2022

COMMUNITY HEALTH NEEDS ASSESSMENT

Providence San Fernando Valley Medical Centers

Providence Holy Cross Medical Center, Mission Hills, California
Providence Saint Joseph Medical Center, Burbank, California
Providence Cedars Sinai Tarzana Medical Center, Tarzana, California

Providence Holy Cross Medical Center | Providence Cedars Sinai Tarzana Medical Center | Providence St. Joseph Medical Center

To provide feedback on this CHNA or obtain printed a copy free of charge, please email Anthony Ortiz-Luis at Anthony.OrtizLuis@providence.org.

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MESSAGE TO THE COMMUNITY

The Providence Mission calls for us to be steadfast in serving all, especially our neighbors who are most poor and vulnerable. The Providence San Fernando Valley Medical Centers which includes Providence Holy Cross Medical Center, Providence Saint Joseph Medical Center, and Providence Cedars Sinai Tarzana Medical Center has been serving the communities of the San Fernando Valley for more than 100 years. The Community Health Needs Assessment (CHNA) is an opportunity to engage the communities we serve every three years with the goal of better understanding community strengths and needs. Our Vision is "Health for a Better World," and to achieve that we believe we must address not only the clinical care factors that determine a person's length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes.

The last three years of the pandemic has been difficult and challenging for many of the communities we serve. However, it has also displayed the compassionate, resilient, and generous qualities of our communities willing to help our most vulnerable, poor neighbors. This was evident on how the communities of the San Fernando Valley banded together to provide food to seniors that were immunocompromised or homebound unable to go grocery shopping, community groups showing their appreciation to frontline and healthcare workers on a regular basis at our hospital ministries, and how neighbors worked to help and assist one another.

Providence is hopeful that as our communities move beyond the pandemic that we can work collaboratively together to meet the identified needs of our communities so that we can get closer to the vision of the Sisters of Providence and Saint Joseph of a "Health for a Better World".

ACKNOWLEDGEMENTS

This joint Community Health Needs Assessment was conducted between Providence Holy Cross Medical Center, Providence Saint Joseph Medical Center, and Providence Cedars Sinai Tarzana Medical Center.

EXECUTIVE SUMMARY

Understanding and Responding to Community Needs

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

The 2022 CHNA was approved by the Valley Service Area Board of Directors on October 20, 2022 and the Providence Cedars Sinai Tarzana Medical Center Board of Managers approved the CHNA on November 15, 2022. The CHNA report was made publicly available on December 28, 2022.

Gathering Community Health Data and Community Input

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

- Access to quality, affordable care continues to be an issue for many families
- Housing instability remains a problem for many of our communities especially those that are already vulnerable like seniors on fixed income, households spending more than half of their income on housing, and at-risk youth
- The pandemic caused many individuals and families to delay care due to the fear of contracting the COVID virus which resulted in compounding of chronic conditions as well as mental health illness for youth and adults
- Substance use/misuse is an escalating concern for our communities particularly related to marijuana use, tobacco and alcohol abuse, and overdoses

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

Identifying Top Health Priorities

Working with local community members, public and private partners, Providence leadership, and the Mission Community Health Committee members prioritized and identified the top three priority areas below.

PRIORITY NUMBER 1: ACCESS TO HEALTH CARE

Access to health care refers to the availability of primary care, specialty care, vision care and dental care services. Health insurance coverage is considered a key component to ensure access to health care. Barriers to care can include lack of transportation and a lack of linguistically appropriate and culturally responsive care.

PRIORITY NUMBER 2: HOUSING AND HOMELESSNESS

Homelessness is known as a state of being unhoused or unsheltered and is the condition of lacking stable, safe, and adequate housing. Housing instability encompasses several challenges such as having trouble paying rent, overcrowding, moving frequently, staying with relatives, or spending the bulk of household income on housing.

PRIORITY NUMBER 3: MENTAL HEALTH INCLUDING SUBSTANCE USE/MISUSE

Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. Substance use is the use of tobacco products, illegal drugs or prescription or over-the-counter drugs or alcohol. Excessive use of these substances or use for purposes other than those for which they are meant to be used can lead to physical, social or emotional harm.

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

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

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

INTRODUCTION

Who We Are

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

Providence San Fernando Valley (SFV) includes three medical centers: Providence Saint Joseph Medical Center, Providence Holy Cross Medical Center, and Providence Cedars-Sinai Tarzana Medical Center.

Providence Saint Joseph Medical Center is located at 501 S Buena Vista St, Burbank, CA 91505. It is an acute care hospital with 392 licensed beds founded in 1943. The medical center provides the full range of diagnostic, treatment, care and support for San Fernando Valley communities. Key services include comprehensive maternity care and a state-of-the-art neuroscience institute.

Providence Holy Cross Medical Center is located at 15031 Rinaldi St, Mission Hills, CA 91345. It is an acute care hospital with 377 licensed beds founded in 1961. As essential caretake of the San Fernando, Santa Clarita, and Simi Valley Communities, Providence Holy Cross Medical Center offers both inpatient and outpatient health services, all of which embrace a holistic and family-centered approach to care. Key services include a state-of-the-art Cancer Center and emergency and trauma services.

Providence Cedars-Sinai Tarzana Medical Center is located at 18321 Clark St, Tarzana, CA 91356. It is an acute care hospital with 249 licensed beds founded in 1973. In addition to heart, vascular, orthopedic, cancer, and women's services, the medical center houses the largest Level III Neonatal Intensive Care Unit (NICU) in the area and the emergency department has been designated by the Los Angeles County Department of Health as a STEMI and stroke receiving center.

These three Providence San Fernando Valley community medical centers share a common geography because of their close proximity to each other.

Our Commitment to Community

Providence San Fernando Valley Medical Centers dedicate resources to improve the health and quality of life for the communities we serve. During 2021, the Providence Los Angeles Region provided $287

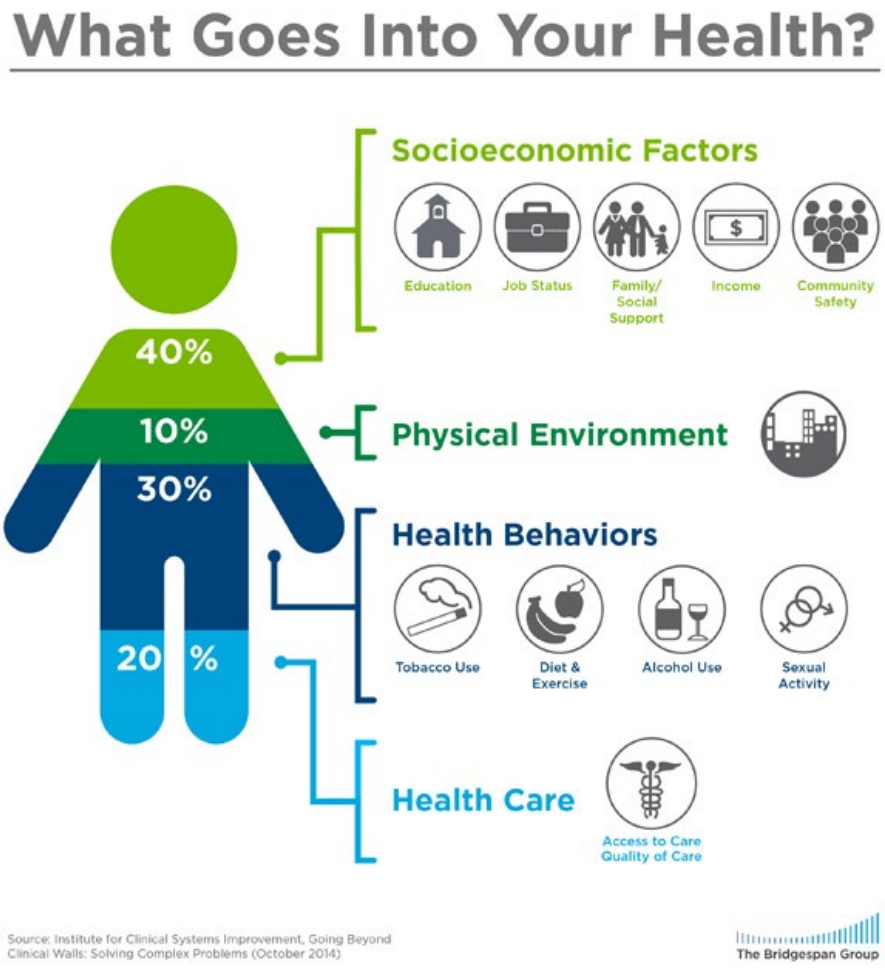
Million in Community Benefit[1] in response to unmet needs and to improve the health and well-being of those we serve in the west Los Angeles community.

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

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

Health Equity

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



Factors contributing to overall health and well-being

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

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

Health Equity

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

Health Disparities

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

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

Approach

Explicitly name our commitment to equity

Take an asset-based approach, highlighting community strengths

Use people first and non-stigmatizing language

Community Engagement

Actively seek input from the communities we serve using multiple methods

Implement equitable practices for community participation

Report findings back to communities

Quantitative Data

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

Disaggregate data when responsible and appropriate

Acknowledge inherent bias in data and screening tools

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

For this CHNA, community stakeholders were asked to identify vulnerable populations who were most impacted by the identified significant community needs.

Project Oversight

The Community Health Needs Assessment process was overseen by:

Anthony Ortiz-Luis, MS

Director, Community Health

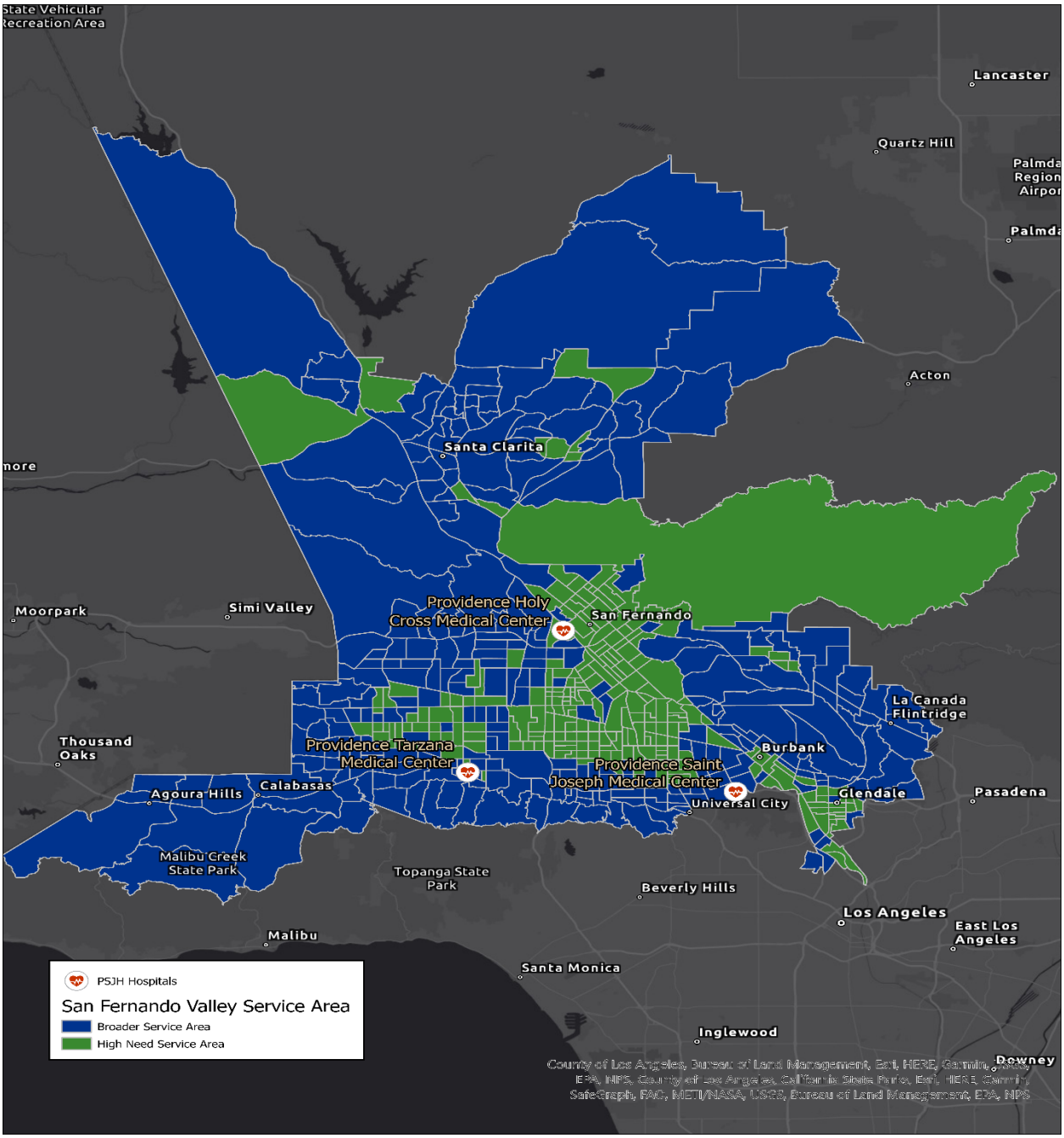
Providence San Fernando Valley Medical Centers

Consultant

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

OUR COMMUNITY

Hospital Service Area and Community Served



The three Providence SFV medical centers share a common geographic service area because of their close proximity to each other. Based on the availability of data, geographic access to these facilities, and

other hospitals in neighboring counties, the San Fernando Valley, as outlined in the map, serves as the boundary for the service area.

Providence Need Index

Within the medical centers' total service area there is a high need service area, which is based on the social determinants of health specific to the inhabitants of the service area census tracts. Based on work done by the Public Health Alliance of Southern California and their Healthy Places Index (HPI) tool, the following variables were used to calculate a high need census tract:

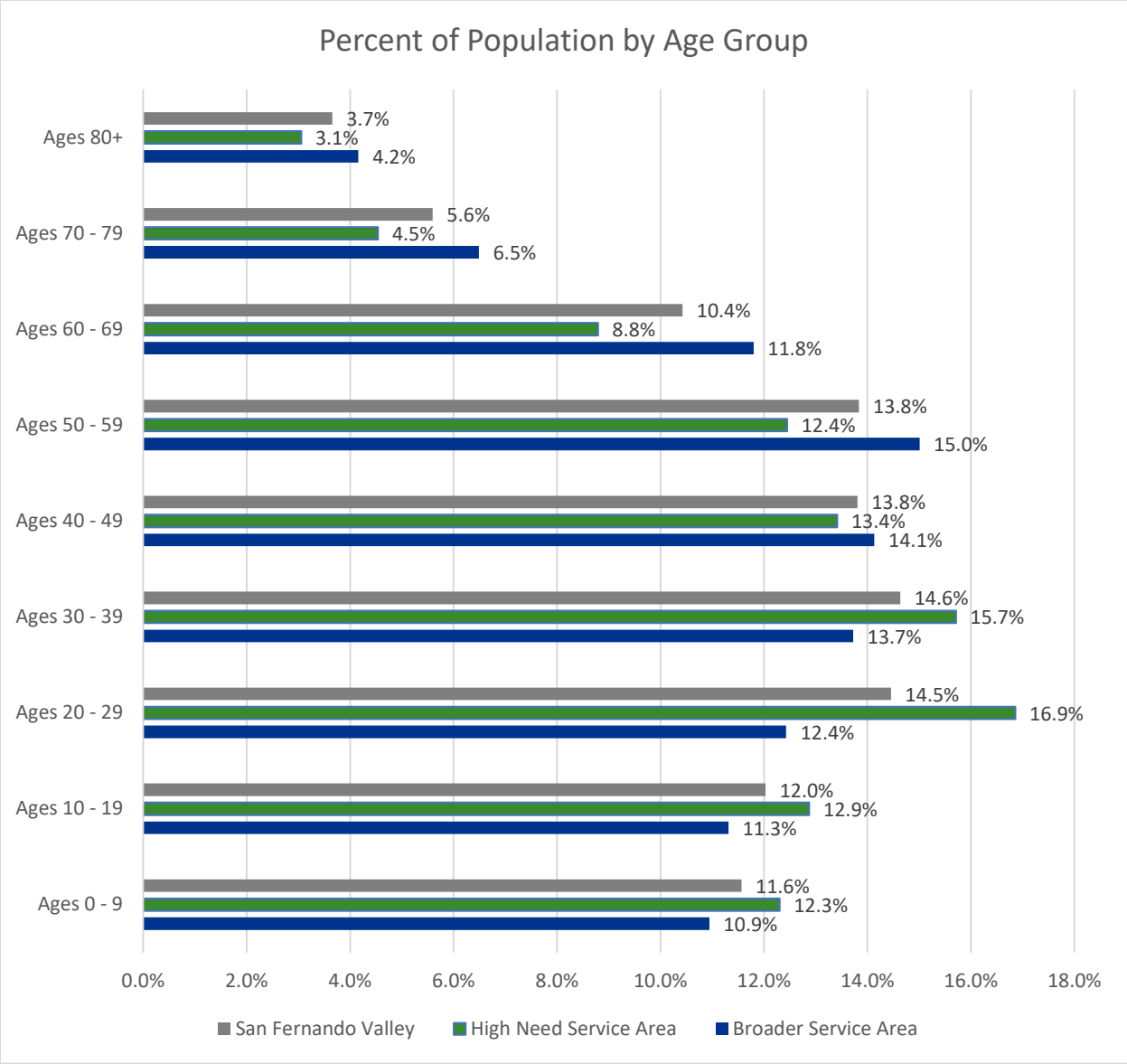
- Population below 200% the Federal Poverty Level (American Community Survey, 2019)
- Percent of population with at least a high school education (American Community Survey, 2019)
- Percent of population, ages 5 Years and older in Limited English Households (American Community Survey, 2020)
- Life expectancy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

For this analysis, census tracts with more people below 200% FPL, fewer people with at least a high school education, more people in limited English households and a lower life expectancy at birth were identified as "high need." All variables were weighted equally and the average value of the population was assigned to census tracts that did not have an estimated life expectancy at birth. Ultimately, the census tracts were given a score between 0 and 100 where 0 represents the best performing census tract and 100 is the worst performing census tract according to the criteria. Census tracts that scored higher than the average were classified as a high need service area and are depicted in green. In the SFV service area, 234 of 518 census tracts (45.2%) scored above the average of 38.1 on the PNI, indicating a high need.

Community Demographics

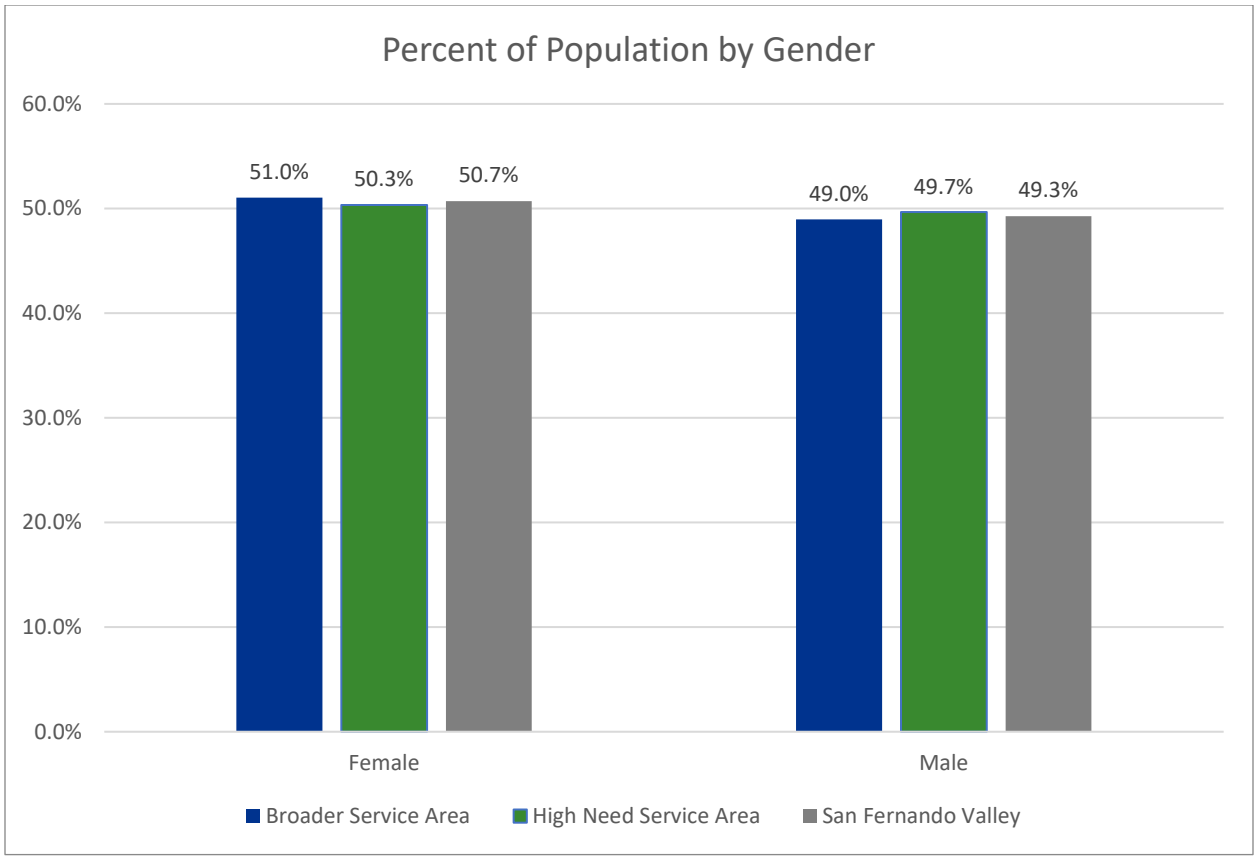
The figures below provide basic demographic and socioeconomic information about the service area and how the high need area compares to the broader service area. We have developed a dashboard that maps each CHNA indicator at the census tract level. The dashboard can be found here:

https://experience.arcgis.com/experience/4ed9db9eb2a6443180938b2a4bbeed83/



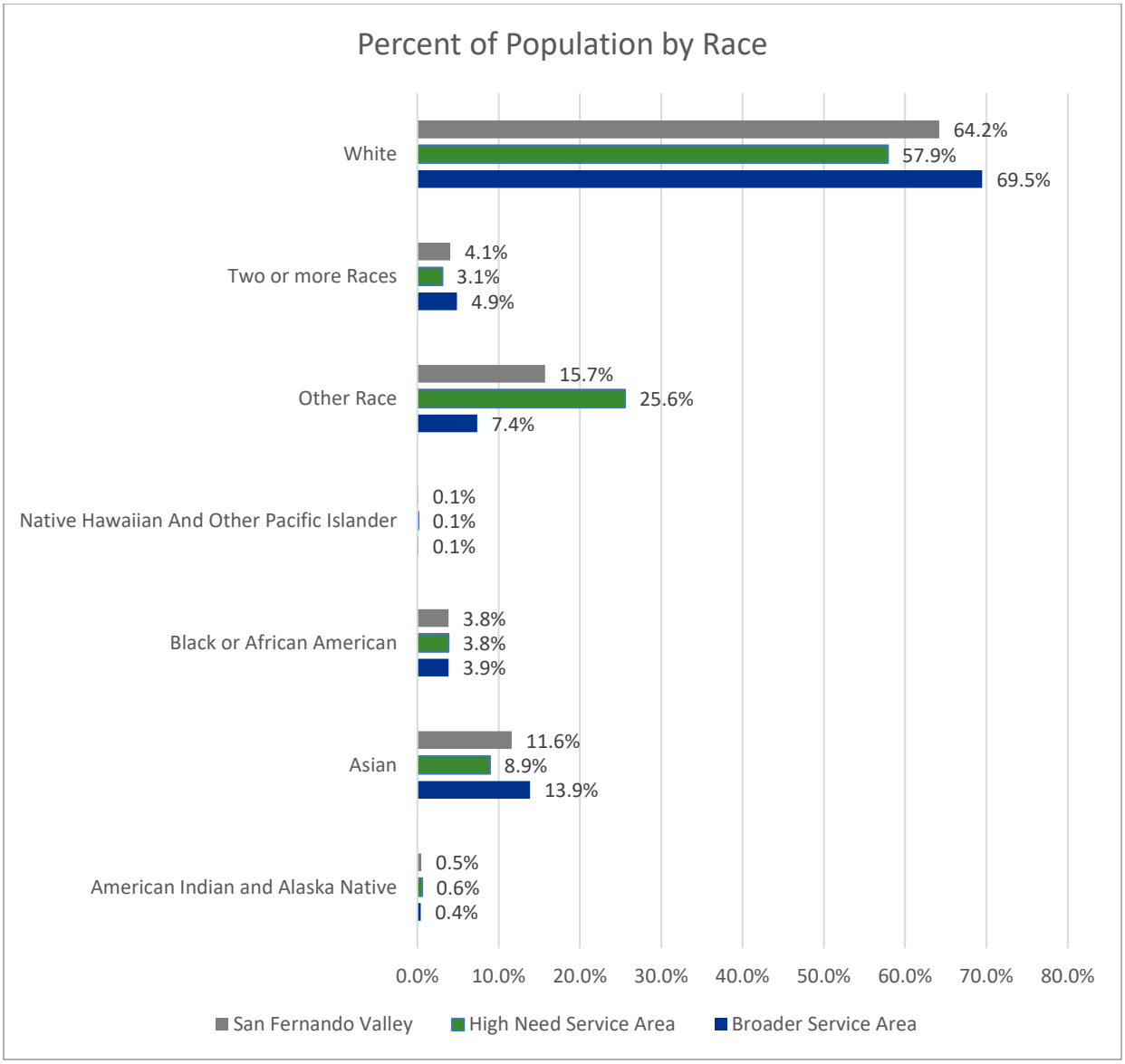
Population by Age Groups by Geography

People under the age of 40 are disproportionately represented in the high need service area, while people aged 40 and older are more likely to live in the broader service area.



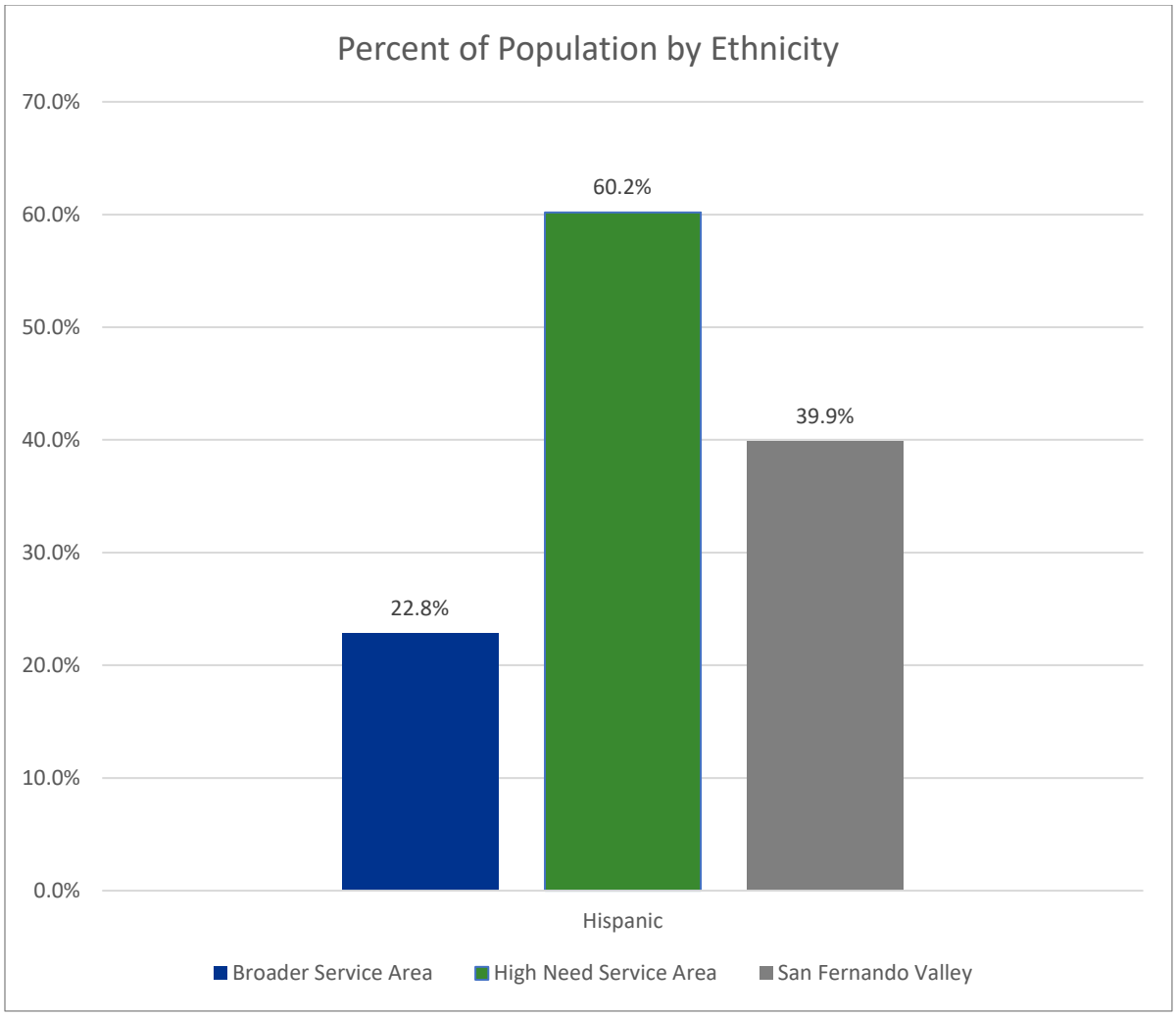
Population by Gender by Geography

The population in the San Fernando Valley is split fairly even by sex, with males making up 49.3% of the population and females 50.7%.



Population by Race by Geography

People identifying as “other race” are disproportionately represented in the high need service area, with Asian and white people more likely to live in the broader service area.



Population by Ethnicity by Geography

The Hispanic population is over-represented in the high need service area, with 60.2% of the high need service area identifying as Hispanic compared to 22.8% in the broader service area and 39.9% in the San Fernando Valley overall.

HEALTH PROFESSIONAL SHORTAGE AREA

Los Angeles County is designated as a Medically Underserved Area (MUA) and a Health Professional Shortage Area (HPSA) for primary care, dental health and mental health.

See Appendix 1 for additional demographic data

OVERVIEW OF CHNA FRAMEWORK AND PROCESS

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

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

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

Data Limitations and Information Gaps

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

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

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

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

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

HEALTH INDICATORS

Please refer to the San Fernando Valley Data Hub 2022 to review each of the following health indicators mapped at the census tract level: https://experience.arcgis.com/experience/4ed9db9eb2a6443180938b2a4bbeed83/.
The hub provides data on each indicator in the San Fernando Valley, high need and broader need service areas, Los Angeles County, and California, as well as information about the importance of each indicator (homelessness data are not included in the hub).

Health Insurance, Uninsured

	San Fernando Valley	High Need	Broader Need	Los Angeles County
Uninsured	8.3%	12.1%	5.3%	9.6%

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

Chronic Diseases

	San Fernando Valley	High Need	Broader Need	Los Angeles County
Asthma prevalence	7.8%	8.2%	7.4%	7.5%
Cancer prevalence	5.6%	4.6%	6.4%	5.0%
Chronic kidney disease prevalence	2.7%	2.9%	2.5%	3.0%
Chronic Obstructive Pulmonary Disease prevalence	4.6%	5.1%	4.3%	4.3%
Coronary heart disease	4.6%	4.7%	4.4%	4.8%
Diabetes prevalence	9.1%	10.5%	8.0%	11.1%

Source: Behavioral Risk Factor Surveillance System Survey, 2019.

Physical Inactivity and Obesity

	San Fernando Valley	High Need	Broader Need	Los Angeles County
Physical inactivity	22.5%	27.9%	18.0%	25.1%
Obesity	26.0%	29.1%	23.4%	27.7%

Source: Behavioral Risk Factor Surveillance System Survey, 2019.

Mental Health

	San Fernando Valley	High Need	Broader Need	Los Angeles County
Mental health distress (14 or more days in past 30 days with poor mental health)	12.9%	14.8%	11.3%	12.4%
Depression	15.9%	16.3%	15.7%	21.6%

Source: Behavioral Risk Factor Surveillance System Survey, 2019.

Substance Use

	San Fernando Valley	High Need	Broader Need	Los Angeles County
Binge drinking	18.1%	17.5%	18.5%	16.8%
Smoking	11.7%	13.7%	9.9%	10.9%

Source: Behavioral Risk Factor Surveillance System Survey, 2019.

Persons Experiencing Homelessness, 2018-2020 Comparison*

	SPA 2		Los Angeles City/County CoC	
	2018	2020	2018	2020
Total homeless count	7,478	9,108	49,955	63,706
Sheltered	25.6%	27.4%	24.8%	27.7%
Unsheltered	74.4%	72.6%	75.2%	72.3%
Individual adults	73.0%	65.0%	80.0%	76.0%
Families/family members	23.0%	25.0%	16.0%	19.0%
Unaccompanied minors (<18)	.01%	.01%	0.1%	0.1%

Source: Los Angeles Homeless Service Authority, 2018 & 2020 Greater Los Angeles Homeless Count. https://www.lahsa.org/homeless-count/

**These data represent the homeless counts from the LA County Continuum of Care, which does not include Glendale, Long Beach and Pasadena homeless counts.*

Persons Experiencing Homelessness, Subpopulations*

	SPA 2		Los Angeles City/County CoC	
	2018	**2020**	**2018**	**2020**
Chronically homeless	25.0%	34.0%	27.0%	38.0%
Domestic violence experience	30.0%	35.0%	30.0%	33.0%
Persons with HIV/AIDS	1.0%	1.0%	1.0%	2.0%
Physical disability	15.0%	17.0%	15.0%	19.0%
Developmental disability	28.0%	20.0%	27.0%	25.0%
Serious mental illness	17.0%	27.0%	15.0%	27.0%
Substance abuse disorder	5.0%	5.0%	7.0%	6.0%
Veterans	25.0%	34.0%	27.0%	38.0%

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

Hospital Utilization Data

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

Avoidable Emergency Department Cases

Emergency department yearly cases for Providence Holy Cross Medical Center, Providence Saint Joseph Medical Center and Providence Cedars Sinai Tarzana Medical Center have declined by 25.4% between

2019 and 2021. Similarly, the percentage of emergency department cases that were avoidable visits declined from 38.5% in 2019 to 30.2% in 2021.

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

- Combined across all Providence medical centers in the San Fernando Valley service area there was a higher percentage of avoidable ED visits for patients who self-reported their race as Black or African American (31.4%) compared to the total patient population (30.2%)
- Combined across all Providence medical centers in the San Fernando Valley service there was a higher percentage of avoidable ED visits for patients who self-reported their ethnicity as Hispanic or Latino (32.1%) compared to the total patient population (30.2%)
- 28.7% of avoidable visits across all Providence medical centers in the San Fernando Valley service area in 2021 were from diagnoses related to urinary tract infections (12.8%), bronchitis (8.4%) and other upper respiratory disease and skin infections (7.5%)
- Substance use disorder was in the top ten diagnoses groups for avoidable emergency department visits at Providence Saint Joseph Medical Center (6.3%) and Providence Cedar Sinai Tarzana Medical Center (5.6%)

Behavioral Health Emergency Department Cases

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

- Behavioral health related diagnoses as a portion of all emergency department visits have increased from 3.0% in 2019 to 3.5% in 2021 of all emergency department visits at Providence medical centers in the San Fernando Valley service area. Furthermore, Providence Saint Joseph Medical Center had the highest percent of behavioral health related emergency department visits (4.9%) in 2021.
- 38.5% of behavioral health related emergency department visits across the three Providence medical centers in the San Fernando Valley service area were related to substance use disorders in 2021.

COMMUNITY INPUT

Summary of Community Input

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, Providence San Fernando conducted 26 stakeholder interviews with representatives from community-based organizations during June and July 2022 and 4 listening sessions with 43 community members in June 2022. During these interviews and listening sessions, community members and nonprofit and government stakeholders discussed the issues and opportunities of the people, neighborhoods, and cities of the service area. Below is a high-level summary of the findings of these sessions. Using the notes from the interviews and listening sessions, analysts identified themes related to community needs and the associated gaps in services, barriers, and affected populations. A listing of the interview and listening session participants is provided in Appendix 2. Full details on the findings are available in Appendix 3.

Vision for a Healthy Community

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

- Safety
- Housing
- Community engagement and caring for one another
- Behavioral health services (mental health and substance use/misuse)
- Availability of resources, including health care and education

Community Needs

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

- Behavioral health (mental health and substance use/misuse)
- Homelessness and housing instability
- Opportunity gap in education
- Community building and inclusion
- Access to health care and preventive care

The following findings summarize the **high-priority health-related needs**, based on stakeholder interviews and listening sessions:

Behavioral health (mental health and substance use/misuse)	A lack of access for **higher acuity care** and **services at maximum capacity** were the main barriers to mental health and substance use care. Even though the needs have increased, **funding has stagnated,** and the **reimbursement system** has become a barrier to care. There is a need for more **certified chemical dependency counselors and bilingual services.** There has been an increase in the availability of **fentanyl.** Youth experienced **depression, anxiety,** and **social isolation** with the pandemic. **Youth mental health** is our biggest societal issue. Kids are exposed to **school shootings**, **suicide rates** and **ideation** are on the rise, and the pandemic has resulted in kids who have **lost their social skills**. Youth use of cigarettes and marijuana was a concern of listening session participants. Health care and service organizations are under severe strain, due to **staff shortages** and **increased personnel costs**, and many have had to **turn away patients**, even though needs have increased for behavioral health services. Listening session participants were concerned about a lack of therapists and long wait times for appointments. It will be detrimental to the community if the **infrastructure of nonprofits and health systems** are **not stable**.
Homelessness and housing instability	There is little money left over at the end of the month after **housing, food, gas, and utility costs**. **Wages are not keeping pace** with increased living costs**.** Some people in the community are just an **episode** away from being unhoused. Populations at risk include **LGBTQIA+, Black, Brown, Indigenous and People of Color (BBIPOC), immigrants**, **older adults**, **youth**, those **not paying their rent**, and those who need **recuperative care**. Listening session participants were particularly concerned about low-income and senior housing, as well as shelters for youth identifying as LGBTQIA+. Complicated dynamics within the housing field include **funding, NIMBYism**, **housing shortages**, **increased rent prices**, **permit and zoning** issues, and meeting the needs of those who are **service resistant**. Getting someone housed is easier than **keeping** them housed. There is a need for more **wraparound services** and **interim housing** that address **mental health**, **substance use, job issues**, and **ADLs**. Housing is essential to the overall health of a community. We need to look at different strategies and place **more emphasis on preventive measures.** Once someone becomes unsheltered, their issues can quickly spiral out of control.

Access to health care and preventive care	Barriers to accessing care include **language**, a **complicated health care system, transportation**, a **lack of awareness of resources**, **siloed programs**, and a **lack of integration and collaboration** among hospitals, community clinics, and urgent care. Listening session participants would like to see more assistance navigating these services. They also shared racism and discirmination prevent health equity, particularly for people identifying as LGBTIA+ and BBIPOC communities. Telehealth made health care more **accessible and convenient** for patients and **no-show rates** for health care appointments dropped significantly. However, it still takes months to get an appointment, especially for **specialty care,** and telehealth is not appropriate for **preventive screenings**. Health care provider appointments may be an ideal opportunity to address **social determinates of health** and provide **community linkages**. Prior to the pandemic, health care was experiencing **staffing shortages** with doctors and midlevel providers. Now, shortages are amplified, and support staff positions are difficult to fill, causing **workflow changes**.
Chronic diseases	Chronic diseases have been impacted by **delayed preventive and routine care.** People **not refilling prescriptions**, **noncompliance**, people **isolating** at home and **not exercising,** impacted overall health and management of chronic diseases. Listening session participants would like more **health education** to support healthy living and financial support for **gym memberships.** There is a need for a **holistic** approach to addressing chronic diseases, where patients receive **wraparound services** to meet all their **social determinates of health** as part of **trauma-informed care**. Populations of concern include **BBIPOC communities, older adults, those with language barriers, those experiencing homelessness, and recent immigrant populations**.
Food insecurity	COVID ignited community need, resulting in an increase in the number of people **impacted by food and housing insecurity**. Populations disproportionately impacted include: **older adults on fixed incomes**, **people experiencing homelessness**, **people precariously housed,** and those with **chronic diseases**. **Supply chain issues** and more recently, **inflation,** are causing food prices to escalate. With inflation erasing all gains in wages, more people are being **pushed to the margins** and that is putting more **strain on the safety net** system. Listening session participants would like to see more **supermarkets** that sell healthy foods nearby.

COVID-19	During the pandemic, community organizations often **pivoted their services** to meet the community's needs, changing the types of services as well as the way they provided services, with a focus on **virtual and remote** services. What was already difficult for people with low incomes was made worse with COVID, including **transportation, housing security, health care access, affordable childcare,** and **the cost of groceries**. The pandemic increased learning gaps for vulnerable **students**, while **older adults** and **adults with developmental disabilities** experienced more social isolation. Populations of particular concern are **people not making a living wage**, and those people disproportionately affected by economic insecurity due to systemic inequities, including f**oster youth, people identifying as LGBTQIA+, older adults, adults with developmental disabilities,** and **immigrants**.
Senior health	There has been an **escalation in cognitive decline** among older adults. Older adults who were mobile and socially active before the pandemic may now be **homebound**, **less mobile, and more isolated**. The pandemic also increased the number of older people facing **loneliness**, and **depression.** Many seniors are **fearful to re-engage** and are unsure how to reconnect with individuals. Listening session participants would like to see more social opportunities for older adults to engage in the community. There is a growing population of older adults losing their **housing**. Older adults, who rely on **fixed incomes**, are vulnerable to **increasing rent, gas, and food costs** and do **not qualify** for most **homeless services**.
Violence and injury prevention	People are under **continuous stress** and feel they are **at their limit.** People may become more easily aggressive or agitated. COVID is still present, finances are stretched thin, politics are increasingly polarized, and people are **drifting into despair**. **Urban density, gangs charging rent in homeless encampments, substance use, mental health issues, and people feeling powerless toward external factors** are all amplifying violence. Listening session participants would like to see increased gun control, safer parks and streets, and a number to call to get help in unsafe situations. Reports of **domestic violence** and **child abuse** have increased.

SIGNIFICANT HEALTH NEEDS

Significant Community Needs

Initially, significant health needs were identified through a review of the secondary health data collected. The identified significant needs (listed in alphabetical order) included:

- Access to Care
- Chronic Diseases
- COVID-19
- Food Insecurity
- Housing and Homelessness
- Mental Health
- Preventive Practices (screenings, vaccines)
- Senior Health
- Substance Use and Misuse
- Violence and Injury Prevention

The hospitals conducted interviews with community stakeholders to obtain input on significant community needs, barriers to care and resources available to address the identified health needs.

The identified significant community needs were prioritized with input from the community. The following criteria were used to prioritize the significant needs:

- The perceived severity of a health or community issue as it affects the health and lives of those in the community.
- Improving or worsening of an issue in the community.
- Availability of resources to address the need.
- The level of importance the hospital should place on addressing the issue.

Each of the stakeholder interviewees was sent a link to an electronic survey (SurveyMonkey) in advance of the interview. The stakeholders were asked to rank each identified need. The percentage of responses was noted as those that identified the need as having severe or very severe impact on the community, had worsened over time, and had a shortage or absence of resources available in the community. Not all survey respondents answered every question, therefore, the response percentages were calculated based on respondents only and not on the entire sample size. COVID-19, housing and homelessness and mental health had the highest scores for severe and very severe impact on the community. Housing and homelessness, mental health and substance use were the needs with the highest scores for worsened over time. Housing and homelessness, mental health and chronic diseases had the highest scores for insufficient resources available to address the need.

Significant Health Needs	Severe and Very Severe Impact on the Community	Worsened Over Time	Insufficient or Absent Resources
Access to Care	73.3%	40%	60%
Chronic Diseases	93.3%	53.3%	73.3%
COVID-19	100%	6.7%	26.7%
Food Insecurity	73.3%	60%	46.7%
Housing and Homelessness	100%	100%	86.7%
Mental Health	100%	93.3%	83.3%
Preventive Practices (screenings, vaccines)	73.3%	33.3%	26.7%
Senior Health	53.3%	40%	33.3%
Substance Use and Misuse	93.3%	86.7%	20%
Violence and Injury Prevention	53.3%	46.7%	33.3%

The interviewees were also asked to prioritize the health needs according to the highest level of importance in the community. The total score for each significant need (possible score of 4) was divided by the total number of responses for which data were provided, resulting in an overall score for each significant need. Mental health, housing and homelessness, access to care, chronic diseases and substance use were ranked as the top five priority needs in the service area. Calculations resulted in the following prioritization of the significant needs.

Significant Needs	Priority Ranking (Total Possible Score of 4)
Mental Health	3.87
Housing and Homelessness	3.80
Access to Care	3.73
Chronic Diseases	3.67
Substance Use and Misuse	3.67
Food Insecurity	3.47
Preventive Practices (screenings, vaccines)	3.47
COVID-19	3.33
Senior Health	3.33
Violence and Injury Prevention	3.33

Prioritization Process and Criteria

Providence San Fernando Valley Medical Center's Mission Community Health Committee (MCHC) is responsible for the Community Health Needs Assessment and the prioritization of identified community health needs. The Mission Community Health Committee met on September 20, 2022 and October 4, 2022 to review key findings and select the top three identified health needs.

Through a collaborative process engaging MCHC members, the Director of Community Health Investment presented a staff recommendation of the ranking of the significant health needs and shared a prioritization scorecard with the rationale for that suggested ranking. A robust in-depth discussion followed on the needs across the seven categories used to evaluate the needs on the score card. The seven categories included:

- Opportunity to Impact: Current SFV Community Health Programs/Services
- Opportunity to Impact: Current Community Benefit Investments (operations and grants)
- Opportunity to Impact: Partnerships
- Alignment with Providence Regional Strategies
- Service Area Rates Comparison to State or National Benchmarks
- Impact of the problem on vulnerable populations
- Key Stakeholder Survey Prioritization Score

Working with local community members, public and private partners, Providence leadership, and the Mission Community Health Committee members prioritized and identified the top three priority areas below.

PRIORITY NUMBER 1: ACCESS TO HEALTH CARE

Access to health care refers to the availability of primary care, specialty care, vision care and dental care services. Health insurance coverage is considered a key component to ensure access to health care. Barriers to care can include lack of transportation and a lack of linguistically appropriate and culturally responsive care.

PRIORITY NUMBER 2: HOUSING AND HOMELESSNESS

Homelessness is known as a state of being unhoused or unsheltered and is the condition of lacking stable, safe, and adequate housing. Housing instability encompasses several challenges such as having trouble paying rent, overcrowding, moving frequently, staying with relatives, or spending the bulk of household income on housing.

PRIORITY NUMBER 3: MENTAL HEALTH INCLUDING SUBSTANCE USE/MISUSE

Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. Substance use is the use of tobacco products, illegal drugs or prescription or over-the-counter

drugs or alcohol. Excessive use of these substances or use for purposes other than those for which they are meant to be used can lead to physical, social or emotional harm.

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

Potential Resources Available to Address Significant Health Needs

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

EVALUATION OF 2020-2022 CHIP IMPACT

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

In 2019, the hospital conducted the previous CHNA. Significant needs were identified from issues supported by primary and secondary data sources gathered for the CHNA. The hospitals' 2020-2022 CHIP associated with the 2019 CHNA addressed homelessness and housing insecurity, access to health care, preventive care, food insecurity, chronic disease, substance use and mental health through a commitment of community benefit programs and resources.

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

Focus Population	Strategies	Progress
Persons experiencing homelessness and housing instability	Hospital emergency department-based Community Health Workers assist patients experiencing homelessness with discharge to shelter or homeless service providers.	1,128 screened for homelessness. 559 linked to homeless services or housing resources. 398 placed in temporary or permanent housing.
	Implement screening for risk of homelessness and identify public and private funded resources that focus on prevention of homelessness.	A Community Health Worker Homeless Navigator was hired in 2020 to screen patients for housing instability. Conducted outreach to those most at risk for homelessness. Persons screened and identified as in need of support were referred to community partners.
	Improve the infrastructure of available recuperative care/interim shelter for patients experiencing homelessness who are not medically stable enough to be discharged back to the streets.	Providence participated in the UniHealth Foundation's Recuperative Care Advisory Group to develop recommendations for strengthening the infrastructure of recuperative care in Los Angeles County. Partnerships with recuperative care agencies were strengthened, particularly

Focus Population	Strategies	Progress
		with the National Health Foundation and Ascensia.

Initiative 2: Increase Utilization of Community-Based Wellness and Activity Centers

Focus Population	Strategies	Progress
Residents who are food insecure, have a chronic disease, at-risk or diagnosed with mental health illness, social isolation or substance use disorders.	Pacoima Wellness Center School-based partnership with Vaughn Next Century Learning Center. Provided opportunities for students and parents in the Providence Holy Cross Medical Center community to access programs and services for substance use, chronic disease management and food insecurity.	As a result of COVID, a limited number of virtual classes took place.
	Van Nuys Wellness Center Provided wellness programs and support services. Provided opportunities for residents in the Providence Saint Joseph and Tarzana Medical Centers communities to access services and programs for mental health, food insecurity and chronic disease management.	As a result of COVID, a limited number of virtual classes took place. 272 senior clients were served. 226 senior clients participated in group counseling.

Initiative 3: Improve Access to Health Care Services and Preventive Resources

Focus Population	Strategies	Progress
Persons with limited access to health care services and	Community Health Insurance Project Bilingual community health workers provided outreach, education and health insurance application assistance	684 health insurance applications completed.

Focus Population	Strategies	Progress
preventive resources, including those that face socioeconomic, linguistic and cultural barriers.	for Medi-Cal and Covered California for hard-to-reach populations.	414 persons (61%) persons enrolled in health insurance programs.
	CalFresh Enrollment Bilingual community health workers assisted families to enroll in CalFresh.	344 CalFresh applications completed. 171 persons (50%) persons enrolled in CalFresh.
	Emergency Department Health Workers Community health workers assigned to the ED assisted patients to apply for health insurance, make primary care follow-up visits, and navigate community resources.	500 appointments made with primary care providers for follow-up after ED visit. 68.4% appointments kept.
	FEAST Education and support group supported healthy eating and active lifestyles	56 persons completed the twelve-lesson program.
	Mental Health First Aid Trained individuals on signs and symptoms of mental health and substance use issues.	317 persons trained.
	Latino Health Promoters Program Bilingual community health workers provided educational wellness programs at local schools and churches.	588 persons participated in 323 classes.
	Faith Community Partnerships Provided health education, referrals and support groups.	Provided 110 referrals and follow-ups to needed community resources.

Initiative 4: Support Collaborative Partnerships for Better Health (focus on vaccines)

Focus Population	Strategies	Progress
Persons with limited access to vaccines	Flu vaccines	1,019 free flu shots administered at 67 community sites.
	COVID-19 vaccines	15,212 free COVID vaccines administered at 56 community sites.

Addressing Identified Needs

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

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

2022 CHNA GOVERNANCE APPROVAL

This Community Health Needs Assessment was adopted by the Valley Service Area Board of Directors on October 20, 2022. The final report was made widely available by December 28, 2022.

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12/8/2022

Kenya Beckmann — Date
Chief Philanthropy and Health Equity Officer, South Division, Providence

12/1/2022

Bernie Klein, MD — Date
Chief Executive, Providence Holy Cross Medical Center

12/1/22

Karl Keeler — Date
Chief Executive, Providence Saint Joseph Medical Center

12/1/22

Judie Wilke — Date
Mission Community Health Committee Chairperson, Valley Service Area Board of Directors

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

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12/8/2022

Kenya Beckmann — Date
Chief Philanthropy and Health Equity Officer, South Division, Providence

11/28/2022

Nick Lymberopoulos — Date
Chief Executive, Providence Cedars Sinai Tarzana Medical Center

11/29/2022

Thomas M. Priselac — Date
Board Chair, Providence Cedars Sinai Tarzana Medical Center

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APPENDICES

Appendix 1: Quantitative Data

COMMUNITY DEMOGRAPHICS

Demographic Profile for the Service Area

Indicator	San Fernando Valley	Broader Service Area	High Need Service Area
Population by Age Groups			
Total Population	2,230,501	1,210,210	1,020,291
Population Ages 0 - 9	257,959	132,446	125,513
Population Ages 10 - 19	268,287	136,914	131,373
Population Ages 20 - 29	322,424	150,413	172,011
Population Ages 30 - 39	326,384	166,089	160,295
Population Ages 40 - 49	307,919	171,047	136,872
Population Ages 50 - 59	308,616	181,610	127,006
Population Ages 60 - 69	232,511	142,779	89,732
Population Ages 70 - 79	124,866	78,551	46,315
Population Ages 80+	81,535	50,361	31,174
% Population Ages 0 - 9	11.6%	10.9%	12.3%
% Population Ages 10 - 19	12.0%	11.3%	12.9%
% Population Ages 20 - 29	14.5%	12.4%	16.9%
% Population Ages 30 - 39	14.6%	13.7%	15.7%
% Population Ages 40 - 49	13.8%	14.1%	13.4%
% Population Ages 50 - 59	13.8%	15.0%	12.4%
% Population Ages 60 - 69	10.4%	11.8%	8.8%
% Population Ages 70 - 79	5.6%	6.5%	4.5%
% Population Ages 80+	3.7%	4.2%	3.1%
Population by Gender			

Indicator	San Fernando Valley	Broader Service Area	High Need Service Area
Female Population	1,131,228	617,633	513,595
Male Population	1,099,273	592,577	506,696
% Female Population	50.7%	51.0%	50.3%
% Male Population	49.3%	49.0%	49.7%
Population by Race			
American Indian and Alaska Native	11,164	5,181	5,983
Asian Population	258,895	167,686	91,209
Black or African American Population	85,683	46,619	39,064
Native Hawaiian and Other Pacific Islander Population	2,653	1,433	1,220
Other Race Population	350,017	89,213	260,804
Two or more Races Population	90,467	59,123	31,344
White Population	1,431,622	840,955	590,667
% American Indian and Alaska Native	0.5%	0.4%	0.6%
% Asian Population	11.6%	13.9%	8.9%
% Black or African American Population	3.8%	3.9%	3.8%
% Native Hawaiian and Other Pacific Islander Population	0.1%	0.1%	0.1%
% Other Race Population	15.7%	7.4%	25.6%
% Two or more Races Population	4.1%	4.9%	3.1%
% White Population	64.2%	69.5%	57.9%
Population by Ethnicity			
Hispanic Population	889,739	275,747	613,992

Indicator	San Fernando Valley	Broader Service Area	High Need Service Area
% Hispanic Population	39.9%	22.8%	60.2%

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

POPULATION LEVEL DATA

	San Fernando Valley	High Need	Broader Need	Los Angeles County
Population below 200% of Federal Poverty Level	29.6%	45.0%	17.3%	34.9%
Language proficiency limited English	9.4%	16.0%	4.9%	10.8%
Population with a High School diploma	83.6%	71.6%	92.3%	79.1%
Households without Internet access	10.7%	16.3%	6.1%	12.6%
Labor force, unemployed	3.1%	6.5%	5.3%	6.1%
Households receiving SNAP (Supplemental Nutrition Assistance Program) benefits	7.1%	12.9%	3.3%	8.7%
Household median income	$76,123	$55,396	$102,078	$67,817

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

HEALTH PROFESSIONAL SHORTAGE AREA

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

MEDICALLY UNDERSERVED AREA/MEDICAL PROFESSIONAL SHORTAGE AREA

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are defined by the Federal Government to include areas or populations that demonstrate a shortage of health care

services. This designation process was originally established to assist the government in allocating the Community Health Center Fund to the areas of greatest need. MUAs are identified by calculating a composite index of need indicators compiled and with national averages to determine an area's level of medical "under service." MUPs are identified based on documentation of unusual local conditions that result in access barriers to medical services. MUAs and MUPs are permanently set, and no renewal process is necessary. Los Angeles County is designated as an MUA.

Appendix 2: Community Input

Community Input

Community Input Type and Population	Location of Session	Date	Language
Listening session with adults at Tarzana Treatment Centers	Zoom	6/24/22	English
Listening session with adults at Burbank YMCA	Burbank, CA	6/29/22	English
Listening session with older adults at ONEgeneration	Van Nuys, CA	6/30/22	English
Listening session with young and middle-aged adults at North Valley Caring Services	North Hills, CA	6/30/22	Spanish

Key Community Stakeholder Participants

Name	Title	Organization
True Beck, MS, MPA	Senior Public Health Analyst, San Fernando, Santa Clarita and Antelope Valleys (SPA 1 & 2)	Los Angeles County Department of Public Health, Community and Field Services Division
Ken Craft	Chief Executive Officer	Hope of the Valley Rescue Mission
Laura Duncan, PhD	Executive Director	Ascencia
Marine Dzhgalyan	Chief Executive Officer	All-Inclusive Community Health Center
Manuel Flores	Executive Director	North Valley Caring Services
Kris Freed	Chief Program Officer	LA Family Housing
Stephanie Galloway, MSW	Executive Director	Sherman Oaks Adult Center & Bernardi Senior Center
Dale Gorman	Executive Director	Kids' Community Dental Clinic
Lauren Hall	Vice President, Development and Communications	The Village Family Services
Jenna Hauss, MSW	President and Chief Executive Officer	ONEgeneration J.O.Y. (Joining Old and Young)
Albert Hernandez	Executive Director	Home Again LA

Name	Title	Organization
Nathan V.T. Lehman, MPH	Health Program Analyst, San Fernando, Santa Clarita and Antelope Valleys (SPA 1 & 2)	Los Angeles County Department of Public Health, Community and Field Services Division
David Lontok	Chief Executive Officer	Comprehensive Community Health Center
Esmeralda Marcial	Director of Community Engagement and Advocacy	Office of Board President Kelly Gonez, Los Angeles Unified School District
Janet Marinaccio	President and Chief Executive Officer	Meet Each Need with Dignity (MEND)
Sean Markie	Program Director	Helping Hands Senior Foundation
Edward Parker, MPA	Executive Director	Bridging Community Resources
Tim Ryder	President and Chief Executive Officer	San Fernando Valley Community Mental Health Medical Center, Inc.
Jose C. Salazar, DrPH, MPH	Director, Program Development and Contract Compliance	Tarzana Treatment Centers
Eddie Sanders	Director of Grants	Northeast Valley Health Corporation
Audrey L. Simons, MSHA	Chief Executive Officer	San Fernando Community Health Center
Bryan Snodgrass	Chief Operating Officer	Burbank Community YMCA
Karmen Tatulian, MD	Chief Medical Officer and Medical Director	El Proyecto
Julian Venegas	Director of Recreation and Community Services	City of San Fernando
Judie Wilke	Assistant City Manager	City of Burbank
Lionnel Zaragoza	District Vice President	YMCA of Metropolitan Los Angeles

Appendix 3: Findings from Listening Sessions and Interviews

FINDINGS FROM COMMUNITY LISTENING SESSIONS

Vision for a Healthy Community

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

- **Safety**: Listening session participants shared a healthy community is a safe one. This includes gun control, safe parks and streets, and a police presence. Participants equated fear with an unhealthy community, expressing that community members need to feel safe to be vulnerable.
- **Housing**: Listening session participants shared that in a healthy community there is enough low income, senior, and permanent housing to meet the need. There are also services for people experiencing homelessness, including staffing to help people with housing, and services for older adults.
- **Community Engagement**: Listening session participants shared that a healthy community means people clean up their neighborhoods, neighbors communicate, and people respect each other. They expressed that health begins at home and that empathy, respect, and cultural humility are important in a healthy community. Participants would also like to see community representation at the neighborhood and local government levels by people who are knowledgeable about their community.
- **Behavioral Health Services (mental health and substance use/misuse):** Participants shared that in a healthy community everyone can access mental health and substance use/misuse services and there is less substance use/misuse. They also noted there is no cigarette or marijuana smoking and there are therapists and support systems for people who need help with their mental health.
- **Resource Availability (including health care and education):** Listening session participants identified a healthy community as one where the community has access to resources, including public transportation, hospitals, and schools. They shared families should be able to get support accessing resources, jobs, and educational opportunities.

Community Needs

High priority community needs identified from listening sessions

- **Behavioral Health (mental health and substance use/misuse):** Listening session participants expressed concern about smoking, cigarettes and marijuana, availability of these in smoke shops, and their influence on increased smoking behaviors in youth. Participants emphasized the need for additional mental health services and having accessibility to those services when needed.

Participants want more available therapists, and less wait time to see those therapists and acquire services. There is a concern amongst participants about the lack of mental health resources in the community, particularly for youth identifying as LGBTQIA+. They would also like substance use services for people experiencing homelessness.

- **Homelessness and Housing Instability:** Listening session participants are concerned about services for people experiencing homelessness and shared a need for more senior housing programs like *One Generation*. Limited senior housing resources, a lack of permanent housing, a lack of availability in buildings, long wait times for low-income and senior housing, and insufficient staffing to assist with housing issues are all concerns of the participants. Participants would like to see more housing and recreational activities for seniors, less restrictions on seniors in social settings, and more transparency about the housing reality; there is a concern that social media does not show the entire picture. There is also a need for more shelters and services for young people experiencing homelessness who identify as LGBTQIA+.
- **Educational Opportunities:** Participants want more educational opportunities including parental classes, community classes offered at school or workplace to help with poor behaviors, and access to one-on-one interactions for application or online system help.
- **Community Building and Inclusion:** Listening session participants want more communication between community members and more involvement in community initiatives. Participants also expressed a need for more neighborhood and local representation by people who are knowledgeable about the community; they said more people need to vote. They would like more representative leadership, and more awareness of racism and discrimination. They noted a need for more cultural humility and classes for young adults to learn about other groups and cultures. They also mentioned a need for more inclusion of people with disabilities or special needs, including more accessible public transportation.
- **Access to Health Care and Preventive Care:** Listening session participants noted a need for closer hospitals, more available adaptive programs, and facilities that offer whole person care. They also need more assistance navigating health care services. Participants shared racism and discrimination prevent health equity, particularly for people identifying as LGBTQIA+ and Black, Brown, Indigenous, and People of Color (BBIPOC). There needs to be improved access to responsive and respectful health care services for these groups.

Medium priority community needs identified from listening sessions

- **Senior Health:** Participants would like to see more opportunities for older adults to engage with one another and in activities. They would like additional resources for older adults, more staffing to facilitate these resources, and more opportunity for socialization.
- **Economic Insecurity (living wage jobs, job skills training, employment):** Listening session participants would like to see more programs that educate and prepare young adults for the workforce. Economic insecurity is connected to people's ability to afford wellness opportunities, like a gym membership.

- **Violence and Injury Prevention:** For listening session participants, safety is needed in the community, stores, and apartments. They would like gun control, safer parks and streets, the towing of non-operational vehicles parked on streets, designated smoking areas away from non-smokers and children, and a larger police presence. Listening session participants would like to see an available contact phone number that community members could use to get help and improved lighting in parks. There is a focus on people gaining awareness about racism in schools and work.
- **Chronic Diseases and Obesity:** Listening session participants shared a need for classes that teach healthy living and how to cook healthy meals. They would also like people to have more time to exercise, and the financial ability to afford a gym class. More supermarkets that sell healthy foods nearby are also needed.

FINDINGS FROM STAKEHOLDER INTERVIEWS

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

- Trust in the health care system and not going to the doctor. Diabetes, high blood pressure and a sedentary lifestyle.
- Food insecurity, obesity and challenges with mental health.
- Mental health, substance use and homelessness.
- Rampant decay in teeth for low-income children. Oral health literacy, knowledge of obesity, and the lack of dental providers throughout our city.
- Mental health, homelessness and the prevention of homelessness.
- Housing affordability. For those who are on a fixed income it is hard to afford housing here in Los Angeles. Also, access to care and social services. A lot of people are still afraid to get out of the house and be in a community setting.
- People are using crack and meth pipes out in the open, in the parking lots while walking, like it is a cigarette. We are seeing a lot of dual diagnosis persons who are homeless with mental health and substance use issues.
- Homelessness, diabetes, heart disease and mental illness.
- Mental health for adults and adolescents. Substance use, chronic disease management and childhood immunizations. Parents are not on board with immunizing their children anymore.
- Behavioral health issues. We need to do a better job of preventing overdoses. Homelessness is pretty visible in our community and in our patient population.
- Access to affordable health care, access to affordable housing and food, and mental health services.
- The pandemic has made everything worse. For the marginalized and BIPOC, access to everything is insufficient. We work under the housing first model, so a person doesn't have to be clean and sober or mentally fit to be housed. We have seen a huge uptick in mental health needs and requests for

services. More than double from before the pandemic. The pandemic has taken a toll on preventive routine care.

- Addiction, diabetes, mental health and high blood pressure.
- We have a homeless population and there are significant health concerns for them. There is a lot of food insecurity and fixed incomes.
- Social and emotional needs of kids. Our school district has the highest number of students who are homeless in all of Los Angeles Unified School District.
- We are not doing enough preventive screenings in our community. People wait until they have aggressive symptoms before they see a doctor and then they have a more serious issue rather than being able to do more preventive care.
- The economic impact of COVID is that everything is so costly like gas and groceries. This is linked with chronic diseases.
- Housing and mental health access, access to substance use services, particularly detox and rental assistance so people can maintain their homes.
- Diabetes, high blood pressure, and high cholesterol. With COVID we are starting to see more mental health issues like depression. It is prevalent in all age groups.
- People are traumatized by the pandemic. As a result, the demand for behavioral health services has risen. And with the great resignation, we are under severe strain. We have to turn away clients. The acuity level we are seeing has increased. Normally we would see patients who would be outpatient mental health patients. Now they are much more severe. Now they need to be in an intensive program and they are much more acute and ill.
- So many families have struggled with food insecurity for the first time and housing insecurity with rising rents. There has been a lot of income insecurity. There has also been an uptick in domestic violence attributable to all the stress families have suffered over the last couple of years.
- Even if people have insurance, sometimes they are assigned to a doctor that is far away, across the Valley and that means there is no real connection between the primary care provider and the patient. This leads to use of the Emergency Department and urgent care when there is a primary care medical need and that impacts the entire health system. We have uninsured who have no medical home so they tend to use whatever mechanism they feel is most likely to get them the services they need.
- There are a lot of mental health issues from COVID. So, we see a lot of isolation and fear. There is still a great need for food especially now with higher prices for gas and food. It makes it that much harder for seniors to access services now. Seniors are resistant to going out in public and socializing. All our senior center activities are free, but so many of them are fearful and won't come in because they know they are vulnerable.

Interview participants were asked what factors or conditions contribute to these health issues. Their responses included:

- Fear of receiving services, a sedentary lifestyle, and a perception that care is not affordable. People do not feel they have the financial resources to seek out medical care, nor do they have the time.
- The economic impact from the pandemic and inflation costs. We continue to see new people experiencing food insecurity with the rising costs of gas and groceries.
- Substance use, financial issues, housing costs, and the pandemic have caused more financial hardship and increased mental health and substance use issues.
- High sugar foods, a fear of dentistry, lack of understanding Medi-Cal benefits, lack of drinking tap water, fluoride concerns, high fat food available everywhere. High fat foods are cheaper and more accessible, like fast food.
- Inflation and housing costs are increasing for people on fixed incomes.
- Socioeconomic issues like poverty disproportionately impact people of color. Racism is a contributing factor and root cause of some ills we see in the community. Housing and the cost of living. So many people are precariously housed. Becoming homeless overnight is one of the most psychologically debilitating things that can happen to someone.
- For behavioral health, it is pandemic related. Chronic diseases were exacerbated by the pandemic. There was greater convenience with the use of telehealth, but it is difficult to engage patients in their intervention when it is over the phone versus the patient being in front of you. Some practitioners are also not on board with immunizations.
- Poverty and a lack of access to stable employment and steady financial resources. Locally, patients have to travel further and further to get the services they need. A lack of childcare makes it difficult for parents to take advantage of services and employment opportunities. They can't afford to send their kids to childcare because it is cost prohibitive.
- There are only so many mental health professionals and people are burned out.
- Equitable access to farmers markets is needed. Where we put food pantries and access to healthy foods versus fast food are all barriers to health. We see youth who lack affordable options once they turn 18, especially if they are leaving the foster care system. They often don't know where to go and it is very hard to live in LA. Affordable housing is a big issue as well as services for education and employment.
- Being homeless, drug use and trauma.
- Economics for the seniors and many people lack health insurance.
- Economic opportunities. There is a history of disinvestment in the Valley. There was a big factory in Pacoima that closed down, so there is a lack of economic opportunities in that area.
- Accessibility to doctors. There is a stigma about going to the doctor and waiting. Also relying on services that might impact your legal status or how that might impact a family member's status in the future are all consideration.

- Housing, homelessness, underemployment. People still don't know how to access health care. Sometimes immigrants don't trust of government programs.
- The overburdened mental health system had people waiting 3 to 4 months for an appointment with a psychiatrist.
- We still have populations who are underinsured or uninsured because they are undocumented.
- Age, chronic illness along with age, economical strain, lack of support for older adults or family or friends have passed.

Who or what groups in the community are most affected by these issues? Responses included:

- Low-income disadvantaged populations.
- Our Hispanic families and seniors.
- People who are living paycheck to paycheck are struggling. They have been pushed into homelessness
- Students, older adults, and single parents.
- Business owners. Where I live, there are vans and campers parked in front of my house. They take all of the parking in our community.
- People living in poverty, working class families, communities of color, women. And persons experiencing homelessness.
- People of color, economically disadvantaged, LGBTQ, children in the foster system and incarcerated youth.
- Homeless, homeless youth 19-24, singles and the elderly.
- English learners, those who are new to the country, low-income households, and persons who are homeless.
- The community in the northeast San Fernando Valley, they suffer more intensely.
- Disproportionately people of color. Systematic racism happens in the housing market and results in a lack of health care access. Social security isn't keeping up with inflation and people are in deep trouble.

How has the COVID-19 pandemic influenced or changed the unmet health-related needs in your community? Responses included:

- We developed online programs but many families do not have internet access or the equipment to participate.
- It has forced organizations to pivot to meet the needs of the community. We ended up getting into food distribution because we saw a shift and a need. And we don't see that we will be stopping anytime soon. The need continues and grows.

- We are seeing an increased need for mental health services for every population, from youth to older adults.
- The fear of going anywhere is good reason to withdraw from regular preventive care appointments and people are staying home with more access to junk food throughout the day. We saw severe increases in cavities in kids who were previously cavity free in our population.
- It has enhanced the problems. There are more barriers and struggles to access basic services.
- Telehealth has been widely adopted so now people don't have to take off work, they can just take a video conference call.
- For persons experiencing homelessness, I think people became accustomed to Room Key where they got their own private apartment and now at the end of the voucher system, they have to go back to not being housed. We saw a lot of people fall back into homelessness after the safety net ended. A lot of people expected that program to go on forever and just went back to homelessness even with the help of social workers and homeless advocates trying to help them get services, food, transportation and housing.
- The pandemic has in many cases exacerbated the needs. The isolation, the constant worrying has had a devastating impact on everyone and particularly children. At the same time, it streamlined access to care and it broadened the use of telehealth services.
- People are afraid to visit health centers for fear of being exposed, so they have delayed care.
- It has made things worse and it has also complicated our service delivery.
- The pandemic has widened the gap. The number of people in need has increased and affordable housing has decreased. The need for mental health practitioners has gone up but people are leaving the field.
- Our numbers of seniors needing meal deliveries went way up. We saw outreach increase for our seniors.
- We were always aware of an achievement gap with our vulnerable students who are disenfranchised toward academic achievement. The pandemic increased those gaps.
- During the pandemic there wasn't access for screenings and regular doctor visits.
- Many people in our community live doubled up in housing, like a family of 6 living in a garage. How do you isolate and keep socially distant when someone gets sick? Add to that a layer of poverty where you have to juggle and prioritize what you spend money on.
- Those that work as essential workers often have to work multiple jobs and take public transportation. What was already bad for people in poverty was made that much worse with COVID.
- My hope with COVID is that we don't walk away not fixing the lessons learned. Filling open staff positions is very challenging and I do not understand all the reasons behind it. But I think there is still a lot of COVID trauma. We lost a million people. Some people lost multiple people in their family, they got sick themselves or are still struggling with long COVID.

- Telehealth has been really lifesaving. We can continue to provide care. With COVID, all those people trapped in the same small house or apartment, that was very stressful. We are seeing increased levels of depression and it impacts the outcome of chronic diseases.
- It brought to the surface some mental health issues that were lingering and being managed. People fell out of control. Telehealth services have been good. It has increased access and that is the positive side. No show rates dropped with telehealth. We had 15 to 30% no show rates previously. But with teens, they can completely disconnect and they are hard to contact. They don't answer their phone or respond to texts. People underestimate the positive effect support groups have on depression and anxiety and wellbeing - socialization is so important for people of all ages.
- We pivoted to telehealth and that helped our behavioral health patients. Our no-show rates dropped and people can now talk to their provider wherever they feel most comfortable. Many people are not comfortable with the video calls, but audio telehealth works for most people.
- For those already struggling before the pandemic, they are even more isolated and their access to resources is more diminished.

Appendix 4: Community Resources Available to Address Significant Health Needs

Providence San Fernando Valley Medical Centers cannot address all of the significant community health needs. Improving community health requires collaboration with community stakeholders. The table below lists community resources potentially available to address identified community needs. This is not a comprehensive list of all available resources. For additional resources refer to https://www.211la.org/.

Community Resources Available to Address Significant Health Needs

Significant Needs	Community Resources
Access to health care	African American Infant Mortality Group, All-Inclusive Community Health Center, Aunt Bertha, Valley Care Community Consortium, Bienestar East Los Angeles, Central Neighborhood Health Foundation, El Proyecto, Health Advocated, Kids' Community Dental Clinic, Meet Each Need with Dignity (MEND), North Valley Caring Services, ONEgeneration, San Fernando Community Health Center
Chronic diseases	All Inclusive Community Health Center, Bienestar East Los Angeles, Burbank Non-Profit Executive Directors Coalition, Central Neighborhood Health Foundation, El Proyecto, Family Services Agency Burbank, First 5, Glendale Healthier Community Coalition, Pacoima Community Initiative, San Fernando Community Health Center
COVID-19	All Inclusive Community Health Center, Bienestar East Los Angeles, Central Neighborhood Health Foundation, El Proyecto, San Fernando Community Health Center, Valley Care Community Consortium
Food insecurity	Burbank Temporary Aid Center, Catholic Charities, Christian Food Center, Colby's Kitchen Irwindale, Family Rescue Center, First Harvest, Hawaiian Gardens Food Bank, Holy Family Giving Bank, Home Again LA, Loaves and Fishes Glendale, MEND, North Valley Caring Services, ONEgeneration, Regional Food Bank, Rotary Club, San Gabriel Mission Food Pantry, Santa Clarita Valley Food Pantry, Shepherd's Pantry, SOVA Community Food and Resource Program, SOVA Metro Food Pantry, West Valley Food Pantry, Westside Food Bank
Housing and homelessness	All People's Community Center, Ascencia Glendale, Bridge to Home, Brownson House Community Service Center, Burbank Housing Corporation, Burbank Temporary Aid Center, Central City Neighborhood Partners, Centro Maravilla. Children of the Night, Coalition for Responsible Community Development (CRCD), Department of Public Social Services, Door of Hope Community Center, Downtown Women's Center, El Nido Family Centers, Estrella Del Mar De Los Angeles Regis House Community Center, Family Promises, Florence Firestone Community Center, Glendale YMCA, Home Again LA, Hope of the Valley, HOPICS, Inland Valley Hope Partners, LA Family Housing, Los Angeles Homeless Services Authority, Make it Happen INC., Mexican-American

Significant Needs	Community Resources
	Opportunity Foundation, New Direction Community Program, New Economics for Women, North Valley Caring Services, PATH, Safe Park LA, Salvation Army Glendale, Salvation Army Pasadena, Santa Clarita Homeless Coalition, Shields for Families Social Service Agency, South Antelope Valley Emergency Services, St. Joseph Center, Valley Women's Center, Village Family Services
Mental health	All Inclusive Community Health Center, Bienestar East Los Angeles, Catholic Charities, Central Neighborhood Health Foundation, Department of Mental Foundation, Didi Hirsch, El Proyecto, Family First Therapy, Jewish Family Services, Leeza's Care Connections, NAMI, San Fernando Community Health Center, San Fernando Valley Community Mental Health Center, Tarzana Treatment Centers, Valley Family Center
Preventive practices	All Inclusive Community Health Center, Bienestar East Los Angeles, California Primary Care Association, Central Neighborhood Health Foundation, Community Clinic Association, Didi Hirsch, El Proyecto, San Fernando Community Health Center
Senior health	Adult Protective Services, All Inclusive Community Health Center, Bienestar East Los Angeles, Central Neighborhood Health Foundation, El Proyecto, One Generation, San Fernando Community Health Center, SPA 2 Older Adults Workgroup
Substance use	Client Engagement and Navigation Services (CENS), El Nido Family Services, MEND, Pueblo Salud, Socorro Cri-Help Center, Tarzana Treatment Centers, The Teen Project
Violence and injury prevention	Domestic Abuse Center, Domestic Violence Center of Santa Clarita Valley, Glendale YWCA, Haven Hills, Hope of the Valley, Strength United

Appendix 5: Mission Community Health Committee Members

Name	Title	Organization
Jordan Abushawish	Director, Government Affairs	Providence
Teresa David	Chief Operating Officer	Facey Medical Group
DW Donovan	Chief Mission Integration Officer	Providence Holy Cross Medical Center
Sister Mary Hawkins	Committee Member	Providence
Jenna Hauss	Community Member	Mission Community Health Committee
Sister Nancy Jurecki	Chief Mission Integration Officer	Providence
Shawn Kiley	Chief Mission Integration Officer	Providence Cedars Sinai Tarzana Medical Center
Richard Marciniak	Community Member	Mission Community Health Committee
Juliette Marsh	Chief Mission Integration Officer	Providence Saint Joseph Medical Center
Audrey Simons	Community Member	Mission Community Health Committee
Jeanne Sulka	Director, Business Development	Providence Cedars Sinai Tarzana Medical Center
Jim Tehan	Regional Director, Community Health	Providence
Anthony Ortiz-Luis	Director, Community Health	Providence
Karen Pavic-Zabinski	Regional Director of Ethics	Providence
Judie Umeck	Director, Mission Integration and Adult Formation	Providence High School

Terry Walker	Director, Clinical Institutes and Community Engagement	Providence Saint Joseph Medical Center
Bill Wiggins	Community Member	Mission Community Health Committee
Judie Wilke	Chairperson, Mission Community Mission Committee	Mission Community Health Committee