. Additional cities were Los Angeles, Lawndale, and Inglewood. The main themes surrounding the pride for the community were focused on the people and programs available. Eighteen respondents referred to the availability of the programs offered including nutrition, diabetes, smoking cessation, programs for kids, gardening, communication, and education. People was a commonly mentioned theme, such as 'everyone knows one another' and supports one another, people are friendly, diverse cultures, and organizations and resources are willing to help people in need. Additionally, changes in parks and recreation, everything in walking distance, and safety were also mentioned as points of community pride.

The key informant interviews were similar in response to the focus groups. Most of the respondents focused on services in Hawthorne, South Bay, and Los Angeles County. In addition, San Pedro, Wilmington, Gardena, Inglewood, Lennox, Lawndale, and SPA 7 and SPA 8 were also mentioned. Within the key informant group, most were directors of their organizations and programs and leaders in education such as superintendent and adjunct professor.
The survey responses included many of the same service areas and respondents as the focus groups and key informant interviews. The main responses were provided by educators and health program leaders. The areas of service most mentioned were Wilmington and Hawthorne. Additionally, mentioned were Lawndale, Lennox, Inglewood, Long Beach, Lakewood, San Pedro, SPA 8, and surrounding areas.

Vision

The main themes surrounding the vision of a healthy community were programs for youth and parent involvement. The programs for children were among the most mentioned responses regarding obesity and nutrition classes, classes where parents could join, sports programs for children, and inexpensive exercise programs for families. Parental involvement was focused largely on male involvement in education and support groups. Courses on pregnancy, drug prevention, and mental health services were mentioned as healthy community components. In addition, a community garden, less smoke shops, safety, unity, and specialists for educating children were mentioned.

> *Sometimes they are also painting graffiti in the community. I would want someone that would educate them or teach them which areas are fine to paint on. We have to be the difference. We need different things that encourage these young individuals.*
>
> *Many of those young individuals have a lot of necessities because mom and dad work. And sometimes the children are alone. They need love, conversations with others, and share with others. Those programs would help them a lot. They would like the group because they will be able to share with others. Today we will learn this, we will learn that.*
>
> *For example, create more programs of football, volleyball, support children to go out to play, and so that they are not alone in their houses locked in. Have more places that offer information regarding nutrition.*

Contrary to the main themes of the focus groups, the key informant interview responses were highly responsive towards having opportunities for fairness, success, advancement, access, and racial and income equity. A healthy community in the responses of the key informants also

focused on lower stress, increased safety, collaboration, utilization of services, and public health initiatives surrounding exercise and health.

> *A healthy community, I think, my vision is one that has all service providers working together towards the common goal of the community that's been identified through a series of studies or you know client feedback or patient feedback. But one that addresses the need and the problem of the community, and by addressing working in a collaborative effort to work towards that goal and partnership anywhere from health services, to housing, to mental health, to food, and just anything that you could imagine that is a need for the community. And pulling in child care, so one that has all of these different resources all of these different partners working to, for the better good of the community.*

> *An integrated approach to health and wellness and also for individuals being better educated about their own health and what they can do to stay healthy so that they take responsibility for their own health. The community needs to have ongoing education on the different chronic disease to prevent and manage better. To reduce the rate of diabetes among Latinos especially. My mother had diabetes. Integrated approach includes not only physical health but mental and spiritual health. Not just focusing in one area. Many times people may be aware of health conditions to have a healthier lifestyle sometimes mentally they are not ready to make those changes. Dealing with depression with other issues. The spiritual plays a role with the motivation. Feeling empowered that you have more control over how you function day to day. Another factor in the spiritual where catholic charities plays a role is with economics. Especially in spa 8 there is less financial resources – transportation, lack of ability to buy quality food, some of may not have health insurance or language barriers. Factor to reach out to part of the education. Identify additional resources to assist them.*

Many survey respondents rated the health of the community as fair (14 out of 24), followed by poor (4 out of 24). Only one respondent felt that the health of their community was good.

Top Issues

The top health and social issues among the focus groups, interviews, and surveys varied greatly. However, the commonly mentioned among the three were:

- Poverty
- Violence
- Mental health
- Obesity and diabetes among children
- Access to health care and resources
- Homelessness

The focus groups mentioned violence as the top health and social issue. This issue was followed by low income, mental health counseling, and obesity and diabetes. A few of the respondents also discussed dental, alcohol abuse, affordable extra-curricular activities, bilingual services, and cleaner streets.

Violence. It can be said that this is a social problem. There is a lot of gangs in Wilmington, one asks, "why is this?" But we can say it comes from the family, it starts from the family. Then the kids make bad decisions. There are families that are dysfunctional. Sometimes the mom isn't there; sometimes the dad isn't there. And they get lost. But overall, it is the gangs in Wilmington.

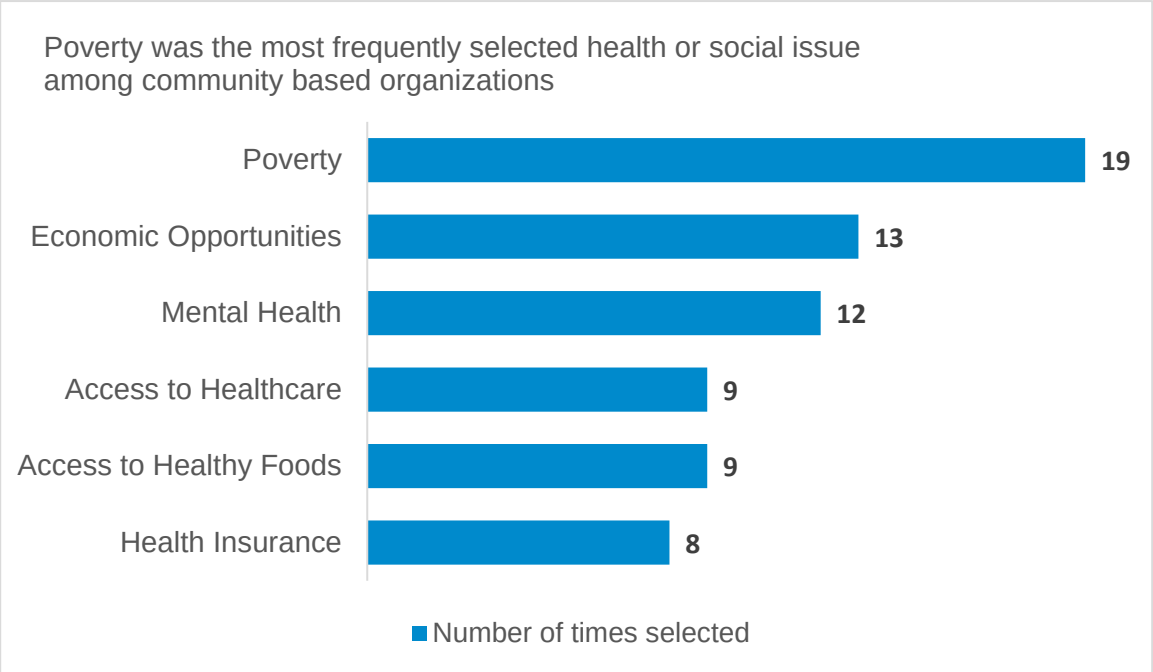
The key informant interviews illuminated many issues related to homelessness, child abuse, lack of resources, unemployment, economic and health disparities, chronic disease and lack of physical activity. The key informant interviews and surveys also pointed out the lack of affordable and safe housing as a major issue in the community. Similar to the focus groups, poverty, violence and mental health were frequently mentioned.

One lack of resource that comes up often is high quality child care and preschool. So that's a huge thing for families because it becomes intertwined with other issues. If you can't find a safe and healthy place for your child to be, it's hard to maintain employment. And then if you can't maintain employment, then you know your housing your basic needs are threatened. So, those are the things that come up with us, come up in our world often. And similarly with child abuse, child abuse being a cyclical problem where when someone has experienced child abuse they tend to be more likely to experience interpersonal violence later in their lives and maybe even be the perpetrator of interpersonal violence. So that becomes cyclical and has a significant impact on communities. And children who are abused have challenges in terms of their ability to learn and, you know, we then know now that people that aren't successful in education are an impact on a community's health because then they're not able to contribute into their community in the same way others are able to.

Mental health is always a big need. Basic health services for those who lack insurance, can't afford insurance or don't have insurance. The dental aspect of it. I think the food insecurity. And you know it all comes together, because what we find is that if someone is in a homeless situation just from our perspective, they're usually missing those key things that makes for a healthy environment that allows for a kid to thrive in school and to focus and pay attention. So if they're hungry or if they have a tooth ache, or if they have some type of health issue if it's not being addressed if they don't have the resources to get it then it becomes a bigger problem.

The surveys were given options for the top 5 health issues in the community. Although the top 5 are shown in the table below, all responses were selected at least once. The options were: Access to health care, Health education and outreach, Help navigating assistance programs, Poverty, Education, Homelessness, Food insecurity, Health insurance, Dental care, Mental health services (including substance abuse services), Pediatric care, Geriatric care, Access to healthy foods, Early childhood education/daycare, Economic opportunities and job growth, and Other (please specify).

Societal Factors and Needs



This section of societal factors and needs included the questions regarding positive and negative factors of the community, societal factors which have influence on the issues in the community, physical and emotional needs to be fit, and how usual needs are met along with barriers and facilitators to meeting needs.

The most frequently mentioned societal factors by the key informants were issues around job availability, immigration, poverty or economic issues, and racism or discrimination. Many key informants felt that safety, housing, food availability, and having a healthy environment were also factors. Low birth weight, behavioral health, asthma from pollution, health literacy by English Language Learners, education, and obesity and diabetes were also factors.

Part of it is, the housing crisis. That it's not just, people not having enough money but it's the whole system of like the market driven housing system that we have. Not even market driven, its market controlled. And I don't think we have, I've not seen any policy maker that has policies that are going to make a real difference in affordable housing. Because, you're basically rearranging the chairs on the sinking Titanic. There's going to be a small shifts here or there, we're going to build some affordable units, or when we mandate new developments make sure a certain number of units are affordable; but that's not changing the fundamentals and it's not making a big measurable difference in the percent of people who can afford housing.

Completely societal. Nationally, there's a conversation about certain communities that have access to Whole Foods or those types of things and communities that are bombarded with fast food and other types of things that we often see as well as the economic factors that allow someone to go out and shop for produce versus McDonald's drive through or something. Those are all societal, as well as the safety of the neighborhood can influence the ability for students to be able to be outside and be physically active.

Psychological, the fact that many families have suffered extreme poverty, lack of support, education, support. High rates of domestic violence. And the resources for individuals that are in the households are limited, very limited.

In addition to questioning about a healthy community, focus group participants were asked what was needed to be physically and mentally or emotionally fit. The most frequently mentioned responses were mental health services access and needs, health, and God. Responses related to mental health services included, resource access, tools to deal with emotions, self-esteem programs, and working together. Health included, nutrition, exercise, and yoga. Church and God was mentioned several times among the participants as a method of staying fit. Work was also mentioned as having the means to provide for self and children. Unity of all aspects of life and equilibrium was added by a few participants.

I also know someone close to me who just came recently and doesn't know anyone. She is very depressed. I told her where I go but she doesn't have a car, she doesn't have family, she doesn't have anything. I say, we really need it here, more than anything so that people, just like in my family, I tell my husband go because counseling can help him. But he says "No because I work, I don't have time." They can only do it in the afternoon. If there was mental health and emotional health, I would really like that.

The survey responses provided positive and negative aspects of the community. Positive aspects included, neighborhood and community spaces and programs such as sports, dancing, and life programs. One respondent gave examples of "*…our resident service program we provide monthly workshops, resident meetings, support groups, opportunities to volunteer and referral based services."* The negative aspects focused on air pollution, limited food choices, and safety concerns with crime as a factor at many community locations. Most of the respondents commented on the air quality of Wilmington area. Other aspects included bus routes and transportation issues, health education, education, housing issues, homelessness, poverty, and lack of access to healthcare.

Challenges

The focus group participants provided barriers and facilitators or resources to meeting the needs mentioned above. The top mentioned barriers were timing of programs and transportation and distance to programs. Other barriers included, need for expansion of

services, lack of cultural dancing classes, lack of occupational training, lack of communication and information, lack of counseling, and intimate partner violence.

> *A barrier would be that people are not too informed. For example, when I lost my medical insurance because I am over age, I didn't know what to do. I didn't know where to go. I didn't know whom to ask. I know that I have to look to find. But I couldn't find pamphlets or something that would say "we can help you here with your medical insurance." We can say that we need to create more medical centers that offer information.*

> *I think the barrier is that there are not enough places that speak in Spanish. And in this community, there are many Latino people. Most of the people who live in this community are Latinos.*

The common themes among the key informant interviews and focus groups had to do with economic and education factors. The most commonly mentioned challenges among the key informants were financial or economic issues related to healthcare and access to healthcare, followed by lack of resources, decriminalization, inclusion, obesity, asthma, transportation, language barriers, and gentrification.

> *I have to say, related to that the homeless issue. It's been growing and it's a huge priority for my boss. We're about 400 billion shy of providing the services we need, that's excluding capital. But it's just in terms of the gap we need to meet the growing, the social service need and number of homeless individuals. And of course, there's a huge correlation of homelessness and whether you're sick or compliant with whatever medication. I think another challenge is, it's nice to see the decriminalization of lower level non-violent offenses. But, if individuals are release without any money attached at all for social services, including job training, then they become homeless. And it just worsens the problem.*

> *Part of it is through community will. Ex: with HIV, we have the medication to keep people healthy and acquiring HIV. We can end HIV tomorrow if not for community and political will. Same with diabetes, meds, interventions, programs and yet we still have increasing diabetes. Can the communities move together and policy making bodies responsible for health be mobilized to stop this trend. Not lacking in technical and information but it's the movement solved.*

Affect

The focus groups suggested many affects when the needs of self, community, and family are not satisfied. These were grouped into negative and positive themes. The negative themes were loneliness, sadness, frustration, boredom, feelings of being locked in, stress, inability to get help, every aspect of life is affected and third parties.

> *Well I think that if we aren't well, then our family nor our community will be well*

> *What I understood is that there are ways for the community of people, and not just here, to have opportunities to socialize and share what causes joy for them, happiness, of making the community.*

Positive themes were given as examples or strategies for dealing with needs not being met, which included the meaning of community, satisfaction in life, praise, dancing, and spirituality.

> *I think that once you feel satisfied with your life, with what you do, and you feel productive, you feel calm with what you have accomplished, and you are at a stable level and have no need to be going up and down, your house is also more stable. At that point, you are able to place limits with everything in your family as you give the responsibilities that correspond to everyone of them, and you don't finish everything by yourself. I told them once at my house, my house there are four pillars. It is my husband, my kids, and I. We are four pillars in this house. If the four pillars are strong, and stable, our house will be fine. If one of the four pillars sinks, the house will sink because it will tip over. We have to try to be connected and I am aware that there are times where there are ups and downs. But I, as the principal person in the house, or a part of the house, if I am doing bad, then I will sink everyone else. If I wake up doing great, and tell them "let's go, the day has started" I can motivate them to do their things. We have to feel good but if we know that one isn't doing well, we have to get help. And we have to communicate with one and another. We also have to be positive. I know that we all pass through depression because things happen, but it is important to look for people close by and not lock ourselves in. Locking yourself in won't bring you the help you need. Get help and I will help.*

Populations

The top mentioned populations disproportionately affected by the needs in the community were Latino and African American. Probing further into the focus groups, lower income in displaced communities, mental health and substance abuse, and homeless were among the next highly mentioned populations. Other responses included the general population, parolees, LGBTQ, and Asian population due to low birth rates.

> *Working poor, obviously the Spanish speakers who haven't mastered the second language – English. Probably of school aged children mainly because they are in a position to have an impact to make decision for a family and don't have enough time to devote to this. Managing a family with numerous children, working, they don't have the resources to go to a training or class. That segment of a Spanish speaking population needs more support and understanding day to day stresses. Because of that, they don't have the ability to acquire what they need to make changes and they don't have the support. Day to day living issues, family issues, many of them don't have formal education either.*

Resources and Strategies

This section describes the resources and strategies participants feel are needed to satisfy the needs of the communities. The most commonly mentioned were opportunities to socialize, for both children and adults, cultural activities to supplement spiritual activities, different ways to promote activities, and mental health services. Many classes were mentioned as strategies to address the needs. These included, classes to deal with problematic people, taking action, mental counseling, programs for men, computer classes, English classes with daycare provided, GED, and woman leagues. In addition, transportation and schedules more suitable for working families are ways to promote these classes success.

The focus group respondents mentioned Mental Health LA County as a resource. Among the key informants many commented on organizations that are providing resources and could be used to do more. The mentioned organizations include, Little Company of Mary clinics which

could form relationships with community organizations, community clinics such as Harbor and Wilmington, non-profit organizations, local hospitals, faith-based organizations, and teaching institutions such as UCLA.

> *We have non-profits who are trying to piece it together. We can do a better job of coordination of care. A better job of resources. Better communication. Better IT infrastructure and collaboration because we don't share data. So that impacts coordination of all of our resources. Even the ones that are available now. It costs money to do that. Require a huge investment from a lot of people for the infrastructure to improve it infrastructure and coordination.*

> *I think community becoming more politically aware and involved. When they do that and have a voice and hold elective representatives accountable that is when change happens. When people don't participate aren't connected to the process they are entitled to, those that are engaged and have access to them the better opportunities they will have. If community members are engaged and motivated to do so and existing agencies willing to do so. It means we have enough admin support and financial backing. A small stand-alone, all existing community assess can be leverage but some more than others depending on their admin support and financial resources. Encouraging funding sources to do pilot projects in the area.*

> *I think further developing relationships with the local hospitals or medical facilities would be a great resource, because it addresses that health related problem. There are partnerships that already exist, there are resources that exist but really just further developing those resources would be helpful. And then, there are funds available for housing and for food but again depending on their income level, people will disqualify for those services just based on the poverty guidelines. They may be a dollar, two dollars, ten dollars over. So even with the food stamps that are available through the federal government, we find that, you know, that senior that is looking for assistance their social security pushes them over the limit. So there's resources there, it's just about how people qualify when taken into account to help them qualify.*

Partnerships

The key informants were questioned about opportunities for systems-level partnerships that could help address challenges discussed and how Providence fits into this opportunity. Many respondents provided education focused for ER misuse and services for children and thought partnering in this service would be beneficial. Other responses included areas to further build relationships with community partners to engage the community, such as community gardens, homelessness, pre-school for better prepared Latino and African American children, willingness from community, violence, safe areas, and osteoporosis campaigns. Challenges were noted including issues with communication among health care providers and safety net providers, continuity of care for patients, and the ability to share data.

I had to name a few things, I think further developing any health related resources that can benefit the clients to address whatever medical issues they may have. Taking advantage of the expertise and professionals who are employed by Little Company of Mary to teach classes that will enhance the skills of our clients or to provide the basic CPR. Because those are sometimes, that's the cost associated with a mom being successful in whatever medical class she may be taking, but maybe she can't afford it at that particular time. Something that already exists, that's already required for a health facility.

It's too complicated to get two systems talking to each other on such a basic level and the patients and care suffers. The physicians are frustrated. We don't know how to interact with the system and things fall through the cracks. We really are not a community partner, there isn't a meet and greet. Same issue with San Pedro mental health, it's hard to get the warm hand off. We are tiny and working incredibly frustrating being a tiny clinic with a huge system up the road and there isn't integration and really not a community partner. There is this meet and greet. We have this issues with San Pedro mental health. Have an issue with a warm hand off and I'm not even in the clinical parts. Our patients are really upset. No one knew they were coming. We may be turning away people that need medical attention. We got to have our EMR systems talking to each other and that is not going to happen anytime soon.

With specific health related goals. And again, going back to the community participation part, you know, I'm not, I think, as a priority in the community, I've heard people say things like that. Maybe they would feel differently if they were asked. But I think that kind of strategic planning, kind of needs to be institutionalized in setting these priorities. And also making sure that you get the different voices. There are sometimes that there'll be a single voice or a small group of voices that you hear over and over and over, about what the community needs are. And I'm sure, this is part of what you're doing, getting these different perspectives. But I think that we need to find, whether it's neighborhood councils or other ways of institutionalizing that.

Gaps in Healthcare

The survey respondents provide the top 3 healthcare gaps within each population that is recognized by the organization concerning access to primary care and specialty care, wellness education, and connecting people to services. The results are based on 24 responses and listed in the tables below.

ACCESS TO PRIMARY AND SPECIALTY CARE	Children (0-17)	Adult (18-64)	Senior (65+)
1	Acute mental health services (12)	Acute mental health services (11)	Acute mental health services (9)
2	Primary care medical services (11)	Primary care medical services (10)	Abuse treatment (8)
3	Affordable dental care (9)	Abuse treatment (8)	Homecare, hospice, long-term care (8)

WELLNESS EDUCATION	Children (0-17)	Adult (18-64)	Senior (65+)
1	Mental health education and coping (13)	Self-care education (9)	Self-care education programs after diagnosis (10)
2	Physical activity and fitness (10)	Education about navigating health care system (8)	Education about navigating the health care system (8)

3	Violence prevention and anger management (10)	Mental health education and coping skills (8)	Mental health coping (8)

CONNECTING PEOPLE TO SERVICES	Children (0-17)	Adult (18-64)	Senior (65+)
1	Access to medical services outside business hours (12)	Affordable housing (13)	Cultural and language barriers to obtain health care (9)
2	Sliding scale or free services for low income (10)	Access to medical services outside regular business hours (9)	Affordable housing (7)
3	Specialized testing and mental health services (10)	Cultural and language barriers to obtain health care (8)	Affordable medical transportation (7)

Additional Comments

The respondents of the focus groups, key informant interviews, and surveys provided final comments. These comments included a reiteration of partnerships, violence, immigration issues, poverty, drug and alcohol, and obesity. One new comment was illuminated in this section as the need for school-based health.

> *You know I think the one other thing that I should raise that my Supervisor is proud of is the school-based health center. That he's done and expanded. And we've done that largely in partnership with the federally qualified health centers. But that's such a good thing. And I think one of the things that he likes about the school based health center, and it kind of harkens back to the partnerships and the job development, it starts with the things we started talking about on economic opportunities. If there's ways where you could get at youth at an early age, and really try to groom them so they stay in LA and they give back to the community. And it would be a remarkable thing.*
>
> *Goal moving forward is to focus on programs for men or encourage them to attend existing programs. There have also been new parks, exercise machine, and tracks to walk around. People normally find an excuse to not use these resources, though timing of programs is important.*
>
> *Any provider has an opportunity to promote, educate, and promote healthy behaviors with families, those families will then demand those things in their community…Healthy communities are built by your patients. Think of them as the assets.*
>
> *Poverty, obesity, illiteracy - Every social issues we deal with to try and narrow down – we only deal with primary care we don't deal with the psycho/social does. Anything that impacts our patients impacts what we are trying to do here.*

Partnerships was a major concern of the survey respondents as well as care integration with mental health and behavioral health services, strategic health promotion and education, and better ways of informing the community. Participation in health fairs and revitalization was also mentioned as final comments.

Identified priority health needs

This section describes the significant priority health needs that were identified during the CHNA. This section also describes the process and criteria used to prioritize the needs. Potential resources in the community to address the significant health needs are also described in the section.

Prioritization process and criteria

On November 1, 2016, PLCM Oversight Committee members met to debrief on the findings of the CHNA and prioritize the needs identified through the CHNA process. The table below describes the top needs identified and the rationale for selections.

Priority Health Issue	Rationale/contributing factors
Access to healthcare and resources • **Enrollment services** • **Specialty services** • **Medical home**	• Even after ACA, the Community Benefit Service Area has lower percentages of insured adults and children, adults and children receiving dental care services in the past year, and mothers receiving prenatal care in the first trimester in comparison to the Broader South Bay Service Area. • Issues with access to care, navigating the system, or other social resources were among the top barriers mentioned by key informants, focus group participants, and community based organizations • Key informants consistently cited a need for more health and physical education and outreach to ensure client access to and use of services. The need for health navigator type services in combination with medical care was also expressed.
Affordable housing and homelessness	• SPA 8 has the 5th largest homeless population among the SPAs with a growing population of those in need. From 2015 to 2016, the homeless population in SPA increased by 22 percent. • Key informants mentioned homelessness as an inevitable consequence of housing cost burden, low-income, and lack of economic opportunities. Participants also noted a growing number of homeless persons served in the past year.
Low educational attainment and unemployment	• Unemployment is as high as 21 percent in neighborhoods in the Community Benefit Service Areas. These areas also have higher rates of people employed full time, yet still living below the poverty level. • Economic opportunities and job growth were consistently mentioned by focus group participants. Participants expressed a need for occupational training and availability of jobs paying a living wage.
Mental health (services including substance abuse)	• Mental health was one of the most frequently mentioned health need by key informants, focus group participants, and community based organizations. All participants noted a need for more specialty (substance, trauma, coping skills) and integrated services for all age levels.

Priority Health Issue	Rationale/contributing factors
	• 13 percent of adults in the Community Benefit Service Area are at risk for major depression, in comparison to 7 percent in the Broader South Bay Service Area and 12 percent in Los Angeles County.
Poverty and food insecurity	• Poverty was consistently mentioned as a key driver of health across key informant interviews and focus groups and was the top ranked health or social determinant mentioned. • 21 percent of households in the Community Benefit Service Areas are living in poverty in comparison to 8 percent in the Broader South Bay Service Area. • In the Community Benefit Service Area, about 35 percent of households with annual incomes less than 300 percent of the federal poverty level are food insecure. Comparatively, 15 percent of households in the South Bay service area and 30 percent in LA County are experiencing food insecurity.
Prevention and management of chronic diseases • **Obesity** • **Diabetes** • **Physical activity**	• Secondary data showed lower rates of adults diagnosed with diabetes in the Community Benefit Service Area in comparison to other areas, but higher hospital admissions rates. This suggests issues in connecting to primary care providers and/or screening services. • Obesity and diabetes rates among children was one of the most frequently mentioned health issues among key informants and focus group participants. Participants expressed a need for more opportunities for physical activity in a safe environment for all members of the family.
Senior care and resources	• The Alzheimer's disease-specific death rate for the Broader South Bay Service Area (26.2 per 100,000) is greater than the Community Benefit Service Area (22.0 per 100,000).and LA County (25.1 per 100,000) estimates. • 27 percent of adults age 65 and older in the Broader South Bay Service Area have fallen in the past year in comparison to 25 percent in the Community Benefit Service Area.
Violence	• Violence was the top health or social issue noted by focus group participants. Key informants also mentioned violence as having a significant impact on health in our communities. • 17 percent of adults living in the Community Benefit Service Area have experienced physical or intimate partner violence in the past year in comparison to 9 percent in the Broader South Bay Service Area.

Following a review of the data, Board members asked clarifying questions prior to separating into two work groups for a deeper dive into the issues and potential priorities. The Committee was broken out into two groups, with an even mix of Providence staff and Community representatives. Using the priority matrix pictured below, the two groups ranked and weighted each need against the criteria to determine the priority score. Jim Tehan and Justin Joe facilitated a discussion of each health need against the criteria, and the scores from the 2 groups were added to determine the final ranking. For more details on the prioritization process and results, please find the Board meeting minutes in the appendix.

Prioritization Matrix

Identified Need	Input from community (.75)	Severity and magnitude (.75)	Required by Attorney General (.75)	Addresses disparities underserved populations (.5)	Lack of existing resources and programs (.25)	Mission alignment and resources of hospital (.75)	Opportunity for partnership (.25)	Priority Score
1. Access to healthcare and resources • Enrollment services • Specialty services • Medical home	4 (3)	4 (3)	4 (3)					
2. Affordable housing and homelessness	4(3)	4 (3)	1 (.75)					
3. Low educational attainment and unemployment	4 (3)	4 (3)	1 (.75)					
4. Mental health services (including substance abuse)	4 (3)	4 (3)	1 (.75)					
5. Poverty and food insecurity	4 (3)	4 (3)	1 (.75)					
6. Prevention and management of chronic diseases • Obesity • Diabetes • Physical activity	4 (3)	4 (3)	4 (3)					
7. Senior care and resources	3 (2.25)	3 (2.25)	1 (.75)					
8. Violence	4 (3)	4 (3)	1 (.75)					

Final Rankings for Identified Needs				
Identified Need	**Group 1 Scaled Score**	**Group 2 Scaled Score**	**Final Summed Scaled Score**	**Final Rank**
Access to healthcare and resources				
□ Enrollment services				
□ Specialty services				
□ Medical home	15.75	15.25	31	1
Prevention and management of chronic diseases				
□ Obesity				
□ Diabetes				
□ Physical activity	15.5	15	30.5	2
Mental health services (including substance abuse)	13.75	13	26.75	3
Violence	13.25	12.25	25.5	4
Affordable housing and homelessness	12	13	25	5
Poverty and food insecurity	12.25	12.5	24.75	6
Low educational attainment and unemployment	11.5	12.5	24	7
Senior care and resources	11.75	10	21.75	8

Addressing identifed needs

This section describes how Providence will develop and adopt an implementation strategy (i.e. community health improvement plan) to address the prioritized community needs.

Plan development

Providence Little Company of Mary Medical Centers, San Pedro and Torrance will consider the prioritized health needs identified through this community health needs assessment and develop a strategy to address each need. Strategies will be documented in a community health improvement plan (CHIP). The CHIP will describe how Providence plans to address the health needs. If Providence does not intend to address a need, the CHIP will explain why[3].

The CHIP will describe the actions Providence intends to take to address the health need and the anticipated impact of these actions. Providence will also identify the resources the hospital plans to commit to address the health need. Because partnership is important to addressing health needs, the CHIP will describe any planned collaboration between Providence and other facilities or organizations in addressing the health need.

The improvement plan will be approved by the Providence Community Ministry Board by May 15, 2016. When approved, the CHIP will be attached to this community health needs assessment report in Appendix V.

Providence prioritized needs

Providence prioritized needs
1. **Access to healthcare and resources** 2. **Prevention and management of chronic diseases** 3. **Mental health services (including substance abuse treatment)** 4. **Violence** 5. **Affordable housing and homelessness**

[3]Reasons may include resource constraints, other facilities or organizations in the community addressing the need, a relative lack of expertise or competency to address the need, the need being a relatively low priority, and/or a lack of identified effective interventions to address the need.

Evaluation of impact from 2014-2016 Community Health Improvement Plan

This section evaluates the impact of actions that were taken to address the significant health needs identified in the prior community health needs assessment and associated implementation strategy (i.e. community health improvement plan).

Following the prior CHNA, Providence collaborated with community partners to develop a community health improvement plan (CHIP) to address the needs identified below. The top health issues for the 2014-2016 CHNA/CHIP were:

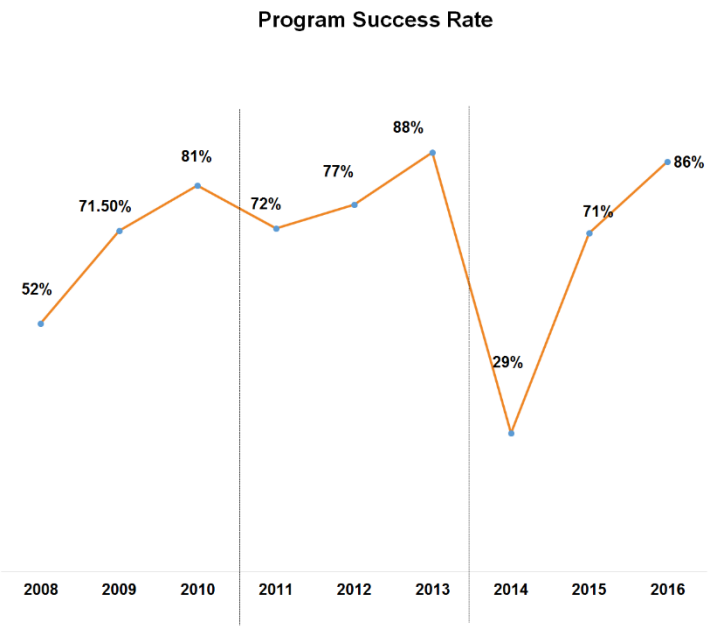
1. Increased Access to Health Care
2. Primary and Secondary Prevention Services
3. Capacity Building with External Community Partners
4. Program Development in new priority areas of need identified by the CHNA

The following is an overview, evaluating our CHIP efforts and their impact on the identified needs.

Establishing benchmarks

The concept of committing to three-year benchmarks was first approved by the South Bay Community governing board in 2007 as part of our triennial needs assessment and was repeated at the time of adoption of the Community Health Needs Assessment in 2010 and 2013. Benchmarks represent key performance indicators that provide the best evidence of the impact of the Community Benefit Plan on local communities related to access to health care, primary and secondary prevention, capacity building, and program development in new priority areas.

In the first cycle, beginning in 2008, our success rate towards accomplishing our 21 benchmarks were 52 percent in the first year (i.e. 11 of 21 benchmarks accomplished). This success rate increased significantly in the second year, to 71.5 percent (15 of 21 benchmarks accomplished); in the third year, the success rate increased to 81 percent (17 of 21 benchmarks accomplished).



The Providence Little Company of Mary 2010 triennial needs assessment adopted by the governing board established four measurable objectives with 18 specific benchmarks to be addressed between 2011 and 2013. In the first year (2011), 13 of 18 benchmarks were

accomplished, for a success rate of 72 percent. In 2012, this increased to 77 percent (14 of 18 benchmarks accomplished) and to 88 percent in 2013 (16 of 18 benchmarks accomplished).

This third cycle from 2014 to 2016, 6 of 21 benchmarks were accomplished in 2014 for a success rate of 29 percent. This figure increased in 2015 to a rate of 71 percent (15 of 21 benchmarks completed). In 2016, 18 of 21 benchmarks were accomplished at the time of writing this report (86 percent success rate) and 19 benchmarks have either been accomplished or on track/in progress (90 percent success rate).

In the absence of accepted State or national standards of community health improvement, these benchmarks also measure the strength of the three-year benchmarks (i.e. realistic, but not too easy to accomplish and continuing year-to-year improvement in results). The expectation is NOT that all benchmarks will be achieved because many factors can thwart a three-year plan.

The implementation of the ACA has clearly impacted several benchmarks that previously were consistently met. In addition, the benchmarks for this 2014-16 cycle place greater emphasis on community capacity building and collaboration with partners, which is more difficult to measure.

By sticking with the same benchmarks for a three-year period, stakeholders gain an appreciation for the importance of achieving specific results and the importance of continuing to press for improvement. In every Community Benefit program area, we are fully engaged with community partners in a collaborative process to improve working relationships built on trust and respect among stakeholders. Ultimately, there is recognition among community stakeholders that no single organization can meet all the identified community needs and when truly collaborative relationships exist, community partners working together can achieve far more than any single organization working on its own.

Priority Strategy	Activities	Outcomes	
		Short/Med	Long
Increased Access to Health Care	1. Enroll or renew 2,000 children or adults annually. 2. Link 600 adults discharged from the ER to a medical home, as verified by kept appointments. 3. Increase from 10 to 16 sites where the mobile clinic regularly sees patients. 4. Increase the number of people receiving HPV immunizations over the 2013 baseline, by 20%. 5. Improve identification and successful referral of Providence patients to Get Out and Live (GOAL) diabetes project by 20%, using the first six months of 2015 as baseline. 6. Provide medical management for 150 uninsured adults at Vasek Polak, including subspecialty consults, advanced diagnostics and referral for those with ongoing chronic specialty conditions.	Increase access to free primary and subsidized health care, including insurance coverage through Medi-Cal and Covered California	As people of Providence, we partner with community stakeholders, reach out to high-need communities, and build a path to better health, for children and adults, through improved access to primary care and involvement in skills-based health and wellness programs.

Priority Strategy	Activities	Outcomes	
		Short/Med	Long
Primary and Secondary Prevention Services	1. Increase physical activity in children by 10% over (March 2014) baseline, as measured by pedometers, SOFIT, or FitnessGram.	Strengthen existing primary and secondary prevention programs (COPA, GOAL, and Welcome Baby)	As people of Providence, we partner with community stakeholders, reach out to high-need communities, and build a path to better health, for children and adults, through improved access to primary care and involvement in skills-based health and wellness programs.
	2. Provide Creating Opportunities for Physical Activity (COPA) program consultative services to 10 new locations, verified by trainings or MOU/contracts with school districts or community-based organizations.		
	3. Increase to 50 the number of chronic disease self-care cohorts (6-9 lessons) offered throughout the PLCM service areas.		
	4. Sustain average decrease in A1C levels for all GOAL patient participants, using 2013 pre-post baseline data. 2013 average A1C reduction = 1.3%, (9.81% pre to 8.50% post)		
	5. Increase Welcome Bay prenatal enrollments by 40%, using 2013 as baseline [16].		
	6. Increase program acceptance rate by 5% using the first six months of expanded home visits as baseline [Revised baseline period = 48.8% acceptance rate Jan-June 2015].		

Priority Strategy	Activities	Outcomes	
		Short/Med	Long
Address Board Committee on Community Benefits Priorities	1. Design, pilot, and implement a new program that addresses one of three new priority areas identified by the BCCB: 1) Services that allow Seniors to live at home 2) Mental Health Education/Coping Skills 3) Skills to Navigate Health Care System. 2. Convene an internal collaborative task force that addresses one of the BCCB priorities.	Explore feasibility of program development/stakeholder collaboration in three areas prioritized by Board Committee on Community Benefits	As people of Providence, we partner with community stakeholders, reach out to high-need communities, and build a path to better health, for children and adults, through improved access to primary care and involvement in skills-based health and wellness programs.

Priority Strategy	Activities	Outcomes	
		Short/Med	Long
Capacity Building with External Community Partners	1. [NEW for 2015] Increase utilization of Providence Wellness and Activity Center by 40%; Baseline established during Jan-June 2015 = 2,238 attendees.	Increase and strengthen partnerships with external stakeholders	As people of Providence, we partner with community stakeholders, reach out to high-need communities, and build a path to better health, for children and adults, through improved access to primary care and involvement in skills-based health and wellness programs.
	2. Develop and sustain two collaborative task forces that address any of the top healthcare needs identified in the 2013 needs assessment AND that accomplish outcomes identified by the task force.		
	3. Implement at least two capacity building projects that provide an infrastructure improvement for or in partnership with community partners (i.e. funding/ facilities/joint use agreement).		

2014-2016 PLCM Logic Model (continued)

Priority Strategy	Activities	Outcomes	
		Short/Med	Long
Monitor Community Benefit	1. Increase charity care expense by 5%, using 2014 baseline [Revised baseline year].	Monitor Community Benefit programs and expenditure, consistent with Catholic Health Association guidelines	As people of Providence, we partner with community stakeholders, reach out to high-need communities, and build a path to better health, for children and adults, through improved access to primary care and involvement in skills-based health and wellness programs.
	2. Increase community outreach expense (non-billed) by 10%, using 2013 baseline [Baseline = $6,656,388].		
	3. Under the direction of the Mission Committee, conduct 6 site visits to explore client, stakeholder, and employee satisfaction with specific programs provided by the Medical Centers' Community Health Department.		
	4. Define, design, and develop a data exchange project between PLCM and safety net and/or Public Health stakeholders.		

Prioritized Need #1—Increased access to health care

Objective: Increase access to free primary and subsidized health care, including insurance coverage through Medi-Cal and Covered California.

Data Point	2014	2015	2016 (Annualized)	Trend	Status
By 2016, enroll or renew 2,000 children or adults annually.	2,891	2,730	2,493		✓
By 2016, link 600 adults discharged from the ER to a medical home, as verified by kept appointments.	403	314	350		✓
By 2016, increase from 10 to 16 sites where the mobile clinic regularly sees patients.	16	16	16		✓
By 2016, increase the number of people receiving HPV immunizations over the 2013 baseline, by 20%.	37%	480%	710%		✓
By 2016, improve identification and successful referral of Providence patients to GOAL diabetes project by 20%, using the first six months of 2015 as baseline.	0	22.80%	559.00%		✓
By 2016, provide medical management for 150 uninsured adults at Vasek Polak, including subspecialty consults, advanced diagnostics and referral for those with ongoing chronic specialty conditions.	0	104	250		✓

Benchmark not met or no information available

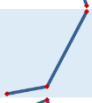
6 benchmarks met

✓ Benchmark met

On track or in progress

Prioritized Need #2—Primary and secondary prevention services

Objective: Strengthen existing primary and secondary prevention programs (COPA, GOAL, and Welcome Baby)

Data Point	2014	2015	2016 (Annualized)	Trend	Status
By 2016, increase physical activity in children by 10% over (March 2014) baseline, as measured by pedometers, SOFIT, or FitnessGram. Baseline=51% of elementary school children met the national standard for aerobic fitness as measured by the Fitnessgram pacer test.	0%	6%	14%		✓
By 2016, provide COPA consultative services to 10 new locations, verified by trainings or MOU/contracts with school districts or community-based organizations.	4	6	1		✓
By 2016, increase to 50 the number of chronic disease self-care cohorts (6-9 lessons) offered throughout the PLCMSA.	16	18	37		✓
By 2016, sustain average decrease in A1C levels for all GOAL patient participants, using 2013 pre-post baseline data. 2013 average A1C reduction = 1.3%, (9.81% pre to 8.50% post).	1.44%	1.46%	1.33%		✓
By 2016, increase Welcome Baby program acceptance rate enrollments by 40%, using 2013 as baseline [16].	5.70%	125%	113%		✓
By 2016, increase program acceptance rate by 5% using the first six months of expanded home visits as baseline [Revised baseline period = 48.8% acceptance rate Jan-June 2015].	0	6.50%	5.20%		✓

Benchmark not met or no information available

Benchmark met

On track or in progress

6 benchmarks met

Prioritized Need #3—External partnerships

Objective: Increase and strengthen partnerships with external stakeholder

Data Point	2014	2015	2016	Trend	Status
[NEW for 2015] Increase utilization of Providence Wellness and Activity Center by 40%; Baseline established during Jan-June 2015 = 2,238 attendees.	0	86%	93%		✓
By 2016, develop and sustain two collaborative task forces that address any of the top healthcare needs identified in the 2013 needs assessment AND that accomplish outcomes identified by the task force.	1	1	0		✓
By 2016, implement at least two capacity building projects that provide an infrastructure improvement for or in partnership with community partners (i.e. funding/ facilities/joint use agreement).	1	1	0		✓

⃠ Benchmark not met or no information available

✓ Benchmark met

On track or in progress

3 benchmarks met

Note: 2016 figure for the first indicator was collected from January to June 2016

Prioritized Need #4—Address BCCB priorities

Objective: Explore feasibility of program development/stakeholder collaboration in three areas prioritized by Board Committee on Community Benefits

Data Point	2014	2015	2016	Trend	Status
By 2016, design, pilot, and implement a new program that addresses one of three new priority areas identified by the BCCB: 1) Services that allow Seniors to live at home 2) Mental Health Education/Coping Skills 3) Skills to Navigate Health Care System	0	1	0		✓
By 2016, convene an internal collaborative task force that addresses one of the BCCB priorities.	0	0	0		⊘

⊘ Benchmark not met or no information available

✓ Benchmark met

🛠 On track or in progress

1 benchmark met
1 benchmark not met or no information available

Prioritized Need #5—Monitor community benefit

Objective: Monitor Community Benefit programs and expenditure, consistent with Catholic Health Association guidelines.

Data Point	2014	2015	2016	Trend	Status
By 2016, increase charity care expense by 5%, using 2014 baseline [Revised baseline year].	0	-43%	16%		✓
By 2016, increase community outreach expense (non-billed) by 10%, using 2013 baseline [Baseline = $6,656,388].	9.80%	18.80%	18.00%		✓
By 2016, under the direction of the Mission Committee, conduct 6 site visits to explore client, stakeholder, and employee satisfaction with specific programs provided by the Medical Centers' Community Health Department.	0	1	0		🛠
By 2016, define, design, and develop a data exchange project between PLCM and safety net and/or Public Health stakeholders	0	0	0		⊘

⊘ Benchmark not met or no information available

✓ Benchmark met

🛠 On track or in progress

2 benchmarks met
1 benchmark on track or in progress
1 benchmark not met or no information available

Note: Charity Care and Community Outreach expenses are finalized at the end of the year. Numbers provided for the first two indicators are estimates. However, trends strongly suggest meeting these benchmarks.

2016 CHNA approval

This Community Health Needs Assessment was adopted on November 29, 2016 by the Providence Little Company of Mary Community Ministry Board. The final report was made widely available[4] on December 31, 2016.

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http://california.providence.org/torrance/
http://california.providence.org/san-pedro/

[4] Per § 1.501(r)-3 IRS Requirements

Appendices

Appendix I – LA County Health Survey Core Indicators

		Community Benefit Service Area	Broader South Bay Service Area	Los Angeles County
	Physical & Social Determinants			
1	Percent of adults who completed high school[1]	78.6%	93.2%	77.6%
2	Percent of adults who are employed[1]	62.7%	58.2%	56.6%
3	Percent of population with household incomes <100% Federal Poverty Level (FPL)	21.2%	7.6%	18.4%
4	Percent of households (owner/renter-occupied) who spend ≥30% of their income on housing.	51.6%	39.8%	49.9%
5	Housing instability (Percent of adults who reported being homeless or not having their own place to live or sleep in the past 5 years)[1]	* 5.9%	-	4.8%
6	Percent of households with incomes <300% who are food insecure[1]	34.8%	* 14.6%	29.2%
7	Percent of children with excellent or good access to fresh fruits and vegetables in their community[1]	69.8%	91.2%	75.0%
8	Percent of adults who believe their neighborhood is safe from crime[1]	83.5%	91.5%	84.0%
9	Percent of children ages 1-17 years who can easily get to a park, playground, or other safe place to play[1]	82.3%	96.1%	86.8%
10	Percent of adults who use walking paths, parks, playgrounds, or sports fields in their neighborhood[1]	38.3%	53.6%	47.5%
11	Amount of green space (park acres) per 1,000 population[2]	1.42	2.77	8.06
12	Percent of children ages 0-5 years who are read to daily by a parent or family members[1]	38.5%	80.2%	56.4%
	Health Status			
13	Percent of adults reporting their health to be fair or poor[1]	19.8%	18.8%	21.5%
14	Average number of days in past month adults reported regular daily activities were limited due to poor physical/mental health[1]	2.2	1.8	2.3
15	Percent of children ages 0-17 years who have special health care needs[1]	16.9%	16.1%	14.5%
	Access to Care			
16	Percent of children ages 0-17 years who are insured[1]	95.4%	97.7%	96.6%
17	Percent of adults ages 18-64 years who are insured[1]	85.9%	93.9%	88.3%
18	Percent of children ages 0-17 years with a regular source of health care[1]	96.4%	95.7%	94.3%
19	Percent of adults 18-64 years with a regular source of health care[1]	82.2%	78.8%	77.7%
20	Percent of adults who did not see a dentist or go to a dental clinic in the past year[1]	42.6%	29.8%	40.7%
21	Percent of children ages 3-17 years who did not obtain dental care (including check-ups) in the past year because they could not afford it[1]	20.2%	* 5.3%	11.5%

		Community Benefit Service Area	Broader South Bay Service Area	Los Angeles County
	Preventive Services			
22	Percent of all live births where mother received prenatal care during 1st trimester	**79.4%**	**86.5%**	**83.1%**
23	Percent of women ages 21 - 65 years who had a Pap smear within the past 3 years[1]	**87.4%**	**76.1%**	**84.4%**
24	Percent of women ages 50- 74 years who had a mammogram within the past 2 years[1]	**66.9%**	**73.8%**	**77.3%**
25	Percent of children ages 6 months - 17 years vaccinated for influenza[1]	**52.4%**	**61.4%**	**55.2%**
26	Percent of adults vaccinated for influenza[1]	**28.8%**	**51.3%**	**40.1%**
	Health Behaviors			
27	Percent of adults who binge drink (men who had 5 or more alcoholic drinks, women 4 or more, on at least one occasion in the past 30 days)[1]	**20.1%**	**16.1%**	**15.9%**
28	Percent of adults who consume five or more servings of fruits & vegetables a day[1]	**12.1%**	**17.8%**	**14.7%**
29	Percent of children who drink at least one soda or sweetened drink a day[1]	**44.6%**	**33.1%**	**39.2%**
30	Percent of children ages 0-2 years who were exclusively breastfed for at least 3 months[3]	**29.2%**	**57.0%**	**38.3%**
31	Percent of adults who smoke cigarettes[1]	**16.3%**	**12.8%**	**13.3%**
32	Percent of adults who obtain recommended amount of aerobic exercise (≥150 minutes/wk of moderate exercise, or ≥75 minutes/wk of vigorous exercise) and muscle-strengthening (at least 2 days/wk) each week[1]	**34.2%**	**29.7%**	**34.1%**
33	Percent of children ages 6-17 years who obtain recommended amount of aerobic exercise (≥60 minutes, daily) and muscle-strengthening (at least 2 days/wk) each week[1]	**14.8%**	**22.2%**	**17.7%**
	Health Outcomes			
	Obesity			
34	Percent of children in grades 5,7&9 who are obese (BMI above the 95th percentile)	**Data Not Available**	**Data Not Available**	**Data Not Available**
35	Percent of adults who are obese (BMI≥30.0)[1]	**24.8%**	**20.0%**	**23.5%**
	Diabetes			
36	Percent of adults ever diagnosed with diabetes[1]	**8.3%**	**9.9%**	**9.8%**
37	Diabetes-related hospital admissions (per 10,000 population)[4]	**20.9**	**10.0**	**15.8**
38	Diabetes-specific death rate (per 100,000 population)[5]	**24.3**	**15.5**	**21.9**

		Community Benefit Service Area	Broader South Bay Service Area	Los Angeles County
	Cardiovascular Disease			
39	Hypertension-related hospital admissions (per 10,000 population)[4]	7.6	4.1	5.5
40	Percent of adults ever diagnosed with hypertension[1]	18.3%	25.2%	23.5%
41	Coronary heart disease-specific death rate (per 100,000 population)[5]	132.5	99.9	116.7
42	Stroke-specific death rate (per 100,000 population)[5]	40.3	29.6	32.8
	Reproductive Health			
43	Rate of births (per 1,000 females) to teens ages 15-19[6]	58.8	19.5	53.4
44	Percent of low birth weight (,2,500 grams) births (per 100 live births)[6]	7.0%	6.3%	6.9%
45	Infant death rate (per 1,000 live births)[7]	5.8	3.1	4.4
	Injury			
46	Premature death rate due to suicide in total Years of Potential Life Lost (YPLL) per 100,000 population[8]	140.5	205.0	208.4
47	Premature death rate due to homicide in total Years of Potential Life Lost (YPLL) per 100,000 population[8]	347.3	193.0	235.2
48	Premature death rate due to motor vehicle crashes in total Years of Potential Life Lost (YPLL) per 100,000 population[8]	204.9	188.0	227.5
49	Percent of adults who have ever experienced physical (hit, slapped, pushed, kicked, etc.) or sexual (unwanted sex) violence by an intimate partner[1]	16.5%	9.3%	13.4%
50	Percent of adults ages 65+ years who have fallen in the past year[1]	24.8%	26.6%	27.1%
	Drug Overdose			
51	Rate (per 10,000 population) of adult opioid use-related hospitalizations[4]	0.7	0.6	0.5
52	Premature death rate due to drug overdose in total Years of Potential Life Lost (YPLL) per 100,000 population[8]	275.5	183.0	218.1
	Mental Health			
53	Percent of adults at risk for major depression[1]	12.5%	* 7.2%	11.8%
54	Alzheimer's disease-specific death rate (per 100,000 population)[5]	22.0	26.2	25.1

		Community Benefit Service Area	Broader South Bay Service Area	Los Angeles County
	STD and HIV Disease			
55	Incidence of HIV (annual new cases per 100,000 population) among adolescents and adults (ages 13+ years)[9]	**20.5**	**5.6**	**20.7**
56	Incidence of primary & secondary syphilis (annual new cases per 100,000)[10]	**10.7**	**6.5**	**14.3**
57	Incidence of gonorrhea (annual new cases per 100,000 population)[10]	**177.5**	**79.5**	**165.1**
58	Incidence of chlamydia (annual new cases per 100,000 population)[10]	**622.6**	**298.9**	**532.1**
	Respiratory Disease			
59	Percent of children ages 0-17 years with current asthma (ever diagnosed with asthma and reported still have asthma and/or had an asthma attack in the past year)[1]	* **4.4%**	**7.0%**	**7.4%**
60	Pediatric asthma-related hospital admissions per 10,000 child population[4]	**13.1**	**9.4**	**12.0**
61	COPD specific mortality rate (per 100,000 population)[5]	**34.2**	**28.1**	**29.2**
	Cancer			
62	Lung-specific cancer death rate (per 100,000 population)[5]	**33.0**	**24.5**	**27.5**
63	Breast cancer-specific death rate among females (per 100,000 females)[5]	**21.6**	**19.3**	**20.5**
64	Colorectal cancer-specific death rate (per 100,000 population)[5]	**16.4**	**11.7**	**13.8**
	Liver Disease			
65	Liver disease-specific death rate (per 100,000 population)[5]	**12.6**	**8.3**	**12.8**

* Unstable percentages due to small numbers. Interpret with caution.

Data Sources

1: 2015 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

2: 2015 Park Acres: LA County GIS Data Portal, Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

3: 2014 Los Angeles Mommy and Baby (LAMB) Survey Data; Office of Maternal and Child Health, Los Angeles County Department of Public Health

4: 2014 Hospital Admissions: California Office of Statewide Health Planning and Development, Nonpublic Emergency Department Data (AB2876 File); Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

5: 2013 Los Angeles County Linked Death Data, California Department of Public Health; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

6: 2014 Preliminary live births vital statistics data; Office of Maternal and Child Health, Los Angeles County Department of Public Health

7: 2013 Death Statistical Master File and 2013 Birth Statistical Master File

8: 2013 Death Statistical Master File; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health

9: 2014 HIV Surveillance Database; Division of HIV and STD programs, Los Angeles County Department of Public Health

10: 2015 HIV Surveillance Database; Division of HIV and STD programs, Los Angeles County Department of Public Health

Appendix II – Resources potentially available to address the significant needs identified through the CHNA

This section inventories community partners that are addressing the identified needs in the CHNA. This table begins to outline our strategy of creating healthier communities together.

Providence and partners cannot address the significant community health needs independently. Improving community health requires collaboration across community stakeholders. Below outlines a list of community resources potentially available to address identified community needs

Organization Type	Organization	Description	Address	City	Zip
Advocacy Organization	SBCC Thrive LA	For more than forty years, SBCC has empowered communities across Los Angeles to discover and develop tools for individual and collective well-being. Across our full range of innovative, grassroots programs and initiatives, they reach more than 10,000 families annually.	540 North Marine Ave	Wilmington	90744

Organization Type	Organization	Description	Address	City	Zip
Child abuse treatment and prevention	Richstone Family Center	The Richstone Family Center is dedicated to preventing and treating child abuse, strengthening families, and preventing violence in schools and communities	13634 Cordary Ave	Hawthorne	90250
Civic Organization	San Pedro Neighborhood Council	The mission of the San Pedro Neighborhood Council is to improve the quality of life for all in San Pedro by creating and fostering a safe, healthy, orderly and clean environment that welcomes ethnic and cultural diversity and promotes a community spirit of inclusion, cooperation, participation and collaboration.	638 S. Beacon Street, Suite 552	San Pedro	90731

Organization Type	Organization	Description	Address	City	Zip
Comprehensive Social Services	Catholic Charities of Los Angeles, Inc., San Pedro Region	The programs of Catholic Charities focus on empowerment and seek to enact long-term, positive change in individuals, families and communities. As a nonprofit, public benefit corporation, the agency is built on the principles of dignity and inclusion, providing services irrespective of race, ethnicity, gender or religious belief.	10217 S. Inglewood Ave	Lennox	90304
Comprehensive Social Services	Love, Inc.	As a non-profit, this organization relies on volunteers and community support to provide services to those who qualify, including transportation to the homebound, auto and home repairs, tutoring, and basic goods. For programs, they don't offer, referrals are made to community resources or agencies.	1881 N Gaffey St # D	San Pedro	90731

Organization Type	Organization	Description	Address	City	Zip
Comprehensive Social Services	Stillman Sawyer Family Service Center	The Stillman Center offers a variety of assistance to individuals and families. These services include the food bank, back to school backpacks & supplies, Christmas toys & food, referrals, job search assistance, and A/C & Refrigeration Vocational Training Courses.	820 Lomita Blvd	Harbor City	90710
Comprehensive Social Services	St. Margaret's Center	St. Margaret's Center, a program of Catholic Charities since 1987, provides relief, dignity, and support to low-income persons in crisis and assists individuals through case management and skills development to become more self-sufficient and achieve greater economic security.	10217 Inglewood Ave	Lennox	90304
Comprehensive Social Services	Toberman Neighborhood Center	A non-profit community based organization committed to assisting local individuals and families to live healthy purposeful lives.	131 N Grand Ave	San Pedro	90731

Organization Type	Organization	Description	Address	City	Zip
Comprehensive Social Services	Volunteers of America	Since 1896 Volunteers of America Greater Los Angeles has provided a diverse range of human services throughout the community.	334 Figueroa St	Wilmington	90744
Comprehensive Social Services	YWCA of the Harbor Area and South Bay	The YWCA of the Harbor Area & South Bay is dedicated to eliminating racism, empowering women and promoting peace, justice, freedom and dignity for all. Programs include: teen pregnancy prevention, Zumba, cradle closet, encore plus, women's closet, child care services, and holiday programs	437 W 9th St	San Pedro	90731
Consumer Education	Clearpoint Credit Counseling Solutions	Provides consumers with budget, credit, debt, and housing advice. Helps consumers identify and resolve their financial concerns through budgeting, an understanding of credit, learning how to set financial goals, prioritizing debt repayments and making the most effective financial choices.	6055 E Washington Blvd, Ste. 390	Commerce	90040

Organization Type	Organization	Description	Address	City	Zip
Domestic Violence	Rainbow Services	Rainbow Services, along with other domestic violence agencies, is part of a network that aims to keep families safe. We do our best to provide support and assistance for women and children dealing with family violence.	453 W 7th St	San Pedro	90731
Economic Development	Harbor Gateway WorkSource Center	Public agency dedicated to workforce development	1851 N Gaffey St. Ste: #F	San Pedro	90731
Education	186th Street Elementary School	School	1581 W 186th St.	Gardena	90248
Education	Broad Avenue Elementary School	School	24815 Broad Ave	Wilmington	90744
Education	Centinela Valley Union High School District	School	14901 South Inglewood Ave	Lawndale	90260
Education	Fries Avenue Elementary School	School	1301 Fries Ave	Wilmington	90744

Organization Type	Organization	Description	Address	City	Zip
Education	George De La Torre Junior Elementary School	School	500 N. Island Ave	Wilmington	90744
Education	Gulf Avenue Elementary School	School	828 West “L” Street	Wilmington	90744
Education	Harry Bridges Span School	School	1235 Broad Ave	Wilmington	90744
Education	Hawaiian Avenue Elementary School	School	540 Hawaiian Ave	Wilmington	90744
Education	Eucalyptus Elementary School	School	12044 Eucalyptus Ave	Hawthorne	90250
Education	Jefferson Elementary School	School	4091 139th St	Hawthorne	90250
Education	Kornblum Elementary School	School	3620 El Segundo Blvd	Hawthorne	90250
Education	Ramona Elementary School	School	4617 W 136th St	Hawthorne	90250

Organization Type	Organization	Description	Address	City	Zip
Education	Washington Elementary School	School	4339 W 129th St	Hawthorne	90250
Education	York Elementary School	School	11838 York Ave	Hawthorne	90250
Education	Zela Davis Elementary School	School	13435 Yukon Ave	Hawthorne	90250
Education	Hawthorne School District	School District	14120 Hawthorne Blvd	Hawthorne	90250
Education	Inglewood School District	School District	401 S. Inglewood Ave	Inglewood	90301
Education	Billy Mitchell Elementary School	School	14429 S Condon Ave	Lawndale	90260
Education	F. D. Roosevelt Elementary School	School	3533 Marine Ave	Lawndale	90260
Education	Lucille J. Smith Elementary School	School	4521 W 147th St	Lawndale	90260
Education	Mark Twain Elementary School	School	3728 W 154th St	Lawndale	90260

Organization Type	Organization	Description	Address	City	Zip
Education	William Anderson Elementary School	School	4130 W 154th St	Lawndale	90260
Education	William Green Elementary School	School	4520 168th St	Lawndale	90260
Education	Lawndale Elementary School District	School District	4161 W. 147th St	Lawndale	90260
Education	Wilmington Park Elementary School	School	1140 Mahar Ave	Wilmington	90744
Emergency Assistance/Food	Bible Enrichment Fellowship	Free groceries, fellowship, bible study	400 E Kelso St	Inglewood	90301
Emergency Assistance/Food	Calvary Hawthorne Presbyterian	Free groceries, fellowship, bible study	13560 Hawthorne Blvd	Hawthorne	90250
Emergency Assistance/Food	City of Gardena	Free groceries to Gardena residents only	1651 W 162nd St	Gardena	90247
Emergency Assistance/Food	First Lutheran Church	Free groceries, fellowship, bible study	600 W Queen St	Inglewood	90301

Organization Type	Organization	Description	Address	City	Zip
Emergency Assistance/Food	Food Pantry LAX	Food Pantry, LAX is an emergency food resource for low income clients in Inglewood, Westchester, El Segundo, Hawthorne and portions of Los Angeles.	355 E Beach Ave	Inglewood	90302
Emergency Assistance/Food	Hope in Action	Once a month food items distributed to South Bay residents including Beach Cities, Torrance, Hawthorne, and Inglewood. Free bag of food that will last a week	2420 Pacific Coast Hwy	Hermosa Beach	90254
Federally Qualified Health Center (FQHC)	Harbor Community Clinic	Provides services for men, women and children throughout San Pedro and the surrounding Los Angeles and South Bay areas. The clinic provides low-cost and no-cost health services to residents with low incomes and those whose employers do not provide health insurance coverage.	593 W 6th St	San Pedro	90731

Organization Type	Organization	Description	Address	City	Zip
Federally Qualified Health Center (FQHC)	Northeast Community Clinic	Provides primary and preventive healthcare services to the low-income, uninsured and underserved residents of Los Angeles County. NECC also provides counseling, mental health, referrals and other supportive services through coordination of community resources.	200 E. Anaheim St 1403 W. Lomita Blvd., Suite 100	Wilmington Harbor City	90744 90710
Federally Qualified Health Center (FQHC)	South Bay Family Health Care	Provides high-quality, low-and-no cost health care to economically disadvantaged and uninsured populations throughout Los Angeles County's South Bay and Harbor Gateway communities.	23430 Hawthorne Blvd. Suite 210	Torrance	90505
Federally Qualified Health Center (FQHC)	Wilmington Community Clinic	Provides primary and preventive health care services, including wellness visits and school physicals, women's health services, STD testing, health maintenance guidance, primary care visits, prenatal exams, pediatric care, and mental health services.	1009 N Avalon Blvd	Wilmington	90744

Organization Type	Organization	Description	Address	City	Zip
Homeless Shelters/Housing	Harbor Interfaith Services, Inc.	The mission of Harbor Interfaith Services is to empower the homeless and working poor to achieve self-sufficiency by providing support services including shelter, transitional housing, food, job placement, advocacy, childcare, education, and life-skills training.	670 W. 9th St.	San Pedro	90731
Homeless Shelters/Housing	South Bay Coalition to End Homelessness	The South Bay Coalition to End Homelessness (SBCEH) is the lead homelessness collaborative in the Los Angeles Continuum of Care (CoC). The mission is to transform and end homelessness in the South Bay through education, advocacy and coordination.	670 W. 9th Street	San Pedro	90731

Organization Type	Organization	Description	Address	City	Zip
Homeless Shelters/Housing	Weingart Center Association - San Pedro	The Weingart Center is a non-profit comprehensive human services organization. Their mission is to empower and transform lives by delivering innovative solutions to combat poverty and break the cycle of homelessness.	566 S San Pedro St	Los Angeles	90013
Hospital	Harbor UCLA Medical Center	Harbor-UCLA Medical Center is one of only five level one trauma centers in Los Angeles County and a major academic teaching hospital with nearly 450 residents and fellows in over 34 accredited programs.	1000 W Carson St	Torrance	90502
Housing	Abode Communities	Abode Communities' mission is to create service-enhanced affordable housing and socially-beneficial community facilities that promote social, economic, and physical transformation of underserved communities.	1149 S. Hill Street, Suite 700 470 N. Hawaiian Ave	Los Angeles Wilmington	90015 90744

Organization Type	Organization	Description	Address	City	Zip
Housing	Los Angeles Homeless Services Authority	LAHSA is the lead agency in the Los Angeles Continuum of Care, which is the regional planning body that coordinates housing and services for homeless families and individuals in Los Angeles County. LAHSA coordinates and manages over $70 million dollars annually in Federal, State, County and City funds for programs that provide shelter, housing and services to homeless persons in Los Angeles City and County.	811 Wilshire Blvd. #600	Los Angeles	90017

Organization Type	Organization	Description	Address	City	Zip
Housing	Mercy Housing California	Mercy Housing California offers affordable low-income housing programs and Resident Services. We are proud to serve our residents and California communities through the development of 128 rental properties across 36 California counties serving low- and very-low-income working poor families, seniors and individuals.	1500 South Grand Avenue 470 N. Hawaiian Ave	Los Angeles Wilmington	90015 90744
Legal Aid	Legal Aid Foundation LA	Now with five neighborhood offices, three Domestic Violence Clinics and four Self-Help Legal Access Centers, LAFLA serves communities as diverse as East Los Angeles, the Westside, South Los Angeles, Koreatown and Long Beach. LAFLA is the first place thousands of poor people turn to when they need legal assistance for a crisis that threatens their shelter, health and livelihood.	825 Maple Ave	Torrance	90503

Organization Type	Organization	Description	Address	City	Zip
Mental Health	Del Amo Hospital	Del Amo Behavioral Health System provides inpatient and outpatient behavioral health treatment for children, adolescents and adults in the Los Angeles, CA area. Led by clinicians recognized for their expertise in mental illness, Del Amo Behavioral Health System provides a peaceful setting for those seeking treatment for mental health, detoxification, sexual addiction, eating disorders, and trauma-related issues.	23700 Camino Del Sol	Torrance	90505
Mental Health	Airport Marina Counseling Services	Airport Marina Counseling Service (AMCS) is a nonprofit, community based mental health clinic that serves the LAX, South Bay and Westside areas of Los Angeles. The mission of AMCS is two-fold: to provide affordable, community based mental health services, and to train mental health therapists.	7891 La Tijera Blvd	Westchester	90045

Organization Type	Organization	Description	Address	City	Zip
Mental Health	Behavioral Health Services	Behavioral Health Services is a not-for-profit community-based healthcare organization providing substance abuse, mental health, drug-free transitional living, older adult services, HIV/AIDS education and prevention, and other related health services to the residents of Southern California.	15519 Crenshaw Blvd 2501 West El Segundo Blvd	Gardena Hawthorne	90249 90250
Mental Health	Didi Hirsch	Didi Hirsch Mental Health Services transforms lives by providing quality mental health care and substance use disorder services in communities where stigma or poverty limit access.	323 N Prairie Ave	Inglewood	90301
Mental Health	LA County Department of Mental Health (San Pedro Clinic)	In addition to serving clients with serious emotional disorders (SED), the San Pedro Clinic also provides medication support, mental health services, and targeted case management services	150 West 7th St.	San Pedro	90731

Organization Type	Organization	Description	Address	City	Zip
Mental Health	Los Angeles Vets Center	Counseling and health services for US Vets	1045 W Redondo Beach Blvd	Gardena	90249
Mental Health	Our House Grief Support Center	Our House Grief Support Center was founded on the premise that grievers need understanding, support, and connection. Services include grief support services, education, resources, and hope.	1663 Sawtelle Blvd., Suite 300 470 N. Hawaiian Ave	Los Angeles Wilmington	90025 90744
Mental Health	San Martin De Porres Counseling Center	San Martin de Porres Center, a non-profit mental health agency, designed to use therapeutic and Psycho-educational methods to treat psychological and emotional problems to enhance a healthier and happier living for the individual and family.	15342 Hawthorne Blvd, Suite 305	Lawndale	90260
Mental Health	South Bay Center for Counseling	Community based counseling/mental health provider	540 North Marine Avenue	Wilmington	90744

Organization Type	Organization	Description	Address	City	Zip
Mental Health	St. Margaret's Center	St. Margaret's Center, a program of Catholic Charities since 1987, provides relief, dignity, and support to low-income persons in crisis and assists individuals through case management and skills development to become more self-sufficient and achieve greater economic security.	10217 Inglewood Ave.	Lennox	90304

Organization Type	Organization	Description	Address	City	Zip
Mental Health	The Children's Institute	Children's Institute, Inc. (CII) serves more than 28,000 children and their families in the city's most challenged neighborhoods, and trains more than 9,000 professionals in the realm of child development, mental health and welfare. CII provides healing so traumatized children can recover and lead healthy lives, while working to shape the field of children's services through innovative research, demonstration projects, and professionally accredited training programs.	21810 Normandie Ave	Torrance	90502
Reproductive Health	Harbor Pregnancy Center	Primary care and family planning services	705 W Pacific Coast Hwy,	Wilmington	90744

Organization Type	Organization	Description	Address	City	Zip
Seniors	Bartlett Senior Center	Bartlett Center is open daily and provides a full range of programs and services. Activities include special interest classes, weekday hot lunches for a nominal fee, exercise and dance classes, card playing, shuffleboard, bingo, pool shooting, lapidary shop, singing groups, speakers and more! Monthly dances are held the first Sunday afternoon of each month for only $2 per person. Call for appointments for free legal and financial advice. Information on social services including Medicare, Medi-Cal, SSI, transportation, and other needs is also available.	1318 Cravens Ave	Torrance	90501
Seniors	Herma Tillim Senior Citizens Center	Recreational and social services for seniors	314 Artesia Blvd	Torrance	90504

Organization Type	Organization	Description	Address	City	Zip
Seniors	H.E.L.P.	H.E.L.P. (Healthcare and Elder Law Programs Corporation) is a 501(c)(3) non-profit organization dedicated to empowering older adults and their families by providing impartial information, education and counseling on elder care, law, finances and consumer protection so they may lead lives with security and dignity.	1404 Cravens Ave	Torrance	90501

Organization Type	Organization	Description	Address	City	Zip
Seniors	Easter Seals Redondo Senior Program	Easter Seals Redondo Senior Program is an adult day program licensed by the state of California. Their mission is to assist seniors with Alzheimer's, dementia, stroke, Parkinson's, or other special needs conditions that cause them to stay in their home communities with their families or in other community settings by providing a safe, stimulating social environment outside the home for them to enjoy, while at the same time providing respite for their caregivers.	3007 Vail Avenue	Redondo Beach	90278
Seniors	Gardena Senior Day Care Center	Recreational and social services for seniors	14517 Crenshaw Boulevard	Gardena	90249
Seniors	Hawthorne Senior Center	Recreational and social services for seniors	3901 El Segundo Blvd.	Hawthorne	90250
Seniors	Inglewood Senior Center	Recreational and social services for seniors	390 El Segundo Blvd.	Hawthorne	90250

Organization Type	Organization	Description	Address	City	Zip
Seniors	San Pedro Service Center-LA County, Senior Lunch Program	$2 Mon-Fri 11a-12	769 W Third St	San Pedro	90731

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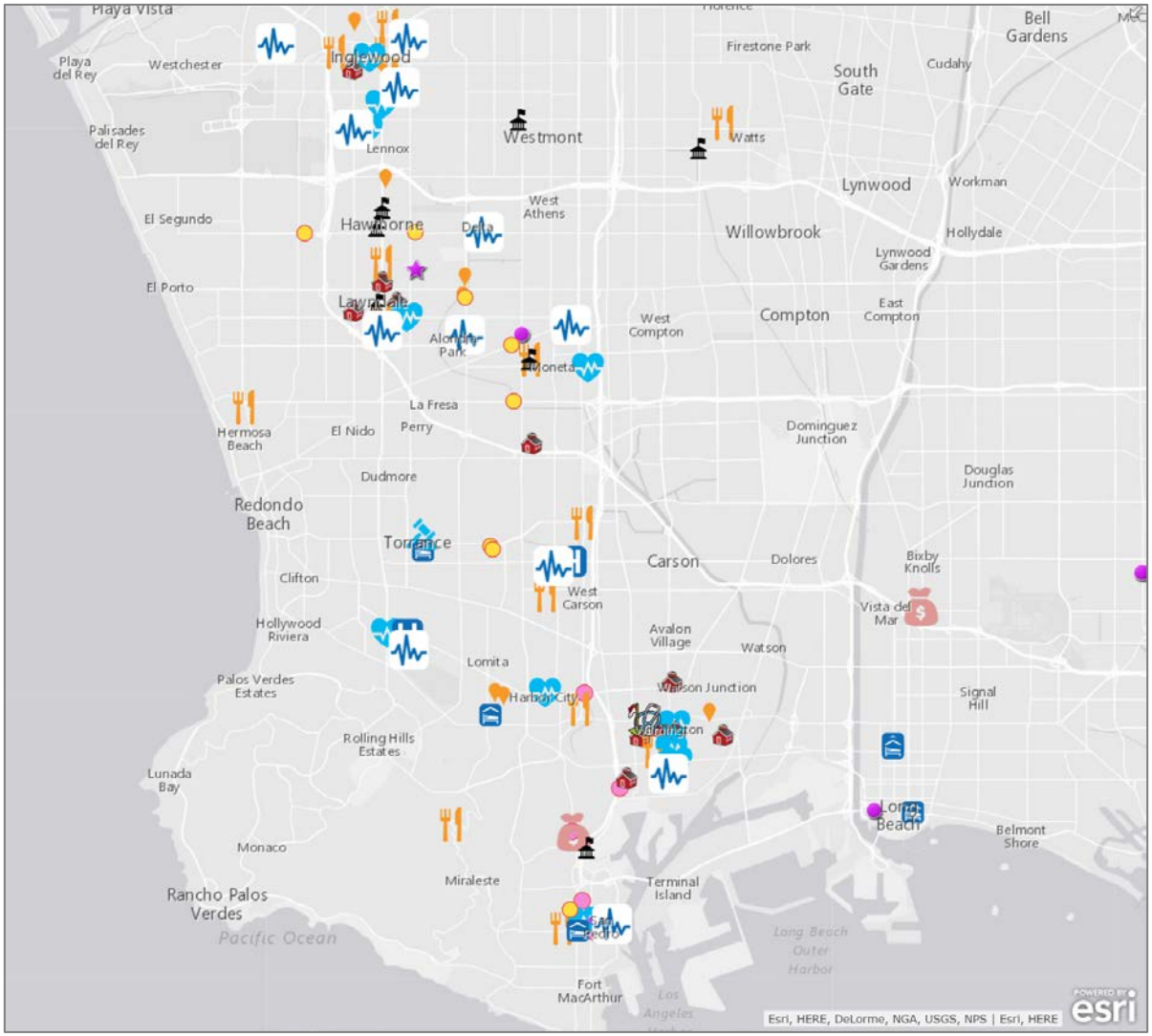

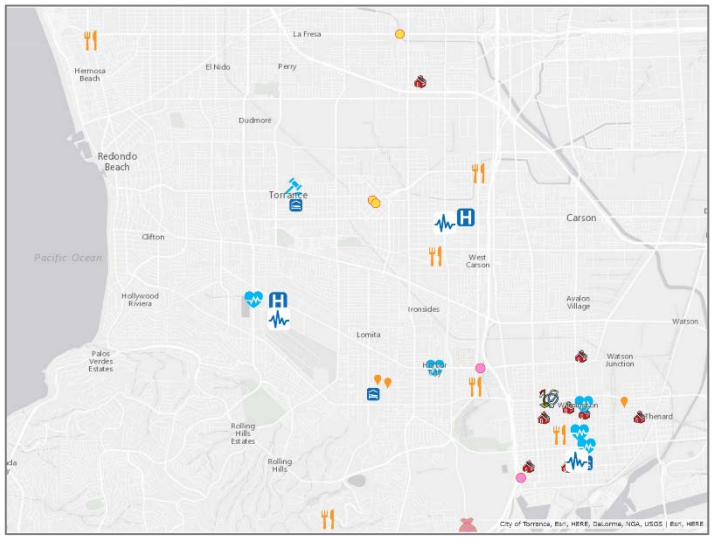

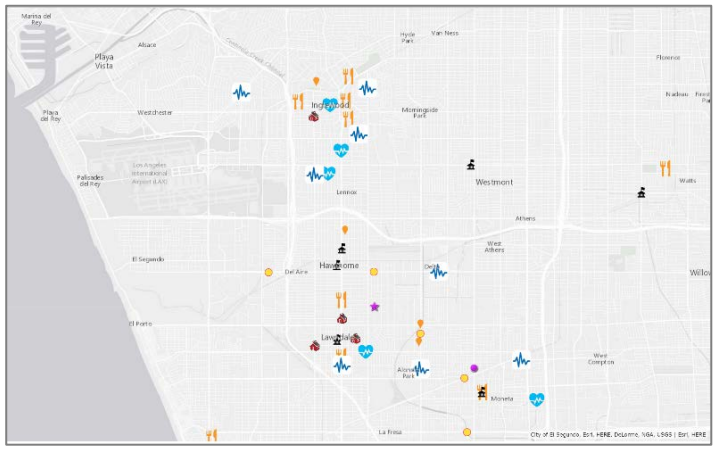

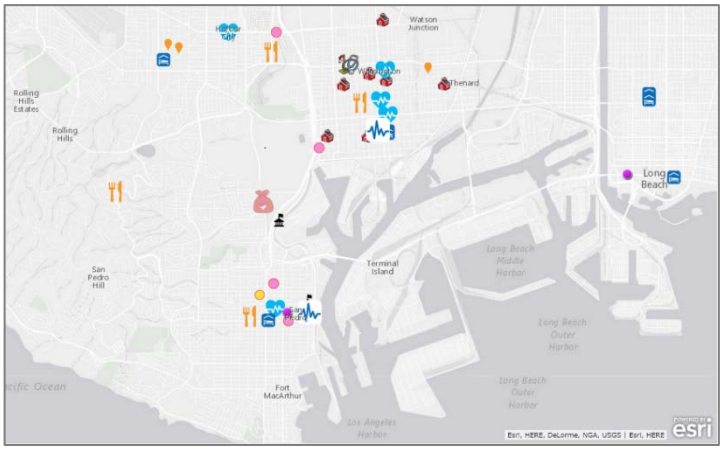

Legend

- Advocacy Organization
- Child abuse treatment and prevention
- Civic Organization
- Comprehensive Social Services
- Consumer Education
- Education
- Economic Development
- Emergency Assistance/Food
- Domestic Violence
- Faith Based Organization
- Government Agency
- Health Care Services
- Homeless Shelters/Housing
- Hospital
- Housing
- Legal Aid
- Mental Health
- Reproductive Health
- Seniors

Appendix III – Qualitative Data Collection Tools

This section inventories the questions used for focus groups, the community based organization partner survey, and key informant interviews.

CHAT Focus Group Questions

1. Let's start by introducing ourselves. Please tell us very briefly your first name, the town/city you live in, and one thing that you are proud of about your community.

2. What do you feel you need to be physically, socially, mentally/emotionally fit?

3. How do you usually meet these needs? What are the biggest barriers and helpful resources to meeting these needs (in your family, community)?

4. How does not meeting these needs affect you? Your family/children? Your community?

5. What resources and strategies do you and your community need to meet these needs?

6. Who/which groups in your community do you think need the most help? (How should resources be prioritized?)

7. In what specific ways has CHAT been beneficial to you? How has your daily routine changed from anything you learned in class?

8. How were you encouraged to actively participate in class? If you did not feel encouraged to participate, what would have made you feel more engaged?

9. What other topics would you like to see covered in classes?

10. Thank you for the information you've shared with me on issues in your community and potential solutions. Is there anything else you would like to add that we haven't discussed?

Preguntas

1. Vamos a empezar con una introducción de nosotros mismos. Por favor, nos puede decir muy brevemente su nombre, la ciudad donde vive, y una cosa por cual usted está orgulloso acerca de su comunidad.

2. ¿ Que necesita usted para sentirse bien físicamente, socialmente, o mentalmente/emocionalmente?

3. ¿Cómo responde usted a estas necesidades ? ¿Cuáles son los obstáculos que usted enfrenta o los recursos que usted necesita para responder a estas necesidades (en su familia, comunidad)?

4. ¿Cómo le afecta a usted no satisfacer estas necesidades? Como le afecta a su familia/ hijos? ¿Cómo le afecta a su comunidad?

5. ¿Qué recursos y estrategias necesita usted y su comunidad para satisfacer estas necesidades?

6. ¿Cuales grupos en su comunidad cree usted que necesitan más ayuda? (¿Cómo debemos priorizar los recursos?)

7. ¿De qué manera ha sido CHAT beneficioso para usted? ¿ Cómo es que lo que usted aprendido en la clase cambio su rutina diaria?

8. ¿Qué lo animo a usted a participar activamente en las clases? Si no se anima a participar, que puede ayudar a usted a sentirse más involucrado?

9. ¿Qué otros temas le gustaría discutir en las clases?

10. Gracias por la información que compartieron con nosotros sobre temas de su comunidad y posibles soluciones . ¿Hay algo más que les gustaría compartir que no hemos platicado?

Insurance Assistance (End-User) Focus Group

1. Let's start by introducing ourselves. Please tell us very briefly your first name, the town/city you live in, and one thing that you are proud of about your community.

2. What is your vision of a healthy community?

3. From your perspective, what are the biggest health and social issues in your community? Why?
    a. Any populations disproportionately affected?

4. What are the barriers to accessing resources in your community? What resources are missing?

5. Did the program help you to successfully enroll in a plan or secure benefits? If so, have you used them and what has been your experience with the enrollment assistance you received and with your new plan (probes: doc available, benefits, pharmacy benefits, premium)?

6. How satisfied are you with the services you received while participating in this program?

7. What do you feel that you struggle the most with financially? What types of educational programs, services, or opportunities do you think would help?

8. Thank you for the information you've shared with me on issues in your community and potential solutions. Is there anything else you would like to add that we haven't discussed?

Preguntas

1. Vamos a empezar con una introducción de nosotros mismos. Por favor, nos puede decir muy brevemente su nombre, la ciudad donde vive, y una cosa por cual usted está orgulloso acerca de su comunidad.

2. ¿Cuál es su visión de una comunidad saludable ?

3. De su perspectiva, ¿cuáles son los mayores problemas sociales y de salud en su comunidad? ¿Por qué?
    a. Cuales grupos en su comunidad cree usted que son mas afectados?

4. ¿Cuáles son las barreras que impiden que usted obtenga los recursos de su comunidad? ¿Con qué recursos faltan?

5. Usted piensa que el programa le ayudo a inscribirse a un plan o obtener beneficios/servicios médicos? Si el programa le ayudo a usted usado sus beneficios y como fue su experiencia con la asistencia para inscribirse con su plan de salud nuevo? (Probes: doctores disponibles, beneficios, beneficios de farmacia, premium)?

6. ¿Qué tan satisfecho está usted con los servicios que recibió durante su participación en este programa ?

7. Financieramente, que gastos se le hacen mas difícil a usted? ¿Qué tipos de programas educativos, servicios, o oportunidades sienten ustedes ocupar?

8. Gracias por la información que compartieron con nosotros sobre temas de su comunidad y posibles soluciones . ¿Hay algo más que les gustaría compartir que no hemos platicado?

Wellness Center Focus Group

1. Let's start by introducing ourselves. Please tell us very briefly your first name, the town/city you live in, and one thing that you are proud of about your community.

2. What is your vision of a healthy community?

3. What are some social problems in your community?

4. Who/which groups in your community do you think need the most help? (How should resources be prioritized?)

5. What do you feel you need to be physically, socially, mentally/emotionally fit?

6. How do you usually meet these needs? What are the biggest barriers and helpful resources to meeting these needs (in your family, community)?

7. How does not meeting these needs affect you? Your family/children? Your community?

8. If courses became available, which courses would you like to see offered?

9. Thank you for the information you've shared with me on issues in your community and potential solutions. Is there anything else you would like to add that we haven't discussed?

Preguntas

1. Vamos a empezar con una introducción de nosotros mismos. Por favor, nos puede decir muy brevemente su nombre, la ciudad donde vive, y una cosa por cual usted está orgulloso acerca de su comunidad.

2. ¿Cuál es su visión de una comunidad saludable?

3. Cuales son los problemas sociales en su comunidad?

4. Cuales grupos en su comunidad cree usted que son mas afectados? (Como deben ser los recursos priorizados?)

5. ¿ Que necesita usted para sentirse bien físicamente, socialmente, o mentalmente/emocionalmente?

6. ¿Cómo responde usted a estas necesidades ? ¿Cuáles son los obstáculos que usted enfrenta o los recursos que usted necesita para responder a estas necesidades (en su familia, comunidad)?

7. ¿Cómo le afecta a usted no satisfacer estas necesidades? Como le afecta a su familia/ hijos? ¿Cómo le afecta a su comunidad?

8. Si cursos fueran disponibles, cuales cursos le gustarian fueran ofrecidos?

9. Gracias por la información que compartieron con nosotros sobre temas de su comunidad y posibles soluciones . ¿Hay algo más que les gustaría compartir que no hemos platicado?

Early Childhood Education (Welcome Baby) Focus Group

1. Let's start by introducing ourselves. Please tell us very briefly your first name, the town/city you live in, and one thing that you are proud of about your community.

2. What is your vision of a healthy community?

3. From your perspective, what are the biggest health and social issues in your community? Why?
    a. Any populations disproportionately affected?

4. How would you assess the quality of the in-home visits? How satisfied are you with the services?
    a. What could they do to improve services?

5. What are some of the barriers you have experienced in trying to get health care or social services for either yourself or your newborn?

6. Did the Welcome Baby program help you to overcome some of these barriers and connect to resources?

7. What other types of services would you be interested in receiving for either yourself or your new born?

8. If you had access to a mobile clinic in your neighborhood, would you use it? If so, what types of services would you want available on board?

9. Is there anything else you would like to add that we haven't discussed?

Preguntas

1. Vamos a empezar con una introducción de nosotros mismos. Por favor, nos puede decir muy brevemente su nombre, la ciudad donde vive, y una cosa por cual usted está orgulloso acerca de su comunidad.

2. ¿Cuál es su visión de una comunidad saludable ?

3. De su perspectiva, ¿cuáles son los mayores problemas sociales y de salud en su comunidad? ¿Por qué?
    a. Cuales grupos en su comunidad cree usted que son mas afectados?

4. ¿Cómo evaluaría la calidad de las visitas en el hogar ? ¿Qué tan satisfecho está usted con los servicios?
    a. ¿Qué podrían hacer para mejorar los servicios?

5. ¿Cuáles son algunas de las barreras que encontraron al tratar de obtener atención médica o servicios sociales, ya sea para usted o su recién nacido?

6. ¿Cómo es que el programa de Welcome Baby le a de ayudado a superar algunas de estas barreras y lo a conectado con los recursos ?

7. ¿Qué otros tipos de servicios estaría usted interesado en recibir, ya sean servicios para usted para su recién nacido?

8. Si usted tuviera acceso a una clínica móvil en su vecindario, la usaría? Si es así , ¿qué tipos de servicios le gustaría fueran disponibles?

9. Gracias por la información que compartieron con nosotros sobre temas de su comunidad y posibles soluciones . ¿Hay algo más que les gustaría compartir que no hemos platicado?

Invitation to Community Based Organizations to Participate in Survey

July 26, 2016

Dear Community Partner,

Every three years, Providence Little Company of Mary Medical Centers (PLCM) conduct a community health needs assessment to further refine how to best meet identified needs, particularly in the most economically disadvantaged communities in our Service Area. As a community stakeholder with direct experience of one or more of our community outreach programs, I am asking for your opinion of the greatest healthcare needs in the communities served by your organization.

The information you provide us, along with quantitative data from government and private sources, will be used to identify the program areas of greatest need across the 15 South Bay communities that make up our Service Area. We also include local feedback from patients, clients, teachers and students who have actively participated in PLCM community outreach programs in the assessment. These multiple data sources and local feedback form the foundation of our analysis of community needs and help us refine our Community Benefit Plan for the next three years.

The name of the person completing this form, and the organization they represent, will be listed in our needs assessment report but none of your comments will be attributed to you, unless I personally request your permission. If you believe other representatives of your organization should participate in this survey, please email this letter and survey to them. Please return by August 19th, 2016.

You can either respond by going online to Survey Monkey at: https://www.surveymonkey.com/r/9CV9VGP or complete the attached form and either email it to Abraham.gossai@providence.org or mail back to me. If you have any further questions you would like to discuss, you can call me directly at 310.303.5086 or reach me through my email, James.tehan@providence.org.

So, *PLEASE*, take a moment to communicate your opinion of the greatest needs of the people you work with on a daily basis. Your input will be considered as we plan for the next three years. Thank you so much for your time.

Sincerely,

Jim Tehan

Regional Director, Community Partnerships
2601 Airport Drive, Suite 220
Torrance, CA 90505
James.Tehan@providence.org
310.303.5086 (direct)
310.257.3599 (fax)

Providence Little Company of Mary Medical Centers, San Pedro & Torrance
2016 Community Health Needs Assessment Survey

1. What aspects of your community contribute to people's health in a positive way? (Ex. neighborhood associations, volunteer groups, accessible parks, etc.)

2. What aspects of your community contribute to people's health in a negative way? (Ex. crime, lack of parks, air quality, lack of access to nutritious foods)

3. How would you rate the health of your community?

   ☐ Excellent

   ☐ Good

   ☐ Fair

   ☐ Poor

   ☐ Don't Know

4. What do you believe are the top 3 health or social issues for the community you serve?

- ☐ Access to health care
- ☐ Health education and outreach
- ☐ Help navigating assistance programs
- ☐ Poverty
- ☐ Education
- ☐ Homelessness
- ☐ Food insecurity
- ☐ Affordable housing
- ☐ Health insurance
- ☐ Dental care
- ☐ Mental health services (including substance abuse services)
- ☐ Pediatric care
- ☐ Geriatric care
- ☐ Access to healthy foods
- ☐ Early childhood education/daycare
- ☐ Economic opportunities and job growth
- ☐ Other _____

5. For each target age group that your organization works with, please SELECT your opinion of the TOP 5 healthcare gaps in EACH CATEGORY below: Access to Primary and Specialty Care, Wellness Education and Connecting People to Services.

ACCESS TO PRIMARY AND SPECIALTY CARE	Children (0-17)	Adults (18-64)	Seniors (65+)
Abuse treatment (i.e. child, domestic elder, sexual assault			
Acute mental health services			
Advanced diagnostic procedures (MRI, CAT, ultrasound)			
Dental care that is affordable			
Screening for acute/chronic conditions (i.e. diabetes, blood pressure, asthma, high cholesterol)			
Home care, hospice, long term care			
Optometry services that are affordable			
Primary care medical services (a regular place to go for health care that is accessible and affordable)			
Specialty medical services (i.e. cardiology, dermatology, orthopedics, endocrinology, neurology, etc.)			
Substance abuse treatment programs			
Other (please specify) _____			

WELLNESS EDUCATION	Children (0-17)	Adults (18-64)	Seniors (65+)
Self-care education programs after diagnosis (i.e. diabetes, blood pressure, asthma)			
Education about navigating the health care system			
Mental health education/coping skills			
Nutrition skills education (healthy choices, counting carbs, reading labels, etc.)			
Parenting education			
Physical activity/physical fitness (goal setting, classes, etc.)			
Substance abuse prevention programs			
Violence prevention/anger management programs			
Other (please specify) _____			

CONNECTING PEOPLE TO SERVICES	Children (0-17)	Adults (18-64)	Seniors (65+)
Cultural and language barriers to obtaining health care			
Affordable housing			
Access to medical services outside of regular business hours (i.e. after 5:00 pm during the week or on weekends)			
Sliding scale or free services for low-income			
Outreach and enrollment into health insurance			
Services with persons with developmental disabilities			
Specialized testing and mental health services for children			
Providers who accept Medi-Cal and Healthy Families			
Services that allow seniors to live at home			
Affordable medical transportation			
Linkage to affordable prescriptions			
Other (please specify) _____			

6. Do you have any additional comments or suggestions that would improve health in the communities you serve?

7. What communities does your organization serve? List by city.

8. Briefly describe the purpose of your organization and who you serve.

Organization Name
Address
City/Zip
Phone
Name/Title of Person Completing the Survey
What are the core services you provide to your clients?
About how many clients did your organization serve last year?
Populations served (Age, race/ethnicity, income levels)

Please complete and return by email or mail to:

James Tehan

Providence Little Company of Mary

Community Health Department

2601 Airport Dr. Suite #220

Torrance, CA, 90505

2016 Community Health Needs Assessment
Key Informant Interview

Name:
Date:
Organization:
Title:

1. Please share your role within your organization and a brief description of your organization.

2. What geographic area do you primarily serve?

3. What is your vision of a healthy community?

4. From your perspective, what are the biggest health and social issues in your community (or among the population you work with)? Why?
    a. Any populations disproportionately affected?

5. Are you aware of societal factors that have influence on the issues we've discussed for your community? If so, what societal issues have the biggest influence on these issues?

6. What are the challenges your community faces in addressing health needs?

7. What existing community assets and resources could be used to address these health issues and inequities?

8. Do you see opportunities for systems-level partnerships that could help address the challenges discussed? (Ex. Between PLCM and your/other organizations in your community)

9. Thank you for the information you've shared with me on issues in your community and potential solutions. Is there anything else you would like to add that we haven't discussed?

Appendix IV—Glossary of Terms

Benchmark

A benchmark is a measurement that serves as a standard by which other measurements and/or statistics may be measured or judged. A "benchmark" indicates a standard by which a community can determine how well or not well the community is performing in comparison to the standard for specific health outcomes.

Community asset

Community assets include organizations, people, partnerships, facilities, funding, policies, regulations, and a community's collective experience. Any positive aspect of the community is an asset that can be leveraged to develop effective solutions.

Federal poverty level

The set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the Department of Health and Human Services and used to determine financial eligibility for certain federal programs. One can calculate various percentage multiples of the guidelines by taking the current guidelines and multiplying each number by 1.25 for 125 percent, 1.50 for 150 percent, etc. 150%, 200%, and 400% are included in the table below.

2016 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in Family/ Household	Poverty Guideline (Level)	150% of the FPL	300% of the FPL	400% of the FPL
1	$11,880	$17,820	$35,640	$47,520
2	$16,020	$24,030	$48,064	$64,080
3	$20,160	$30,240	$60,480	$80,640
4	$24,300	$36,450	$72,900	$97,200
5	$28,400	$42,660	$85,200	$113,760
6	$32,580	$48,870	$97,740	$130,320
7	$36,730	$55,095	$110,190	$146,920
8	$40,890	$61,335	$122,670	$163,560
For families/households with more than 8 persons, add $4,160 for each additional person				

Focus group

A group of people questioned together about their opinions on an issue. For this CHNA, focus groups answered questions related to components of a healthy community and issues in their community.

Food insecurity

A lack of consistent access to food resulting in reduced quality, variety, or desirability of diet or multiple indications of disrupted eating patterns and reduced food intake.

Housing cost burden

Measures the percentage of household income spent on mortgage costs or gross rent. The US Department of Housing and Urban Development currently calls housing affordable if housing for that income group costs no more than 30 percent of the household's income. Families who pay more than 30 percent of their income for housing are considered cost burdened; families who pay more than 50 percent of their income for housing are severely cost burdened.

Health indicator

A single measure that is reported on regularly and that provides relevant and actionable information about population health and/or health system performance and characteristics. An indicator can provide comparable information, as well as track progress and performance over time.

Health professional shortage area

A HPSA is a geographic area, population group, or health care facility that has been designated by the Federal government as having a shortage of health professionals. There are three categories of HPSAs: primary care (shortage of primary care clinicians), dental (shortage of oral health professionals), and mental health (shortage of mental health professionals).

HPSAs are designated using several criteria, including population-to-clinician ratios. This ratio is usually 3,500 to 1 for primary care, 5,000 to 1 for dental health care, and 30,000 to 1 for mental health care.

Healthy People 2020

Healthy People 2020 provides science-based, 10-year national objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress over time to encourage collaborations across communities and sectors, empower individuals toward making informed health decisions, and measure the impact of prevention activities.

Inadequate prenatal care

Expressed as a rate per 1,000 births, inadequate prenatal care refers to an expectant mother having less than five prenatal visits (or none), or care began in the third trimester. This could also be expressed as a percentage.

Infant mortality rate

Expressed as a rate per 1,000 births, this is defined as the death of a child prior to its first birthday (should be read, for example, as 7.8 infant deaths for every 1,000 births).

Live or crude birth rate

Expressed as a rate per 1,000 births, this is calculated by dividing the total number of births in a given year by the total population.

Low birth weight

Expressed as a rate per 1,000 births, this refers to infants born with a weight between 1,500 and 2,500 grams or between 3.3 and 5.5 pounds. Very low birth weight infants are born with a weight less than 1,500 grams.

Medically underserved area

Designation involves application of the Index of Medical Underservice (IMU) to data on a service area to obtain a score for the area. The IMU scale is from 0 to 100, where 0 represents completely underserved and 100 represents best served or least underserved. Under the established criteria, each service area found to have an IMU of 62.0 or less qualifies for designation as an MUA.

The IMU involves four variables - ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and

percentage of the population age 65 or over. The value of each of these variables for the service area is converted to a weighted value, per established criteria. The four values are summed to obtain the area's IMU score.

Medically underserved population

Designation involves application of the Index of Medical Underservice (IMU) to data on an underserved population group within an area of residence to obtain a score for the population group. Population groups requested for MUP designation should be those with economic barriers (low-income or Medicaid-eligible populations), or cultural and/or linguistic access barriers to primary medical care services. This MUP process involves assembling the same data elements and carrying out the same computational steps as stated for MUAs, however, the population is now the population of the requested group within the area rather than the total resident civilian population of the area.

Primary data

Primary data are new data collected or observed directly from first-hand experience. They are typically qualitative (not numerical) in nature. For this CHNA, primary data were collected through focus groups and key informant interviews.

Secondary data

Data that has already been collected and published by another party. Typically, secondary data collected for CHNAs is quantitative (numerical) in nature (for example, data collected by the Centers for Disease Control and Prevention, Los Angeles County Department of Public Health, or Office of Superintendent of Public Instruction).

Stakeholder

A person, group, or organization that has an interest or concern in an organization and its actions. Stakeholders can be upstream (those who worked on the design, implementation, or management of an intervention) or downstream (immediate recipients of an intervention or service or others who did not directly benefit from an intervention or service but are affected nonetheless).

Teen birth rate

Expressed as a rate per 1,000 births, this refers to the quantity of live births by teenagers between the ages of 15 and 19 years of age.

Appendix V- Minutes from 2016 Community Health Needs Assessment Oversight Committee

Providence Little Company of Mary Medical Center, San Pedro
Providence Little Company of Mary Medical Center, Torrance

Minutes from 2016 Community Health Needs Assessment Oversight Committee
November 1, 2016
12:30 – 2:30 pm

Meeting Leaders: Chuck Miller, Dora Barilla, Jim Tehan
Meeting Organizers: Justin Joe, Laura Acosta, Joshua Mendez, Abraham Gossai
Meeting Participants:

Jorge Arroyo	Jan Brandmeyer
Michael Ballue	Gary Carnes, BSN, RN
Eloìsa Gonzalez	Lori Eastman, MSW, LCSW
Tahia Hayslet	Sr. Nancy Jurecki
Robin Hughes	Allison Partridge, RN, BSN
Ben Schirmer, MBA, JD	Elizabeth Sander, MD, FACP

1. Welcome and Reflection [Video] – Chuck Miller, Justin Joe

    a. Chuck began the meeting with a brief welcome and set a goal of prioritizing community health needs identified during the needs assessment process. Justin then shared a video with the group as the Reflection. In the video, a man walks through his community and helps those he passes. He receives nothing in return, except for the emotions he feels for his good deeds. This Reflection served as a reminder to use our hearts when deciding on the needs of the community.

2. Purpose – Dora Barilla

    a. Dora introduced her new position as Executive Leader of Community Investment with Providence Health and Services. She then explained how not-for-profits were required to conduct Community Health Needs Assessments (CHNA). The CHNA process includes data collection and analysis to identify health needs in the Providence Little Company of Mary Service Area. The purpose of this Committee is to then prioritize which health needs will be recommended to the governing Community Ministry Board. After the priority health needs are approved, an implementation plan is developed to address those needs. Once the CHNA and implementation strategies are approved, they are disseminated to the larger community.

    b. Dora went over the different types of data that were collected as part of this CHNA. Secondary data consisted of publicly available state and nationally recognized data sources, including US Census Bureau and Centers for Disease Control. We also received geographically customized data from the Los Angeles County Department of Public Health on 65 core indicators. There were also three sources for primary data. First, we conducted key informant interviews of leaders in community organizations that serve low-income and other vulnerable populations. Next, we used an online survey to gain a better understanding of

the communities we serve and the health needs present. Lastly, we conducted end-user focus groups of our community benefit programs.

3. CHNA Findings – Dora Barilla

    a. Dora listed the top priority health issues that were found in the CHNA:
        (i) Access to healthcare and resources
            1. Enrollment services
            2. Specialty services
            3. Medical home
        (ii) Affordable housing and homelessness
        (iii) Low educational attainment and unemployment
        (iv) Mental Health Services (including substance abuse)
        (v) Poverty and food insecurity
        (vi) Prevention and management of chronic diseases
            1. Obesity
            2. Diabetes
            3. Lack of physical activity
        (vii) Senior care and resources
        (viii) Violence

    Dora asked the Committee if the results were surprising and the group acknowledged that these are issues that they see. Dora stated the importance of looking at social determinants and their social and economic impact. As an example, she noted that diabetes admissions tend to go up near the end of the month as a result of food insecurity when individuals use up their monthly food budget. She also explained the importance of collaboration and partnerships, reiterating that hospitals cannot do everything alone.

    b. For each of the aforementioned health issues, Dora presented data that highlighted disparities between the Community Benefit Service Area (CBSA) and the Broader Service Area (BSA). Data for all of LA County was often included as a baseline. Some of the data presented included:
        (i) A lower percentage of children and adults are insured in the CBSA than in the BSA
        (ii) The Homeless Population in Service planning Area 8 (SPA 8) increased 22% from 2015 – 2016
        (iii) 21% of households in the CBSA are living in poverty in comparison to 8% in the BSA

4. Criteria for Prioritization – Dora Barilla, Jim Tehan

    a. Dora presented the criteria that the group will consider for prioritization. Criteria included:
        (i) Attorney General requirements
        (ii) Input from community
        (iii) Mission alignment and resources of hospital
        (iv) Severity and magnitude
        (v) Addresses disparities of subgroups
        (vi) Existing resources and programs
        (vii) Opportunity for partnership

    Jim expanded on the Attorney General Requirements and explained that each medical center is required to continue certain community benefit programs for the next six years.

b. Dora went over the Prioritization Matrix and how the group was to rank each need against each criterion; a score of 1 denotes that the criterion is not met and a score of 4 indicates that the criterion is well met. Another factor was the weight of each criterion (see example below):
   (i) Need: Affordable housing/homelessness
   Criterion: Opportunity for partnership
   Criterion Weight: 0.25
   If one ranked this as a 4 (meaning that several partnership opportunities exist and the criterion is well met), then the scaled score here is: 4 X 0.25 = 1
   After performing this task for this need with each criterion, the scores were added to come up with one final score for "Affordable housing/homelessness."

The Committee was broken out into two groups, with an even mix of Providence staff and Community representatives. Jim Tehan and Justin Joe facilitated a discussion of each health need against the criteria and the scores from the 2 groups were added.

Below are the results of the prioritization:

Table 1: Prioritized Health Needs 2016

Identified Need	Group 1 Scaled Score	Group 2 Scaled Score	Final Summed Scaled Score	Final Rank
Access to healthcare and resources □ Enrollment services □ Specialty services □ Medical home	**15.75**	**15.25**	**31**	**1**
Prevention and management of chronic diseases □ Obesity □ Diabetes □ Physical activity	**15.5**	**15**	**30.5**	**2**
Mental health services (including substance abuse)	**13.75**	**13**	**26.75**	**3**
Violence	**13.25**	**12.25**	**25.5**	**4**
Affordable housing and homelessness	**12**	**13**	**25**	**5**
Poverty and food insecurity	**12.25**	**12.5**	**24.75**	**6**
Low educational attainment and unemployment	**11.5**	**12.5**	**24**	**7**
Senior care and resources	**11.75**	**10**	**21.75**	**8**

5. Results and Next Steps – Dora Barilla

a) Dora announced the results of the prioritization (shown above in Table 1). The top 5 needs, from highest to lowest score, were as follows:
    1) Access to healthcare and resources
    2) Prevention and management of chronic diseases
    3) Mental health services (including substance abuse)
    4) Violence
    5) Affordable housing and homelessness

Dora explained that the next step is to present this subcommittee's recommendations to the Community Ministry Board on November 29th. An implementation strategy would then be developed to address the priority needs.

Before adjourning the meeting, Chuck asked the subcommittee if it would be helpful to meet annually to discuss the progress that was being made on the implementation strategy and in addressing the priority needs identified by the group. He mentioned that annual meetings would also serve to improve networking and partnerships between the medical centers and community organizations. There was a general consensus from the subcommittee that they would like to participate in annual meetings and it was decided that a survey would be distributed to determine meeting frequency. The survey would also provide a place for subcommittee members to voice their thoughts on how they viewed their role in the needs assessment process.

PROVIDENCE
Little Company of Mary
Medical Centers
San Pedro and Torrance

Community Health Improvement Plan: 2017-19

Providence Little Company of Mary Medical Center—Torrance, California

Providence Little Company of Mary Medical Center—San Pedro, California

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Community Health Improvement Plan 2017-19

Executive Summary

2017 – 2019 Community Health Improvement Plan

Providence Little Company of Mary Medical Center San Pedro

San Pedro, California

Providence Little Company of Mary Medical Center Torrance

Torrance, California

Creating healthier communities, together

As health care continues to evolve, Providence is responding with dedication to its Mission, a vision to simplify health for everyone, and a strategic plan to create healthier communities, together. Partnering with community organizations, we conducted a formal Community Health Needs Assessment (CHNA) to learn about the greatest needs and assets from the perspective of some of the most marginalized groups of people in communities we serve. The CHNA helped us develop collaborative solutions to fulfill unmet needs and guides our community benefit investments, not only for our own programs but also for many partners.

Based on the 2016 CHNA, we identified eight priority health needs. This Community Health Improvement Plan sets forth a framework that will help us measure our progress over the next three years. The objective of this plan is to measurably improve the health of individuals and families living in the communities served by both Providence Little Company of Mary Torrance and Providence Little Company of Mary San Pedro. The plan's target population includes the community as a whole, and specific population groups including minorities and other underserved demographics in lower income communities, which we have labeled for purposes of this report, the Community Benefit Service Area.

Responding to community need, together

These primary and secondary data findings and more are helping us develop collaborative solutions to fulfill unmet needs for some of the most vulnerable groups of people in communities we serve.

- **Access to Care:** Issues with access to care, navigating the system, or other social resources were among the top barriers mentioned by key informants, focus group participants, and community based organizations
- **Homelessness:** From 2015 to 2016, the homeless population in SPA 8 increased by 22 percent, to 3,663 people, according to the Los Angeles Homeless Services Authority.
- **Mental Health:** 13 percent of adults in the Community Benefit Service Area are at risk for major depression, in comparison to 7 percent in the Broader Service Area and 12 percent in Los Angeles County.
- **Violence:** Violence was the top health or social issue noted by focus group participants. Key informants also mentioned violence as having a significant impact on health in our communities.
- **Poverty/Food Insecurity:** In the Community Benefit Service Area, about 35 percent of households with annual incomes less than 300 percent of the federal poverty level are food insecure. Comparatively, 15 percent of households in the Broader Service Area and 30 percent in LA County are experiencing food insecurity.

- **Prevention of Chronic Disease:** Obesity and diabetes rates among children was one of the most frequently mentioned health issues among key informants and focus group participants. Participants expressed a need for more opportunities for physical activity in a safe environment for all members of the family.

This plan includes components of education, prevention, disease management and treatment, and addressing social determinants of health. This work requires collaboration with other hospitals, community agencies, and care providers. It will be facilitated by the Providence Little Company of Mary Community Health Department with assistance from key staff across both Medical Centers.

Priority health needs

This community health improvement plan will respond to the following priorities:

1. Access to Healthcare and Community Resources
2. Prevention and Management of Chronic Diseases
3. Mental Health Services (including substance abuse)
4. Violence
5. Affordable Housing and Homelessness
6. Poverty and Food Insecurity

Action Plans

1) Improve Access to Health Care Services

Our goal is to improve access to quality health care services for vulnerable populations. We will do this by collaborating with community partners to provide services that increase enrollment in and utilization of health insurance, increase the number of people with access to primary care, and increase the number of children who receive their recommended immunizations. Complete details are on pages 14-15 of the full report.

2) Implement Prevention Interventions to Reduce the Prevalence or Progression of Chronic Disease

Our goal is to reduce the prevalence of diabetes and obesity. We will do this by partnering with organizations to increase physical activity, promote healthy nutrition, and educate individuals with diabetes or at-risk of developing diabetes on how to manage the disease. Complete details are on pages 16-17 of the full report.

3) Strengthen Community Based Mental Health Infrastructure to Better Align with Hospital-Based Mental Health Services

Our goal is to improve access to the mental health continuum of care in the South Bay. We will do this by improving integration of mental health in primary care settings, teaching community classes and workshops that build resilience in and reduce the stigma of mental illness, and coordinate access to community mental health resources for patients discharged from our ministries. Complete details are on pages 18-19 of the full report.

4) Develop Partnerships that Address Social Determinants of Health

Our goal is to collaborate with like-minded partners to create social and physical environments that promote good health for local communities. We will particularly focus on the social determinants that were prioritized identified community needs, namely: violence, affordable housing and homelessness, and poverty and food insecurity. We will do this by sustaining and expanding services at the Providence Wellness and Activity Center in Wilmington, strengthening collaborative partnerships with community organizations that focus on the prioritized social determinants of health, and providing services that improve access to healthy food in underserved communities. Complete details are on pages 20-22 of the full report.

This community health improvement plan guides our community benefit investments, and invites other community partners to collectively create a culture of health. Please join us in making our communities healthier together.

Introduction

Creating healthier communities, together

As health care continues to evolve, Providence is responding with dedication to its Mission and a core strategy to *create healthier communities, together*. Partnering with others of goodwill, we conducted a formal community health needs assessment to learn about the greatest needs and assets from the perspective of some of the most marginalized groups of people in communities we serve. This assessment helped us develop collaborative solutions to fulfill unmet needs while continuing to strengthen local resources. It guides our community benefit investments, not only for our own programs but also for many partners, toward improving the health of entire populations.

Serving the South Bay Community

During 2016, the Providence Little Company of Mary Medical Centers provided $72,724,947 in community benefit in response to unmet needs and to improve the health and well-being of those we serve in the South Bay. This includes $8.1 million in Charity Care, $16.7 million in Community Benefit Services, and $47.8 million in Medi-Cal Shortfall. For 2016, the California region provided $250,960,992 in community benefit. The following entities are sponsored by the Providence Little Company of Mary Medical Centers and include:

- Two Providence hospitals:
  - Providence Little Company of Mary Medical Center San Pedro
  - Providence Little Company of Mary Medical Center Torrance
- One home health provider:
  - Providence Little Company of Mary Home Health
- Two Long-term care, assisted living and adult day centers:
  - Providence Little Company of Mary Transitional Care Center
  - Providence Little Company of Mary Sub Acute Care Center
- One hospice for adults
  - Providence TrinityCare Hospice
- One hospice for children
  - Providence TrinityKids Care

About us

Providence Health & Services is a not-for-profit Catholic health care ministry committed to providing for the needs of the communities it serves – especially for those who are poor and vulnerable. Providence's combined scope of services includes 34 hospitals, 475 physician clinics, senior services, supportive housing and many other health and educational services. The health system and its affiliates employs more than 76,000 people across five states – Alaska, California, Montana, Oregon and Washington – with its system office located in Renton, Washington. Our community health activities are rooted in the charitable work the Sisters of Providence started nearly 160 years ago when they answered a call for help from a new pioneer community in the West.

Mission

As people of Providence, we reveal God's love for all, especially the poor and vulnerable, through our compassionate service.

Vision

Together, we answer the call of every person we serve: Know me, Care for me, Ease my way.

Values

Respect, Compassion, Justice, Excellence, Stewardship

Purpose of this Plan

In 2016, Providence Little Company of Mary Medical Centers in San Pedro and Torrance conducted a Joint Community Health Needs Assessment. This community health improvement plan is designed to address key health needs identified in that assessment. The prioritized needs were ranked by the Board Committee on Community Benefit (BCCB) authorized by the Community Ministry Board for Providence Little Company of Mary. The BCCB prioritized needs based on primary and secondary data on community health, while taking into account identifiable gaps in available care and services. In the course of our collaborative work, we determined that emphasis on these needs would have the greatest impact on the community's overall health with significant opportunities for collaboration. These are:

Prioritized Needs Addressed by Community Health Improvement Plan
1. Access to Healthcare and Community Resources 2. Prevention and Management of Chronic Diseases 3. Mental Health Services (including substance abuse) 4. Violence 5. Affordable Housing and Homelessness 6. Poverty and Food Insecurity

Our overall goal for this plan

As we work to create healthier communities, together, the goal of this improvement plan is to measurably improve the health of individuals and families living in the areas served by Providence Little Company of Mary Medical Centers in San Pedro and Torrance. The plan's target population includes the South Bay community as a whole, with special attention to low-income and minority neighborhoods which have been defined in our Community Health Needs Assessment as the Community Benefit Service Area.

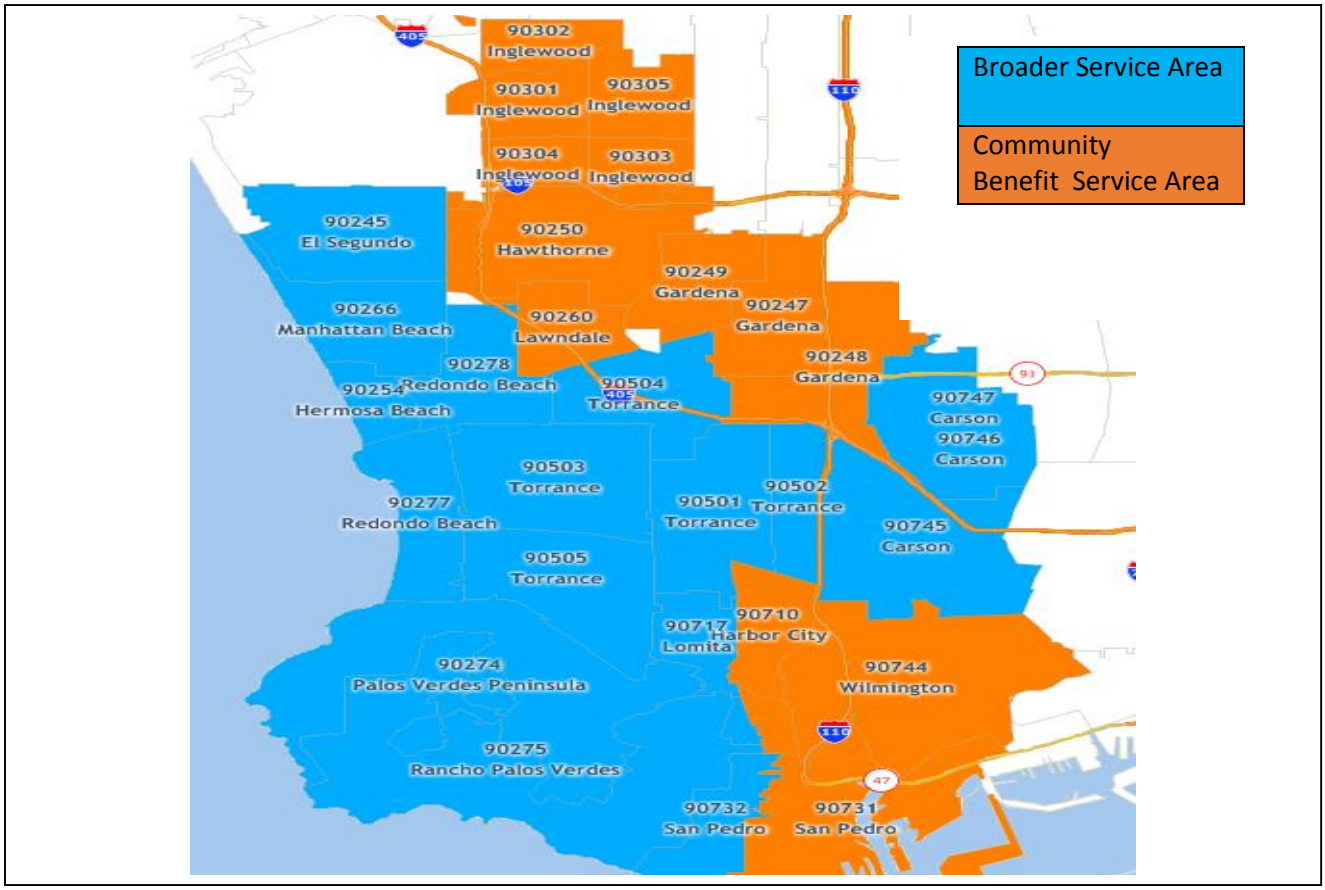
This plan includes components of education, prevention, disease management and treatment, and addressing social determinants of health. This work requires collaboration with other hospitals, community agencies, and care providers. It will be facilitated by the Providence Little Company of Mary Community Health Department with assistance from key staff across both Medical Centers.

Community Profile

The total service area of the two Providence Little Company of Mary Medical Centers encompasses the South Bay region of Los Angeles County. The South Bay is a demographically and geographically diverse area stretching from El Segundo and Inglewood in the north, Carson to the East, the Los Angeles port to the South, and the Pacific Ocean in the west. For purposes of this report, the total service area for Providence Little Company of Mary San Pedro and Torrance is divided into the "Broader South Bay Service Area" and the "Community Benefit Service Area". Secondary data was collected in this manner to highlight the disparities within the service area, between the high need communities and more resource-rich communities.

The Community Benefit Service Area was defined using the Community Need Index (CNI) mapping tool from Dignity Health and Truven Health Analytics. All communities with a score of 4 or greater on the scale were included. Communities identified as having higher need using the scale experience greater barriers to health care including income, cultural, educational, health insurance, and housing barriers. Areas identified as "Community Benefit Service Areas" include the neighborhoods and surrounding areas of Inglewood, Hawthorne, Lawndale, Gardena, Harbor City, San Pedro (90731), and Wilmington. The Broader South Bay Service Area are the communities in blue within the Total Service Area of the two Medical Centers that remain after application of the Community Need Index. These areas are more resource-rich with a population on the higher end of the socioeconomic spectrum.

Providence Little Company of Mary Service Area



Population and Age Demographics

Total population is 1,028,238, with an annual growth rate of about 0.46 percent. Age demographics reveal that 77 percent of the population is aged 18 years or older. The median age in this area is 37.8, compared to U.S. median age of 38.0. In 2016, the population comprised:

- 19 percent youth (0-14 years)
- 13.6 percent adolescent and young adults (15-24)
- 27.1 percent adults (25-44 years)
- 26.4 percent older adults (45-64 years)
- 14 percent seniors (65 years and older)

Ethnicity

Among residents in the Total Service Area in 2016, 45.1 percent were White, 16.8 percent Asian, 39.5 percent were Hispanic or Latino, 0.6 percent were Alaska Native or American Indian, 13.2 percent were African American or Black, 0.7 percent were Native Hawaiian or other Pacific Islander, and 5.4 percent were of two or more races.

Income Levels and Housing

In 2016, the median household income in the Total Service Area was $65,240, compared to $54,149 for all U.S. households. Median household income is projected to be $75,368 in five years, compared to $59,476 for all U.S. households. 47 percent of the 375,048 housing units in the area are owner occupied; 47.9 percent, renter occupied; and 5.1 percent are vacant. Comparatively, in the U.S., 55.4 percent of the housing units in the area are owner occupied; 32.9 percent are renter occupied; and 11.7 percent are vacant.

Half of the households in the Community Benefit Service Area could be considered low-income, earning $50,000 or less per year (50 percent). Comparatively, 27 percent of households in the Broader South Bay Service Area have a household income of $50,000 or less and 47 percent earn $100,000 or more per year.

Health Care and Coverage

In 2016, the percent of individuals who were uninsured was 5.2 percent. In 2015, 43 percent of adults in the Community Benefit Service Area had not seen a dentist or gone to a dental clinic in the past year. Comparatively, 30 percent of adults throughout the Broader South Bay Service Area and 41 percent of adults throughout Los Angeles County did not receive dental care in the past year.

Health and Wellbeing

In 2015, 20 percent of adults in the Community Benefit Service Area reported their health to be fair or poor. Comparatively, 19 percent of adults in the Broader South Bay Service Area and 22 percent of adults in LA County reported fair or poor health. The percentages of children living with special needs are 17 percent in the Community Benefit Service Area, 16 percent in the Broader South Bay Service Area and 15 percent throughout LA County.

Summary of Providence Prioritized Needs and Associated Action Plans

Assessment process

Every three years, Providence Little Company of Mary Medical Centers, San Pedro and Torrance conduct a community health needs assessment (CHNA) across the South Bay Community. The passage of California Senate Bill (SB) 697 in 1994 initiated a requirement that non-profit Hospitals in California conduct a triennial CHNA. Additionally, the CHNA is conducted to satisfy our annual community benefit obligations by meeting requirements that are outlined in section 501(r)(3) of the Federal IRS Code and to create partnerships that address identified needs. The goals of this assessment are to:

- Engage public health and community stakeholders including low-income, minority, and other underserved populations
- Assess and understand the community's health issues and needs
- Understand the health behaviors, risk factors and social determinants that impact health
- Identify community resources and collaborate with community partners
- Use Assessment findings to develop and implement a 2017-2019 implementation plan based on the prioritized issues

Beginning with the 2013 CHNA, the two medical centers agreed to conduct a Joint CHNA in accordance with §1.501(r)-3(b)(6)(v) of the Federal IRS code 26 CFR Parts 1, 53, and 602 ("Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return; Final Rule"). Accordingly, representatives of both medical centers agreed to participate on the Board Committee on Community Benefit (BCCB) authorized by the South Bay Community Ministry Board. In collaboration with community representatives, the oversight group considered primary and secondary data collected and prioritized community needs as described below.

Outside Consultant: HC2 Strategies, Inc.

Little Company of Mary Medical Centers, San Pedro and Torrance utilized HC2 Strategies, Inc. to conduct and document this community health needs assessment. HC2 Strategies, Inc. is a healthcare consulting firm with expertise in health care systems, strategy and innovation, community health needs assessments, and program evaluation.

Data collection

Primary Data

Providence Little Company of Mary Medical Centers conducted key informant interviews, focus groups, and an online survey with community based organizations to gather more insightful data and aid in describing the community. Key informants were selected based on their expertise in working with low-income, medically underserved, minority, or otherwise vulnerable populations. Focus groups focused on end-user experiences and needs. The online survey was targeted to community based safety net organizations and focused on service needs among clients. **Secondary Data**

In 2016, regional staff from Providence Health and Services Southern California provided leadership that resulted in the formation of a coalition of hospitals across Los Angeles County. This group—the LA County Community Health Assessment and Action Partnership ("LA Partnership")—worked to devise

standard core indicators for community health to be used in community health needs assessments, implementation plans, and program planning. The efforts of the coalition resulted in an enhanced custom report furnished by the Epidemiology Unit at the Los Angeles Public Health Department.

The custom report presented data grouped by zip code to further breakout and define communities of greater and lower need in the Total Service Area and identify disparities between communities. For each of the 65 core indicators, data was obtained for the Community Benefit Service Area (neighborhoods of greater need), the Broader South Bay Service Area (remaining zip codes after application of the Community Need Index), and Los Angeles County. Other secondary data sources included publicly available state and nationally recognized data sources, such as the US Census Bureau, Centers for Disease Control and Prevention, Community Commons, Nielsen, and various other state and federal databases.

Identification of significant health needs

The criteria selected for determining significant health needs were chosen per the IRS 501(r) regulations for conducting community health needs assessments and developing implementation plans. The BCCB used these criteria in a prioritization matrix to determine the final list of prioritized needs.

The Prioritization Matrix uses a mathematical process whereby participants assign a priority ranking to issues based on how they measure against established criteria. Weighting of each criteria was selected based on input from the panel of experts at HC2 Strategies, Inc. that included public health professionals, persons with expertise in hospital administration, and persons with expertise in conducting community health needs assessments from the Providence Medical Centers in Los Angeles County.

Identified Community Health Needs in 2016	
Priority Health Issue	**Rationale/contributing factors**
Access to healthcare and resources • **Enrollment services** • **Specialty services** • **Medical home**	• Even after ACA, the Community Benefit Service Area has lower percentages of insured adults and children, adults and children receiving dental care services in the past year, and mothers receiving prenatal care in the first trimester in comparison to the Broader Service Area. • Issues with access to care, navigating the health system, or other social resources were among the top barriers mentioned by key informants, focus group participants, and community based organizations • Key informants consistently cited a need for more health and physical education and outreach to ensure client access to and use of services. The need for health navigator type services in combination with medical care was also expressed.
Affordable housing and homelessness	• SPA 8 has the 5th largest homeless population among the SPAs with a growing population of those in need. From 2015 to 2016, the homeless population in SPA increased by 22 percent, to 3,663 people,

	according to the Los Angeles Homeless Services Authority. • Key informants mentioned homelessness as an inevitable consequence of housing cost burden, low-income, and lack of economic opportunities. Participants also noted a growing number of homeless persons served in the past year.
Low educational attainment and unemployment	• Unemployment is as high as 21 percent in neighborhoods in the Community Benefit Service Areas. These areas also have higher rates of people who are living below the poverty level and employed full time. • Economic opportunities and job growth were consistently mentioned by focus group participants. Participants expressed a need for occupational training and availability of jobs paying a living wage.
Mental health (services including substance abuse)	• Mental health was one of the most frequently mentioned health need by key informants, focus group participants, and community based organizations. All participants noted a need for more specialty (substance, trauma, coping skills) and integrated services for all age levels. • 13 percent of adults in the Community Benefit Service Area are at risk for major depression, in comparison to 7 percent in the Broader Service Area and 12 percent in Los Angeles County.
Poverty and food insecurity	• Poverty was consistently mentioned as a key driver of health across key informant interviews and focus groups and was the top ranked health or social determinant mentioned. • 21 percent of households in the Community Benefit Service Areas are living in poverty in comparison to 8 percent in the Broader Service Area. • In the Community Benefit Service Area, about 35 percent of households with annual incomes less than 300 percent of the federal poverty level are food insecure. Comparatively, 15 percent of households in the Broader Service Area and 30 percent in LA County are experiencing food insecurity.
Prevention and management of chronic diseases • **Obesity** • **Diabetes** • **Physical activity**	• Secondary data showed lower rates of adults diagnosed with diabetes in the Community Benefit Service Area in comparison to other areas, but higher hospital admissions rates. This suggests issues in connecting to primary care providers and/or screening services. • Obesity and diabetes rates among children was one of the most frequently mentioned health issues among key informants and focus group participants.

	Participants expressed a need for more opportunities for physical activity in a safe environment for all members of the family.
Senior care and resources	• The Alzheimer's disease-specific death rate for the Broader South Bay Service Area (26.2 per 100,000) is greater than the Community Benefit Service Area (22.0 per 100,000).and LA County (25.1 per 100,000) estimates. • 27 percent of adults age 65 and older in the Broader South Bay Service Area have fallen in the past year in comparison to 25 percent in the Community Benefit Service Area.
Violence	• Violence was the top health or social issue noted by focus group participants. Key informants also mentioned violence as having a significant impact on health in our communities. • 17 percent of adults living in the Community Benefit Service Area have experienced physical or intimate partner violence in the past year in comparison to 9 percent in the Broader South Bay Service Area.

Prioritization of Community Health Needs

On November 1, 2016, BCCB members, authorized by the Community Ministry Board for PLCM, met to debrief on the findings of the CHNA and prioritize the identified needs. Committee members were provided the scores for three criteria: input from the community (primary data), severity and magnitude (secondary data), and programs required by the Attorney General as part of the Combination Agreement between Providence Health and Services and St. Joseph Health. Committee members were broken into two separate groups and asked to rank the remaining four criteria based on their expertise, using a scale of 1 (criterion not met) to 4 (criterion well met). Two facilitators helped participants reach a ranking for each of the eight identified priority issues. The rankings for each group were scored and the scores were tallied for each priority health need. The final ranked list:

(1) Access to healthcare and resources,
(2) Prevention and management of chronic diseases
(3) Mental health services (including substance abuse treatment)
(4) Violence
(5) Affordable housing and homelessness
(6) Poverty and food insecurity
(7) Low educational attainment and unemployment
(8) Senior care and resources.

Based on the prioritized health needs, Providence staff, in consultation with the South Bay Chief Executive, developed four strategies that address the top six priority needs. These strategies include a goal statement, measurable objectives designed to reach the goal, and tactics that will be employed to accomplish each measurable objective.

Strategy 1: Improve Access to Health Care Services

Community need addressed: Access to Healthcare and Resources

Goal: Improve access to quality health care services for vulnerable populations

Objectives:

- Increase enrollment in and utilization of health insurance
- Increase the number of people with a primary care provider
- Increase the number of children who receive the recommended immunizations

Action plan

Health Insurance

Tactics

- Community Health Insurance Program: utilize community health workers—bilingual in English and Spanish--to provide outreach and education about affordable health insurance options to hard-to-reach populations. Community health workers assist clients with completing applications for Medi-Cal and Covered California.
- Provide information and skills to newly insured adults on how to effectively utilized health insurance benefits
- Emergency Room Promotoras: screen uninsured patients in the emergency departments of our medical centers for Medi-Cal and assist them with applying for Medi-Cal coverage.

Primary Care

Tactics

- Vasek Polak Health Clinic: Continue to operate as a clinic for uninsured or underinsured adults. Expand the clinic to serve patients with Medi-Cal, and develop additional whole-person services to be provided at the clinic to serve as medical home for patients. This includes health education, referrals to low-cost social services, linkage to specialty services and mental health support.
- Emergency Room Promotoras: link uninsured emergency department patients with a local community clinic to serve as their medical home for future primary care visits
- Provide sports physicals at local high schools

Immunizations

Tactics

- Partners for Healthy Kids: sustain operations of mobile pediatric clinic that offers free weekly immunizations at elementary, middle, and high schools.
- Promote HPV and meningococcal immunizations with local pediatricians and family practice physicians to encourage parents to have their children receive these vaccinations

Partners in collaboration

Harbor Community Clinic, San Pedro

Wilmington Community Clinic

South Bay Family Health Care, Torrance

Hawthorne School District

Inglewood Unified School District

Lawndale Elementary School District

Torrance Unified School District

Centinela Valley Union High School District

Los Angeles Unified School District

St Joseph's Church, Hawthorne

St Margaret Mary Church, Lomita

Harbor Interfaith Services, San Pedro

Harbor UCLA Department of Family Medicine, Harbor City

Behavioral Health Services, Gardena

L.A. Harbor College, Harbor City

Measurement

- # of clients provided application assistance
- # of clients enrolled in health insurance
- # of patients receiving recommended immunizations
- # of ER patients linked to primary care provider appointment schedule

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

Community needs addressed: Prevention and Management of Chronic Diseases

Goal: To reduce the prevalence of diabetes and obesity

Objectives:

- Partner with local schools to reach the state-recommended standard of minutes of physical education instruction
- Increase number of adults who meet the CDC recommended standard of physical activity
- Increase the number of structured movement activities available for children and adults
- Raise awareness of better eating habits through structured nutrition education events
- Increase access to healthier foods in lower-income communities
- Reduce the average A1C % of diabetic GOAL program participants by 1.3%
- Implement a diabetes prevention program for an at-risk adult population

Action plan

Increase Physical Activity for Children and Adults

Tactics

- Sustain the delivery of the COPA program in LAUSD and Lawndale school districts
- Expand COPA into the Inglewood Unified School District
- Increase the scope of physical activity classes for children, adults and seniors at the Providence Wellness and Activity Center
- Partner with other organizations to develop wellness visits, including physical activity programs for adults in community settings such as churches or parks

Promote Healthy Eating

Tactics

- Host "Fit Food Fairs" at the Wellness and Activity Center which teach local residents on how to cook healthy foods
- Pilot Groceryships—a non-profit nutrition education and support group program—at the Wellness and Activity Center. Expand into additional community settings throughout the South Bay Community based on lessons learned in pilot phase.
- Increase CalFresh enrollment through application assistance in community settings
- Work with local farmers markets to accept CalFresh as a form of payment

Diabetes Self-Management Education

Tactics

- Grow the number of community sites where GOAL (Diabetes Self-Management Classes) is delivered
- Strengthen the linkage of Providence patients with diabetes and refer to community based GOAL classes
- Adopt an evidence based curriculum for Pre-diabetic patients and work with hospital or community partner to strengthen the infrastructure of classes

Partners in collaboration

Hawthorne School District

Inglewood Unified School District

Lawndale Elementary School District

Los Angeles Unified School District

Centinela Valley Union High School District

Los Angeles County Department of Health Services including Public Health & Mental Health

St. Joseph Church, Hawthorne

Holy Family Church, Wilmington

Measurement

- # of schools, teachers, and students in COPA
- Increased physical activity time by students in PE lessons
- # of adult COPA participants, including attendance rate, BMI and other metrics TBD
- # of households enrolled in CalFresh
- Average reduction in A1C for GOAL participants
- # of Groceryships cohorts, # of participants who complete course, attendance rate and course completion rate
- # of Fit Food Fairs hosted

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

Community needs addressed: Mental Health (including substance abuse treatment)

Goal: Improve access to the mental health continuum of care in the South Bay

Objectives:

- Improve integration of mental health in primary care settings
- Build resilience in children, teens, families and seniors
- Reduce the stigma of mental illness
- Reduce symptoms of depression and anxiety

Action plan

Prevention

Tactics

- Teach coping skills and resiliency classes for adults at the Providence Wellness and Activity Center and in community settings such as local churches.
- Pilot Adolescent Coping Education Series (ACES) for middle school students
- Provide educational outreach presentations in community settings to reduce the stigma associated with mental health services, including Mental Health First Aid

Treatment

Tactics

- Collaborate with Richstone Family Center to provide a licensed therapist located within the Vasek Polak Health Clinic for patients diagnosed with depression or anxiety
- Coordinate post discharge linkage to community resources for patients discharged from PLCMMC, San Pedro Crisis Stabilization Unit

Partners in collaboration

Richstone Family Center, Hawthorne

Behavioral Health Services, Gardena

LAC Department of Mental Health, San Pedro

Mental Health America, San Pedro

Didi Hirsch Mental Health Services, Inglewood

Harbor UCLA CTSI/LA Biomed, Torrance

National Council for Behavioral Health

Measurement

- % of primary care patients screened for depression and/or anxiety
- # of community members trained on Mental Health First Aid
- # of adults and youth who complete CHAT or ACES curriculum
- Pre-post decrease in average PHQ-9 score of patients who complete therapy sessions

Strategy 4: Develop Partnerships that Address Social Determinants of Health*

*Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins.

- Healthy People 2020. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion

Community needs addressed: Violence, Affordable Housing & Homelessness, Poverty and Food Insecurity

Goal: Collaborate with like-minded partners to create social and physical environments that promote good health for local communities.

Objectives:

- Reduce household food insecurity
- Reduce social isolation by providing opportunities for residents to build social connections
- Increase breadth/diversity of programs provided at the Providence Wellness and Activity Center in Wilmington provided by community partners or volunteers
- Establish a subcommittee of the local coalition to end homelessness attended by area hospital representative who have regular involvement with homeless adults and families

Action plan

Providence Wellness and Activity Center

Tactics

- Aim to reduce social isolation and develop skills in local residents by partnering with organizations and volunteers to provide classes and activities at the Providence Wellness and Activity Center in Wilmington, CA. Examples of classes and activities include: exercise, sports, nutrition, music, financial literacy, culture, and mental health education.

- Seek out opportunities to replicate some or all of services provided at Wellness Center by partnering with a school district or church in the northern portion of the Community Benefit Service Area

Strengthen Collaborative Organizational Partnerships

Tactics

- Host briefings for community leaders/stakeholders centered around violence, affordable housing and homelessness, or poverty and food insecurity
- Sexual Assault Response Teams: Partner with local law enforcement to provide a safe and private space for victims of sexual assault and linkage to community organizations who provide ongoing victim support services
- Explore partnering with local nonprofit hospitals to fund or develop projects that address social determinants (i.e. health careers pipeline at a local school district; subsidy of an identified number of homeless high utilizers to arrange housing solutions)

Improve Access to Healthy Food

Tactics

- Increase CalFresh enrollment through application assistance and work with local farmers markets to accept CalFresh as a form of payment
- Work with hospital departments to facilitate donations to local South Bay safety net organizations

Partners in collaboration

Los Angeles Police Department

Los Angeles County Sheriff

Los Angeles County Department of Health Services

Harbor Interfaith Services

Catholic Charities

Abode Communities

Mercy Housing

State of California Department of Social Services (Cal Fresh)

South Bay Coalition to End Homelessness

SBCC Thrive

First 5 LA

Measurement

- # of households enrolled in CalFresh
- # of events hosted by trained community resident leaders
- # of classes/activities held at the Providence Wellness and Activity Center
- # of participants at Providence Wellness and Activity Center events

Identified Health Needs Not Addressed in Plan

As part of the CHNA process, the South Bay Community Ministry Board (CMB) approved the formation of the Board Committee on Community Benefit (BCCB), a group of seven Providence employees across both medical centers and seven external representatives from Public Health, local schools, community based organizations, an FQHC and a local grant-making agency, After considering all of the assembled data, this group of 14, along with the CMB Chair, prioritized the identified health needs using specific criteria described in the CHNA.

Of the top eight identified needs, this 2017 – 19 Community Health Improvement Plan will address six:

(1) Access to healthcare and resources
(2) Prevention and management of chronic diseases
(3) Mental health services (including substance abuse treatment)
(4) Violence
(5) Affordable housing and homelessness
(6) Poverty and food insecurity

After consultation with the South Bay Chief Executive, consideration of existing resources, and the potential to identify new resources, the decision was made that the two identified needs below will not be a focus of the 2017 – 19 Community Health Improvement Plan.

- Low educational attainment and unemployment
- Senior care and resources.

2017-19 Plan approval

This Community Health Improvement Plan was adopted on March 28, 2017 by the Providence Little Company of Mary Community Ministry Board.

Mary E Kingston

Mary Kingston
South Bay Chief Executive

4/19/17
Date

John Armato

John Armato, MD
Chair, South Bay Community Ministry Board

4/27/17
Date

Jim Tehan

Jim Tehan
Regional Director, Community Benefit and Partnerships
Providence Health and Services

4/28/17
Date

Joel Gilbertson

Joel Gilbertson
Senior Vice President, Community Partnerships
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