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PROVIDENCE
Little Company of Mary
Medical Centers
San Pedro and Torrance

Community Health

May 29, 2020

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

Dear Mr. Dhami,

On behalf of our two Medical Centers, Providence Little Company of Mary, San Pedro and Providence Little Company of Mary, Torrance, I am pleased to provide you the:

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

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

Sincerely,

Justin Joe, MPH
Director, Community Health Investment
Providence Little Company of Mary
Justin.Joe@providence.org

Providence South Bay Community

2019 Joint Community Health Needs Assessment

2020 – 2022 Joint Community Health Improvement Plan

2019 Annual Update to the Community Benefit Plan

Providence Little Company of Mary Medical Center, San Pedro

Providence Little Company of Mary Medical Center, Torrance

PROVIDENCE
Little Company of Mary Medical Center
San Pedro

PROVIDENCE
Little Company of Mary Medical Center
Torrance

Table of Contents

Providence South Bay Community

Joint Community Health Needs Assessment 2019

Providence Little Company of Mary Medical Center San Pedro

San Pedro, CA

Providence Little Company of Mary Medical Center Torrance

Torrance, CA

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

To provide feedback about this Community Health Needs Assessment or to request a printed copy free of charge, email Justin Joe at Justin.Joe@providence.org.

TABLE OF CONTENTS

2019 Community Health Needs Assessment

Contents

Acknowledgements

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

Community Input and Hospital Collaboration

The 2019 Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance Joint Community Health Needs Assessment key informant interview data collection process was conducted by Providence Community Health Investment staff. Eight organizational leaders participated in individual key stakeholder interviews. Additionally, three listening sessions with 37 participants were conducted with the help of community-based organizations.

Consultants

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

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

Executive Summary

Introduction

For the Sisters of Little Company of Mary, the heritage of compassionately caring for the needs of others 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 for the sick and dying. In 1982, Little Company of Mary Hospital voluntarily adopted a social accountability budget and, when the organization expanded to include San Pedro Hospital, the commitment continued. Today, these two nonprofit Medical Centers—Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance—have agreed to jointly sponsor this Community Health Needs Assessment as part of the continuing commitment to live out this 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. Today, the two Little Company of Mary Medical Centers are part of Providence Health & Services – Southern California and are fully aligned with both the Mission and Core Values of the seven-state Providence Saint Joseph Health system:

"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."

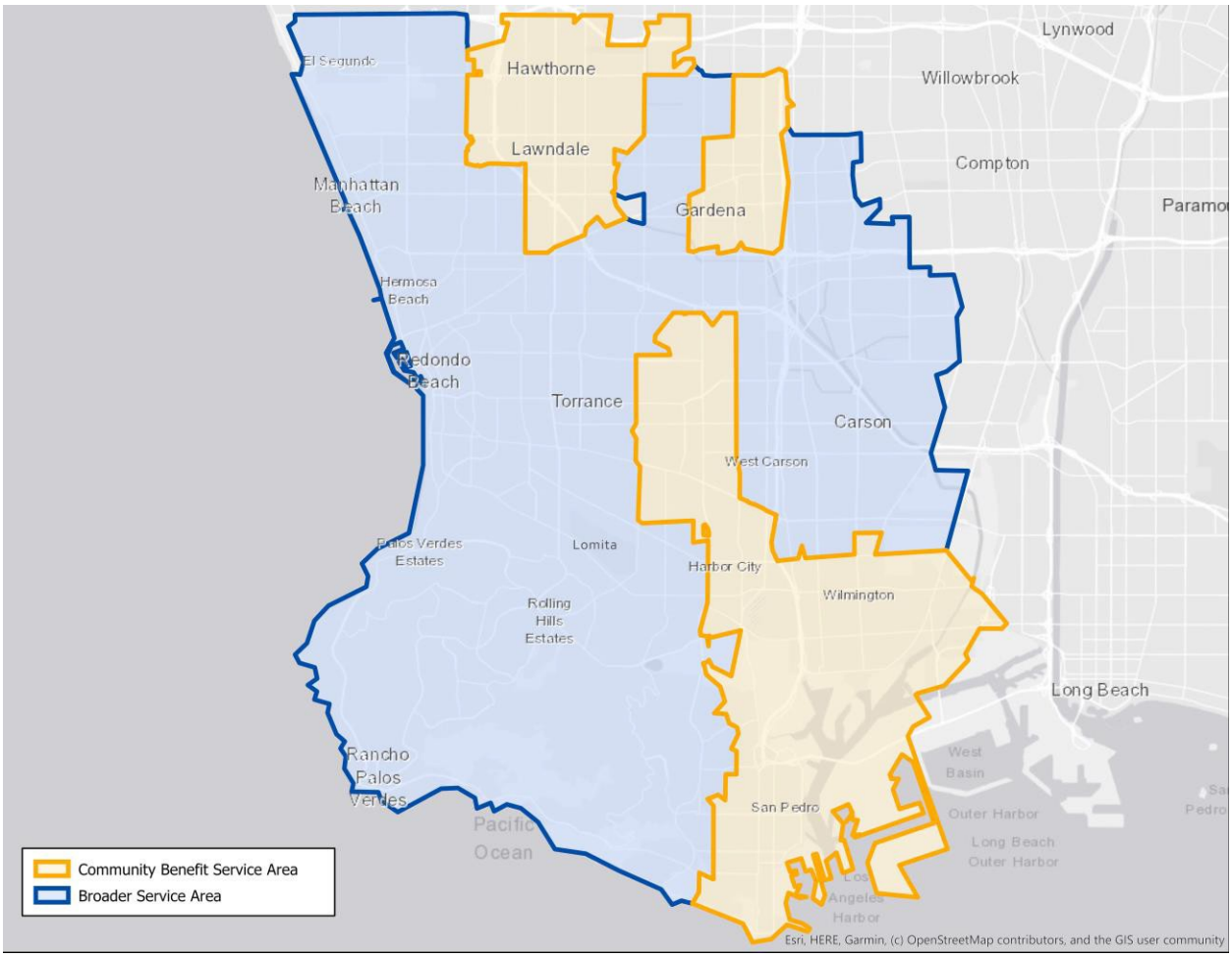
Our Community

The two Providence South Bay community medical centers, Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance (hereafter jointly referred to as the South Bay Community), share a common geography because of their close proximity to each other. The South Bay Community Service Area is composed of 16 distinct municipalities, and is a demographically and geographically diverse region stretching from El Segundo (North), to Carson (East), to the Port of Los Angeles (South), to the Pacific Ocean (West).

For purposes of this CHNA, the South Bay Community is divided into the "Community Benefit Service Area" and the "Broader South Bay Service Area." 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 Hawthorne, Lawndale, Gardena, Torrance (90501), Harbor City, San Pedro (90731), and Wilmington.

The Broader South Bay Service Area is the balance of communities within the Total Service Area with a CNI score below 4. These areas are more resource rich with a population on the higher end of the socioeconomic spectrum.

Figure_ES 1. Providence South Bay Community CHNA Service Area Map



CHNA Framework

To ensure that the Providence Little Company of Mary Medical Centers (PLCM) comply with federal and state regulations on Community Health Needs Assessments, PLCM staff recommended the Community Ministry Board (CMB) authorize the creation of an ad hoc CHNA Oversight Committee made up of an equal number of Providence representatives and external Stakeholders to prioritize the identified health needs. At its March 2019 meeting, the CMB authorized this CHNA Oversight Committee with board member, Tim McOsker, appointed as the Oversight Committee Chair.

Another important factor in the framework of this CHNA is compliance with IRS Schedule H Regulations. In addition to a required definition of the "community" to be served by the Community Benefit Plan, the IRS also requires broad public input, a description of the process and methods used to collect primary

and secondary data, and an evaluation of the impact of programs on prioritized needs. Specifically, input is expected from the Public Health Department, members of underserved communities and/or the organizations that represent the medically underserved and low-income populations.

Changes in reimbursement models are encouraging hospitals to think about population health models that incentivize keeping people healthy. There is increasing recognition that many other factors beyond the health care system, called the Social Determinants of Health, play an even larger role in the health of the community. For example, the neighborhood and physical environment where a person grows up, as well as the education they receive, the food they eat, and their social support systems all contribute to the health of that individual. For these reasons, the CHNA takes a close look at these factors and the disparities that exist between high need communities and neighborhoods, compared to the broader community within the South Bay Service Area.

CHNA Process and Methods

Gathering data for this CHNA involved systematic collection of both primary and secondary data relevant to the South Bay to identify the high priority needs and issues facing the community. For primary data, 8 organizational leaders provided input through structured phone interviews. In addition, a total of three listening sessions with 37 participants were conducted with the help of community-based organizations.

PLCM chose to conduct listening sessions at Vasek Polak Health Clinic and the Wellness & Activity Center because of their work to promote the health and wellness of all people living in the South Bay. The Vasek Polak Health Clinic in Hawthorne provides affordable primary care services to people who are uninsured or underinsured. It serves as a medical home for patients, supporting management of chronic diseases, referrals to other services in the South Bay and wellness classes. PLCM's Wellness and Activity Center, located in Wilmington, provides numerous wellness programs, assistance with applications for food and health benefits, referrals to resources, and space for community building.

Secondary data collection included the review of demographic, insurance, mortality, morbidity, mental health, economic and social determinant data from multiple sources. The secondary data sources included the following: the U.S. Census, Los Angeles Homeless Services Authority, Think Health L.A. Database, Community Commons Database, the Health Places Index, California Health Interview Survey Dataset, L.A. County Department of Public Health, and California Department of Public Health. Other quantitative data included primary data from PLCM's electronic health record system.

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

- Access to Health Care
- Behavioral Health
- Chronic Diseases

- Early Childhood Development
- Economic Insecurity
- Food Insecurity
- Homelessness and Housing Instability
- Oral Health Care
- Services for Seniors
- Social Cohesion

Key Findings

The following table presents key findings for each identified health-related need base on stakeholder input:

Identified Health Need	Key Findings
Access to Health Care	• For those on Medi-Cal, there is a long wait time between scheduling an appointment and actually receiving care, highlighting the need for increased access to appointments. • Transportation barriers disproportionately impact older adults. • A survey of 100 residents of an affordable housing community in Wilmington found that 20% of survey respondents utilize the emergency department as their usual place of care when sick.
Behavioral Health, including mental health and substance use treatment	• A survey of 133 residents of a low income housing community in Wilmington found that 23.3% self-rated their health status as fair or poor, compared to 21.5% countywide. • The same survey of 133 residents found that 18% had been told by a health professional that they have depression or some other depressive disorder. • LAC DPH data reported that 10.7% of adults in the Community Benefit Service are at risk for major depression, compared to 8.9% in the broader community and 11.8% countywide • Adult participants in a listening session at the Wellness and Activity Center reported experiencing reduced feelings of depression and social isolation and that the Center is a safe place where people feel loved and welcome. • Community stakeholders were particularly concerned about young people using substances and suggested implementing youth-led initiatives for substance use prevention and health promotion.

Identified Health Need	Key Findings
Chronic Diseases	• The percentage of people diagnosed with diabetes in the Community Benefit Service Area (7.0%) is lower than the Broader Service Area (10.2%). The percentage of adults diagnosed with hypertension is lower in the Community Benefit Service Area (14.6%) compared to the Broader Service Area (25.5%). • There are higher hospital admission and death rates related to chronic diseases in the Community Benefit Service Area compared to the Broader Service Area
Early Childhood Development	• There are not enough resources for infants/toddlers and their parents. Licensed child care centers only have the capacity to serve 13% of Los Angeles County's children under the age of 5. • The Los Angeles County Child Care Planning Committee 2017 Needs Assessment reported the cost of care for a young child (below 5) is high. A family's cost of care in Los Angeles County averages between $8,579 and $14,309 depending on age and setting.
Economic Insecurity	• The American Community Survey reported 44.7% of the population living in the Community Benefit Service Area have annual incomes below 200% of the Federal Poverty Level (FPL), compared to 19.2% in the Broader Survive Area. • LAC DPH data reported 19.5% of Community Benefit Service Area residents have annual incomes below 100% FPL, compared to 7.7% in the Broader Service Area, and 17.8% countywide. • 2017 Census data reported that among renter households in the Community Benefit Service Area, 53.5% spend more than 30% of their income on housing (housing-cost burdened) and 28.7% spend more than 50% of their income on housing (severely housing-cost burdened). This compares with the Broader Service Area where 46% are housing-cost burdened and 22.1% are severely housing-cost burdened. • LAC DPH surveys found 83.6% of resident in the Community Benefit Service Area completed high school, compared to 93.6% in the Broader Community and 77.6% countywide.

Identified Health Need	Key Findings
	• Participants from the listening session in Spanish at the Wellness and Activity Center were particularly interested in more opportunities to advance themselves through skill-building classes and educational opportunities. • Community stakeholders shared loss of income due to job elimination contributes to families not having sufficient income to cover their basic necessities. Additionally, lack of living wage jobs, coupled with high cost of living in the South Bay, means that people are not making enough money to cover their needs.
Food Insecurity	• 32.1% of households in the Community Benefit Service Area with incomes below 300% Federal Poverty Level are food insecure. • The current political climate has created fear related to immigration. Some undocumented immigrants will likely avoid applying for food assistance programs because of proposed changes to public charge laws. • There are 38,707 individuals eligible for CalFresh but not yet enrolled in Community Benefit Service Area.
Homelessness and Housing Instability	• According to the 2019 Greater Los Angeles Homeless Count, Los Angeles County has 58,936 people experiencing homelessness—a 12% increase from the year before. • In the Community Benefit Service Area there were 2,057 people experiencing homelessness, which is an increase of 26% from 2018.
Oral Health Care	• Almost 1 out of every 5 children in the Community Benefit Service Area went without dental care in the past year because they could not afford it. • The percent of adults who did not see a dentist or go to a dental clinic in the past year in the Community Benefit Service Area (44.5%) was above that of Los Angeles County (40.7%) and almost double what is seen in the Broader Service Area (27.4%). • Dental deserts exist in San Pedro, Hawthorne and Gardena which are all located in the Community Benefit Service Area.

Identified Health Need	Key Findings
Services for Seniors	• Over the next 5 years the age 65+ population is expected to grow by 15.8% in the Community Benefit Service Area and 12.7% in the Broader Service Area. • The homeless population age 62 and over increased to 540 people in Service Planning Area 8 of LA County between 2018 and 2019. This is an increase of 24%. • Community members who participated in the listening sessions recommended implementing more resources for older adults at the Wellness and Activity Center.
Social Cohesion	• Wellness and Activity Center Listening Session participants reported experiencing reduced feelings of depression and social isolation since participating in programming at the Center. • Participants feel their cultures are celebrated at the Center, helping to build community and learn about one another.

Prioritization Process and Criteria

The CHNA Oversight Committee met on October 15 and October 29, 2019 to prioritize and recommend the top identified health needs. At the first meeting, the CHNA Oversight Committee considered the CHNA Framework, the definition of the South Bay Community and the differing characteristics between the Community Benefit Service Area and Broader Service Area. The group participated in two discussions related to behavioral health and food insecurity and utilized some of the secondary data collected to sharpen the discussion on these two identified needs. This approach was taken to familiarize the group with the identified health-related needs to be presented in the second meeting and to practice a structured discussion that would be followed in the second session.

In advance of the second meeting, committee members received a summary of primary and secondary data collected for the ten identified health-related needs. The second meeting began with each member providing input for the ten identified health needs, based upon the collection of primary and secondary data by PLCM's Community Health staff. For each identified health need, committee participants were asked to rate the severity of the identified health need, change over time, availability of community resources/assets and community readiness to implement/support programs to address the health need. This survey was then followed by a review of the data assembled for each identified health need by Providence staff. Half of the meeting time was then set aside to break the CHNA Oversight Committee into two groups to address three questions for each identified need:

- How does this need impact the work of your organization and the clients you serve?
- What other service gaps currently exist?
- What role can Providence Little Company of Mary play in addressing this need?

Committee members then participated in a dot-voting exercise to indicate which needs rose to the top as highest priority during the dialogue.

2019 Prioritized Health Needs

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

Table_ES 1. Health-Related Needs in Order of Priority

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

Introduction

Who We Are

For the Sisters of Little Company of Mary, the heritage of compassionately caring for the needs of others 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 for the sick and dying. In 1982, Little Company of Mary Hospital voluntarily adopted a social accountability budget and, when the organization expanded to include San Pedro Hospital, the commitment continued. Today, these two nonprofit Medical Centers—Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance—have agreed to jointly sponsor this Community Health Needs Assessment as part of the continuing commitment to live out this Mission.

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"As expressions of God's healing love, witnessed through

the ministry of Jesus, we are steadfast in serving all,

especially those who are poor and vulnerable."

Providence Little Company of Mary Medical Centers San Pedro and Torrance

Providence Little Company of Mary Medical Centers San Pedro and Torrance provide the full spectrum of care from birth through end of life. While each medical center has its own unique character, both are known for providing the South Bay community with clinical excellence, sophisticated technology and care with a personal touch.

In addition to general medical, surgical and critical care services, the medical centers offer a number of specialty programs. Serving the community since 1960, PLCM Torrance offers minimally invasive surgical options using the advanced da Vinci® robotic surgery system and a cardiovascular center of excellence. It also houses a state-of-the-art maternity unit, complete with the county's first single-family level III neonatal intensive care unit to enhance parent-child bonding for even the most fragile of infants, as well as an on-site perinatal center that provides complete fetal diagnostic testing and genetic counseling.

For over 90 years, Providence Little Company of Mary Medical Center San Pedro has been a landmark, serving the community's needs with invaluable clinical services. In addition to establishing the South Bay's first Primary Stroke Center, the hospital offers specialty services such as chemical dependency and advanced rehabilitation therapy. The hospital's Sub Acute Care Center is one of California's largest sub-acute facilities, while the Center for Optimal Aging provides compassionate care for the elderly.

In addition to offering advanced services and technology, both medical centers have received several accolades and national recognition. PLCM Torrance was recognized by U.S. News & World Report as one of California's best hospitals and as a World's Best Hospital by Newsweek. The Leapfrog Group, a National Patient Safety advocacy group, acknowledged both San Pedro and Torrance medical centers with the highest ranking of an "A" for safety five rating periods in a row. Finally, we are proud to have been named the "Best Hospital" in the South Bay by the Daily Breeze.

Providence Saint Joseph Health

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

Our Commitment to Community

As health care continues to evolve, the Providence South Bay Community is responding with dedication to its Mission and a desire to create healthier communities, together. Partnering with other non-profits that share our commitment to the poor and vulnerable, we conduct a formal Community Health Needs Assessment to learn about the greatest needs and assets in our community, especially considering members of medically underserved, low-income, and minority populations. This assessment helps us consider solutions to fulfill unmet needs while continuing to strengthen local resources. It guides our community benefit investments and supports many partners that look to PLCM as a leader in improving the health of our community.

During 2018, PLCM provided $63,824,873 in community benefit in response to unmet needs and to improve the health and well-being of those we serve in the South Bay.

Our Mission, Vision, Values and Promise

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

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

Our Mission

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

Our Values

Compassion, Dignity, Justice, Excellence, Integrity.

Our Vision

Health for a better world.

Our Promise

Know me, Care for me, Ease my way.

Our Community

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

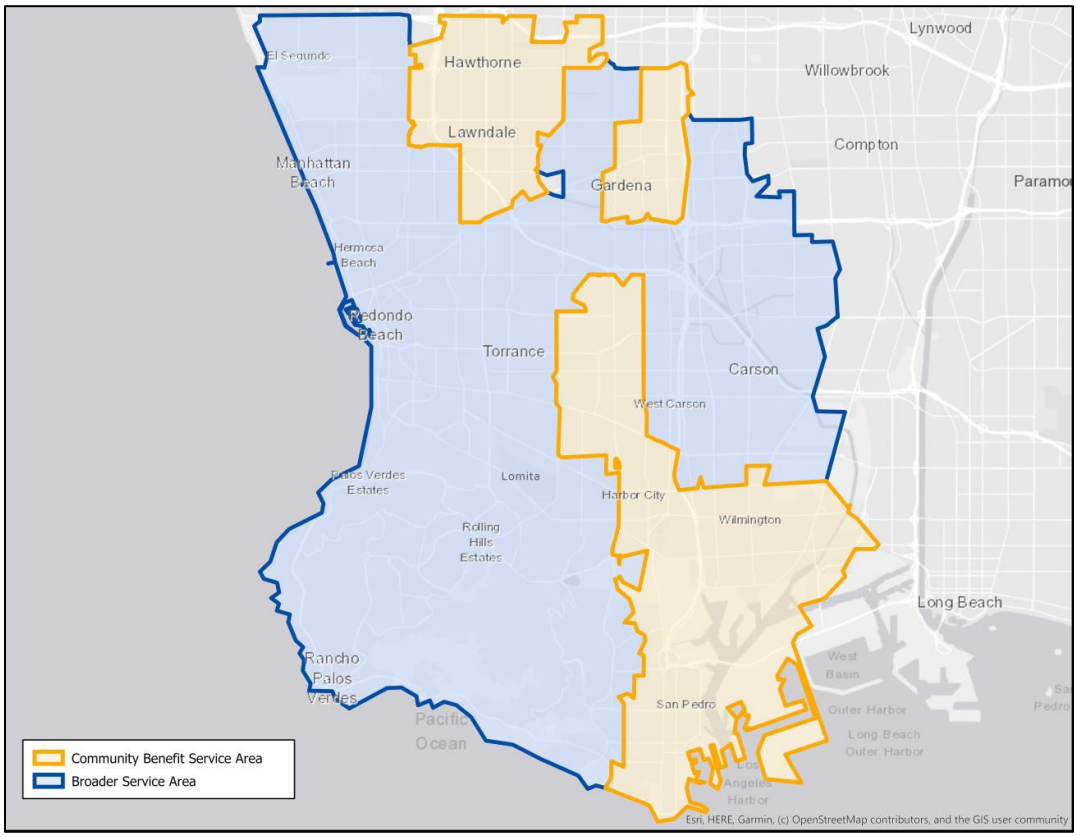
Description of Community Served

The two Providence South Bay Community medical centers, Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance (hereafter South Bay Community), share a common geography because of their close proximity to each other. The South Bay Community Service Area is composed of 16 distinct municipalities, and is a demographically and geographically diverse region stretching from El Segundo (North), to Carson (East), to the Port of Los Angeles (South), to the Pacific Ocean (West).

For purposes of this CHNA, the South Bay Community is divided into the "Community Benefit Service Area" and the "Broader South Bay Service Area." 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 Hawthorne, Lawndale, Gardena, Torrance (90501), Harbor City, San Pedro (90731), and Wilmington.

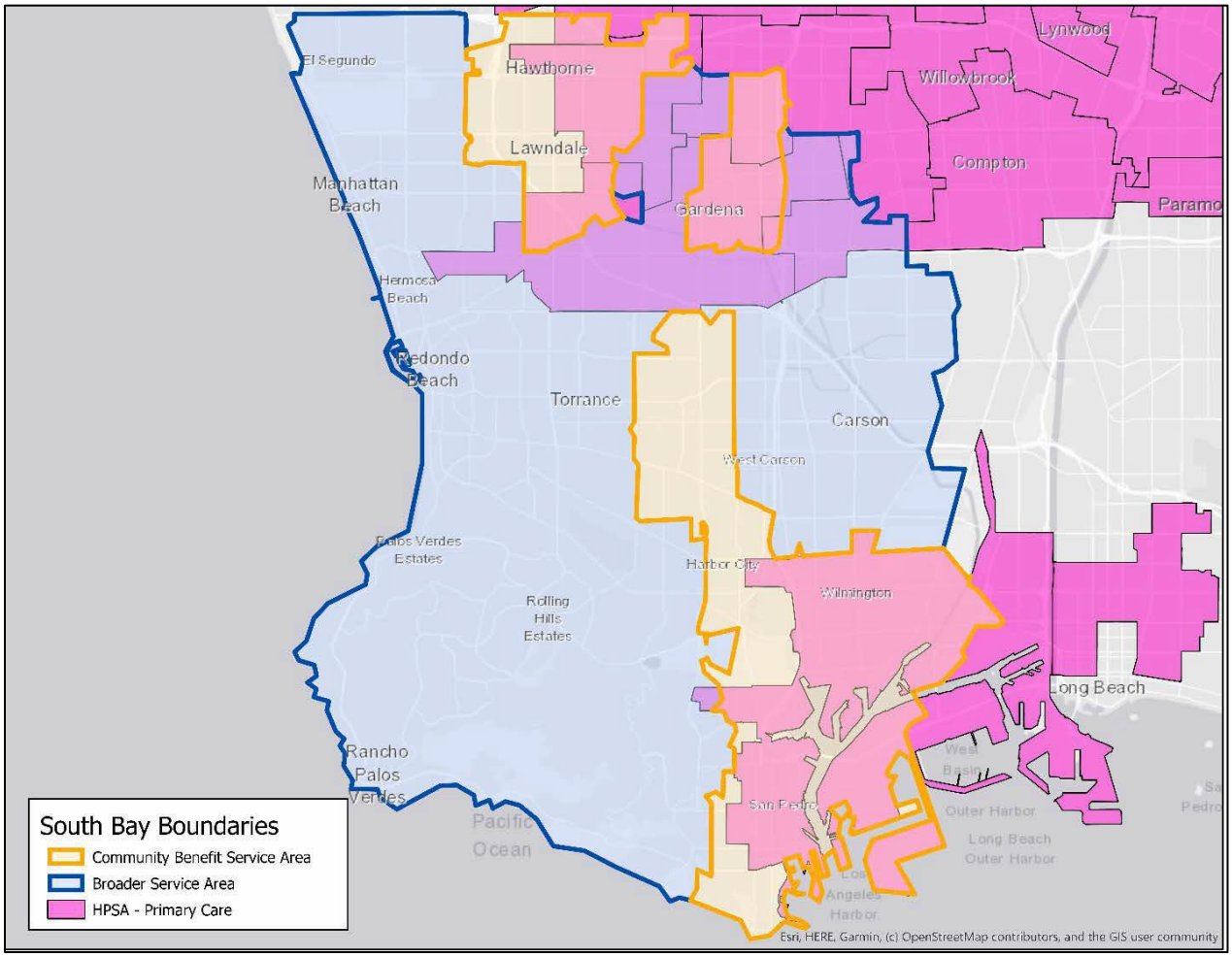
The Broader South Bay Service Area is the balance of communities within the Total Service Area of the two medical centers with a CNI score below 4. These areas are more resource-rich with a population on the higher end of the socioeconomic spectrum.

Figure 1. Providence South Bay Community CHNA Service Area Map



For purposes of this CHNA, in alignment with our Mission to pay special attention to those who are poor and vulnerable, we also looked to the Health Professional Shortage Area (HSPA) to identify any additional high need areas.

Figure 2. Health Professional Shortage Areas in the Broader South Bay Community



Much of the primary care HPSAs are found in the Community Benefit Service Area. Primary care HPSAs span all of Wilmington and Gardena while covering most of San Pedro. There are also primary care HPSAs in parts of Hawthorne, Lawndale and in North Torrance.

Community Demographics

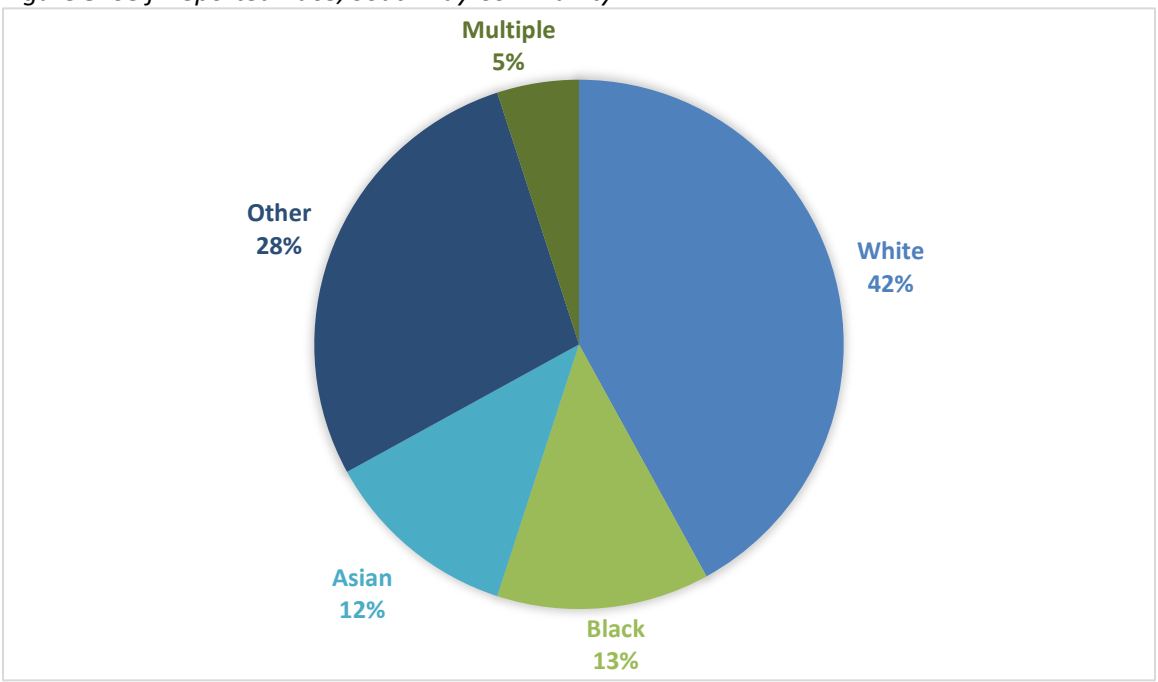
Population and Age Demographics

The South Bay service area is slightly younger, on average, than the total population of the state of California. The majority of residents in the service area are between 10 and 39 years old. Children under the age of 19 make up 29.6% of the population, compared to 22.7% across the state. Adults aged 60 years and older make up 13.7% of the total service area population, which is less than the state population aged 65 and over.

Population by Race/Ethnicity

Of the 358,565 residents in the South Bay Community Service Area in 2019, 56.2% identified as Hispanic/Latino. Approximately 42% of residents identified as White, while 28% identified as Asian/Pacific Islander, American Indian/Alaska Native, or another race. Approximately 13% identified as Black, and 12% as Asian (below).

Figure 3. Self-Reported Race, South Bay Community



Source: U.S. Census Bureau

Income Levels

In 2019, the median household income of the area varied significantly from a low of $43,717 for the community of Wilmington to $189,068 for the community of Palos Verdes Peninsula. Although the South Bay contains many affluent communities, the income data show there are areas within the service area with a higher portion of low-income households. The median household income ($53,598) within the Broader South Bay Service Area is lower than the median of Los Angeles County ($62,751).

Approximately 44.7% of households have annual incomes below 200% of the Federal Poverty Level ($51,500 for a family of 4).

Education Level

While many of the adults age 25+ living in households in the South Bay have at least graduated from high school, there were several zip codes that had a higher percentage of adults who had not completed high school. These zip codes included Wilmington (90744; 43.3%), Lawndale (90260; 24.8%), Hawthorne (90250; 24.0%) and Gardena (90247; 22.1%).

Economic Indicators

The South Bay service area has some notable economic indicators. The percent unemployed in the area averages 4.7%.

Language Proficiency

Within Los Angeles County, 56.6% of residents speak a language other than English at home. Slightly more households (an average of 58.7%) in the Broader South Bay Community service area speak a language other than English at home, and individuals speaking languages other than English at home are concentrated in Wilmington, Carson, and Lawndale.

Overview of CHNA Framework

This section provides a summary of the framework that guided the design of Providence South Bay Joint Community Health Needs Assessment.

To ensure that the Providence Little Company of Mary Medical Centers (PLCM) comply with federal and state regulations on Community Health Needs Assessments, PLCM staff recommended the Community Ministry Board (CMB) authorize the creation of an ad hoc CHNA Oversight Committee made up of an equal number of Providence representatives and external Stakeholders to prioritize the identified health needs. At its March 2019 meeting, the CMB authorized this CHNA Oversight Committee with board member, Tim McOsker, appointed as the Oversight Committee Chair.

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

Changes in reimbursement models are encouraging hospitals to think about population health models that incentivize keeping people healthy. There is increasing recognition that many other factors beyond the health care system, called the Social Determinants of Health, play an even larger role in the health of the community. For example, the neighborhood and physical environment where a person grows up, as well as the education they receive, the food they eat, and their social support systems all contribute to the health of that individual. For these reasons, the CHNA takes a close look at these factors and the disparities that exist between high need communities and neighborhoods, compared to the broader community within the South Bay Service Area.

CHNA Process and Methods: Data Collection and Collaboration

This section provides a summary of the framework that guided the design of the Providence South Bay Joint Community Health Needs Assessment.

Community Input: Qualitative Data

For primary data, 8 organizational leaders provided input through structured phone interviews. In addition, a total of three listening sessions with 37 participants were conducted with the help of community-based organizations. PLCM chose to conduct listening sessions at Vasek Polak Health Clinic and the Wellness & Activity Center because of their work to promote the health and wellness of all people living in the South Bay. The Vasek Polak Health Clinic in Hawthorne provides affordable primary care services to people who are uninsured or underinsured. It serves as a medical home for patients, supporting management of chronic diseases, referrals to other services in the South Bay and wellness classes. PLCM's Wellness and Activity Center, located in Wilmington, provides numerous wellness programs, assistance with applications for food and health benefits, referrals to resources, and space for community building.

Solicited CHNA Comments from the Public

The 2016 South Bay Joint Community Health Needs Assessment is publicly available on each of the hospitals' websites, with a point of contact listed in the report. No written comments were received regarding the 2016 Community Health Needs Assessment and Implementation Strategy report.

Collaborative Partners

As part of the primary data collection process, Providence Little Company of Mary Medical Center San Pedro and Torrance worked in collaboration with Kaiser Permanente South Bay and Torrance Memorial to collect and analyze the information from two listening sessions on homelessness and food insecurity.

- Developing a list of key community stakeholders/leaders to be included in the telephone interviews
- Compiling the list of questions to be used in the telephone interviews to identify the key community needs and contributing factors
- Sharing secondary data sources regarding key information available on the targeted area

Once the CHNA is completed, the hospitals intend to continue the collaborative efforts to identify common health needs that they can jointly address.

Quantitative Data

Secondary data collection included the review of demographic, insurance, mortality, morbidity, mental health, economic and social determinant data from multiple sources. The secondary data sources included the following: the U.S. Census, Los Angeles Homeless Services Authority, Think Health L.A. Database, Community Commons Database, the Healthy Places Index, California Health Interview Survey Dataset, L.A. County Department of Public Health, and California Department of Public Health.

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

Data Limitations and Information Gaps

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

- Disaggregated data for age, ethnicity, race, and gender are not available for all indicators, which limits the ability to evaluate disparities of health issues across the community
- At times, a stakeholder-identified health issue may not have been reflected by the secondary data
- Data are not always collected on an annual basis, meaning that some data are several years old

Identified Health Needs

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

- Access to Health Care
- Behavioral Health
- Chronic Diseases
- Early Childhood Development
- Economic Insecurity and Workforce Development
- Food Insecurity
- Homelessness and Housing Instability
- Oral Health Care
- Social Cohesion

Prioritized Significant Community Health Needs

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

The CHNA Oversight Committee met on October 15 and October 29, 2019 to prioritize and recommend the top identified health needs. At the first meeting, the CHNA Oversight Committee considered the CHNA Framework, the definition of the South Bay Community and the differing characteristics between the Community Benefit Service Area and Broader Service Area. The group participated in two discussions related to behavioral health and food insecurity and utilized some of the secondary data collected to sharpen the discussion on these two identified needs. This approach was taken to familiarize the group with the identified health-related needs to be presented in the second meeting and to practice a structured discussion that would be followed in the second session.

In advance of the second meeting, committee members received a summary of primary and secondary data collected for the ten identified health-related needs. The second meeting began with each member providing input for the ten identified health needs, based upon the collection of primary and secondary data by PLCM's Community Health staff. For each identified health need, committee participants were asked to rate the severity of the identified health need, change over time, availability of community resources/assets and community readiness to implement/support programs to address the health need. This survey was then followed by a review of the data assembled for each identified health need by Providence staff. Half of the meeting time was then set aside to break the CHNA Oversight Committee into two groups to address three questions for each identified need:

- How does this need impact the work of your organization and the clients you serve?
- What other service gaps currently exist?
- What role can Providence Little Company of Mary play in addressing this need?

Committee members then participated in a dot-voting exercise to indicate which needs rose to the top as highest priority during the dialogue. Additionally, Committee participants were asked to complete a survey to rate the severity of the identified health need, change in severity of the need over time, availability of community resources/assets to address the need and community readiness to implement/support programs to address the health need.

2019 Prioritized Health Needs

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

Table 1. Health-Related Needs in Order of Priority

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

Description of Significant Community Health Needs

This section provides primary and secondary data to characterize the significant health needs identified and prioritized during the Providence South Bay Community Health Needs Assessment process.

Homelessness and Housing Instability

Primary Data

Community Stakeholder Listening Session on Homelessness

Stakeholders from community-based organizations shared factors contributing to and barriers to addressing homelessness and housing instability.

Factors contributing to homelessness and housing instability:

- Lack of affordable housing options
- Economic insecurity, including a lack of jobs that pay a living wage
- Mental health and substance use
- Lack of educational opportunities
- Domestic violence

Barriers to addressing homelessness:

- An unsustainable and fragmented approach to addressing homelessness: lack of a scalable model in place, with the current system of developing housing being too time intensive and costly to keep up with demand
- Lack of emergency shelter beds
- Fear and mistrust preventing people experiencing homelessness from engaging with services
- NIMBYism ("Not in My Backyard"-ism): finding locations to build affordable housing is challenging because of the NIMBY attitude
- Lack of funding and flexibility in use of funds for affordable housing and services
- Lack of supportive services for people newly transitioned to housing

Stakeholders identified several populations that are disproportionately impacted by homelessness and housing instability: transitional age youth; older adults; people with physical or developmental disabilities; people who identify as LGBTQ; women; and people of color.

Stakeholders also shared health risks resulting from living unsheltered: 1) diseases such as HIV and hepatitis; 2) exacerbated mental illness, such as anxiety and depression; 3) unmanaged chronic conditions; and 4) untreated dental problems.

Effective strategies or actions for addressing homelessness:

- Outreach teams
- Hospital navigators and increased communication between services providers
- Homelessness prevention and diversion
- Community education
- Housing First and supportive services

Community needs related to homelessness:

- Collaboration and sharing between organizations, particularly related to post-discharge planning and warm handoffs from hospitals to social service organizations
- Leadership from stakeholders involved
- Advocacy from health care organizations that can leverage their authority and power to address homelessness
- Prevention efforts, such as investing in workforce development, job skill building, education and vocational opportunities
- Harm reduction strategies, such as needle exchanges
- Flexible funding to allow organizations to decide how best to spend money to meet clients' needs
- Recuperative care or transitional care for patients experiencing homelessness

Secondary Data

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

The table below displays the results of the 2019 Greater Los Angeles Homeless Count with a focused look at the results of Service Planning Area (SPA) 8 and the community.

Table 2. 2019 Point-In-Time Homeless Count, Providence South Bay Service Area, SPA 8 and Los Angeles County

Geographic Area	Sheltered	Unsheltered	Total	Percent Change 2018-2019
Los Angeles County	14,722	44,214	58,936	+12%
SPA 8	1,429	4,874	6,303	+5%
Broader Service Area	25	1730	1755	-3%
Community Benefit Service Area	198	1859	2057	+26%

Source: The Los Angeles Homeless Services Authority (LAHSA), https://www.lahsa.org/documents

As reported widely in news outlets, homelessness in Los Angeles County has been steadily growing since 2016, including a 12% increase between 2018 and 2019.

In SPA 8, among the 6,303 persons experiencing homelessness, 87% are individuals and 13% are family members. Approximately 3 out of 4 individuals experiencing homelessness are male. The homeless population in Los Angeles County is increasingly older. Seniors 62 years and over represent 12% of the homeless population, a 24% increase since 2018. Close to 60% of individuals experiencing homelessness are between the ages of 25 and 64, while 8% are under the age of 18.

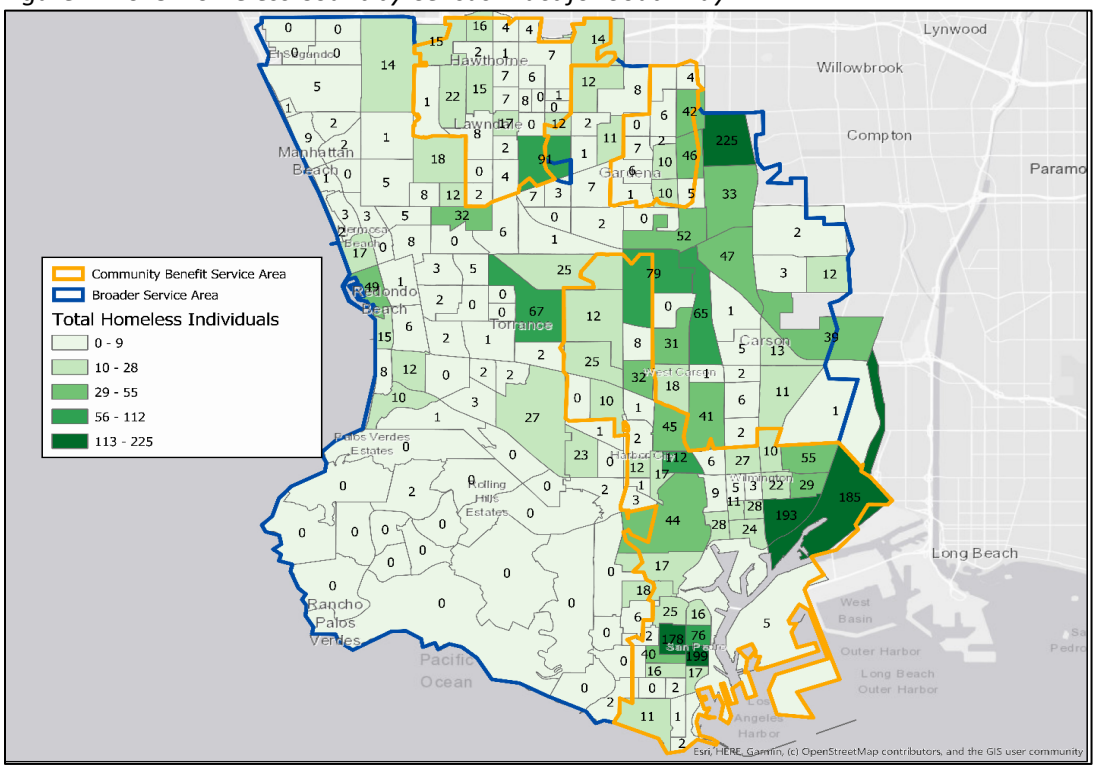
With respect to patterns of homelessness among racial/ethnic subgroups, prevalence of homelessness is highest among Latinos and African-Americans, who represent 38% and 31% of the homeless population respectively. Rates of homelessness among African Americans decreased by 4% in one year. By contrast, only 46 individuals identifying as Asian were experiencing homeless in SPA 8 in 2019, and rates of homelessness among Whites decreased 25% in one year. Meanwhile, rates of homelessness among native-Hawaiian/other Pacific Islanders and Latinos have grown by 50% and 30% in one year, respectively.

The homeless rate in the Community Benefit Service Area has soared 26% in one year, the largest yearly increase in four years. In 2019, 42,560 renter households (54%) are housing-cost burdened, meaning housing costs exceed 30% of their household income. Furthermore, 21,633 renter households (29%) are severely housing-cost burdened, with housing costs exceeding 50% of their household income.

As shown in the figure below, the cities of Carson, San Pedro, Wilmington and Inglewood reported the highest concentration of homelessness. In particular, Wilmington and San Pedro have a combined 1,290 individuals experiencing homelessness. This accounts for 33% of all persons in the PLCM Service Area who are experiencing homelessness.

The greatest proportional increase in homelessness in one year occurred in Harbor City (47%), Harbor Gateway (68%), Gardena (62%), and Lomita (86%). The largest downward trend in homeless rate occurred in Manhattan Beach (49%), Rancho Palos Verdes (50%) and West Carson (52%).

Figure 4. 2019 Homeless Count by Census Tract for South Bay



Source: The Los Angeles Homeless Services Authority (LAHSA), https://www.lahsa.org/documents

Access to Health Care

Primary Data

Stakeholder Interviews

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

- High cost of care and medications, which disproportionately affects young people and individuals with insurance other than Medicaid
- Lack of health literacy, including challenges navigating the complexity of the health care system, which disproportionately affects people with language or literacy barriers
- Fear related to immigration status and finding out about an illness, as well as distrust of the health care system
- Transportation barriers, particularly amongst older adults
- Limited availability of appointments, particularly outside of normal working hours

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

- Medical homes that combine health education, medical care, and social-emotional support
- Outreach and navigation to help families learn about and navigate the available resources in the community

Listening Sessions with Community Members

Participants' vision for a healthy community includes local, affordable health care services: Participants need low-cost or free health care services that are available for everyone, particularly for people who are uninsured

Participants choose where to receive health care services largely depending on their insurance status and type of insurance: They seek medical services at a variety of locations including hospitals and the emergency department, private doctors, and community clinics, such as Vasek Polak Health Clinic and Harbor UCLA.

Participants shared their reasons for using the Emergency Department: 1) a true medical emergency, such as a high fever or sudden onset of pain; 2) the doctor's office is closed, such as on an evening or weekend; 3) they need timely care, but appointments are being scheduled weeks or months in the future; 4) they do not have insurance or are enrolled in Emergency Medi-Cal only.

Barriers to seeking health care services:

- Lack of insurance and cost of care: Copays and surprise bills prevent people from seeking services.
- Discrimination and fear: Participants shared stories of being treated rudely in local health care centers and staff being unhelpful when they have questions or concerns. They felt the care they receive on Medi-Cal is of lower quality, and they experience longer wait times than people on private insurance. They also shared they feel discriminated against for not speaking English.
- Long wait times for appointments

Factors and resources that make accessing services easier:

- Health education classes in a community setting that help people connect to other health care services and learn about their insurance benefits.
- Friendly, welcoming, and linguistically appropriate services.

Community needs for improving access to health care services:

- More health-related classes, including a class dedicated to explaining health insurance benefits.
- A clear summary of health insurance benefits, specifically, information that is accessible and simple, potentially with someone to explain the information in person.
- Opportunities for community members to share information and learnings with one another.

Secondary Data

Overall, the Community Benefit Service Area outperforms LA County on a series of access to medical and dental care indicators. The exception is that fewer adults in the Service Area have health insurance compared to Los Angeles County as a whole.

Table 3. Access to Care Key Indicators

Indicator	Community Benefit Service Area	Broader Service Area	Los Angeles County
Percent of children ages 0-17 years who are insured	96.0%	97.6%	96.6%
Percent of adults ages 18-64 years who are insured	84.4%	96.2%	88.3%
Percent of children ages 0-17 years with a regular source of health care	96.1%	95.7%	94.3%
Percent of adults 18-64 years with a regular source of health care	77.8%	82.0%	77.7%
Percent of adults who did not see a dentist or go to a dental clinic in the past year	44.5%	27.4%	40.7%
Percent of children ages 3-17 years who did not obtain dental care (including check-ups) in the past year because they could not afford it	19.6%	*7.7%	11.5%

*Source: LA County Health Survey, 2015 * Unstable percentages due to small numbers. Interpret with caution.*

Dental Care

Almost one out of every five children (19.6%) in the Community Benefit Service Area went without dental care in the past year because they could not afford it. Additionally, fewer adults in the Service Area (44.5%) sought a dentist or dental clinic in the past year compared to county peers (40.7%).

Medi-Cal Eligibility

Since implementation of the Patient Protection and Affordable Care Act (ACA), many Californians have now become eligible to enroll and receive Medi-Cal benefits. As of March 2019, there are currently 1,225,668 Medi-Cal beneficiaries in Los Angeles. Additionally, Medi-Cal currently covers 233,196 undocumented individuals in Los Angeles County. The following table shows Medi-Cal beneficiaries as of March 2019.

Table 4. Adult Medi-Cal Enrollees in LA County (Ages 19-64 as of March 2019)

	American Indian/ Alaska Native	Asian	Black	Hispanic	Not Reported	White	Grand Total
Population	1,948	138,069	132,842	659,278	88,329	205,202	1,225,668
Percentage	0.2%	11.3%	10.8%	53.8%	7.2%	16.7%	

Behavioral Health, Including Mental Health and Substance Use

Primary Data

Stakeholder Interviews

Stakeholders identified behavioral health, including mental health and substance use, as an urgent need. Stakeholders identified factors contributing to behavioral health needs and proposed possible strategies to address these challenges. Stakeholders were particularly concerned about young people using substances.

F**actors contributing to behavioral health needs:**

- Challenges accessing care, including a lack of providers and mental health care centers: disproportionately affects young people and individuals with insurance other than Medicaid
- Poverty and stress leading to lack of parental engagement: disproportionately affects people of color and immigrants
- Screen time and social media addiction: disproportionately affects young people
- Stigma around seeking mental health services
- Challenges accessing substance use treatment services
- Lack of resources for youth around substance use

Effective strategies for addressing behavioral health challenges:

- Improve access to care by increasing available appointment times, developing community partnerships to pool resources for funding services, and utilizing mobile health vans to bring mental health providers to patients.
- Invest in preventive mental health services, such as group therapy for young people in community- based settings.
- Youth-led initiatives for substance use prevention and health promotion.

Listening Sessions with Community Members

Providence South Bay Community completed one listening session with 12 participants at Vasek Polak Health Clinic and two additional sessions at Providence Wellness and Activity Center. Participants shared

the following information:

Participants' vision for a healthy community includes mental wellbeing

- People can access mental health services
- People have less stress and participate in stress-relieving activities such as meditation

The community needs more accessible mental health services

- Counseling services in schools: participants were particularly concerned about providing support for young people
- More mental health professionals
- More available appointment times for counseling services
- More behavioral health services for people experiencing homelessness

The Wellness & Activity Center improves people's mental health

- Participants reported experiencing reduced feelings of depression and social isolation since participating in programming at the Center
- The Center is a safe place where people feel loved and welcome

Participants would like more mental health services at the Wellness & Activity Center

- Mental health support groups and classes for young people
- Support groups for parents

Secondary Data

Table 5. Behavioral Health Indicators

Indicator	Community Benefit Service Area	Broader Service Area	Los Angeles County
Percent of adults reporting their health to be fair or poor (rather than good or excellent)	20.2%	15.6%	21.5%
Average number of days in past month adults reported regular daily activities were limited due to poor physical/mental health	2.1	2.1	2.3
Percent of children ages 0-17 years who have special health care needs	19.4%	14.1%	14.5%
Percent of adults at risk for major depression	10.7%	8.9%	11.8%

*Source: LA County Health Survey, 2015 * Unstable percentages due to small numbers. Interpret with caution.*

Table 6. Behavioral Health Indicators Comparing SPA 8 and LA County

Indicator	SPA 8	Los Angeles County	Difference Between SPA 8 and LA County
Adults who ever seriously thought about committing suicide (2017)	9.4%	9.60%	0.2% Lower
Saw any healthcare provider for emotional-mental and/or alcohol-drug issues in past year (2016)	8.9%	12.30%	3.4% Lower
Adults who sought help for self-reported mental/emotional and/or alcohol-drug issues and received treatment (2016)	53.9%	60.10%	6.2% Lower

*Source: LA County Health Survey, 2015 * Unstable percentages due to small numbers. Interpret with caution.*

A higher proportion of adults are at risk for major depression in the Community Benefit Service Area (10.7%) than in the Broader Service Area (8.9%). Additionally, a higher portion of adults in the Community Benefit Service Area (20.2%) report their health to be fair or poor compared to the Broader Service Area (15.6%).

Economic Insecurity and Workforce Development

Primary Data

Economic insecurity contributes to homelessness/housing instability, food insecurity, and challenges paying for medical services. Stakeholders explained the amount of money people get paid in their jobs is

not sufficient to cover rent, food or medical bills. Therefore, people are forced to make hard decisions around how they spend their money. This high cost of living outpaces incomes which leads to economic insecurity.

Stakeholder Interviews

Economic insecurity affects people's ability to pay for health care services and buy medications:

The high cost of care and medications makes managing chronic diseases and other conditions very challenging. People with low incomes or individuals with incomes just above the poverty threshold are disproportionately affected by challenges accessing health care.

Economic insecurity affects people's ability to buy nutritious foods:

Healthy food options are often more expensive than unhealthy food options.

Economic insecurity contributes to housing insecurity and homelessness:

Listening session participants shared that loss of income because of job elimination contributes to families not having sufficient income to cover their basic necessities. Additionally, lack of living wage jobs, coupled with high cost of living in the South Bay, means that people are not making enough money to cover their needs.

Lack of educational opportunities contribute to housing insecurity and homelessness: Listening session participants saw education as key for helping people access opportunities—such as better paying jobs—and economic security. Therefore, people who may not have a strong educational background may be limited in their ability to better their circumstances, contributing to poverty and homelessness.

Stakeholders noted needing more investment in education and workforce development to address housing insecurity and homelessness:

Job skill-building, vocational opportunities, and other educational opportunities are important for addressing the root causes of housing insecurity and homelessness.

Poverty and stress contribute to mental health challenges:

Stress from high housing costs, financial insecurity, and long work hours from multiple jobs puts strain on families. Stress and busy schedules contribute to lack of parental engagement and ineffective parenting, contributing to the mental health challenges stakeholders see in young people. Stakeholders shared people of color, particularly Latinx people and immigrants, are disproportionately affected by poverty and stress in the South Bay contributing to poor mental health.

> *"I think it goes back to income and lack of affordable housing. For the populations that I work with, most of them don't have an income or credit to be able to afford [housing] and then what they can afford it's really not necessarily the best housing situation for them." – Community Stakeholder*

Listening Sessions with Community Members

Economic insecurity affects people's ability to pay for health care services and buy medications:

Cost of care, with and without insurance, including copays and a percentage of services, was a main reason participants shared for not seeking needed services in the past

Participants' vision of a healthy community includes opportunities to learn and grow:

Skill-building classes, such as classes to develop English and computer skills that may support people in getting better paying jobs

The community needs more educational and skill-building opportunities

- Participants want to advance themselves and would like to see more free and low-cost classes, such as computer or English classes
- Request for personal development classes at the Wellness and Activity Center

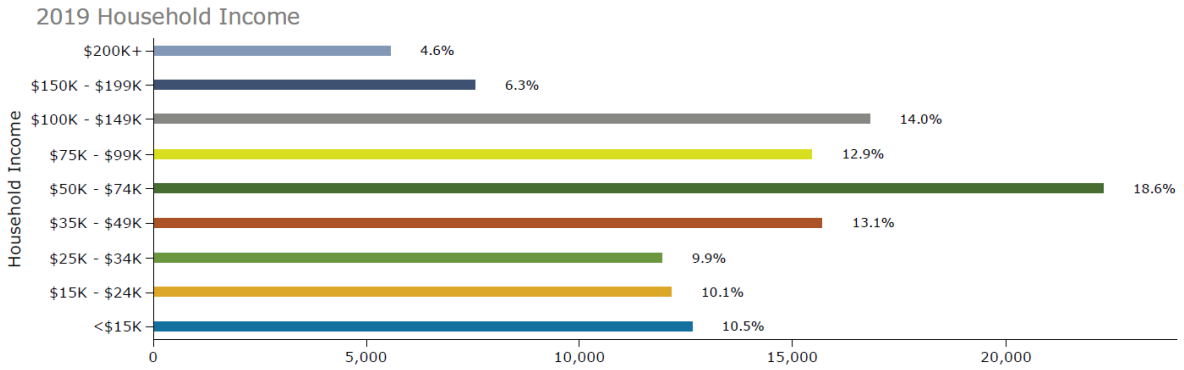
Secondary Data

Table 7. Economic Security and Workforce Development Key Indicators

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

Source: US Census Bureau American Community Survey 5-Year Estimates, 2013-2017

Figure 5. Community Benefit Service Area Income Distribution



The Community Benefit Service Area has a higher percentage households with incomes below the Federal Poverty Level ($25,750 for a family of 4) than the Broader Service Area and Los Angeles County. The area also has a higher percentage of households who spend more than 30% of their income on housing and a higher percentage of households with incomes below 300% the Federal Poverty Level who are food insecure. The above chart also shows that close to a third of household incomes in the Community Benefit Service Area are $25,000 or below.

Food Insecurity

Primary Data

Listening Session with Community Stakeholders

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

Barriers to accessing good-quality, nutritious food

- Fewer grocery stores in low-income communities
- Poorer quality fresh foods in low-income communities
- Healthy foods are more expensive than unhealthy food options
- Transportation to the grocery store
- Stress, busy schedules, and long work hours

> *"From what we were told over and over again, people really didn't want their names being put into the system and didn't really know or trust what was going to happen if they did." – Community Stakeholder*

Barriers to accessing and utilizing food assistance programs

- Fear related to immigration and public charge preventing people from enrolling in CalFresh
- Long, complex CalFresh applications
- Stigma around using public benefits
- Insufficient CalFresh benefits to cover a family's dietary needs for the month
- Insufficient food assistance for individuals receiving SSI

Groups having less access to good-quality, nutritious food

- People with low incomes
- People with incomes slightly above the threshold to qualify for assistance programs
- People with limited mobility
- People of color
- Undocumented immigrants

Health effects related to food insecurity

- Chronic diseases such as obesity, diabetes, and high blood pressure
- Poor physical and mental development for children
- Problems with concentration in school
- Poor decision making

Effective programs and initiatives for addressing food insecurity

- Food pantries and food banks that operate on a subsidized supermarket model
- Community education and outreach: wellness fairs, cooking classes, and market demonstrations
- Market Match helps food assistance dollars go further
- Screening for food insecurity in a medical setting and referring appropriately
- Los Angeles Food Policy Council's Healthy Neighborhood Market Neighborhood (supports small businesses in low-income neighborhoods to bring healthy food to their customers)
- Grassroots initiatives, such as Hunger Action LA

Immigration and public charge

Participants shared that not only are they having a harder time enrolling clients in assistance programs, but individuals are choosing to withdraw from these programs. Heightened fear and mistrust of the current administration have made connecting with immigrant communities more challenging for service providers and left many of the participants unsure how to reassure their clients.

Listening Sessions with Community Members

One listening session was conducted at Vasek Polak Health Clinic and two sessions were conducted at the Providence Wellness & Activity Center in Wilmington. Participants shared the following information:

Participants' vision for a healthy community includes access to healthy, nutritious food

- Affordable and healthy food available locally
- Families know how to cook healthy meals
- Nearby farmers' markets

The community needs healthier eating and exercise habits

- Concerns about childhood obesity

Secondary Data

Table 8. Food Insecurity Key Indicators

Indicator	Community Benefit Service Area	Broader Service Area	Los Angeles County
Percent of households with incomes <300% Federal Poverty Level who are food insecure	32.1%	*17.0%	29.2%
Percent of children with excellent or good access to fresh fruits and vegetables in their community	75.6%	88.5%	75.0%
Percent of adults who consume five or more servings of fruits & vegetables a day	11.5%	18.8%	14.7%
Percent of children who drink at least one soda or sweetened drink a day	40.8%	34.8%	39.2%

Source: US Census Bureau American Community Survey 5-Year Estimates, 2013-2017
*Source: LA County Health Survey, 2015 * Unstable percentages due to small numbers. Interpret with caution.*

The Los Angeles County Health Survey collects data specific to food insecurity. The most recent survey found:

- Latinos make up over two-thirds (67.4%) of food insecure households in Los Angeles County.
- Individuals aged 30-49 make up the largest proportion of food insecure households in Los Angeles County, closely followed by 18-29 year olds and 50-64 year olds.
- Almost half of all adults living in food insecure households (48.1%) reported an education level of less than high school.

Table 9. Demographic Characteristics of Los Angeles County Adults (ages 18+ years) with Household Incomes Less than 300% FPL by Food Security Status

	Living in Food Insecure Household			Living in Food Secure Household		
	Percent	95% CI	Estimated #	Percent	95% CI	Estimated #
GENDER						
Male	42.1%	38.0 -46.1	499,000	46.4%	43.9 - 48.9	1,565,000
Female	57.9%	53.9 - 62.0	687,000	53.6%	51.1 - 56.1	1,810,000
AGE GROUP						
18-29	25.2%	21.3 - 29.2	299,000	29.9%	27.5 - 32.3	1,009,000
30-49	38.4%	34.5 - 42.4	456,000	35.9%	33.5 - 38.3	1,212,000
50-64	25.3%	22.1 - 28.5	300,000	19.4%	17.6 - 21.2	654,000
65 or over	11.0%	8.9 - 13.2	131,000	14.8%	13.5 - 16.2	500,000
RACE/ETHNICITY◊						
Latino	67.4%	63.8 - 71.0	799,000	54.4%	51.9 - 56.8	1,835,000
White	14.7%	12.1 - 17.2	174,000	17.9%	16.3 - 19.6	606,000
African American	10.9%	8.8 - 13.1	130,000	8.8%	7.7 - 10.0	299,000
Asian	6.6%	4.4 - 8.7	78,000	18.4%	16.3 - 20.6	621,000
Native Hawaiian and Other Pacific Islander	-	-	-	0.2%*	0.0 - 0.4	N/A
American Indian/ Alaskan Native	0.3%*	0.1 - 0.6	N/A	0.2%*	0.1 - 0.3	N/A
EDUCATION						
Less than high school	48.1%	44.0 - 52.2	569,000	30.2%	27.7 - 32.6	1,012,000
High school	23.6%	20.2 - 27.1	280,000	25.6%	23.5 - 27.8	860,000
Some college or trade school	20.4%	17.5 - 23.4	242,000	29.8%	27.6 - 32.1	1,000,000
College or post graduate degree	7.8%	6.1 - 9.5	92,000	14.4%	12.9 - 15.8	482,000
EMPLOYMENT STATUS						
Employed	40.5%	36.5 - 44.6	479,000	50.0%	47.5 - 52.5	1,679,000
Unemployed	17.7%	14.6 - 20.8	209,000	12.3%	10.7 - 13.9	412,000
Not in the labor force*	41.8%	37.8 - 45.8	494,000	37.7%	35.3 - 40.0	1,264,000

Source: Los Angeles County Health Survey 2015

Services for Seniors

Primary Data

Stakeholder Interviews

Older adults need housing support services

- Older adults may experience financial insecurity, cognitive impairment, and social isolation which can all contribute to housing instability and homelessness.

Older adults need support accessing health care services

- High cost of care: Stakeholders shared even individuals with insurance struggle to afford the co-pays and bills associated with health care. Additionally, the high cost of medications makes managing chronic diseases or other conditions more challenging. The high cost of health care services and medications may disproportionately affect people with low incomes or individuals with incomes just above the poverty threshold, who may have insurance, but still not be able to afford the care they need. Older adults may also be disproportionately affected by challenges paying for care and medications.
- Transportation barriers: Getting to appointments is not always easy for people, particularly without a car. Older adults may be disproportionately affected by transportation barriers.

Listening Sessions with Community Members

During listening sessions, stakeholders identified the following:

Community members want more resources for older adults at the Wellness & Activity Center

- Participants shared they would like to see more classes designed for older adults, such as exercise and wellbeing classes.

Secondary Data

The population age 55+ accounts for 22.6% of the total population in the Community Benefit Service Area. Over the next 5 years the population age 55+ is expected to grow 8.9% in the Community Benefit Service Area and 6.2% in the Broader Service Area. The population age 65+ accounts for 11.7% of the total population, with an expected growth rate of 15.8%.

Table 10. Services for Seniors Key Indicators

Indicator	Community Benefit Service Area	Broader Service Area	Los Angeles County
Percent of adults ages 65+ years who have fallen in the past year	36.8%	23.1%	27
Alzheimer's disease-specific death rate (per 100,000 population)	27.0	30.2	38.7

Senior Homeless Population
Individuals ages 55 and older made up 29% of all people experiencing homelessness during the 2019 LAHSA point-in-time count. Both age groups, 55 to 61 and 62 and over, have seen increases in total individuals experiencing homelessness (10% and 24% respectively) in the last year.

Changes to CalFresh Eligibility Requirements for Seniors

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

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

Chronic Diseases

Primary Data

Stakeholder Interviews

Stakeholders focused mainly on socioeconomic factors related to chronic disease and named the following contributing factors to the community's chronic disease challenges:

People experiencing food insecurity are disproportionately affected by chronic diseases

- Stakeholders were particularly concerned about obesity, diabetes, and high blood pressure caused from a lack of healthy, fresh foods.

People experiencing homelessness are disproportionately affected by unmanaged chronic diseases

- Accessing preventive and primary care can be challenging
- Lack of resources and necessary medications, as well as nutritious foods, may make managing chronic diseases difficult

"And then also folks [experiencing homelessness] who have chronic medical conditions, it's really hard to treat those or manage those conditions. For example, someone with diabetes, there's no place to refrigerate their insulin, to cleanly dispose of all their medications and then their needles get stoles." – Community stakeholder

Listening Sessions with Community Members

Participants' vision for a healthy community includes healthy eating and exercise habits to prevent and manage chronic diseases

- People are exercising and participating in healthy activities: green space for outdoor activities and exercise classes

- People have access to healthy, nutritious food: affordable and available fresh produce and the knowledge of how to cook healthy meals

The community needs healthier habits related to nutrition and exercise

- Concern for seemingly high levels of childhood obesity
- Desire to see families eat healthier, more nutritious foods
- Need for increased amount of physical activity for all people, especially children

Health education classes are a community asset that help people manage chronic diseases

- Diabetes management classes at Vasek Polak were named as particularly useful
- Health education classes at the Wellness & Activity Center have helped participants learn how to prevent and manage chronic diseases

Abode Health Survey

Providence Little Company of Mary partnered with Abode Communities, a nonprofit affordable housing provider, to administer health surveys to all new residents moving into Camino del Mar & Vista del Mar affordable homes located in the vicinity of the Providence Little Company of Mary Wellness & Activity Center. The health survey covered a wide range of topics including insurance status, self-reported health, chronic conditions, food insecurity and access, physical activity and social cohesion. A total of 133 responses were received for analysis between January and July 2019.

The following table shows the responses to whether or not a healthcare professional has ever told a respondent if they have any of the noted chronic diseases. Nine percent of respondents had been told they have diabetes, while another 14% of respondents were pre-diabetic or borderline diabetic. Seventeen percent of respondents had been told they have depression or some other depressive order.

Table 11. Chronic Disease Responses from Abode Community Survey

Chronic Disease	No	Yes	Did Not Know
Diabetes	119	12	1
Pre-Diabetes or Borderline Diabetes	105	18	3
High Blood Pressure or Hypertension	119	9	2
High Cholesterol	116	10	4
Depression or Some Other Depressive Order	108	23	0

Residents were asked if any of their children had ever been told by a doctor or other health professional if their child had asthma, whether or not if they still had asthma and if in the past year their child had an episode of asthma or asthma attack. Thirty-five adults indicated that they had been told by a doctor or health professional that their child had asthma and of those, 18 still had asthma. Twelve residents reported that their child had an episode of asthma or an asthma attack in the past 12 months

Secondary Data

Table 12. Chronic Disease Key Indicators

	Community Benefit Service Area	Broader Service Area	Los Angeles County
Obesity			
Percent of adults who are obese (BMI≥30.0)	20.6%	20.7%	23.5%
Diabetes			
Percent of adults ever diagnosed with diabetes	7.0%	10.2%	9.8%
Diabetes-related hospital admissions (per 10,000 population)	19.8	11.6	15.74
Diabetes-specific death rate (per 100,000 population)	24.8	16.7	24.21
Cardiovascular Disease			
Hypertension-related hospital admissions (per 10,000 population)	5.7	3.3	5.10
Percent of adults ever diagnosed with hypertension	14.6%	25.5%	23.5%
Coronary heart disease-specific death rate (per 100,000 population population)	117.7	91.6	108.10
Stroke-specific death rate (per 100,000 population)	38.4	31.6	36.20
Respiratory Disease			
Percent of children ages 0-17 years with current asthma (ever diagnosed with asthma and reported still have asthma and/or had an asthma attack in the past year)	*4.7%	7.0%	7.4%
Pediatric asthma-related hospital admissions per 10,000 child population	13.5	9.3	10.82
COPD specific mortality rate (per 100,000 population)	29.2	24.6	29.88
Liver Disease			
Liver disease-specific death rate (per 100,000 population)	15.3	9.0	13.70

Unstable percentages due to small numbers. Interpret with caution.

Although the Community Benefit Service Area has a lower percentage of adults who are obese as compared to the Broader Service Area, there are higher diabetes-related hospital admissions per 10,000 population and higher diabetes-specific death rate per 100,000 population in the Community Benefit Service Area. According the California Health Interview Survey, the prevalence of diabetes for Los Angeles County has jumped from 6.90% in 2003 to 12.10% in 2017. Of the adult population in Los Angeles, 17.40% have been told they are pre-diabetic, a 10% increase in 10 years.

Oral Health Care

Primary Data

Listening Session with Community Stakeholders

Stakeholders identified the following issue in oral health care:

People experiencing homelessness are affected by untreated dental problems

Oral health is related to overall physical health. Stakeholders discussed how dental infections can lead to cardiac complications and make treating other health problems more challenging. They shared people experiencing homelessness may not have access to preventive care, leading to poorer oral health and ultimately affecting their general wellbeing.

Secondary Data

As shown in the following, almost 1 out of every 5 children (20%) in the Community Benefit Service Area went without dental care in the past year because they could not afford it, while almost 50% of adults did not see a dentist or go to a dental clinic in the past year.

The percent of adults who did not see a dentist or go to a dental clinic in the past year was above that of Los Angeles County and almost double what is seen in the Broader Service Area.

Table 13. Oral Health Care Key Indicators

Indicator	Community Benefit Service Area	Broader Service Area	Los Angeles County
Percent of adults who did not see a dentist or go to a dental clinic in the past year	44.5%	27.4%	40.7%
Percent of children ages 3-17 years who did not obtain dental care (including check-ups) in the past year because they could not afford it	19.6%	*7.7%	11.5%

In SPA 8, over 30% of adults do not have insurance that pays for part or all of dental care. About 3 out of 4 adults in SPA 8 did not have a dental visit over the previous year. Approximately, 30% pay for dental insurance, while 38.6% have employer-based insurance and 31.1% carry insurance through government programs.

Table 14. Dental Insurance Key Indicators

Indicator	SPA 8	Los Angeles County
Adults who have insurance that pays for part or all of dental care(CHIS, 2017)	65.5%	61.1%
Children who have insurance that pays for part or all of dental care (CHIS, 2017)	79.7%*	86.1%

* Statistically unstable

Early Childhood Development

Primary Data

Listening Sessions with Community Members

One listening session was conducted at Vasek Polak Health Clinic and two sessions were conducted at the Providence Wellness & Activity Center. Participants shared the following information:

Participants' vision for a healthy community includes resources to support healthy child development

- Support for parents including classes that provide child development information
- Prenatal and postpartum support, such as WIC

The Wellness and Activity Center supports new parents

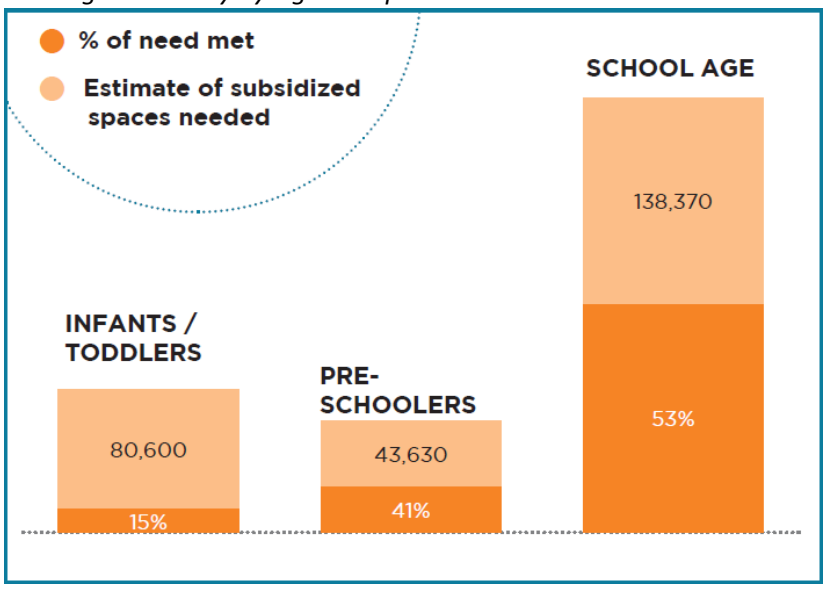
- The Welcome Baby and Building Stronger Families programs provide families with the supports needed to care for their children and help them grow

Secondary Data

Important data on early care and education can be found in "The State of Early Care and Education in Los Angeles County: Los Angeles County Child Care Planning Committee 2017 Needs Assessment."

There are not enough resources for infants/toddlers and their parents. Licensed centers only have the capacity to serve 13% of Los Angeles County's children under the age of 5. Currently, 13% of eligible children ages 0-5 of low-income parents benefit from subsidized early care and education programs, compared to 41% of eligible preschoolers and 53% of eligible school age children.

Figure 6. Unmet Need for Subsidies Among Low-Income Families in Los Angeles County by Age Group



The cost of care for a young child is high. A family's average cost of care in Los Angeles County is $10,303 a year per preschooler in center-based care and $8,579 a year per preschooler in a family child care home. Care for infants and toddlers is even more expensive, with an annual cost of $14,309 in an early care and education center and $9,186 in a family child care home.

Education and professional development of the early care and education workforce is hindered by costs, availability of classes and language barriers. Quality of care for early care and education is directly linked to a highly-qualified workforce yet half of the local work force does not possess a college degree. Early educators also value professional development as a means to increase knowledge but cite costs as a top barrier.

Figure 7. Barriers to Participating in ECE Professional Development in Los Angeles County

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

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

Social Cohesion

Relationships are important for physical health and psychosocial well-being. Social cohesion refers to the strength of relationships and the sense of solidarity among members of a community.

Primary Data

Stakeholder Interviews

Lack of supportive relationships contribute to housing instability for TAY population

Young people between the ages of 16 and 24 transitioning from state or foster care are known as transitional age youth (TAY). These young people may be more at risk of experiencing homelessness because from the age of 18, they no longer qualify for the same support services and programs. Not having strong supportive relationships, a history of trauma, and lacking skills to navigate the responsibilities of adulthood likely contribute to housing instability.

Community Listening Sessions

Participants' vision of a healthy community includes community connectedness

- Participants expressed the importance of people helping and supporting each other in times of need

The Wellness & Activity Center improves people's mental health and connectedness

- Participants reported experiencing reduced feelings of depression and social isolation since participating in programming at the Center
- The Center is a safe place where people feel loved and welcome
- The Center is a space to meet friends and engage with other community members
- Participants shared their cultures are celebrated at the Center, helping to build community and learn about one another
- The Welcome Baby and Building Stronger Families programs provide support for families and new parents

Abode Health Survey

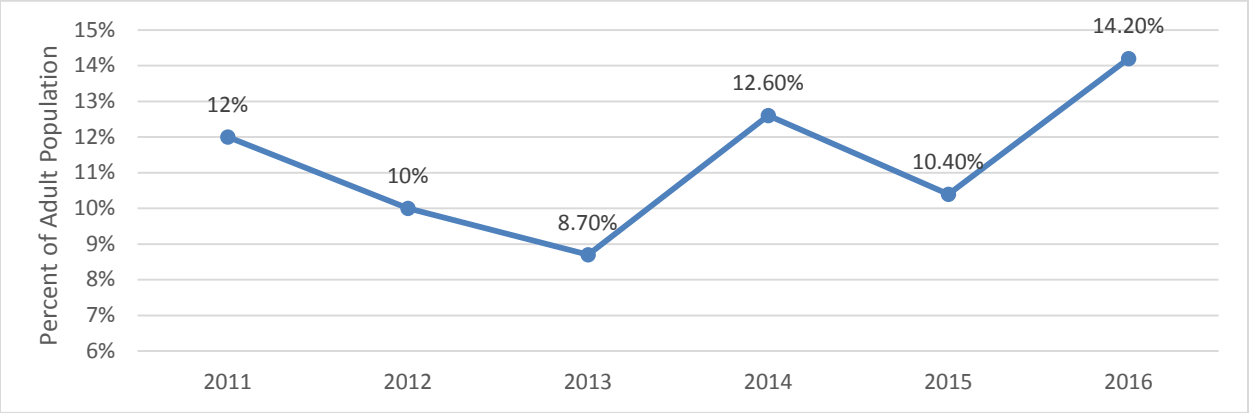
Providence Little Company of Mary partnered with Abode Communities, a nonprofit affordable housing provider, to administer health surveys to all new residents moving into Camino del Mar & Vista del Mar affordable homes located in the vicinity of the Providence Little Company of Mary Wellness and Activity Center. According to the survey, a vast majority of new residents have not served as volunteers in the past 12 months, and have not come together informally with others to deal with community problems. The findings are the following:

- One in ten respondents (N= 129) stated that within the past 12 months, they had served as volunteer on any local board, council, or organizations that deals with community problems
- 23.5% of respondents (N = 132) stated that within the past 12 months, they had done volunteer work or community service for which they had not been paid.
- 23.5% of respondents (N = 132) stated that within the past 12 months, they had gotten informally together with others to deal with community problems.

Secondary Data

The following indicators are taken from the California Health Interview Survey (CHIS). CHIS is a health survey conducted on a continuous basis by the UCLA Center for Health Policy Research in collaboration with the Department of Health Care Services and the California Department of Public Health. Currently the most recent date for CHIS data through the self-service portal "AskCHIS" is from the year 2017 however data from previous years were used when service planning areas values were deemed statistically unstable or for examining trends. According to the following figure, community volunteerism has risen since the year 2013 for adults in Service Planning 8.

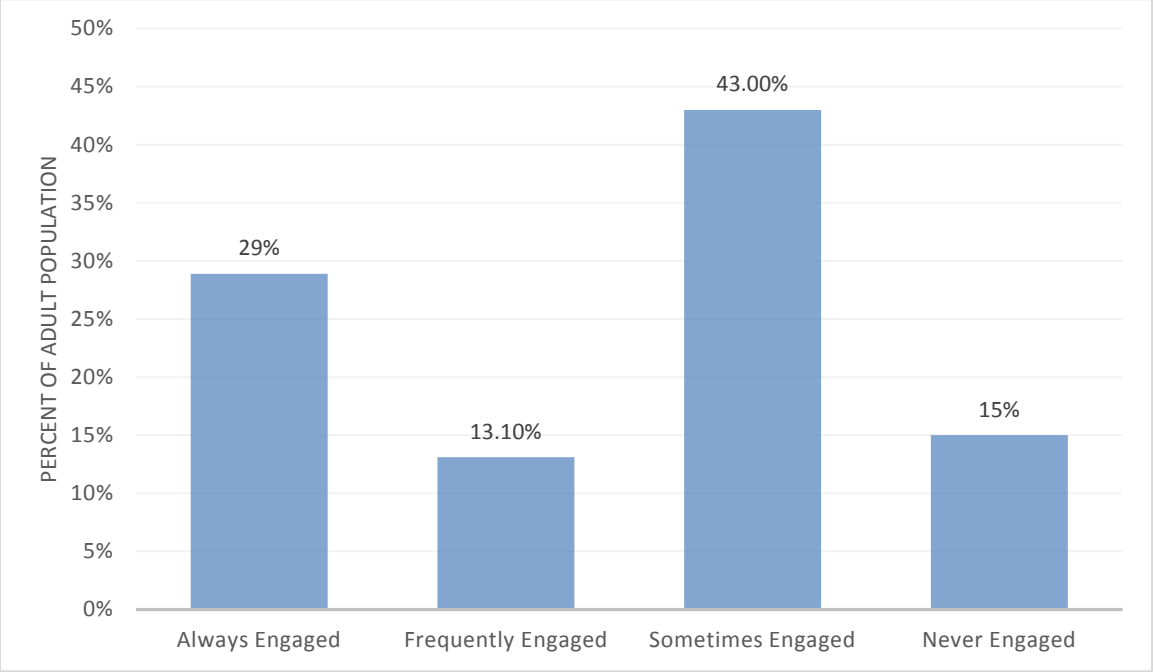
Figure 8. Percent of Adults in SPA 8 Who Have Engaged in Formal Volunteer Work for Community Problems in the Past Year



Source: California Health Interview Survey, self-service portal "AskCHIS"

Voters in SPA 8 appear to engage in various degrees with the national, state and local elections with only 15% reporting no engagement, and 29% of adults reporting being “always engaged.”

Figure 9. Voter Engagement in National, State and Local Elections for Adults in SPA 8



Source: California Health Interview Survey 2017, self-service portal "AskCHIS"

Available Resources to Address Identified Needs

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

Evaluation of 2016 Community Health Improvement Plan Impact

The 2016 CHNA was adopted by the governing board on November 29, 2016. In response to these prioritized health needs, a three-year Implementation Strategy was established with four Strategies, 18 objectives and specific action plans to be accomplished over the next three years.

Strategy 1: Improve Access to Healthcare Services
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

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

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

Strategy 4: Develop Partnerships that Address Social Determinants of Health

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

In light of a challenging shift towards addressing social determinants of health as a healthcare provider, it is worthy to note two innovative programs that Providence has successfully implemented since the 2016 CHNA to address some of these broad, larger scale needs across our local communities:

Providence Little Company of Mary Wellness and Activity Center

The Wellness Center is a 10,000-square- foot complex that includes a soccer field, outdoor basketball court, gymnasium and meeting space for large and small community meetings. Children and adults in Wilmington now have a vibrant physical space – in what was once a neighborhood with few resources - that promotes social connections among residents, reduces social isolation and links children and adults with programs and resources that help them make healthier life choices. The Wellness Center's success is reliant on the strong partnerships with many organizations, most notably the partnerships with affordable housing developers like Mercy Housing and Abode Communities. Our free programs include daily exercise programs (i.e. Zumba®, aerobics and walking groups), assistance with Medi-Cal, Covered California and CalFresh applications, referrals to other local recourses, and ongoing health and wellness classes. In 2020, through a recently awarded grant we plan on scaling out this model and creating an additional Wellness Center in Lawndale in partnership with the Lawndale Elementary School District.

Homeless Services Hospital Liaison

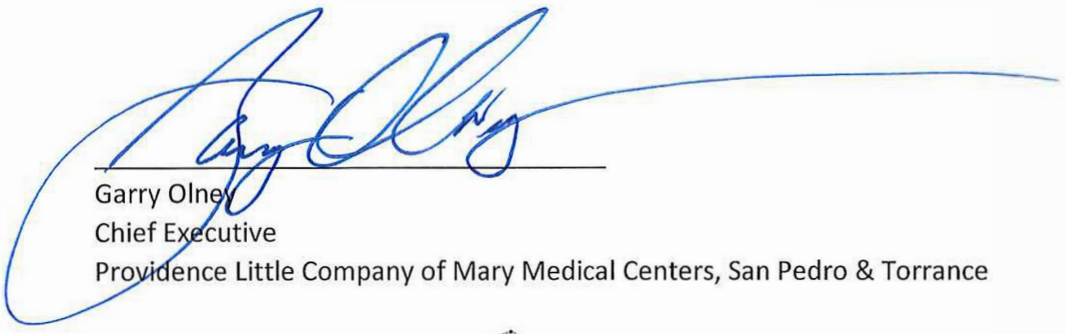
Affordable housing and homelessness was a need identified not only in PLCM's 2016 CHNA but also by other non-profit hospitals in the South Bay. In response to this need and the spirit of collaboration, PLCM, Torrance Memorial, Kaiser Permanente, and Harbor UCLA worked with the South Bay Coalition to End Homelessness to create a Hospital Subcommittee within their coalition. This Subcommittee brought together social workers from each of the hospitals along with our local homeless service provider and Coordinated Entry System lead—Harbor Interfaith—to meet bi-monthly to share information on housing resources and coordinate care for patients experiencing homelessness. In the summer of 2017, Harbor Interfaith received a one year grant through United Way to pilot a Hospital Liaison position dedicated to working with the private non-profit hospital discharge planners and social work staff to link patients to appropriate homeless, health and housing services through the Coordinated Entry System. In this first year, 207 patients were referred to the Hospital Liaison across all of the hospitals with 32 patients approved for Interim Housing and 17 patients linked to permanent housing. Subsequent to this one year grant ending, Providence, Kaiser Permanente, and Torrance Memorial committed to collaboratively continue funding for Harbor Interfaith's Hospital Liaison for an additional two years. Furthermore, the Los Angeles Homeless Services Authority has identified the South

Bay's Hospital Liaison program as a model for success and are planning to replicate it and scale out additional positions throughout Los Angeles County in 2019.

For additional descriptions of impact made across all four of these strategies see Appendix 4.

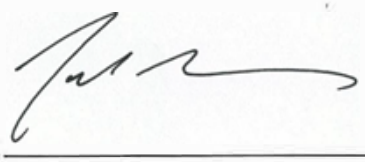
2019 CHNA Governance Approval

The Community Health Needs Assessment was adopted on December 3, 2019 by the Providence Little Company of Mary Ministry Board.



Garry Olney
Chief Executive
Providence Little Company of Mary Medical Centers, San Pedro & Torrance

John Armato, MD
Chairperson of the Board
Providence Little Company of Mary Medical Centers, San Pedro & Torrance



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COMMUNITY HEALTH IMPROVEMENT PLAN

2020 - 2022

Providence South Bay Community

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

PROVIDENCE
Little Company of Mary Medical Centers
San Pedro and Torrance

CONTENTS

EXECUTIVE SUMMARY

Who We Are

Providence Little Company of Mary Medical Centers San Pedro and Torrance provide the full spectrum of care from birth through end of life. While each medical center has its own unique character, both are known for providing the South Bay community with clinical excellence, sophisticated technology and care with a personal touch.

In addition to general medical, surgical and critical care services, the medical centers offer a number of specialty programs. Serving the community since 1960, PLCM Torrance offers minimally invasive surgical options using the advanced da Vinci® robotic surgery system and a cardiovascular center of excellence. It also houses a state-of-the-art maternity unit, complete with the county's first single-family level III neonatal intensive care unit to enhance parent-child bonding for even the most fragile of infants, as well as an on-site perinatal center that provides complete fetal diagnostic testing and genetic counseling.

For over 90 years, Providence Little Company of Mary Medical Center San Pedro has been a landmark, serving the community's needs with invaluable clinical services. In addition to establishing the South Bay's first Primary Stroke Center, the hospital offers specialty services such as chemical dependency and advanced rehabilitation therapy. The hospital's Sub Acute Care Center is one of California's largest sub-acute facilities, while the Center for Optimal Aging provides compassionate care for the elderly.

In addition to offering advanced services and technology, both medical centers have received several accolades and national recognition. PLCM Torrance was recognized by U.S. News & World Report as one of California's best hospitals and as a World's Best Hospital by Newsweek. The Leapfrog Group, a National Patient Safety advocacy group, acknowledged both San Pedro and Torrance medical centers with the highest ranking of an "A" for safety five rating periods in a row. Finally, we are proud to have been named the "Best Hospital" in the South Bay by the Daily Breeze.

Our Commitment to Community

As health care continues to evolve, the Providence South Bay Community is responding with dedication to its Mission and a desire to create healthier communities, together. Partnering with other non-profits that share our commitment to the poor and vulnerable, we conduct a formal Community Health Needs Assessment to learn about the greatest needs and assets in our community, especially considering members of medically underserved, low-income, and minority populations. This assessment helps us consider solutions to fulfill unmet needs while continuing to strengthen local resources. It guides our community benefit investments and supports many partners that look to PLCM as a leader in improving the health of our community.

During 2018, PLCM provided $63,824,873 in community benefit in response to unmet needs and to improve the health and well-being of those we serve in the South Bay.

Description of Community Served

The two Providence South Bay community medical centers, Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance (hereafter jointly referred to as the South Bay Community), share a common geography because of their close proximity to each other. The South Bay Community Service Area is composed of 16 distinct municipalities, and is a demographically and geographically diverse region stretching from El Segundo (North), to Carson (East), to the Port of Los Angeles (South), to the Pacific Ocean (West).

For purposes of this CHNA, the South Bay Community is divided into the "Community Benefit Service Area" and the "Broader South Bay Service Area." 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 Hawthorne, Lawndale, Gardena, Torrance (90501), Harbor City, San Pedro (90731), and Wilmington.

The Broader South Bay Service Area is the balance of communities within the Total Service Area with a CNI score below 4. These areas are more resource rich with a population on the higher end of the socioeconomic spectrum.

Providence Little Company of Mary Community Health Improvement Plan Initiatives

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

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

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

INITIATIVE 2: IMPROVE ACCESS TO HEALTH CARE SERVICES

We will continue to provide avenues of health care services for underserved and vulnerable populations. These target populations include uninsured, low-income households (Medi-Cal), victims of sexual assault, new immigrants, and children.

INITIATIVE 3: INVEST IN EXPANSION OF COMMUNITY-BASED WELLNESS AND ACTIVITY CENTERS

The Wellness and Activity Center gives children and adults in the Wilmington area a physical space to participate in free programs run by Providence, local volunteers and community partners that promote social connections among neighbors and help improve the health of the community. We plan to continue investing in the growth of this Wellness and Activity Center and replicate it in Lawndale, an additional identified undeserved neighborhood in our service area.

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

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

MISSION, VISION, AND VALUES

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

INTRODUCTION

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Planning for the Uninsured and Underinsured

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

One way Providence Little Company of Mary informs the public of FAP is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third party insurers are offered an opportunity to complete the Patient Financial Assistance Application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible. For information on our Financial Assistance Program click https://www.providence.org/obp/ca.

OUR COMMUNITY

Description of Community Served

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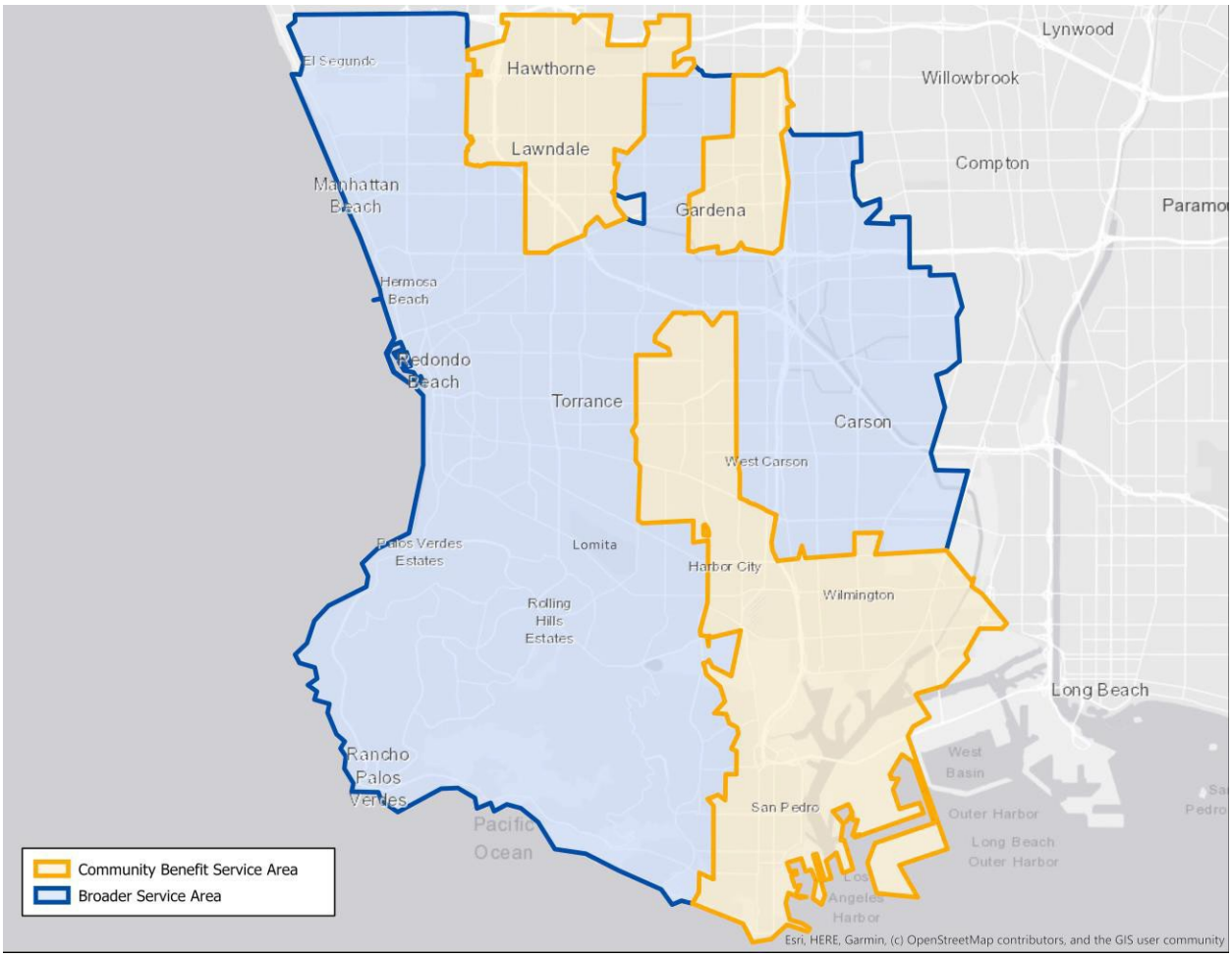
Providence South Bay Community CHNA Service Area Map



COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

To ensure that the Providence Little Company of Mary Medical Centers (PLCM) comply with federal and state regulations on Community Health Needs Assessments, PLCM staff recommended the Community Ministry Board (CMB) authorize the creation of an ad hoc CHNA Oversight Committee made up of an equal number of Providence representatives and external Stakeholders to prioritize the identified health needs. At its March 2019 meeting, the CMB authorized this CHNA Oversight Committee with board member, Tim McOsker, appointed as the Oversight Committee Chair.

Gathering data for this CHNA involved systematic collection of both primary and secondary data relevant to the South Bay to identify the high priority needs and issues facing the community. For primary data, 8 organizational leaders provided input through structured phone interviews. In addition, a total of three listening sessions with 37 participants were conducted with the help of community-based organizations.

PLCM chose to conduct listening sessions at Vasek Polak Health Clinic and the Wellness & Activity Center because of their work to promote the health and wellness of all people living in the South Bay. The Vasek Polak Health Clinic in Hawthorne provides affordable primary care services to people who are uninsured or underinsured. It serves as a medical home for patients, supporting management of chronic diseases, referrals to other services in the South Bay and wellness classes. PLCM's Wellness and Activity Center, located in Wilmington, provides numerous wellness programs, assistance with applications for food and health benefits, referrals to resources, and space for community building.

Secondary data collection included the review of demographic, insurance, mortality, morbidity, mental health, economic and social determinant data from multiple sources. The secondary data sources included the following: the U.S. Census, Los Angeles Homeless Services Authority, Think Health L.A. Database, Community Commons Database, the Health Places Index, California Health Interview Survey Dataset, L.A. County Department of Public Health, and California Department of Public Health. Other quantitative data included primary data from PLCM's electronic health record system.

Identification and Selection of Significant Health Needs

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

- Access to Health Care

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

Community Health Needs Prioritized

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

Needs Beyond the Hospital's Service Program

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

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

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

Based on the prioritized needs, Providence staff developed four strategic initiatives that address eight of the ten prioritized health needs. Taken into account were the existing programs and resources that Providence Little Company of Mary has in place to address these needs and the landscape of community partners to collaborate with together.

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

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

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

Community Need Addressed

Homelessness and Housing Insecurity

Goal (Anticipated Impact)

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

- Reduce the number of people experiencing homelessness

Scope (Target Population)

Patients experiencing homelessness or at risk of becoming homeless

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

Strategies	Strategy Measure	Baseline	FY20 Target	FY22 Target
1. **CHW Homeless Navigators:** Hospital emergency department based Community Health Workers that assist	• Number of Patients Screened for Homelessness • Number of Patients linked to homeless services provider • Number of patients discharged to	No baseline. New program for 2020	• 200 patients screened for homelessness • 100 patients linked to homeless services provider	• 10% increase in patients screened for homelessness as compared to 2021 target • 10% increase in patients linked to homeless service

homeless patients with discharge to shelter or homeless service providers	temporary/permanent housing		• 25 patients discharged to temporary/permanent housing	provider as compared to 2021 target • 10% increase in number of patients discharged to temporary/permanent housing as compared to 2021 target
2. Coordinated Entry System Hospital Liaison: A collaborative workgroup of private non-profit hospitals in the South Bay have a direct single point of contact with the local lead homeless service agency to coordinate referrals and education hospital staff on changing resources	• Clients referred and served by Hospital Liaison • CHW/Social Worker attendance at Bi-monthly meetings of the South Bay Coalition to End Homelessness Hospital Subcommittee	• 120 clients referred and served by Hospital Liaison • CHW/Social Worker attendance not tracked in 2019	• 20% increase in clients referred and served by Hospital Liaison • 75% attendance at SBCEH Hospital Subcommittee meetings	• 10% increase in clients referred and served by Hospital Liaison as compared to 2021 target • 80% attendance at SBCEH Hospital Subcommittee meetings
3. Homeless Prevention: Implement screening for risk of homelessness and identify public and private funded resources that focus on prevention	• # of people screened at high risk of homelessness using PSJH housing insecurity algorithm • Increase the number of families/individuals with confirmed linkage to homeless prevention services	No baseline. New strategy for 2020-2022.	• Implement usage of housing insecurity algorithm in identifying patients who are housing insecure • Identify 5 organizations who provide homelessness prevention	• 10% increase of people screened at high risk of homelessness compared to 2021 target • 10% increase in the number of families/individuals linked to homeless prevention services as compared to 2021 target

	• Increase in the number of organization identified who provide prevention services in PLCM Service Area • Increase CHI/PLCM budget related to services/programs for those living with homelessness in PLCM Service Area, including crisis response and prevention		services in PLCM Service Area • $120,000 budgeted for PLCM services related to homelessness	• 50% increase in dollars budgeted related to services/programs for those experiencing homelessness as compared to 2021 target
4. Recuperative Care: Improve the infrastructure of available recuperative care/interim shelter for homeless patients that are not medically stable enough to be discharged back to the streets	• Identify target population, Interventions and partners to support LA Service Area housing initiative • Support policies to increase temporary housing as a pathway to permanent supportive housing	No baseline. New program for 2020	• Partner with Stakeholders to complete landscape analysis related to recuperative care • Establish consensus among Stakeholders as to the # of recuperative care beds in LA County • Identify gaps/ improvements that would increase # recuperative care/ temporary housing beds for patients	• 2% baseline increase in # of temporary housing/recuperative care beds available to PSJH patients in LA Service Area • Develop standards that define spectrum of temporary housing options for individuals experiencing homelessness that lead to permanent supportive housing • Increase scope of covered Medi-Cal benefits to include recuperative care

			who are unsheltered • Partner with PSJH advocacy and other Stakeholders to support policy changes that reimburse recuperative care/ temporary housing services for homeless • Increase support for local policies that ease construction/remodeling regulations for temporary housing facilities, including case management/housing navigation services • Identify opportunities to leverage existing resources to support recuperative care/temporary housing priorities	• Increase number of recuperative care beds available to patients discharged from hospitals who do not have shelter • Partner with key stakeholders to increase # recuperative care beds and related support services including housing navigation and case management services

Evidence Based Sources

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

Resource Commitment

Homeless Care Navigators, Funding for Recuperative Care Beds

Key Community Partners

Harbor Interfaith Services, UniHealth Foundation, Los Angeles Homeless Services Authority

INITIATIVE #2: IMPROVE ACCESS TO HEALTH CARE SERVICES

Community Need Addressed

- Access to Care
- Behavioral Health

Goal (Anticipated Impact)

Improve access to quality health care services for vulnerable populations

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

Scope (Target Population)

Uninsured and underinsured populations in low-income communities

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

Strategies	Strategy Measure	2019 Baseline	FY20 Target	FY22 Target
1. **Vasek Polak Health Clinic:** Vasek Polak Health Clinic is a clinic that provides an alternative to the emergency room for people who do not have insurance or have Medi-Cal. The clinic provides access to primary care and also acts as a walk-in clinic for treating uncomplicated minor illnesses. The clinic's goal is to care for the needs of the whole person. Patients receive free health education, referrals to low-cost	• Patient Visits • % patients screened for anxiety/depression • Patients enrolled in mental health therapy	• 2,751 medical visits • 86% patients screened for anxiety/depression • 88 patients enrolled in mental health therapy	• 3,500 medical visits • 85% patients screened for anxiety/depression • 100 patients enrolled in mental	• 10% increase in medical visits from 2021 baseline • 2% increase in patients screened from 2021 baseline • Maintain number of patients

	social services and on-site mental health support.			health therapy	enrolled in mental health therapy from 2021 baseline
2.	**Partners for Healthy Kids:** Partners for Healthy Kids is a mobile pediatric clinic that offers free weekly immunizations at elementary and middle schools as well as health insurance enrollment and navigation assistance. We also partner with underserved high schools to provide sports physicals.	Number of Immunizations Given	4,304 immunizations given	4,000 Immunizations	5% increase from 2021 baseline
3.	**Emergency Department Community Health Workers:** Community health workers assist uninsured patients in the emergency department, helping them with affordable health care options, applications for enrollment in eligible health insurance programs and coordination of follow-up visits at a clinic in their community.	Primary Care Appointments Made	1,940 primary care appointments made	2,000 appointments made	5% increase from 2021 baseline
4.	**Health Insurance Enrollment Assistance:** Our Community Health Insurance Program utilizes community health workers to provide education about affordable health care options and assistance with health insurance and CalFresh applications.	Total # of Unduplicated Insurance Applications Assisted	3,346 applications assisted	3,200 applications assisted	5% increase from 2021 baseline
5.	**Sexual Assault Response Team**: A multidisciplinary team providing victim centered response and high quality care to survivors of sexual assault. SART Teams are composed of representatives from agencies that serve victims of sexual assault such as Rape Crisis Centers, Victim Advocates, Law Enforcement, Children's	Total Exams Provided	171 Exams	180 Exams	Maintain number of exams from 2021

Advocacy Center, Hospitals, Sexual Assault Nurse Examiners and the District Attorney's office				

Resource Commitment

- Staffing for all programs
- Two rooms/facilities for Sexual Assault Response Team
- Multiple sources of external grant funding have been awarded to fund these programs.

Key Community Partners

LA Unified School District, Torrance Unified School District, Lawndale Elementary School District, Local Law Enforcement, Harbor Community Clinic, Wilmington Community Clinic, Richstone Family Services, Covered California

INITIATIVE #3: INVEST IN EXPANSION OF COMMUNITY-BASED WELLNESS AND ACTIVITY CENTERS

Community Need Addressed

- Behavioral Health
- Food Insecurity
- Services for Seniors
- Chronic Diseases
- Social Cohesion

Goal (Anticipated Impact)

Increase the number of Wellness and Activity Centers in the South Bay and expand breadth of programming at existing Wellness Center in Wilmington

- Reduction in the prevalence of chronic diseases
- Increase in community engagement
- Increase in the amount of people's daily physical activity

Scope (Target Population)

Residents in two identified higher need municipalities within the PLCM Service Area (Wilmington and Lawndale)

Table 3. Strategies and Strategy Measures for Developing Wellness and Activity Centers

Strategies	Strategy Measure	Baseline	FY20 Target	FY22 Target

1. Wilmington Wellness and Activity Center: The Wilmington Wellness and Activity Center gives children and adults in the Wilmington area a physical space to participate in free programs run by Providence, local volunteers and community partners that promote social connections among neighbors and help improve the health of the community.	• Average number of unduplicated monthly participants • Total number of events available during the year	• Visits by 54 unduplicated registered Wellness Center members/month • 1,000 events at the Wellness and Activity Center	• Increase average number of Wellness Center member visits by 10% • Increase number of events at the Wellness Center by 10% of baseline	• Average 100 visits by unduplicated registered Wellness Center members/month • Increase number of events at the Wellness Center by 25% of baseline
2. Lawndale Wellness and Activity Center: Providence and the Lawndale Elementary School District have been awarded a grant by the California Natural Resources Agency to build a Wellness Center on the campus of one of the Lawndale schools.	Completed construction and opening of Lawndale Wellness and Activity Center	N/A	Final design plans submitted to State	Completed construction and opening of Lawndale Wellness and Activity Center

Resource Commitment

Staffing at both Wellness Centers, Grant Funding from California Natural Resources Agency and California Community Foundation for construction of Lawndale site

Key Community Partners

Mercy Housing, Abode Communities, Lawndale Elementary School District, California Natural Resources Agency

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

Community Need Addressed

- Economic Insecurity and Workforce Development
- Access to Care

- Behavioral Health
- Food Insecurity
- Chronic Diseases

Goal (Anticipated Impact)

Increase the number of Community Health Workers employed in health care settings in roles that address social determinants of health

- Reduction in the number of people who are uninsured
- Reduction the in the number of eligible but unenrolled in CalFresh/SNAP benefits

Scope (Target Population)

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

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

Strategies	Strategy Measure	Baseline	FY20 Target	FY22 Target
1. **Create a CHW Academy:** In collaboration with Charles Drew University, develop an academy for Community Health Workers that focus on integration into health care organizations	# of CHW students who complete program	New program for 2020	20 CHW students enrolled in program	• 25% increase from 2021 in CHW students enrolled • Additional sustainable funding for CHW Academy identified and secured beyond pilot grant funding
2. **Health Insurance Enrollment Assistance:** Our Community Health Insurance Program utilizes community health workers to provide education about affordable health care options and assistance with health insurance and CalFresh applications	Total # of Unduplicated Insurance Applications Assisted	3,346 applications assisted	3,200 applications assisted	• 5% increase from 2021 baseline
3. **CalFresh Enrollment Assistance:** Our Community Health	# of CalFresh applications assisted	1,529 CalFresh applications assisted	1,600 CalFresh applications assisted	• 10% increase from 2021 baseline

	Insurance Program utilizes community health workers to provide education about affordable health care options and assistance with health insurance and CalFresh applications				
4	**Mental Health Education and Prevention:** Health Educators and CHWs paired together teach free community based courses in English and Spanish on mental health awareness and coping skills	• # of participants completing Mental Health First Aid (MHFA) • # of participants completing Creating Healthier Attitudes Today (CHAT)	• MHFA: No baseline, new program for 2020 • CHAT: 69 participants completed CHAT in 2019	• 500 participants complete MHFA certification • 200 participants complete CHAT	• 5% increase from 2021 baseline for Mental Heath First Aid • 10% increase from 2021 baseline for CHAT
5.	**Diabetes Self-Management Education and Prevention Programs:** Health Educators and CHWs paired together teach free community based courses in English and Spanish to patients who have been diagnosed with diabetes or prediabetes	• Diabetes Prevention Program (DPP): Number of Participants who complete year long program • Get Out and Live (GOAL): Number of participants who complete course	• DPP: In progress, 15 participants enrolled in program. • GOAL: 108 participants completed course	• DPP: 10 participants complete year long program • GOAL: 120 participants complete course	• DPP: 10% increase from 2021 baseline in number of participants • GOAL: 5% increase from 2021 baseline in number of participants

Evidence Based Sources

- Center for Disease Control and Prevention: Community Health Worker Toolkit https://www.cdc.gov/dhdsp/pubs/toolkits/chw-toolkit.htm

- Center for Disease Control and Prevention: National Diabetes Prevention Program https://www.cdc.gov/diabetes/prevention/research-behind-ndpp.htm

- Center for Disease Control and Prevention: Self-Management Education https://www.cdc.gov/learnmorefeelbetter/programs/diabetes.htm

- LA Department of Public Health: Food Insecurity in Los Angeles County http://www.publichealth.lacounty.gov/ha/docs/2015LACHS/LA_HEALTH_BRIEFS_2017/LA%20Health_FoodInsecurity_finalB_09282017.pdf

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

Resource Commitment

- Awarded California Community Reinvestment Grant funding by the Governor's Office of Business and Economic Development to create CHW Academy.
- Awarded multiple grants to support CHW positions in outreach and enrollment for Covered CA, Medi-Cal, and CalFresh.
- Awarded grant funding from the Well-Being Trust for mental health education programs.

Key Community Partners

Charles Drew University, Kaiser Permanente, Cedars-Sinai, Harbor Community Clinic. Other LA County healthcare providers

Other Community Benefit Programs and Evaluation Plan

Table 5. Other Community Benefit Programs in Response to Community Needs

Initiative (Community Need Addressed)	Program Name	Description	Target Population (Low Income, Vulnerable or Broader Community)
1. Social Cohesion	Building Stronger Communities	Training of adults as community leaders who then plan events, activities and classes that reduce social isolation for families with children up to age 5.	Low Income
2. Social Cohesion	Best Start Community Partnership-Wilmington Local Support Network	Best Start Community Partnerships provide the opportunity for parents, residents, organizations, non-	Low Income

		profits, elected officials and other stakeholders to collaboratively improve neighborhoods so that young children can thrive and enter kindergarten ready to succeed in school and life. Providence provides operational support and guidance for the Wilmington Community Partnership.	
3. Chronic Diseases	Creating Opportunities for Physical Activity	COPA is a peer coach physical education training program for elementary school teachers that promotes independence in instruction, consistent with California grade level standards. COPA also organizes and implements school-wide health promotion events and sponsors activity camps at our Wellness and Activity Center.	Low Income
4. Early Childhood Development	Welcome Baby	Welcome Baby is a home visitation program that provides pregnant women and new moms with information, support and a trusted partner to help them through the journey of pregnancy and early parenthood.	Low Income

2020- 2020 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the Providence Little Company of Mary Community Ministry Board on March 24th, 2020.

Garry Olney
Chief Executive,
Providence Little Company of Mary Medical Centers, San Pedro & Torrance

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Suzi Gulcher
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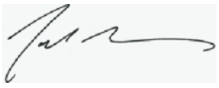
Suzi Gulcher
Chair, Providence Little Company of Mary Community Ministry Board



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

APPENDICES

Appendix 1: Definition of Terms

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

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

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

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

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

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

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

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

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

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

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

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

Providence South Bay Community

2019 Annual Update to the Community Benefit Plan

Providence Little Company of Mary Medical Center, San Pedro

Providence Little Company of Mary Medical Center, Torrance

PROVIDENCE
Little Company of Mary
Medical Center
San Pedro

PROVIDENCE
Little Company of Mary
Medical Center
Torrance

2019 ANNUAL UPDATE TO COMMUNITY BENEFIT PLAN

Table of Contents

I. Executive Summary

A. Overview

The Hospital Community Benefit Program (HCBP), commonly referred to as "SB 697," is a result of a 1994 State law that mandates private, not-for-profit hospitals, including Providence Little Company of Mary Medical Centers in Torrance and San Pedro, to "assume a social obligation to provide community benefits in the public interest" in exchange for their tax-exempt status. Senate Bill 697 requires that non-profit hospitals throughout California conduct a triennial community needs assessment and develop a Community Benefits Plan based on the findings. This Annual Update for 2019 describes progress towards measureable objectives set forth in the 2016 Joint Community Health Needs Assessment adopted by the South Bay Community governing board for both Medical Centers.

The two Providence South Bay Community Medical Centers, Providence Little Company of Mary Medical Center, San Pedro and Providence Little Company of Mary Medical Center, Torrance (hereafter South Bay Community), share a common geography because of their close proximity to each other. The South Bay Community Service Area is composed of 15 distinct municipalities, commonly referred to as the South Bay region of Los Angeles County. In accounting for charity care, the unpaid cost of Medi-Cal, and community benefit services, each Medical Center's Community Benefit expense is calculated separately, consistent with the Catholic Health Association's community benefit guidelines. Community outreach programs operated by the Community Health department on behalf of both Medical Centers are generally allocated 50% to each Medical Center, unless a specific program operates in an underserved community that is geographically linked to a specific Medical Center (i.e. Welcome Baby is specifically linked to the San Pedro Medical Center because program eligibility is based on a threshold of deliveries in the adjacent Wilmington community).

Like most areas of Los Angeles County, communities of wealth and poverty are geographically adjacent. In the South Bay Community of Los Angeles County, these disparities and the Providence Mission have led us to implement community outreach programs in "high need" communities, based on multiple public and private data sources. To the greatest extent possible, we use zip code specific data trends to identify communities with the greatest need and consult with stakeholders within those communities to help us identify the greatest health needs that are susceptible to improvement and within the expertise and scope of the South Bay Community. In 2016, Providence Health & Services and St. Joseph Health came together as Providence St. Joseph Health. Through this organizational change, the new Providence St. Joseph Health mission statement steadfastly continues to direct special attention for the poor and vulnerable:

"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."

This statement of organizational purpose reaffirms our commitment to underserved communities and simultaneously creates new challenges based in the reality that no single organization can

meet all of the health care needs of high need communities. Accordingly, we work in collaboration with nonprofit organizations and public entities that share our purpose.

B. Organization of Community Outreach Resources

The South Bay Community shares a common governing board, overlapping geography and complementary service lines. The governing board authorized the Community Health Department to conduct a joint community health needs assessment on behalf of Providence Little Company of Mary Medical Center, San Pedro and Providence Little Company of Mary Medical Center, Torrance. The two Medical Centers agreed to use a common definition of the community served and the governing board directed staff to conduct the needs assessment in the name of both Medical Centers on all forms, letters, and inquiries related to the conduct of the needs assessment. The South Bay Community Service Area includes 16 separate municipalities and encompasses 30 distinct zip codes in the South Bay/Harbor area of Los Angeles County.

The Community Health Department builds and sustains collaborative relationships with community safety net partners and also designs, implements and evaluates programs/services that are responsive to community health needs, as prioritized by the triennial needs assessment adopted by the governing board. Community Health operates from the premise that:

- Diversity of language, culture, and perspective is an asset,
- Disparities can best be reduced through collaboration
- Targeted direct services facilitate health improvements in underserved communities.
- Limited resources should be targeted to communities with the greatest need.

Simply stated, the South Bay Community is committed to both collaboration with community partners and the delivery of services and programs that address the needs of the 16 communities that make up the South Bay, with particular attention to the seven most economically disadvantaged communities

C. The 2016 Needs Assessment

Gathering data for this Community Health Needs Assessment (CHNA) involved systematic collection of both primary and secondary data relevant to our South Bay community. In 2016, staff from Providence's Community Health department provided leadership that resulted in the formation of a regional coalition of nonprofit hospitals, which has come to be known as LA Partnership. This group defined 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.

We also collected primary data in the form of 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.

The Community Ministry Board authorized a Board Committee on Community Benefit to oversee the CHNA for both Providence Little Company of Mary Medical Centers. This group, composed of an equal number of community stakeholders and representatives from both 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. On November 1, 2016, CHNA Oversight Committee members met again 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. 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

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.

D. Adoption of 2016 CHNA and 2017-19 Implementation Strategy

The 2016 CHNA was adopted by the governing board on November 29, 2016. In response to these prioritized health needs, a three-year Implementation Strategy was established with four Strategies, 18 objectives and specific action plans to be accomplished over the next three years.

Strategy 1: Improve Access to Healthcare Services

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

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

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

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

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

Strategy 4: Develop Partnerships that Address Social Determinants of Health

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

At its March 28, 2017 meeting, the PLCM Community Ministry Board adopted the 2017-19 Implementation Strategy. The Implementation Strategy 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 PLCM Community Health Department with assistance from key staff across both Medical Centers.

The first two strategies, (1) Improve Access to Healthcare and (2) Implement Prevention Interventions to Reduce the Prevalence or Progression of Chronic Disease, are connected to the longstanding community-based programs operated by the Providence Little Company of Mary Medical Centers since 1997. They are also directly linked to the program conditions specified by the Attorney General related to the Combination Agreement between Providence Health and Services and St. Joseph Health System. The third strategy, (3) Strengthen Community-based Mental Health Services, addresses the need for mental health education, including skills development, and linking children and adults to mental health treatment resources as needed. The fourth and final strategy, (4) Develop Partnerships that Address Social Determinants of Health, recognizes that many social and economic factors in the environment affect the health of individuals and the community. This strategy assumes a place where Providence, its community partners, and local residents can work together to address and improve seemingly intractable problems, such as violence, poverty, low educational attainment and economic insecurity. The Providence Wellness and Activity Center in Wilmington, CA, will serve as our vehicle to begin to address the Social Determinants of Health.

II. Mission and Community Benefit

A. Incorporating Mission Philosophy into Community Benefit

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 to return the value of the tax exemption continued.

During the 1990's, the Sisters recognized that their diminishing numbers threatened to undo core mission commitments and they decided, in 1998, to become a Member of the Providence Health System. Today, the two Little Company of Mary Medical Centers are part of Providence St. Joseph Health and are fully aligned with both the Mission and Core Values of the Renton-based health system:

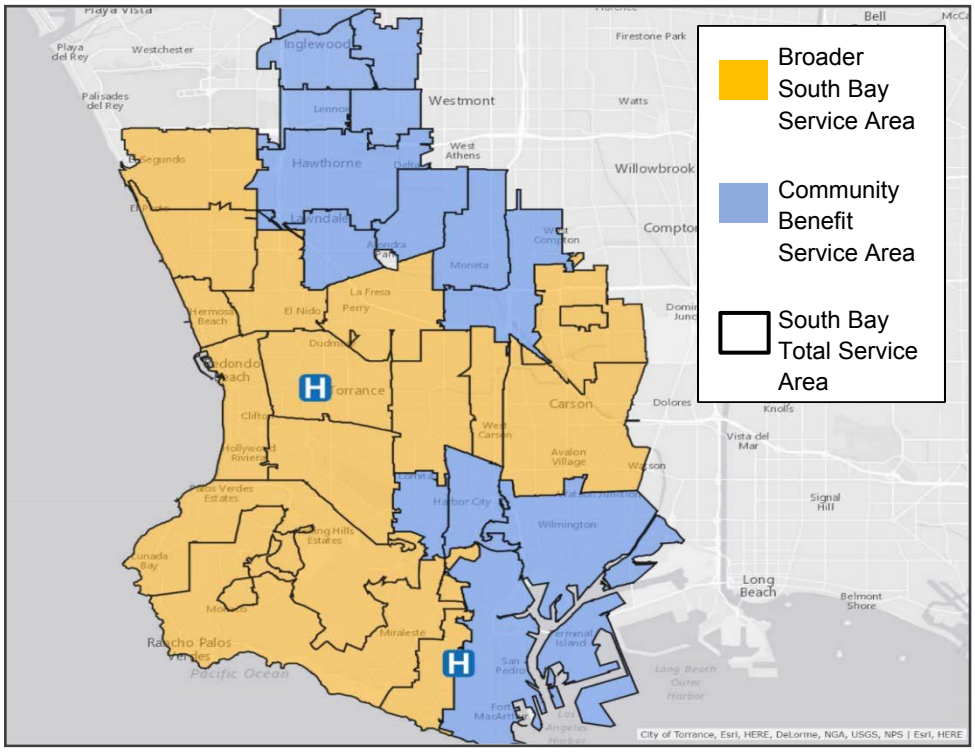
"As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable."

Within this statement of organizational purpose lies the commitment to pay special attention to the poor and vulnerable, reaffirming our commitment to underserved communities. Yet simultaneously in the challenge to serve all people but with finite resources, there lies the reality that no single organization can meet all of the health care needs of high need communities. Accordingly, we design work in collaboration with nonprofit organizations and public entities that share our commitment to serving the community.

B. Allocation of Community Outreach Resources Reflect the Mission

Central to community based outreach is the notion that diversity of language and culture is an asset and that disparities can be reduced through collaboration, advocacy among stakeholders and resources targeted to communities with the greatest need. The 2016 CHNA describes the continuing process for determining which communities have the greatest need, bringing together primary and secondary data sources to prioritize specific disparities, and in collaboration with community partners, develop a three year plan that addresses our priorities. Through this process, the communities which are determined to have the greatest need and which we prioritize community benefit resources to are defined in the CHNA as the Community Benefit Service Area.

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.



While our Mission commands special attention to the poor and vulnerable, the CHNA Implementation Strategy also includes programs that benefit the broader community. Using guidelines developed by the Catholic Health Association[1], our Community Benefit expenses fall into five broad areas: (1) Community Health Improvement Services, (2) Health Professions Education, (3) Subsidized Health Services, (4) Cash and In-Kind Contributions, and (5) Community Benefit Operations. The South Bay Community tracks community benefit expenses throughout the year, as part of its operating commitments.

C. Strengthening Communities through Prevention & Collaboration

Too often, hospitals limit community outreach programs to acute health care problems. The inevitable result is that underlying unhealthy behaviors never get the attention needed to create a positive change in the health of communities. When the intervention is limited to "fixing" a medical problem, the opportunity to prevent unhealthy behaviors is lost.

The South Bay Community seeks to balance the clear need for community benefit investment related to access to medical care and mental health services, along with the needs for skills based prevention education and programs that address social determinants of health. The challenge is to design programs with stakeholder input, implement a successful intervention, sustain it, achieve measurable outcomes and, as new resources are found, expand to as many high need communities as resources will permit. Our ability to accomplish this result is directly linked to successful outcomes.

Our CHNA Implementation Strategy relies upon the South Bay Community to provide the initial funding to its Community Health Department to test out pilot projects that address identified or emerging community needs, develop them to a level of established effectiveness, and then extend them more broadly in partnership with other funding partners, typically private foundations and government entities. This cycle has repeated itself many times and has led to sustained growth in the Community Health budget over the past 19 years, from $1.5 Million in 2000 to $3.9 Million in 2019. Currently, 75 Providence South Bay Community employees provide community outreach programs and services in underserved communities.

D. Benefits for the Broader Community & Health Professions Training

The South Bay Community sponsors two separate longstanding programs that benefit the broader community: Hospice Bereavement/Gathering Place and a paramedic base station. Consistent with Catholic Health Association guidelines, we track the value of employee time spent preceptoring students who are enrolled in a broad range of health professions training programs, for the following disciplines: Registered Nurses/Nurse Practitioners, Pharmacy, Radiology, Ultrasound, Respiratory Care Services, Physical, Occupational and Speech Therapy, Pharmacy, Community Health, Dietetics and Hospice. In 2019, 810 students in health professions training programs were preceptored by Providence employees.

[1] *A guide for Planning and Reporting Community Benefit,* Catholic Health Association of the United State, St Louis, MO, 2012

III. Progress towards Measurable Objectives during 2019

A. Establishing Benchmarks

The concept of committing to 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, 2013 and 2016. Benchmarks represent key performance indicators that provide the best evidence of the impact of the executed Implementation Strategy on local communities related to improving access to health care, prevention of chronic disease, strengthening mental health infrastructure, and developing partnerships that address social determinants of health.

The purpose of establishing measurable benchmarks linked to the 2016 CHNA Implementation Strategy was to challenge the two Providence Little Company of Mary Medical Centers, San Pedro and Torrance, to make a clear difference in underserved communities and reduce existing disparities that:

- Improve Access to Health Care Services
- Implement Prevention Interventions to Reduce the Prevalence or Progression of Chronic Disease
- Strengthen Community Based Mental Health Infrastructure to Better Align with Hospital-Based Mental Health Services
- Develop Partnerships that Address Social Determinants of Health

In addition, consistent with Providence core value of excellence and mindful of our obligation to return the value of our tax exemption for the benefit of our South Bay Community, there are a set of benchmarks that monitor the program quality and expense of Community Benefit programs and services.

B. Progress towards Three-Year Benchmarks

The South Bay Community governing board adopted the 2017-2019 Implementation Strategy at its March 28, 2017 meeting. The three-year plan includes four programmatic strategies, with 18 measurable objectives each of which has multiple benchmarks or indicators, which collectively provide evidence of the impact of the Community Benefit program in local underserved communities.

The charts below on Pages 9-12 document progress towards the specific benchmarks established for each of the four strategies approved by the governing board:

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

Strategy 1: Improve Access to Health Care Services						
Measurable Objectives:	**Action Plan**	**Tactics**	**Progress in 2017**	**Progress in 2018**	**Progress in 2019**	**Comments**
1) Increase enrollment in and utilization of health insurance *2) Increase the number of people with a primary care provider* *3) Increase the number of children who receive the recommended immunizations*	Increase enrollment in and utilization of health insurance	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	•2,517 individuals assisted with health insurance applications •2,264 individuals successfully enrolled into health insurance •2,001 applications assisted with Hospital Presumptive Eligibility Medi-Cal for ER Patients	•2,880 individuals assisted with health insurance applications •2,486 individuals successfully enrolled into health insurance •1,790 applications assisted with Hospital Presumptive Eligibility Medi-Cal •1,427 successful enrollments into Hospital Presumptive Eligibility Medi-Cal	•3,346 individuals assisted with health insurance applications •2,871 individuals successfully enrolled into health insurance •1,640 applications assisted with Hospital Presumptive Eligibility Medi-Cal •1,307 successful enrollments into Hospital Presumptive Eligibility Medi-Cal	
		Provide information and skills to newly insured adults on how to effectively utilize 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				
	Increase the number of people with a primary care provider	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	•1,368 patients seen at Vasek Polak Health Clinic •513 primary care appointments made for ER patients •127 high school students provided with sports physicals	•1,220 unique patients seen at Vasek Polak Health Clinic •848 primary care appointments made for ER patients •128 high school students provided with sports physicals	•1,755 unique patients seen at Vasek Polak Health Clinic •1,940 primary care appointments made for ER patients •116 high school students provided with sports physicals	
		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				
	Increase the number of children who receive the recommended immunizations	Partners for Healthy Kids: sustain operations of mobile pediatric clinic that offers free weekly immunizations at elementary, middle, and high schools	•1,211 immunization patient visits •439 people received doses of HPV vaccinations •Administered 374 doses of MCV4 vaccine	•1,399 immunization patient visits •571 people receive doses of HPV vaccinations •Administered 434 doses of MCV4	•1,703 immunization patient visits •489 people received doses of HPV vaccinations •Administered 355 doses of MCV4	
		Promote HPV and meningococcal immunizations with local pediatricians and family practice physicians to encourage parents to have their children receive these vaccinations				

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

Community need addressed: Prevention and Management of Chronic Diseases
Goal: To reduce the prevalence of diabetes and obesity

Strategy 2: Implement Prevention Interventions to Reduce the Prevalence or Progression of Chronic Disease						
Measurable Objectives:	**Action Plan**	**Tactic**	**Progress in 2017**	**Progress in 2018**	**Progress for 2019**	**Comment**
1) Partner with local schools to reach the state-recommended standard of minutes of physical education instruction *2) Increase number of adults who meet the CDC recommended standard of physical activity* *3) Increase the number of structured movement activities available for children and adults* *4) Raise awareness of better eating habits through structured nutrition education events* *5) Increase access to healthier foods in lower-income communities* *6) Reduce the average A1C % of diabetic GOAL program participants by 1.3%* *7) Implement a diabetes prevention program for an at-risk adult population*	Increase Physical Activity for Children and Adults	Sustain the delivery of the Creating Opportunities for Physical Activity (COPA) program in LAUSD and Lawndale school districts	• COPA program sustained at 10 schools, impacting 243 teachers and 6,561 students •COPA expanded into two new schools in Watts, impacting 47 teachers and 1,269 students •326 Physical Activity related events hosted at the Providence Wellness and Activity Center in Wilmington	•COPA programming sustained at 12 schools impacting 291 teachers and 7,857 students •452 Physical Activity related events hosted at the Providence Wellness and Activity Center in Wilmington	•Sustained COPA programming at 9 schools (six in Lawndale and 3 in LAUSD) for the 2019-2020 school year impacting 298 teachers and 8,046 students. •568 Physical Activity related events hosted at the Providence Wellness and Activity Center in Wilmington	
		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	Host “Fit Food Fairs” at the Wellness and Activity Center which teach local residents on how to cook healthy foods	•4 Fit Food Fairs with average attendance of 77 attendees per event • 2 Groceryships cohorts piloted with a total of 14 participants completing the program •1,194 households (1,529 individuals) assisted with CalFresh applications	•Offered 3 Fit Food Fair events throughout the year 306 families attended. •3 FEAST (formerly Groceryships) cohorts offered in 2018 with an average of 16 participants in each cohort •1,052 households (1,659 individuals) assisted with CalFresh applications •Opened a weekly Farmer's Market in Wilmington at the Providence Wellness and Activity Center that accepts CalFresh as a form of payment in Fall 2018 •Opened a community teaching garden for vegetables at the Providence Wellness and Activity Center in Wilmington	•One Fit Food Fair event hosted in 2019. 68 families attended the event. •Offered 3 FEAST classes in the South Bay •1,529 individuals assisted with CalFresh applications •By end of the year, average CalFresh/EBT spending at Wilmington Farmer's Market was $129/week.	
		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	Grow the number of community sites where GOAL (Diabetes Self-Management Classes) is delivered	•12 GOAL class series delivered in community sites •Average A1C of diabetic GOAL patients lowered from 8.0% to 6.7% (reduction of 1.3%) •179 patients referred to GOAL from Providence clinicians	•14 GOAL class series delivered in community sites •Average A1C of diabetic GOAL patients lowered by 0.87% •157 patients referred to GOAL from Providence clinicians •1 Diabetes Prevention Program cohort started in Fall of 2018	•10 GOAL class series delivered in community sites •Average A1C of diabetic GOAL patients (baseline A1C ≥ 7%) lowered by 1.37% •139 patients referred to GOAL from Providence clinicians •Diabetes Prevention Program: Currently in "Pending Recognition" status from CDC. New cohort started in Fall of 2019.	
		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				

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

Community need addressed: Mental Health (including substance abuse treatment)
Goal: Improve access to the mental health continuum of care in the South Bay

Strategy 3: Strengthen Community Based Mental Health Infrastructure to Better Align with Hospital-Based Mental Health Services						
Measurable Objectives:	**Action Plan**	**Tactic**	**Progress in 2017**	**Progress in 2018**	**Progress in 2019**	**Comment**
1) Improve integration of mental health in primary care settings *2) Build resilience in children, teens, families and seniors* *3) Reduce the stigma of mental illness* *4) Reduce symptoms of depression and anxiety*	Prevention	Teach coping skills and resiliency classes for adults at the Providence Wellness and Activity Center and in community settings such as local churches	• 10 series of CHAT (Creating Healthier Attitudes Today) courses on coping skills and resiliency taught. 83 people completed the entire series. •35 mental health awareness presentations hosted at the Providence Wellness and Activity Center •58 Providence Community Health employees completed Mental Health First Aid •36 community members completed Mental Health First Aid	•12 CHAT cohorts provided in the community, with 110 people completing the series •44 mental health awareness presentations hosted at the Providence Wellness and Activity Center	•Provided 8 CHAT courses in the community, with 74 people completing the series •37 mental health awareness presentations hosted at the Providence Wellness and Activity Center	As part of grant funding we received from the Well Being Trust for Mental Health Promotion, staff on that program were trained to be certified Mental Health First Aid instructors in December 2019.
		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	Collaborate with Richstone Family Center to provide a licensed therapist located within the Vasek Polak Health Clinic for patients diagnosed with depression or anxiety	•917 patients screened for anxiety and depression at Vasek Polak Health Clinic •58 patients enrolled into therapy sessions at Vasek Polak Health Clinic	•941 patients screened for anxiety and depression at Vasek Polak Health Clinic •52 patients enrolled into therapy sessions at Vasek Polak Health Clinic •18 participants enrolled into UCLA Alcohol Consumption Reduction Study	•1,508 patients screened for anxiety and depression at Vasek Polak Health Clinic •88 patients enrolled into therapy sessions at Vasek Polak Health Clinic •Enroll 65 participants into UCLA Alcohol Consumption Reduction Study • Received grant from Well Being Trust to establish Mental Health Assessment Team program which features a Community Health Worker who follows up with patients discharged from PLCM hospitals with lower acuity mental health diagnoses and links them to mental health services	
		Coordinate post discharge linkage to community resources for patients discharged from PLCMMC, San Pedro Crisis Stabilization Unit				

Strategy 4: Develop Partnerships that Address Social Determinants of Health

Community need 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

Strategy 4: Develop Partnerships that Address Social Determinants of Health						
Measurable Objectives:	**Action Plan**	**Tactic**	**Progress in 2017**	**Progress in 2018**	**Progress in 2019**	**Comment**
1) Reduce household food insecurity *2) Reduce social isolation by providing opportunities for residents to build social connections* *3) Increase breadth/diversity of programs provided at the Providence Wellness and Activity Center in Wilmington provided by community partners or volunteers* *4) Establish a subcommittee of the local coalition to end homelessness attended by area hospital representative who have regular involvement with homeless adults and families*	Providence Wellness and Activity Center	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	• 854 events/classes/activities at the Wellness Center in 2017. 13,470 visits by community members •42 Community Leaders trained in Builidng Stronger Families. These leaders led 5 large outreach events and led 27 workshops in the community. •Began discussions with local school district to provide services on one of their school campuses.	•Host 741 events/classes/activities at the Wellness Center. 9,788 visits by community members. •We have replicated Building Stronger Families community leaders training at the Lawndale Elementary School District, rebranded as Building Stronger Communities. We are seeking funding to build a Wellness Center site on one of the Lawndale school campuses.	•Hosted 999 events/classes/activities at the Wellness Center. Instituted new membership program at the Wellness Center to track number of participants who regularly attend multiple activites. Averaged visits from 54 unduplicated members/month. •Secured a multi-year grant from the California Natural Resources Agency for construction of a Wellness Center at Lawndale Elementary School District •Bulding Stronger Communities trained 62 community leaders across Wilmington and Lawndale	
		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	Host briefings for community leaders/stakeholders centered around violence, affordable housing and homelessness, or poverty and food insecurity	•Provided space for SART at both Providence Little Company of Mary Medical Center Torrance and PLCMMC San Pedro. 185 total forensic and suspect exams in 2017. •Began exploration of a partnership with other nonprofit hospitals and Charles Drew University to develop a Community Health Worker workforce development program	•Provided spaces at PLCMMC Torrance and PLCMMC San Pedro for Sexual Assault Response Teams. 200 total forensic and suspect exams in 2018. • We have submitted two proposals to fund a Community Health Worker Academy at Charles Drew University but have not yet found a funder for this project. Will continue to seek funding in 2019. • Hospital Liaison at Harbor Interfaith collaboratively funded by Providence, Torrance Memorial, and Kaiser who connects patients experiencing homelessness to housing resources.	•Continue to provide spaces at PLCMMC Torrance and PLCMMC San Pedro for Sexual Assault Response Teams. 171 total forensic and suspect exams in 2019. • Awarded a 2 year grant from the California Community Reinvestment Grants Program to establish a Community Health Worker Academy in partnership with Charles Drew University • Los Angeles Homeless Services Authority took over funding for Hospital Liaison position based upon demonstrated success of the program and has invested in replicating the model across the county.	
		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	Increase CalFresh enrollment through application assistance and work with local farmers markets to accept CalFresh as a form of payment	•1,529 individuals, 1,194 households assisted with CalFresh applications •Food service department partners with local non-profit, Food Finders, to donate leftovers to local food banks.	•1,052 households (1,659 individuals) assisted with CalFresh applications	•1,529 individuals assisted with CalFresh applications •Implemented food insecurity screening at Vasek Polak Health Clinic •PLCM Torrance and San Pedro hospital food service department donated surplus to Food Finders (3,156 pounds from Torrance; 1,787 pounds from San Pedro)	See Strategy 2 regarding Farmer's Markets.
		Work with hospital departments to facilitate donations to local South Bay safety net organizations				

IV. Community Benefits and Economic Value

A. Community Benefit Expenditures during 2019

PLCM Community Benefit activities are classified into three broad expenditure categories consistent with standards established by the Catholic Health Association[1]: Charity Care, Community Benefit Services, and Unpaid Costs of Medi-Cal. The overall expense for these three categories of Community Benefit increased by 0.34% from $54,052,127 in 2018 to $54,233,478 in 2019. For OSHPD reporting purposes, we also identify the unpaid costs of Medicare.[2] The chart below summarizes all community benefit expense for 2019:

Table 1.1 – Summary of 2019 Community Benefit Expense

	South Bay Community	PLCMSP	PLCMT
Charity Care	$10,030,014	$2,914,931	$7,115,083
Community Benefit Services	$16,776,513	$6,070,393	$10,706,120
Unpaid Costs of Medi-Cal	$27,426,951	$4,320,597	$23,106,354
TOTAL (excludes Medicare)	**$54,233,478**	**$13,305,921**	**$40,927,557**
Unpaid Cost of Medicare	$51,453,010	$20,733,812	$30,719,197

Charity Care: Charity care increased by 16.5%, from $8,613,066 in 2018 to $10,030,014 in 2019.

Unpaid Costs of Medi-Cal:
Medi-Cal shortfall, the difference between the cost of providing care and the amount received from Medi-Cal, decreased by 6.2% from $29,231,687 in 2018 to $27,426,951 in 2019.

Community Benefit Services:
Total expense in the Community Benefit Services category increased by 3.5%, from $16,207,374 in 2018 to $16,776,513 in 2019. Community Benefit Services combines four specific elements: (1) Community Health Improvement Services ($9,830,610), (2) Health Professions Education ($3,745,370), (3) Subsidized Health Services ($2,570,744) and (4) Community Benefit Operations ($629,789). These expenses are broken out in the detailed listing of all Community Benefit Services provided in the three appendices of this report. The first page in the detailed listing combines expenses for both Medical Centers, which collectively total $16,776,513. The second and third pages are the breakout of expenses for each Medical Center.

B. Number of Individuals Impacted by Community Benefit Programs

Overall, the total number of people impacted by PLCM's Community Benefit increased by 5.2%, from 68,931 in 2018 to 72,534 in 2019. This was a result of an increase in people impacted in all

[1] *A Guide for Planning and Reporting Community Benefit, 2015 Edition with 2017 Update*, Catholic Health Association of the United States, St Louis, MO, 2015

[2] OSHPD issued guidance in 2006, notifying hospitals to report Medicare shortfall. Medicare shortfall is not publicly reported as a community benefit expense.

three categories of community benefit: Charity Care (27.0%) and Medi-Cal Shortfall (10.8%), and Community Benefit Services (0.7%).

Table 1.2 - Number of Individuals Impacted in 2019, by community benefit categories

	South Bay Community	PLCMSP	PLCMT
Charity Care	1,997	580	1,417
Community Benefit Services	41,021	17,727	23,294
Unpaid Cost of Medi-Cal	29,516	12,682	16,834
TOTAL	**72,534**	**30,989**	**41,545**

C. Strategic Mission Priorities

Consistent with the PLCM Mission Statement and the Ethical and Religious Directives for Catholic Healthcare Services, our Community Benefit Plan places a priority on community-based outreach to the poor and vulnerable. We carefully track the number of individuals impacted by programs and services provided in underserved communities and seek to leverage PLCM resources with private and governmental support.

Table 1.3 - Number of Individuals Impacted in 2019 (services for poor and vulnerable)

Outreach to Poor/Underserved Populations	South Bay Community	PLCMSP	PLCMT
Building Stronger Communities/Local Support Network	506	506	-
Community Health Insurance Program (CHIP)	4,174	2,087	2,087
Creating Opportunities for Physical Activity (COPA)	6,994	3,497	3,497
Creating Healthier Attitudes Today	69	35	34
Get Out and Live (G.O.A.L.)	390	195	195
Linkage to Community Services	2,592	816	1,776
Mental Health Assessment Team	24	12	12
Mental Health Promotion	44	22	22
Partners for Healthy Kids Mobile Clinic (PFHK)	1,782	891	891
PLCM Wellness and Activity Center	1,200	600	600
Sexual Assault Response Team	159	79	80
Trinity Kids Care	155	62	93
Vasek Polak Health Clinic	1,776	-	1,776
UCLA/Providence Health Study	86	43	43
Welcome Baby Program	1,753	1,753	-
TOTAL	**21,704**	**10,598**	**11,106**

In this area of community-based outreach programs, the number of people impacted increased by 5.7%, from 20,530 in 2018 to 21,704 in 2019. This is largely due to increases in the number of individuals served by the Welcome Baby program (+569) and patients seen at the Vasek Polak Health Clinic (+556).

The 2016 CHNA for Providence Little Company of Mary Medical Centers, San Pedro and Torrance, identified mental health services as one of the priority health needs in the South Bay

Community. In 2019, Providence received funding from the Well Being Trust to begin two new programs that address this identified health need.

Mental Health Assessment Team (MHAT): The MHAT project utilizes a care management team to improve coordination of Medi-Cal patients who are seen in the Emergency Department (ED) for a mental health condition when the visit is determined to be an avoidable ED visit. The care management team, composed of a licensed clinical social worker and a community health worker, identify eligible patients for the MHAT project. Once enrolled into the program, the patient's psychosocial needs are assessed and project staff facilitate warm hand-offs to community-based mental health agencies or FQHC partners. The goal of this project is to reduce avoidable ED visits among patients with Medi-Cal who are suffering from mental health and/or substance use issues.

Mental Health Promotion: This project delivers mental health education programs with partnering community- and faith-based organizations, with an emphasis on residents living in affordable housing developments. Staffed by a Project Supervisor, Health Educator and Community Health Workers, the Mental Health Promotion program offers the following classes to residents:

1. Mental Health First Aid (MHFA): an evidence-based, public education program managed and operated by the National Council for Behavioral Health and aimed at improving participants' knowledge of, and modify their attitudes and perceptions about, mental health disorders and related issues
2. Creating Healthier Attitudes Today (CHAT): teaches practical coping skills that help people manage every day stressors. The curriculum provides six sessions of culturally relevant, coping-skill classes including, self-esteem, resilience, stress management, communication, emotional intelligence, and anger management
3. Food, Education, Access, Support, Together (FEAST): an evidence-based, 16-week nutrition education curriculum that addresses food insecurity. FEAST's mission is to promote wellness and enrich lives through the power of healthy foods and human connection. The program improves behavioral, physical and emotional health for participants and their families.

Providence Little Company of Mary Medical Centers - San Pedro and Torrance
Detailed Listing of Community Benefit Services
Reporting Period: January 1, 2019 - December 31, 2019

Category	Total Expense	Net Revenue	Net Expense	Persons Served
A. Community Health Improvement Services				
Bereavement & Gathering Place	667,541	125,000	542,541	2,953
Building Stronger Communities/Local Support Network	960,861	639,524	321,337	506
CCF Care Coordination/CHAT	619,056	268,797	350,259	69
Community Health Insurance Program (CHIP)	612,593	275,731	336,862	4,174
Creating Opportunities for Physical Activity (COPA)	556,463	290,386	266,077	6,994
Get Out and Live (G.O.A.L.)	129,318	-	129,318	390
Linkage to Community Services	214,993	-	214,993	2,592
Mental Health Assessment Team	71,066	43,077	27,989	24
Mental Health Promotion	181,830	106,538	75,292	44
Paramedic Base Station	1,413,027	-	1,413,027	6,242
Partners for Healthy Kids Mobile Clinic (PFHK)	664,466	52,708	611,758	1,782
Physician Case Management (Hospitalists) for Medically Indigent	2,105,198	-	2,105,198	2,978
PLCM Wellness and Activity Center	228,281	-	228,281	1,200
Post-Discharge for Medically Indigent (including Psych. Patients)	625,824	-	625,824	272
Post-Discharge Pharmacy Medication	203,671	-	203,671	650
Sexual Assault Response Team	231,948	148,060	83,888	159
Specialty Medical Coverage for Medically Indigent	1,403,259	-	1,403,259	-
Transportation/Taxi Vouchers for Medically Indigent	216,716	-	216,716	5,218
UCLA/Providence Health Study	122,285	71,296	50,989	86
Welcome Baby Program	2,113,033	1,489,702	623,331	1,753
Total A	**13,341,429**	**3,510,819**	**9,830,610**	**38,086**
B. Health Professions Education				
Preceptorships	3,952,859	207,489	3,745,370	810
Total B	**3,952,859**	**207,489**	**3,745,370**	**810**
C. Subsidized Health Services				
Palliative Care	1,713,982	529,214	1,184,768	194
Trinity Kids Care	-	-	-	155
Vasek Polak Health Clinic	1,508,920	122,944	1,385,976	1,776
Total C	**3,222,902**	**652,158**	**2,570,744**	**2,125**
G. Community Benefit Operations				
Community Outreach Administration	629,789	-	629,789	-
Total G	**629,789**	**-**	**629,789**	**-**
Total Community Benefit	**21,146,979**	**4,370,466**	**16,776,513**	**41,021**

Providence Little Company of Mary Medical Center - San Pedro
Detailed Listing of Community Benefit Services
Reporting Period: January 1, 2019 - December 31, 2019

Category	Total Expense	Net Revenue	Net Expense	Persons Served
A. Community Health Improvement Services				
Bereavement & Gathering Place	267,014	50,000	217,014	1,181
Building Stronger Communities/Local Support Network	960,861	639,524	321,337	506
CCF Care Coordination/CHAT	309,528	134,398	175,130	35
Community Health Insurance Program (CHIP)	306,295	137,864	168,431	2,087
Creating Opportunities for Physical Activity (COPA)	278,230	145,192	133,038	3,497
Get Out and Live (G.O.A.L.)	64,659	-	64,659	195
Linkage to Community Services	64,311	-	64,311	816
Mental Health Assessment Team	35,535	21,540	13,995	12
Mental Health Promotion	90,915	53,269	37,646	22
Partners for Healthy Kids Mobile Clinic (PFHK)	332,233	26,353	305,880	891
Physician Case Management (Hospitalists) for Medically Indigent	644,369	-	644,369	738
PLCM Wellness and Activity Center	114,141	-	114,141	600
Post-Discharge for Medically Indigent (including Psych. Patients)	228,499	-	228,499	108
Post-Discharge Pharmacy Medication	71,361	-	71,361	346
Sexual Assault Response Team	115,974	74,030	41,944	79
Specialty Medical Coverage for Medically Indigent	527,914	-	527,914	-
Transportation/Taxi Vouchers for Medically Indigent	189,233	-	189,233	4,342
UCLA/Providence Health Study	61,144	35,648	25,496	43
Welcome Baby Program	2,113,033	1,489,702	623,331	1,753
Total A	**6,775,249**	**2,807,520**	**3,967,729**	**17,251**
B. Health Professions Education				
Preceptorships	1,195,385	-	1,195,385	317
Total B	**1,195,385**	**-**	**1,195,385**	**317**
C. Subsidized Health Services				
Palliative Care	856,991	264,607	592,384	97
Trinity Kids Care	-	-	-	62
Total C	**856,991**	**264,607**	**592,384**	**159**
G. Community Benefit Operations				
Community Outreach Administration	314,895	-	314,895	-
Total G	**314,895**	**-**	**314,895**	**-**
Total Community Benefit	**9,142,520**	**3,072,127**	**6,070,393**	**17,727**

Providence Little Company of Mary Medical Center - Torrance
Detailed Listing of Community Benefit Services
Reporting Period: January 1, 2019 - December 31, 2019

Category	Total Expense	Net Revenue	Net Expense	Persons Served
A. Community Health Improvement Services				
Bereavement & Gathering Place	400,527	75,000	325,527	1,772
CCF Care Coordination/CHAT	309,528	134,399	175,129	34
Community Health Insurance Program (CHIP)	306,298	137,867	168,431	2,087
Creating Opportunities for Physical Activity (COPA)	278,233	145,194	133,039	3,497
Get Out and Live (G.O.A.L.)	64,659	-	64,659	195
Linkage to Community Services	150,682	-	150,682	1,776
Mental Health Assessment Team	35,531	21,537	13,994	12
Mental Health Promotion	90,915	53,269	37,646	22
Paramedic Base Station	1,413,027	-	1,413,027	6,242
Partners for Healthy Kids Mobile Clinic (PFHK)	332,233	26,355	305,878	891
Physician Case Management (Hospitalists) for Medically Indigent	1,460,829	-	1,460,829	2,240
PLCM Wellness and Activity Center	114,140	-	114,140	600
Post-Discharge for Medically Indigent (including Psych. Patients)	397,325	-	397,325	164
Post-Discharge Pharmacy Medication	132,310	-	132,310	304
Sexual Assault Response Team	115,974	74,030	41,944	80
Specialty Medical Coverage for Medically Indigent	875,345	-	875,345	-
Transportation/Taxi Vouchers for Medically Indigent	27,483	-	27,483	876
UCLA/Providence Health Study	61,141	35,648	25,493	43
Total A	**6,566,180**	**703,299**	**5,862,881**	**20,835**
B. Health Professions Education				
Preceptorships	2,757,474	207,489	2,549,985	493
Total B	**2,757,474**	**207,489**	**2,549,985**	**493**
C. Subsidized Health Services				
Palliative Care	856,991	264,607	592,384	97
Trinity Kids Care	-	-	-	93
Vasek Polak Health Clinic	1,508,920	122,944	1,385,976	1,776
Total C	**2,365,911**	**387,551**	**1,978,360**	**1,966**
G. Community Benefit Operations				
Community Outreach Administration	314,894	-	314,894	-
Total G	**314,894**	**-**	**314,894**	**-**
Total Community Benefit	**12,004,459**	**1,298,339**	**10,706,120**	**23,294**

Providence South Bay Community

Appendices:
2019 Joint Community Health Needs Assessment

Providence Little Company of Mary Medical Center, San Pedro

Providence Little Company of Mary Medical Center, Torrance

PROVIDENCE
Little Company of Mary
Medical Center
San Pedro

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Little Company of Mary
Medical Center
Torrance

Appendix 1: Fact Sheets on Health Indicators

This section provides comprehensive primary and secondary data relevant to the significant health needs identified and prioritized during the Providence South Bay Community Health Needs Assessment process.

Access to Healthcare

Primary Data

Listening Sessions with Community Members

One listening session was conducted at Vasek Polak Health Clinic and two sessions were conducted at the Providence Wellness and Activity Center in Wilmington. Participants shared the following information:

Participants' vision for a healthy community includes local, affordable health care services

- Low-cost or free health care services available for everyone, particularly for people who are uninsured

Participants choose where to receive health care services largely depending on their insurance status and type of insurance

They seek medical services at a variety of locations including hospitals and the emergency department, private doctors, and community clinics, such as Vasek Polak Health Clinic and Harbor UCLA.

Participants shared primarily using the emergency department when they need timely care

- A true medical emergency, such as a high fever or sudden onset of pain
- Their doctor's office is closed, such as on an evening or weekend
- They need timely care, but appointments are being scheduled weeks or months in the future
- They do not have insurance or are enrolled in Emergency Medi-Cal only

Barriers to seeking health care services

- Lack of insurance and cost of care: Copays and surprise bills prevent people from seeking services.
- Discrimination and fear: Participants shared stories of being treated rudely in local health care centers and staff being unhelpful when they have questions or concerns. They felt the care they receive on Medi-Cal is of lower quality and they experience longer wait times than people on private insurance. They also shared they feel discriminated against for not speaking English.
- Long wait times for appointments: One participant explained the wait time between scheduling an appointment and actually receiving care is so long a patient could die before their appointment date, emphasizing the dire need for more access to appointments.

Factors and resources that make accessing services easier

- Health education classes in a community setting that help people connect to other health care services and learn about their insurance benefits
- Friendly, welcoming, and linguistically appropriate services

Community needs for improving access to health care services

- More health-related classes, including a class dedicated to explaining health insurance benefits
- A clear summary of health insurance benefits, specifically, information that is accessible and simple, potentially with someone to explain the information in person
- Opportunities for community members to share information and learnings with one another

Community Stakeholder Interviews

Factors contributing to access to care needs

- High cost of care and medications: Disproportionately affects young people and individuals with insurance other than Medicaid
- Lack of health literacy, including challenges navigating the complexity of the health care system: Disproportionately affects people with language or literacy barriers
- Fear related to immigration status and finding out about an illness, as well as distrust of the health care system: Disproportionately affects undocumented immigrants
- Transportation barriers: Disproportionately affects older adults
- Limited availability of appointments: Disproportionately affects working individuals

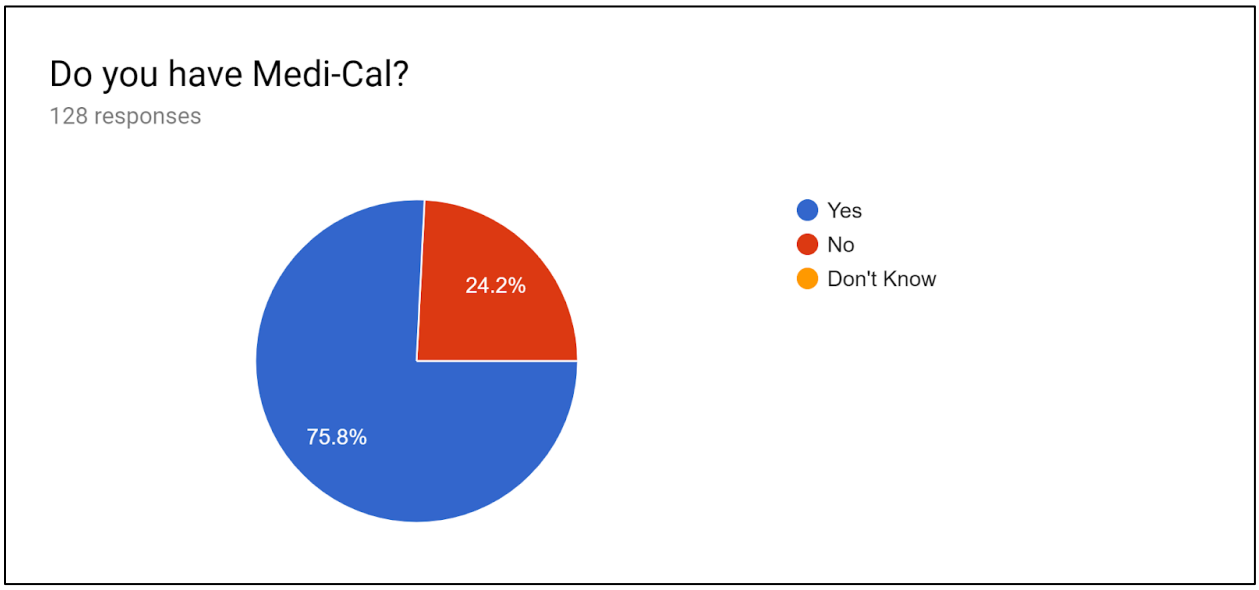
Effective strategies for addressing access to care challenges

- Medical homes that combine health education, medical care, and social- emotional support
- Outreach and navigation to help families learn about and then navigate the available resources in the community

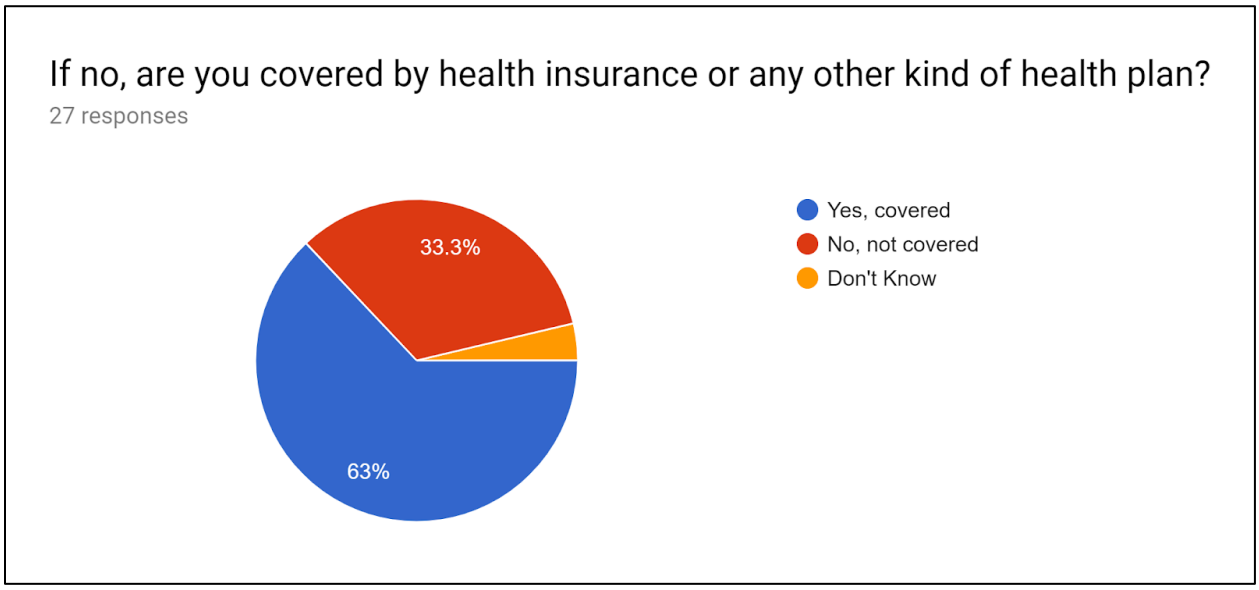
Abode Health Survey

Providence Little Company of Mary partnered with Abode Communities, a nonprofit affordable housing provider, to administer health surveys to all new residents moving into Camino del Mar & Vista del Mar affordable homes located in the vicinity of the Providence Little Company of Mary Wellness and Activity Center. The health survey covered a wide range of topics including insurance status, self-reported health, chronic conditions, food insecurity and access, physical activity and social cohesion. Between January 2019 and July 2019 a total of 133 responses were received and analyzed.

Figure_Apx 1. Medi-Cal Coverage for Abode Health Survey Respondents

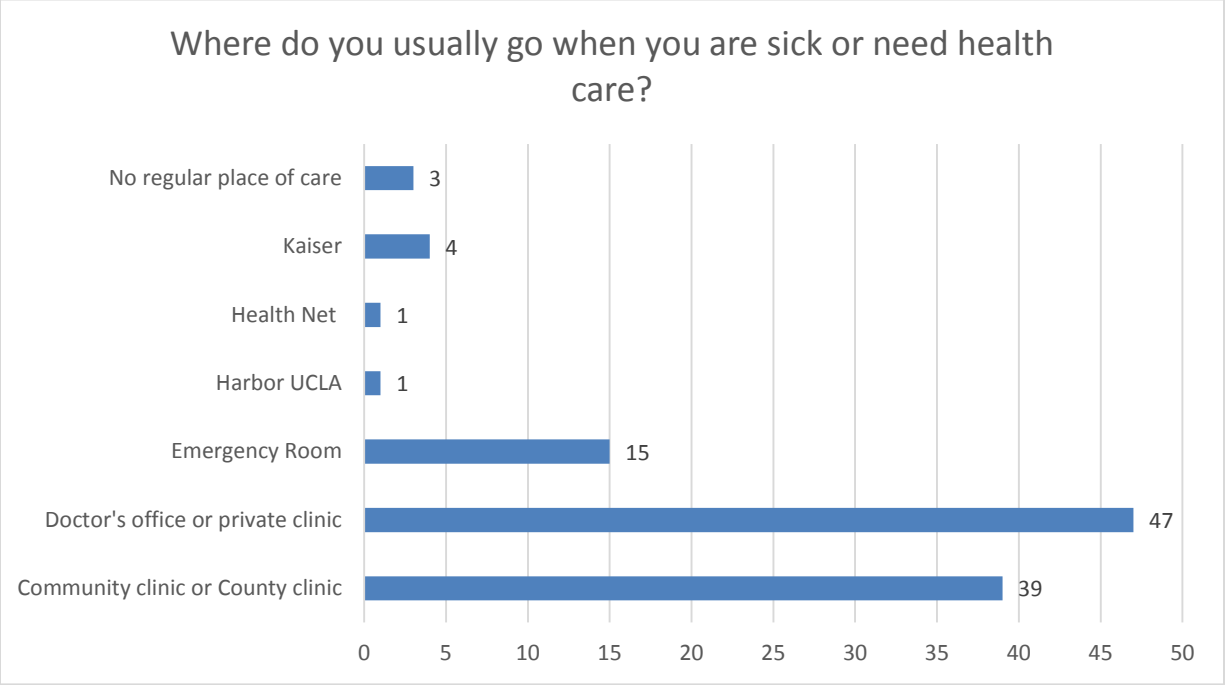


Figure_Apx 2. Health Insurance Coverage for Non Medi-Cal Abode Health Survey Respondents

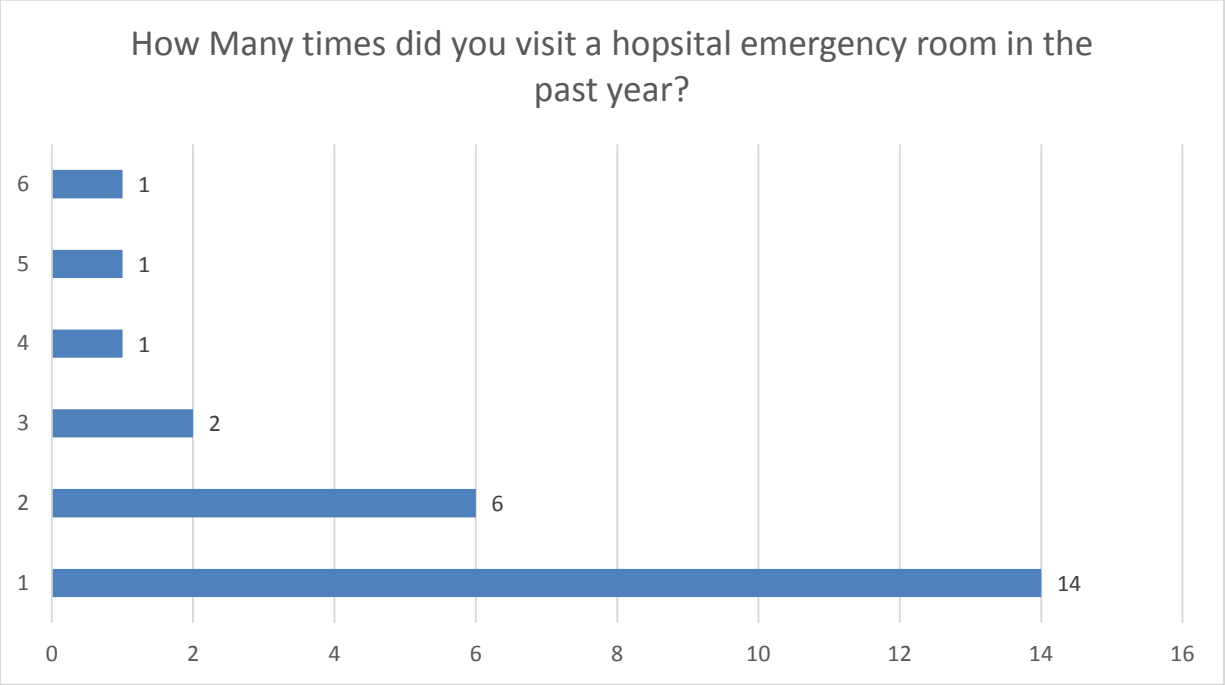


- 97 respondents said they are current recipients of Medi-Cal while 17 respondents are covered by health insurance or some kind of health plan other than Medi-Cal. Ten respondents were not or did not know if they were covered by health insurance or any other kind of health plan.

Figure_Apx 3. Health Care Utilization for Abode Health Survey Respondents



Figure_Apx 4. Emergency Department Use for Abode Health Survey Respondents



- Out of the 25 respondents who visited a hospital emergency room in the past year for their own health, 14 visited the emergency room once while 11 respondents visited the emergency room more than once in the past year.

Secondary Data

Los Angeles County Key Indicators taken from the 2015 Los Angeles County Health Survey
Table_Apx 1. Access to Care Indicators from the Los Angeles County Health Survey

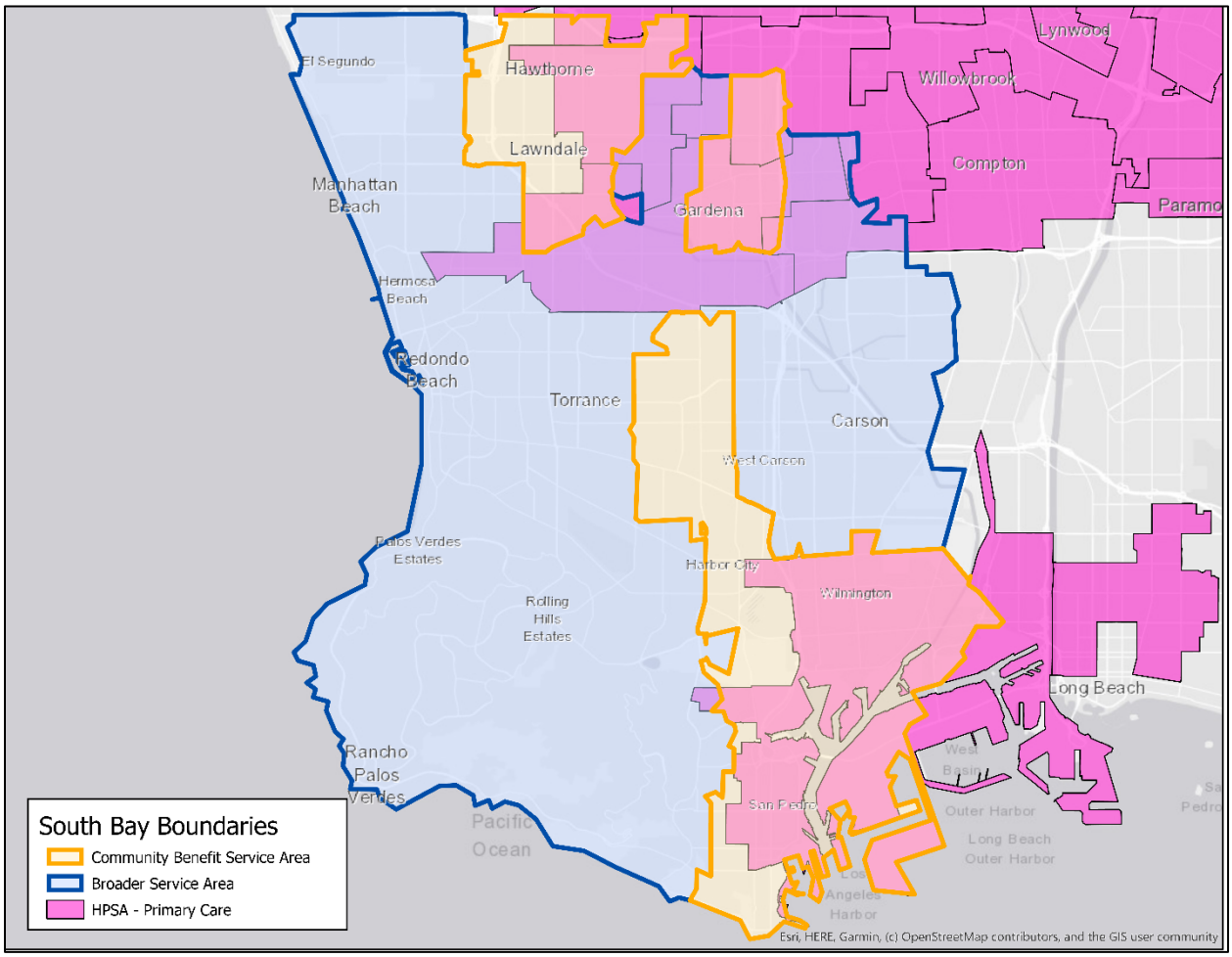
Indicator	Community Benefit Service Area	Broader Service Area	Los Angeles County
Percent of children ages 0-17 years who are insured	96.0%	97.6%	96.6%
Percent of adults ages 18-64 years who are insured	84.4%	96.2%	88.3%
Percent of children ages 0-17 years with a regular source of health care	96.1%	95.7%	94.3%
Percent of adults 18-64 years with a regular source of health care	77.8%	82.0%	77.7%
Percent of adults who did not see a dentist or go to a dental clinic in the past year	44.5%	27.4%	40.7%
Percent of children ages 3-17 years who did not obtain dental care (including check-ups) in the past year because they could not afford it	19.6%	*7.7%	11.5%

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

- Although there are similar rates for percent of children who are insured in the Community Benefit Service Area, Broader Service Area and Los Angeles County, the Community Benefit Service Area has a lower percent of adults who are insured as compared to the Broader Service Area.
- Almost 1 out of every 5 children in the Community Benefit Service Area went without dental care in the past year because they could not afford it while almost 50% of adults did not see a dentist or go to a dental clinic in the past year.

The Health Resources & Services Administration (HRSAs) defines a Health Professional Shortage Area (HPSAs) as shortages of primary care, dental care or mental health providers by geographies or populations. Below we see the Community Benefit Service Area and the Broader Service Area for Providence Little Company of Mary and primary care HPSAs in the South Bay.

Figure_Apx 5. Health Professional Shortage Areas in the south Bay



- Many of the HPSAs are found in the Community Benefit Service Area. Primary care HPSAs span all of Wilmington and Gardena while covering most of San Pedro. There are also primary care HPSAs in parts of Hawthorne, Lawndale and in north Torrance.

Medi-Cal Eligibility

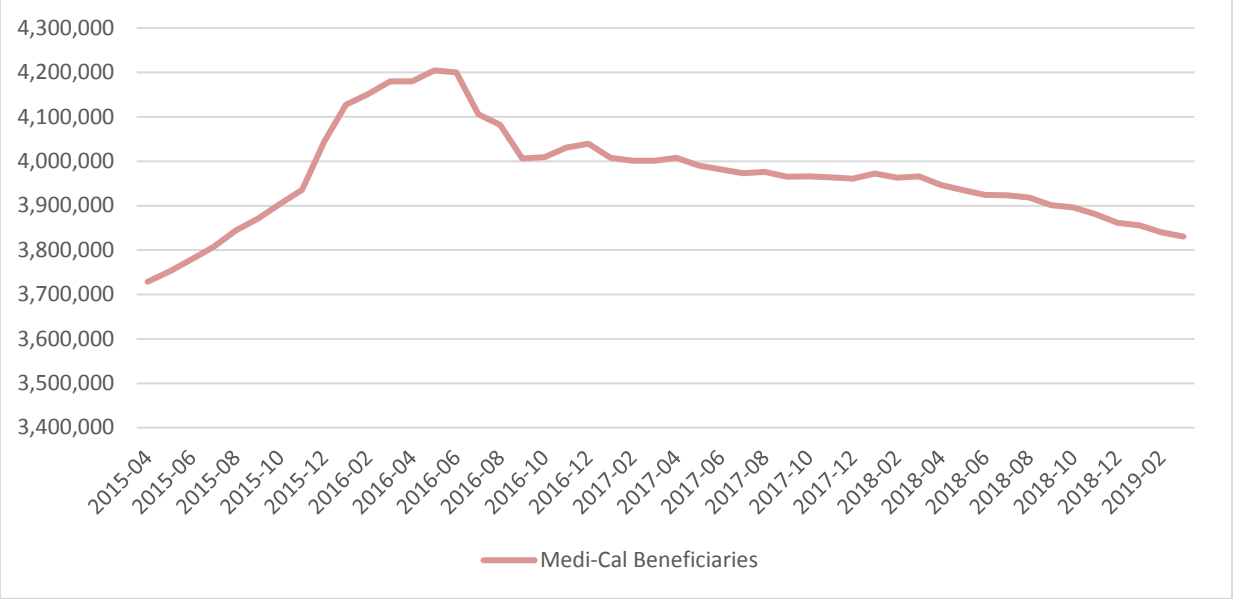
Since the Patient Protection and Affordable Care Act (ACA) many Californians have now become eligible to enroll and receive Medi-Cal benefits. As of March 2019, there are currently 1,225,668 Medi-Cal beneficiaries in Los Angeles due to the ACA expansion to adults ages 19 to 64. Additionally, Medi-Cal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

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

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

County	AI/AN	Asian	Black	Hispanic	Not Reported	White	Grand Total
Los Angeles	1,948	138,069	132,842	659,278	88,329	205,202	1,225,668

Figure_Apx 6. Monthly Medi-Cal Beneficiaries Counts for Los Angeles County



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

Behavioral Health (Including Mental Health and Substance Use)

Primary Data

Listening Sessions with Community Members

One listening session was conducted at Vasek Polak Health Clinic and two sessions were conducted at the Providence Wellness and Activity Center in Wilmington. Participants shared the following information:

Participants' vision for a healthy community includes mental wellbeing

- People can access mental health services
- People have less stress and participate in stress-relieving activities such as meditation

The community needs more accessible mental health services

- Counseling services in schools: participants were particularly concerned about providing support for young people
- More mental health professionals
- More available appointment times for counseling services
- More behavioral health services for people experiencing homelessness

The Wellness and Activity Center improves people's mental health

- Participants reported experiencing improved feelings of depression and social isolation since participating in programming at the Center
- The Center is a safe place where people feel loved and welcome

Participants would like more mental health services at the Wellness and Activity Center

- Mental health support groups and classes for young people
- Support groups for parents

Community Stakeholder Interviews

Factors contributing to behavioral health needs

- Challenges accessing care, including a lack of providers and mental health care centers: Disproportionately affects young people and individuals with insurance other than Medicaid
- Poverty and stress leading to lack of parental engagement: Disproportionately affects people of color and immigrants
- Screen time and social media addiction: Disproportionately affects young people
- Stigma around seeking mental health services
- Challenges accessing substance use treatment services
- Lack of resources for youth around substance use

Effective strategies for addressing behavioral health challenges

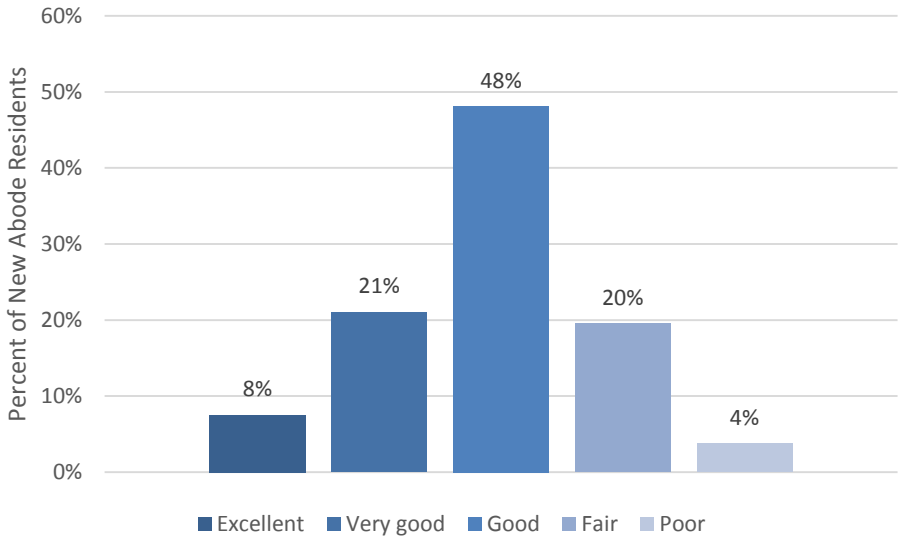
- Improve access to care by increasing available appointment times, developing community partnerships to pool resources for funding services, and utilizing mobile health vans
- Invest in preventive mental health services, such as group therapy for young people in community-based settings
- Youth led initiatives for substance use prevention and health promotion

Stakeholders were particularly concerned about **young people** using substances.

Abode Health Survey

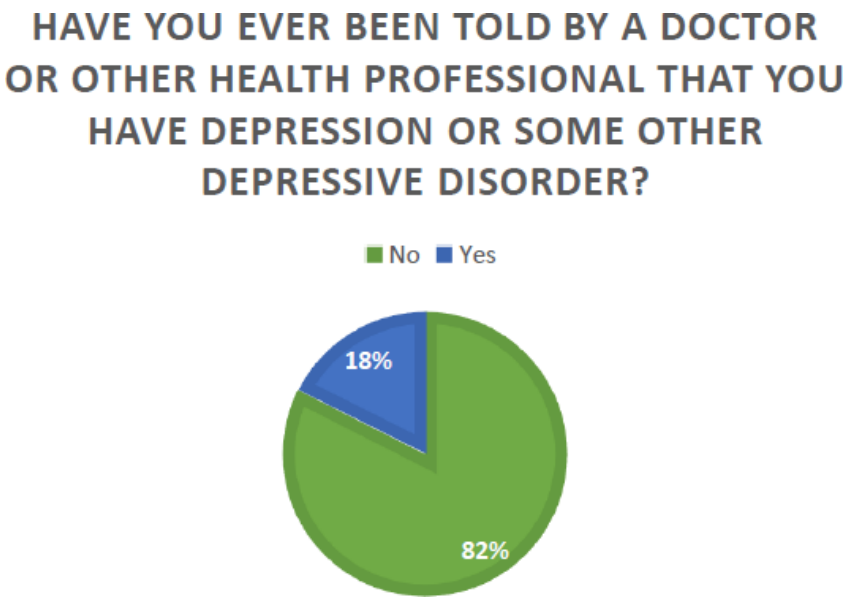
Providence Little Company of Mary partnered with Abode Communities, a nonprofit affordable housing provider, to administer health surveys to all new residents moving into Camino del Mar & Vista del Mar affordable homes located in the vicinity of the Providence Little Company of Mary Wellness and Activity Center. The health survey covered a wide range of topics including insurance status, self-reported health, chronic conditions, food insecurity and access, physical activity and social cohesion. Between January 2019 and July 2019 a total of 133 responses were received and analyzed.

Figure_Apx 7. Abode Health Survey Self-Reported Health Status



A quarter of new residents reported their health status to be “fair” or “poor” during the survey time period.

Figure_Apx 8.Abode Health Survey Self-Reported Depression Diagnosis



About one-fifth of new residents moving into affordable housing near the Providence Little Company of Mary Wellness and Activity Center have been diagnosed with depression or some other depressive disorder.

Secondary Data

Los Angeles County Indicators

Table_Apx 3. Health Status Indicators

Indicator	Community Benefit Service Area	Broader Service Area	Los Angeles County
Percent of adults reporting their health to be fair or poor	20.2%	15.6%	21.5%
Average number of days in past month adults reported regular daily activities were limited due to poor physical/mental health	2.1	2.1	2.3
Percent of children ages 0-17 years who have special health care needs	19.4%	14.1%	14.5%
Percent of adults at risk for major depression	10.7%	8.9%	11.8%

There exists a higher portion of adults at risk for depression in the Community Benefit Service Area compared to the Broader Service Area and a higher portion of adults in the Community Benefit Service Area report their health to be fair or poor. We also see that the percent of children who have special health care needs is about 5% higher than the Broader Service Area and Los Angeles County.

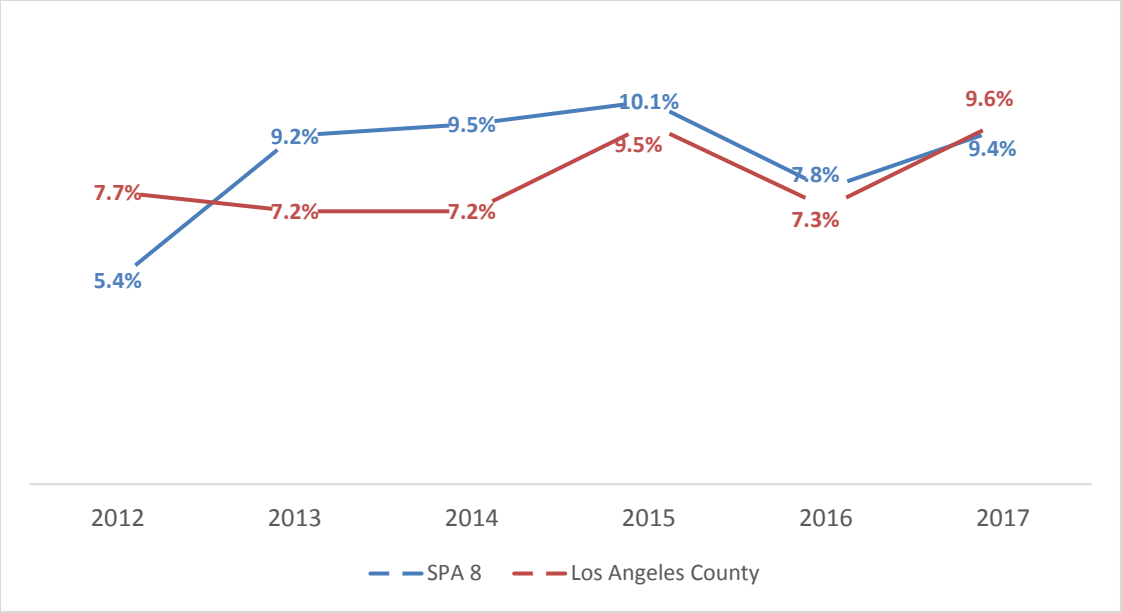
California Health Interview Survey

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

Table_Apx 4. Behavioral Health Indicators from California Health Interview Survey

Indicator	SPA 8	Los Angeles County	Differences Between SPA 8 and County
Adults who ever seriously thought about committing suicide (2017)	9.4%	9.60%	0.2% Lower
Saw any healthcare provider for emotional-mental and/or alcohol-drug issues in past year (2016)	8.9%	12.30%	3.4% Lower
Adults who sought help for self-reported mental/emotional and/or alcohol-drug issues and received treatment (2016)	53.9%	60.10%	6.2% Lower

Figure_Apx 9. Percent of Adults Who Have Seriously Thought About Committing Suicide



Source: California Health Interview Survey

Since 2012, the percent of adults who have seriously thought about committing suicide has risen from 5.4% to 9.4% in Service Planning Area 8, while Los Angeles County has risen from 7.7% to 9.6%.

Current Providence Little Company of Mary Community Health Investments

Screening and Treatment at Vasek Polak: Patients are screened for depression and anxiety at the Vasek Polak Health Clinic. Free therapy sessions with a Marriage and Family Therapist from Richstone are available onsite at the clinic.

- 941 patients screened for anxiety and depression at Vasek Polak Health Clinic (2018)
- 52 patients enrolled into therapy sessions at Vasek Polak Health Clinic (2018)

Mental Health Prevention: Community health workers will be teaching two courses—Mental Health First Aid and Creating Healthier Attitudes Today--in community settings related to mental health awareness and coping skills.

- 12 CHAT cohorts provided in the community, with 110 people completing the series (2018)
- 44 mental health awareness presentations hosted at the Providence Wellness and Activity Center (2018)
- Mental Health First Aid courses will be begin in 2020

Providence/UCLA Alcohol Study: The Alcohol and Health Research Study for Latinos is a research project looking at the impact of Community Health Workers' use of motivational interviewing to impact alcohol use among Latinos. CHWs meet with eligible applicants three times, face-to-face to discuss the participants' alcohol use and the impact of drinking on their health and life.

Chronic Diseases

Primary Data

Listening Sessions with Community Members

One listening session was conducted at Vasek Polak Health Clinic and two sessions were conducted at the Providence Wellness and Activity Center in Wilmington. Participants shared the following information:

Participants' vision for a healthy community includes healthy eating and exercise habits to prevent and manage chronic diseases

- People are exercising and participating in healthy activities: green space for outdoor activities and exercise classes
- People have access to healthy, nutritious food: affordable and available fresh produce and the knowledge of how to cook healthy meals

The community needs healthier habits related to nutrition and exercise

- Concern for seemingly high levels of childhood obesity
- Desire to see families eat healthier, more nutritious foods
- Need for increased amount of physical activity for all people, especially children

Health education classes are a community asset that help people manage chronic diseases

- Diabetes management classes at Vasek Polak were named as particularly useful
- Health education classes at the Wellness and Activity Center have helped participants learn how to prevent and manage chronic diseases

Community Stakeholder Listening Sessions and Interviews

People experiencing food insecurity are disproportionately affected by chronic diseases

- Stakeholders were particularly concerned about obesity, diabetes, and high blood pressure caused from a lack of healthy, fresh foods

People experiencing homelessness are disproportionately affected by unmanaged chronic diseases

- Accessing preventive and primary care can be challenging
- Lack of resources and necessary medications, as well as nutritious foods, may make managing chronic diseases difficult

> *"And then also folks [experiencing homelessness] who have chronic medical conditions, it's really hard to treat those or manage those conditions. For example, someone with diabetes, there's no place to refrigerate their insulin, to cleanly dispose of all their medications and then their needles get stolen." – Community stakeholder*

Abode Health Survey

Providence Little Company of Mary partnered with Abode Communities, a nonprofit affordable housing provider, to administer health surveys to all new residents moving into Camino del Mar & Vista del Mar affordable homes located in the vicinity of the Providence Little Company of Mary Wellness and Activity Center. The health survey covered a wide range of topics including insurance status, self-reported health, chronic conditions, food insecurity and access, physical activity and social cohesion. Between January 2019 and July 2019 a total of 133 responses were received and analyzed.

The following table shows the responses to whether or not a healthcare professional has ever told a respondent if they have any of the following chronic disease:

Table_Apx 5. Chronic Disease Indicators from the Abode Health Survey

Chronic Disease	No	Yes	Did Not Know
Diabetes	119	12	1
Pre-Diabetes or Borderline Diabetes	105	18	3
High Blood Pressure or Hypertension	119	9	2
High Cholesterol	116	10	4
Depression or Some Other Depressive Order	108	23	0

- 22.5% of residents were told they had pre-diabetes/borderline diabetes or diabetes and 17.3% of residents had been told they depression or some other depressive order.

Residents were also asked if any of their children had ever been told by a doctor or other health professional if their child had asthma, whether or not if they still had asthma and if in the past year their child had an episode of asthma or asthma attack. Thirty-five adults indicated that they had been told by a doctor or health professional that their child had asthma and of those, 18 still had asthma. Twelve residents reported that their child had an episode of asthma or an asthma attack in the past 12 months.

Secondary Data

Table_Apx 6. Chronic Disease Key Indicators

	Community Benefit Service Area	Broader Service Area	Los Angeles County
Obesity			
Percent of adults who are obese (BMI≥30.0)	20.6%	20.7%	23.5%
Diabetes			
Percent of adults ever diagnosed with diabetes	7.0%	10.2%	9.8%
Diabetes-related hospital admissions (per 10,000 population)	19.8	11.6	15.74
Diabetes-specific death rate (per 100,000 population)	24.8	16.7	24.21
Cardiovascular Disease			
Hypertension-related hospital admissions (per 10,000 population)	5.7	3.3	5.10
Percent of adults ever diagnosed with hypertension	14.6%	25.5%	23.5%
Coronary heart disease-specific death rate (per 100,000 population population)	117.7	91.6	108.10
Stroke-specific death rate (per 100,000 population)	38.4	31.6	36.20
Respiratory Disease			
Percent of children ages 0-17 years with current asthma (ever diagnosed with asthma and reported still have asthma and/or had an asthma attack in the past year)	*4.7%	7.0%	7.4%
Pediatric asthma-related hospital admissions per 10,000 child population	13.5	9.3	10.82
COPD specific mortality rate (per 100,000 population)	29.2	24.6	29.88
Liver Disease			
Liver disease-specific death rate (per 100,000 population)	15.3	9.0	13.70

Unstable percentages due to small numbers. Interpret with caution.

Although the Community Benefit Service Area has a lower percent of adults who are obese as compared to the Broader Service Area, there are higher diabetes-related hospital admissions per 10,000 population and higher diabetes-specific death rate per 100,000 population in the Community Benefit Service Area.

Similarly to diabetes rates, there exists a lower percent of adults diagnosed with hypertension in the Community Benefit Service Area as compared to the Broader Service Area but higher hypertension-related hospital admissions per 10,000 population, higher coronary heart disease-specific death rate per 100,000 population and higher stroke-specific death rate per 100,000 in the Community Benefit Service area.

Following similar trends of other chronic diseases, pediatrics asthma-related hospitals admissions per 10,000 child population and COPD specific mortality rate per 100,000 population is higher in the Community Benefit Service Area than the Broader Service Area.

California Health Interview Survey

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

Diabetes and Pre-diabetes

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

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

Table_Apx 7. Chronic Disease Diagnoses by Race/Ethnicity

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

*Statistically unstable

- Latinos and African Americans have higher rates of diagnosed diabetes as compared to Los Angeles County.

Early Childhood Development

Primary Data

Listening Sessions with Community Members

One listening session was conducted at Vasek Polak Health Clinic and two sessions were conducted at the Providence Wellness and Activity Center in Wilmington. Participants shared the following information:

Participants' vision for a healthy community includes resources to support healthy child development

- Support for parents including classes that provide child development information
- Prenatal and postpartum support, such as WIC

The Wellness and Activity Center supports new parents

- The Welcome Baby and Building Stronger Families programs provide families with the supports needed to care for their children and help them grow

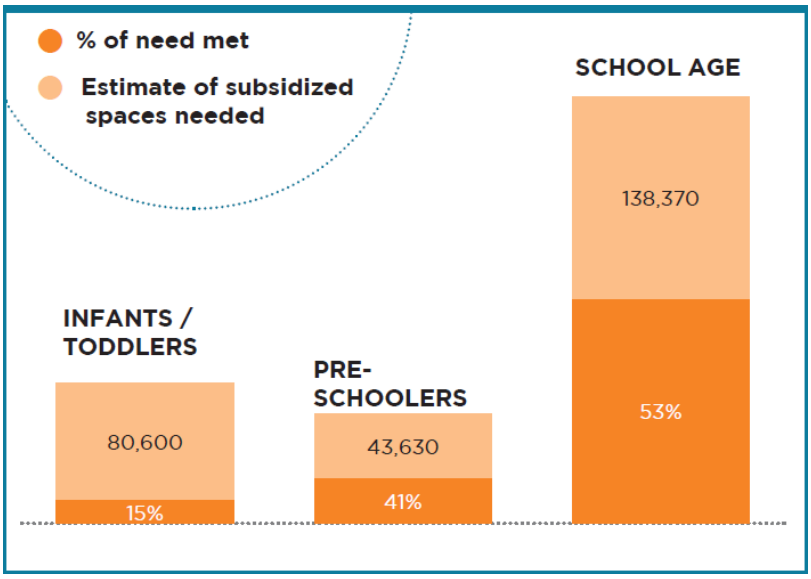
Secondary Data

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

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

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

Figure_Apx 10. Unmet Need for Subsidies Among Low-Income Families in Los Angeles County by Age Group



The cost of care for a young child is high. A family's average cost of care in Los Angeles County is $10,303 a year per preschooler in center-based care and $8,579 a year per preschooler in a family child care home. Care for infants and toddlers is even more expensive, with an annual cost of $14,309 in an early care and education center and $9,186 in a family child care home.

Education and professional development of the early care and education workforce is hindered by costs, availability of classes and language barriers. Quality of care for early care and education is directly linked to a highly-qualified workforce yet half of the local work force does not possess a college degree. Early educators also value professional development as a means to increase knowledge but cite costs as a top barrier.

Figure_Apx 11. Barriers to Participating in ECE Professional Development in Los Angeles County

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

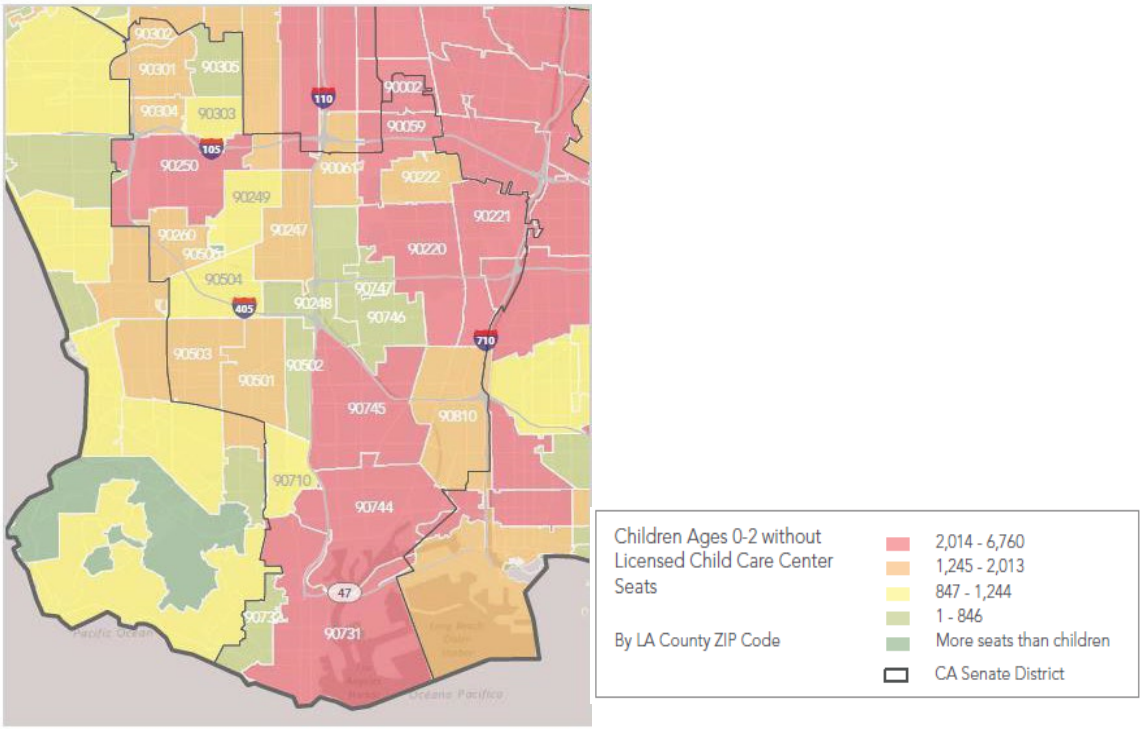
[2] *Data Source: LA Advance spring 2016 early educator survey -- From Table D.4 Barriers for Consortium program participants' participation in PD: Spring 2016 (LA Advance Spring 2016 Analysis).*

Early Childhood Education (ECE) Access Gap

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

Since profiles were developed using the above mentioned geographies, California State Senate District 35 was chosen as an approximation for the Providence Little Company of Mary's Community Benefit Service Area. Below is a map of the zip codes of District 35 and the availability of seats at licensed child care centers for children ages zero to two.

Figure_Apx 12. Children Ages 0-2 Without a Licensed Child Care Center Seat (CA State Senate District 35)



Table_Apx 8. Children Without a Licensed Child Care Center Seat in CA State Denate District 35

CA State Senate District	Children Ages 0-2 Without Seats (#; %)	Children Ages 2-4 Without Seats (#; %)
35	46,283; 98%	31,620; 67%

Hawthorne (90250), San Pedro (90731) and Wilmington (90744) are among the top five zip codes in District 35 with the largest access gap for children ages 0 – 2 and ages 2 – 4 to a licensed child care center. There are 4,638 children ages 0 – 2 in Hawthorne, 2,810 children ages 0 – 2 in Wilmington and 2,741 children ages 0 – 2 in San Pedro without seats to a licensed child care center. Additionally, there are 3,409 children ages 2 – 4 in Hawthorne, 2,029 children ages 2 – 4 in San Pedro and 1,988 children ages 2 – 4 in Wilmington without seats to a licensed child

Economic Insecurity and Workforce Development

Primary Data

Listening Sessions with Community Members

One listening session was conducted at Vasek Polak Health Clinic and two sessions were conducted at the Providence Wellness and Activity Center in Wilmington. Participants shared the following information:

Economic insecurity affects people's ability to pay for health care services and buy medications

- Cost of care, with and without insurance, including copays and a percentage of services, was a main reason participants shared for not seeking needed services in the past

Participants' vision of a healthy community includes opportunities to learn and grow

- Skill-building classes, such as classes to develop English and computer skills, that may support people in getting better paying jobs

The community needs more educational and skill-building opportunities

- Participants want to advance themselves and would like to see more free and low-cost classes, such as computer or English classes
- Request for personal development classes at the Wellness and Activity Center

Community Stakeholder Listening Sessions and Interviews

Economic insecurity affects people's ability to pay for health care services and buy medications

The high cost of care and medications makes managing chronic diseases and other conditions very challenging. People with low incomes or individuals with incomes just above the poverty threshold are disproportionately affected by challenges accessing health care.

Economic insecurity affects people's ability to buy nutritious foods

Healthy food options are often more expensive than unhealthy food options.

Economic insecurity contributes to housing insecurity and homelessness

Participants shared loss of income because of job elimination contributes to families not having sufficient income to cover their basic necessities. Additionally, lack of living wage jobs, coupled with high cost of living in the South Bay, means that people are not making enough money to cover their needs.

> *"I think it goes back to income and lack of affordable housing. For the populations that I work with, most of them don't have an income or credit to be able to afford [housing] and then what they can afford it's really not necessarily the best housing situation for them." – Community stakeholder*

Lack of educational opportunities contribute to housing insecurity and homelessness

Participants saw education as key for helping people access opportunities, such as better paying jobs and economic security. Therefore, people who may not have a strong educational background may be limited in their ability to better their circumstances, contributing to poverty and homelessness.

Stakeholders noted needing more investment in education and workforce development to address housing insecurity and homelessness
Job skill building, vocational opportunities, and other educational opportunities are important for addressing the root causes of housing insecurity and homelessness.

Poverty and stress contribute to mental health challenges
Stress from high housing costs, financial insecurity, and long work hours from multiple jobs puts strain on families. Stress and busy schedules contribute to lack of parental engagement and ineffective parenting, contributing to the mental health challenges stakeholders see in young people. Stakeholders shared people of color, particular Latinx people, and immigrants are disproportionately affected by poverty and stress contributing to poor mental health.

Secondary Data

Los Angeles County Department of Public Health Key Indicators

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

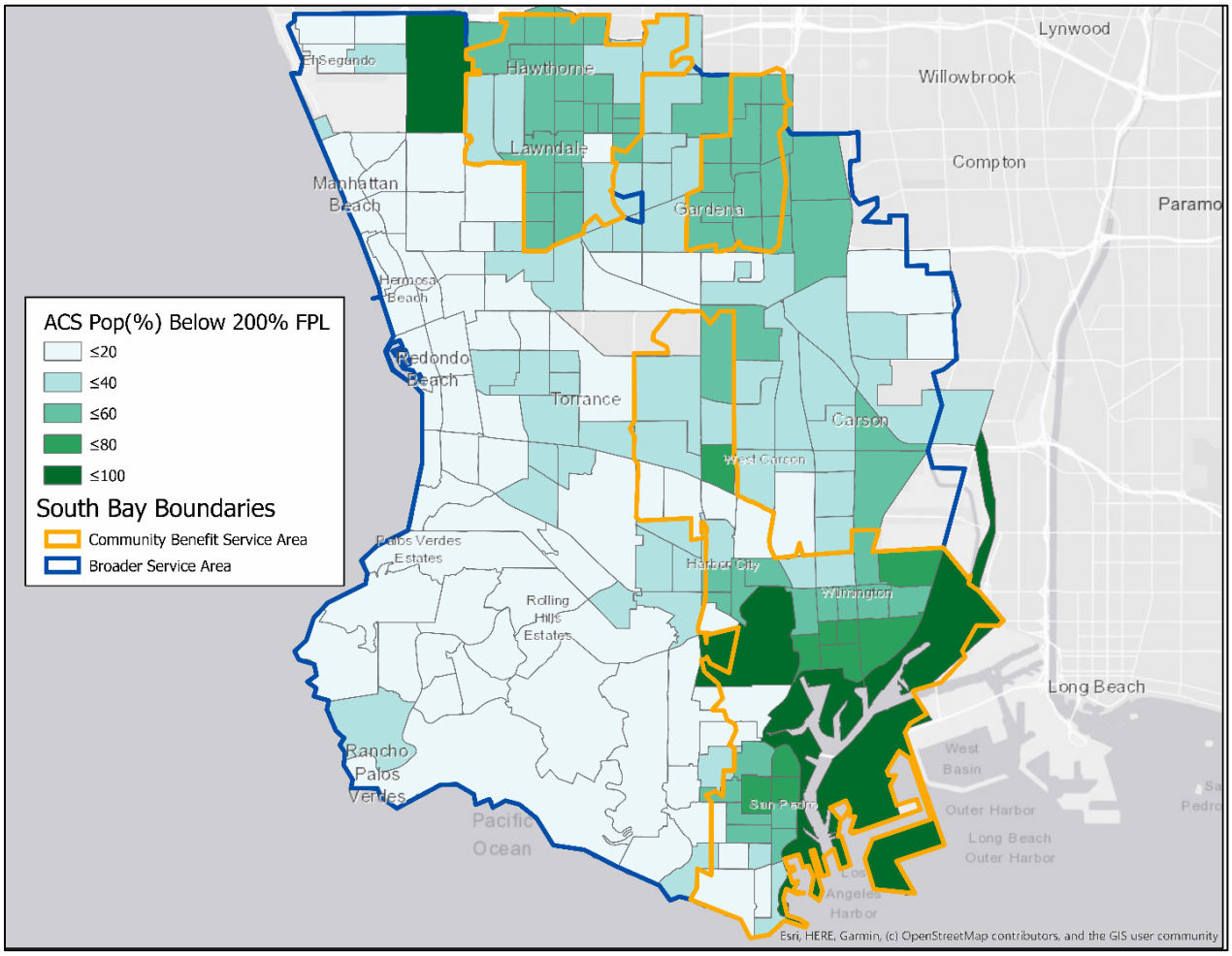
Table_Apx 9. Economic Insecurity Indicators from the Los Angeles County Department of Public Health

Indicator	Community Benefit Service Area	Broader Service Area	Los Angeles County
Percent of adults who completed high school	83.6%	93.6%	77.6%
Percent of adults who are employed	59.6%	59.7%	56.6%
Percent of population with household incomes <100% Federal Poverty Level (FPL)	19.5%	7.7%	17.8%
Percent of households (owner/renter-occupied) who spend ≥30% of their income on housing.	49.8%	37.5%	48.0%
Percent of households with incomes <300% who are food insecure	32.1%	*17.0%	29.2%

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

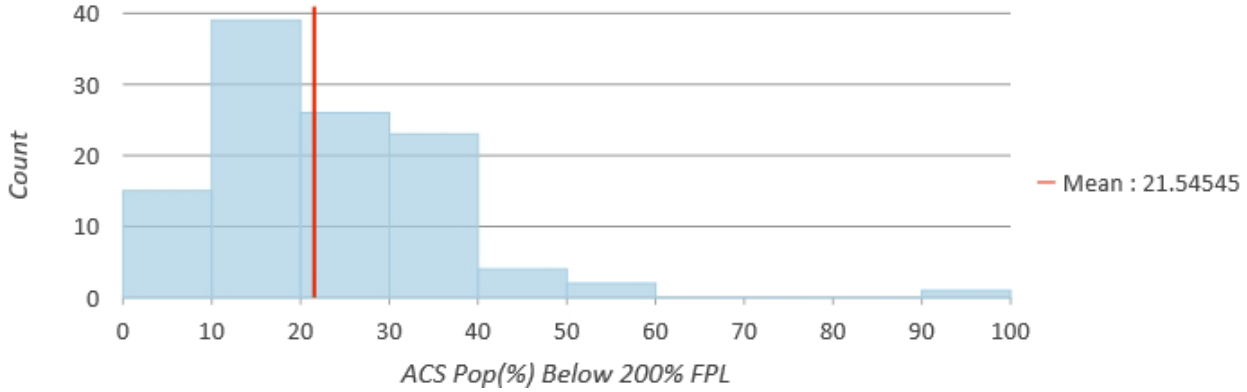
Although the percent of adults who are employed are similar among the Community Benefit Service Area, Broader Service Area and Los Angeles County, the Community Benefit Service Area has a higher percent of population with household incomes below the Federal Poverty Level as compared to the Broader Service Area and Los Angeles County. Furthermore the Community Benefit Service Area has a higher percent of households who spend 30% or more of their income on housing and a higher percent of households with incomes below 300% the Federal Poverty Level who are food insecure.

Figure_Apx 13. Percent of Population Below 200% Poverty Level by Census Tract

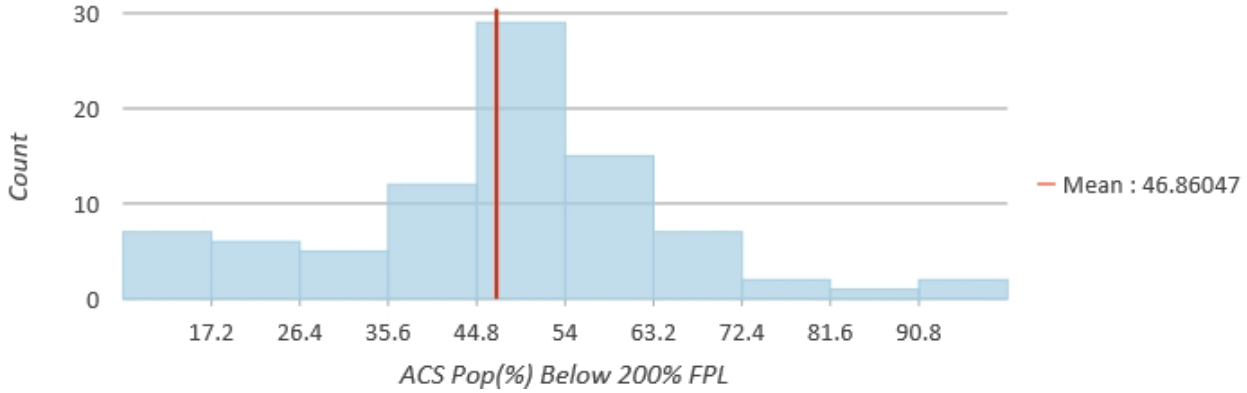


Almost all census tracts that have at least 60% of its population below 200% the federal poverty level are found within the Community Benefit Service Area. Wilmington and San Pedro is a hot spot for a high percentage of population below 200% the federal poverty level as well as Gardena, Lawndale and Hawthorne.

Figure_Apx 14. Distribution of Percent of Population Under 200% Federal Poverty Level by Census Tract for the Broader Service Area

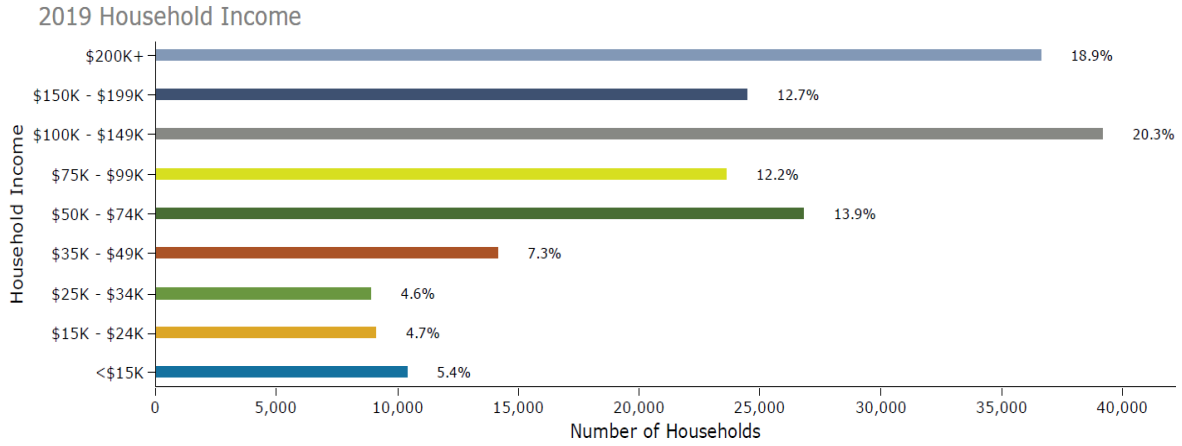


Figure_Apx 15. Distribution of Percent of Population Under 200% Federal Poverty Level by Census Tract for the Community Benefit Service Area

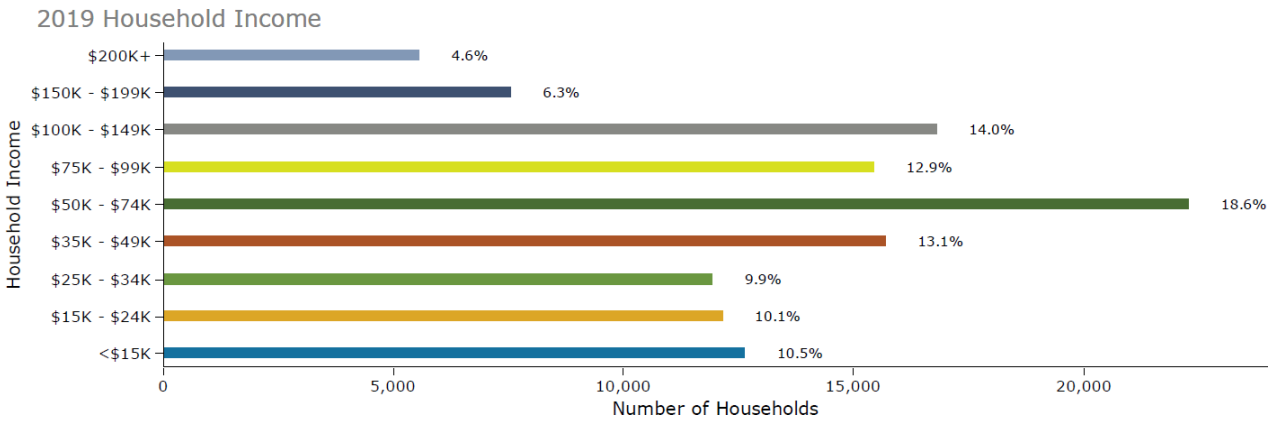


From the distributions above we see that the average census tract in the Community Benefit Service Area has half of its population below 200% the Federal Poverty Level whereas in the Broader Service Area only about 21% of populations in a census tract are below 200% the Federal Poverty Level.

Figure_Apx 16. Broader Service Area Income Distribution



Figure_Apx 17. Community Benefit Service Area Income Distribution



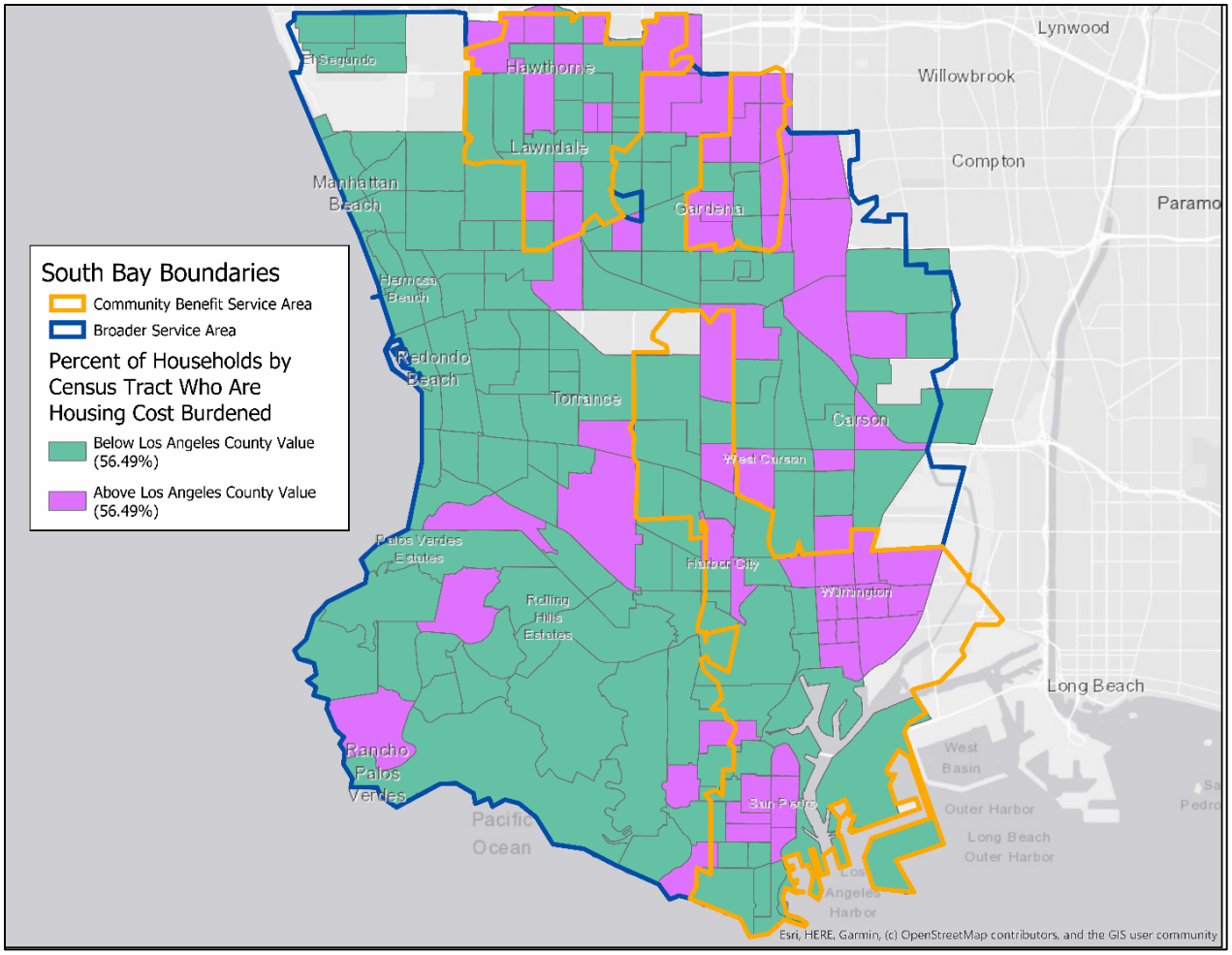
Housing-Cost Burden

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

Table_Apx 10. Housing-Cost Burden Indicators

Variable	Community Benefit Service Area	Broader Service Area	Los Angeles County
2013-2017 ACS Households: Renter Households That Are Housing-Cost Burdened (%)	42,560 (53.53%)	32,937 (46.05%)	1,006,798 (56.49%)
2013-2017 ACS Households: Renter Households That Are Severely Housing-Cost Burdened (%)	21,633 (28.73%)	15,814 (22.11%)	536,832 (30.11%)

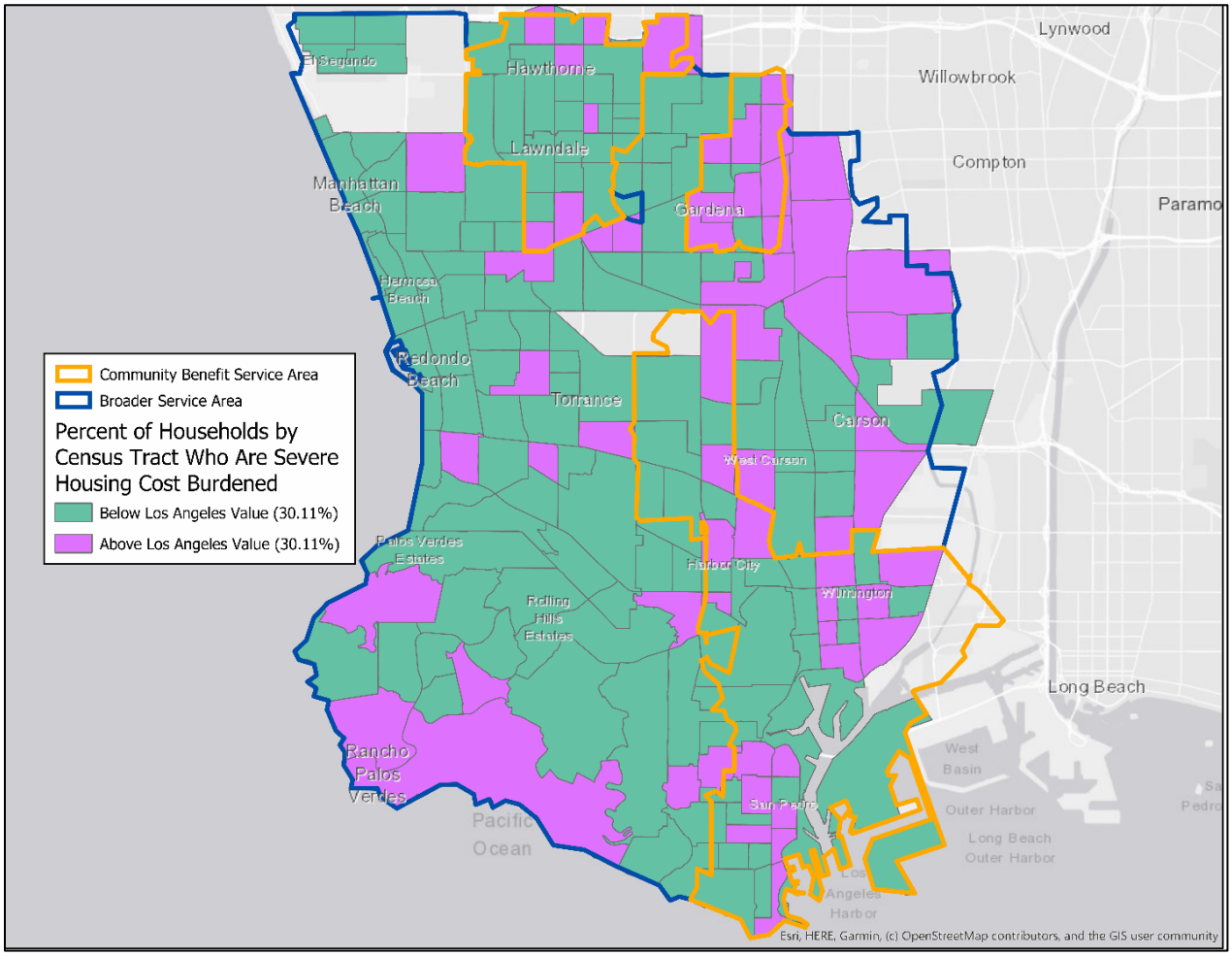
Figure_Apx 18. Renter Households Experiencing Housing-Cost Burden



When looking at the Community Benefit Service Area as a whole we see that 42,560 of renter households are housing cost burdened which equates to about 54% of the total households in the Community Benefit Service Area.

In looking at census tracts within the Community Benefit Service Area we are able to pinpoint communities with a high percentage of renters who are housing cost burdened. When comparing at the census tract level to Los Angeles County in terms of percent of renter households who are housing cost burdened we see that much of Wilmington, San Pedro, Gardena, Lawndale and Hawthorne have communities with values higher than the Los Angeles County value.

Figure_Apx 19. Renter Households Experiencing Severe Housing-Cost Burden



In the Community Benefit Service Area there are 21,633 renter households that are severe housing cost burdened which equates to about 29% of the total households in the Community Benefit Service Area. This value is slightly under what we see for Los Angeles County which is about 30%. The Broader Service Area has 22% of renter households severe housing cost burdened.

Communities in Wilmington, San Pedro, Gardena and Carson have higher rates of severe housing cost burdened as seen in the purple shaded census tracts in the figure above.
Overall, there are more census tracts in the Community Benefit Service Area with rates of renters households who are severe housing cost burdened higher than the Los Angeles County value than in the

Broader Service Area.

Food Insecurity

Primary Data

Listening Sessions with Community Members

One listening session was conducted at Vasek Polak Health Clinic and two sessions were conducted at the Providence Wellness and Activity Center in Wilmington. Participants shared the following information:

Participants' vision for a healthy community includes access to healthy, nutritious food

- Affordable and healthy food available locally
- Families know how to cook healthy meals
- Nearby farmers' markets

The community needs healthier eating and exercise habits

- Concerns about childhood obesity

Community Stakeholder Listening Session and Interviews

Barriers to accessing good-quality, nutritious food

- Fewer grocery stores in low-income communities
- Poorer quality fresh foods in low-income communities
- Healthy foods are more expensive than unhealthy food options
- Transportation to the grocery store
- Stress, busy schedules, and long work hours

"From what we were told over and over again, people really didn't want their names being put into the system and didn't really know or trust what was going to happen if they did." – Community stakeholder

Barriers to accessing and utilizing food assistance programs

- Fear related to immigration and public charge preventing people from enrolling in CalFresh
- Long, complex CalFresh applications
- Stigma around using public benefits
- Insufficient CalFresh benefits to cover a family's dietary needs for the month
- Insufficient food assistance for individuals receiving SSI

Groups having less access to good-quality, nutritious food

- People with low incomes
- People with incomes slightly above the threshold to qualify for assistance programs

- People with limited mobility
- People of color
- Undocumented immigrants

Health effects related to food insecurity

- Chronic diseases such as obesity, diabetes, and high blood pressure
- Poor physical and mental development for children
- Problems with concentration in school
- Poor decision making

Effective programs and initiatives for addressing food insecurity

- Food pantries and food banks that operate on a subsidized supermarket model
- Community education and outreach: wellness fairs, cooking classes, and market demonstrations
- Market Match helps food assistance dollars go further
- Screening for food insecurity in a medical setting and referring appropriately
- Los Angeles Food Policy Council's Healthy Neighborhood Market Neighborhood (supports small businesses in low-income neighborhoods to bring healthy food to their customers)
- Grassroots initiatives, such as Hunger Action LA

"There's a lot of kind of grassroots movements that I do think… [are] essential for any of this to ultimately matter. Because like I was saying, you can increase food access, but if you don't have an engaged community… then it just doesn't go anywhere." – Community stakeholder

Immigration and public charge

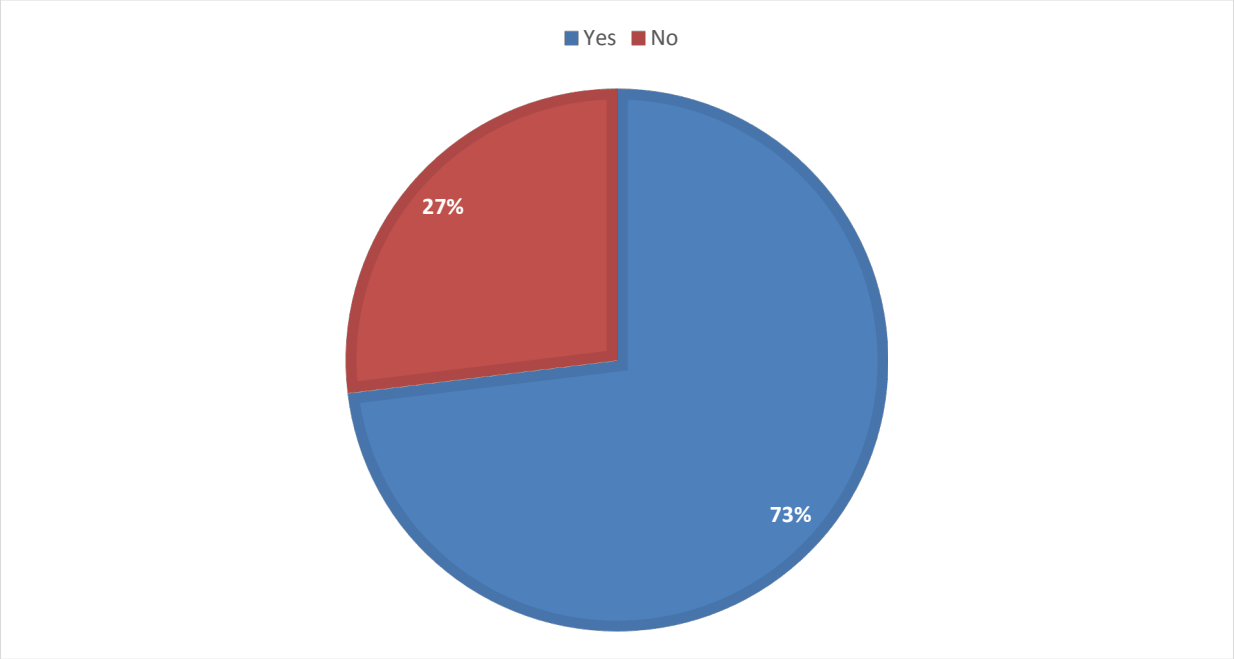
Participants shared that not only are they having a harder time enrolling clients in assistance programs, but individuals are choosing to withdraw from these programs. Heightened fear and mistrust of the current administration have made connecting with immigrant communities more challenging for service providers and left many of the participants unsure how to reassure their clients.

"I want to talk a little bit about this word 'enroll' in federal programs, et cetera. The people I know who are worried about immigration are not simply fearful. They are terrorized. I'm not trying to enroll people in anything. That's because I have no answers for them." – Community stakeholder

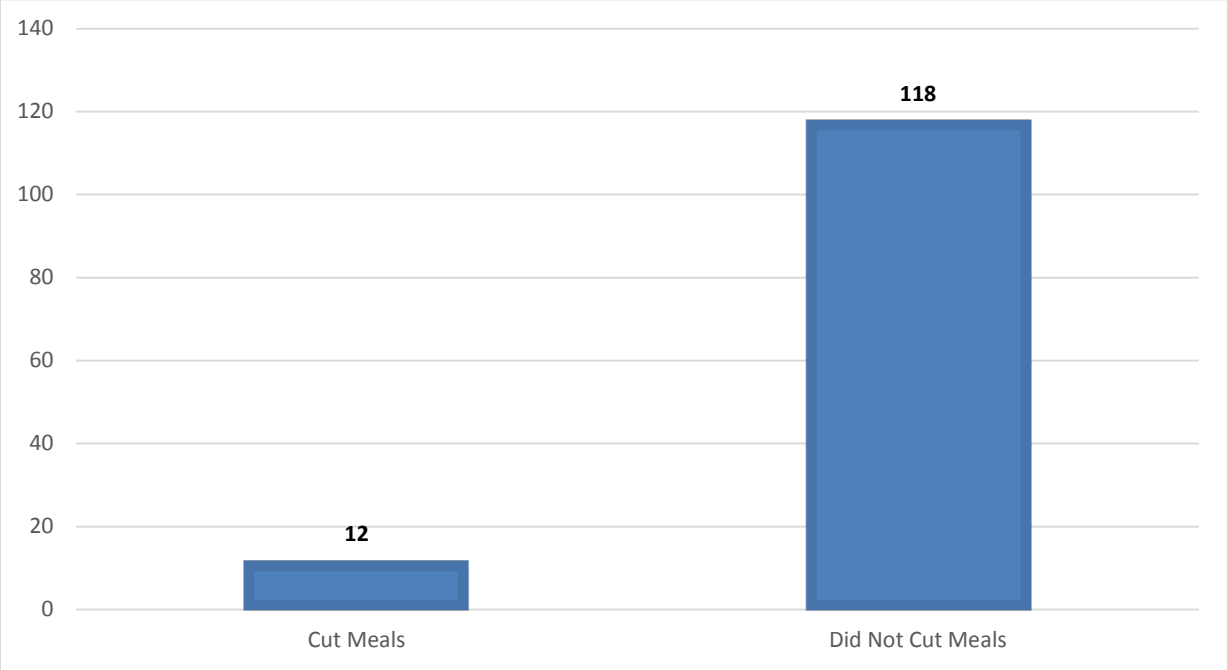
Abode Health Survey

Providence Little Company of Mary partnered with Abode Communities, a nonprofit affordable housing provider, to administer health surveys to all new residents moving into Camino del Mar & Vista del Mar affordable homes located in the vicinity of the Providence Little Company of Mary Wellness and Activity Center. The health survey covered a wide range of topics including insurance status, self-reported health, chronic conditions, food insecurity and access, physical activity and social cohesion. Between January 2019 and July 2019 a total of 133 responses were received and analyzed.

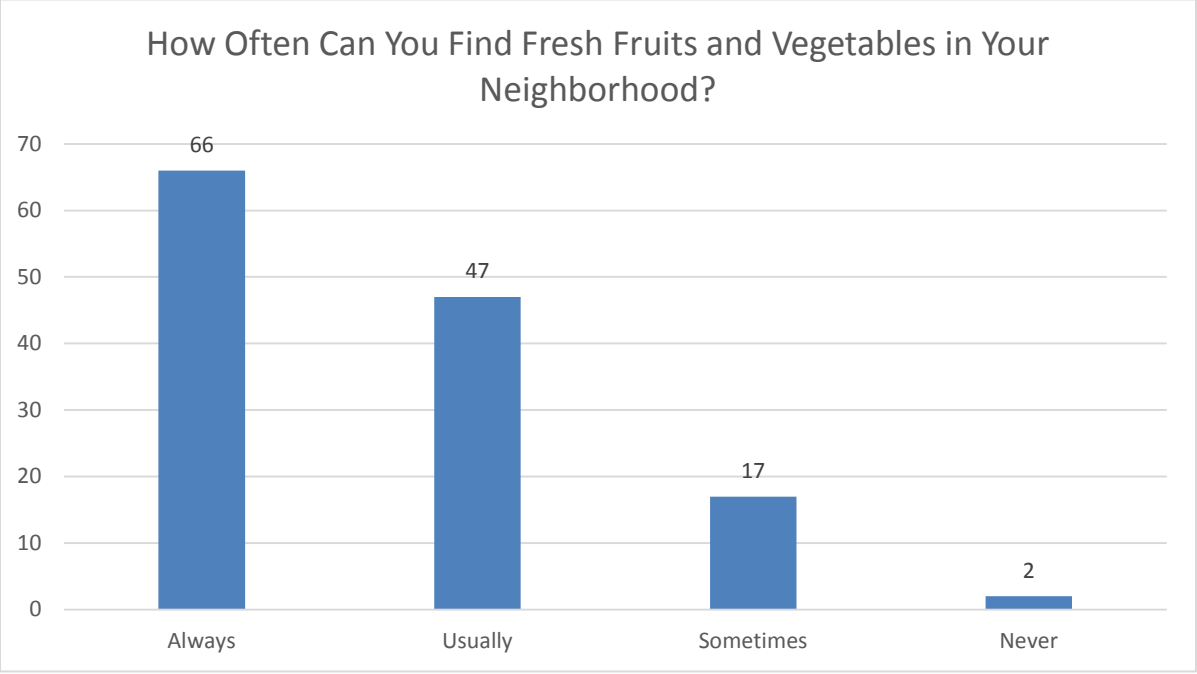
Figure_Apx 20. Proportion of Residents Currently Enrolled in CalFresh Benefits



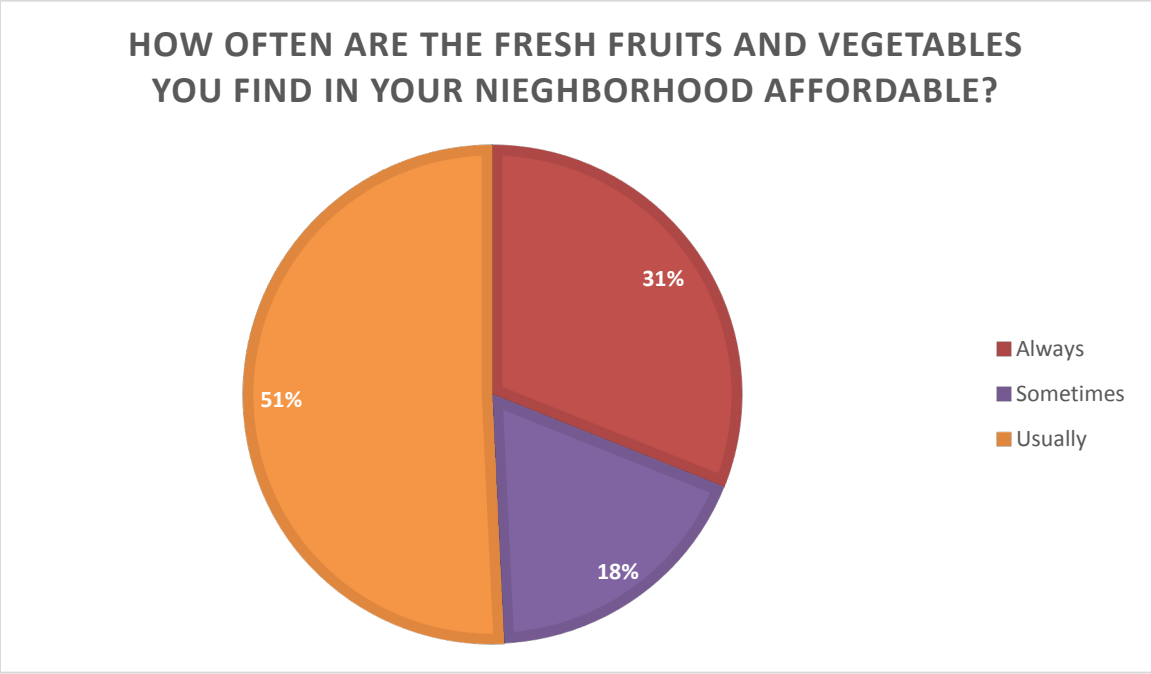
Figure_Apx 21.Number of Families Who Cut Size of Meal or Skipped Meal Due to Food or Financial Resources in Past 12 Months



Figure_Apx 22. Access to Fresh Fruits and Vegetables



Figure_Apx 23. Affordability of Fresh Fruits and Vegetables



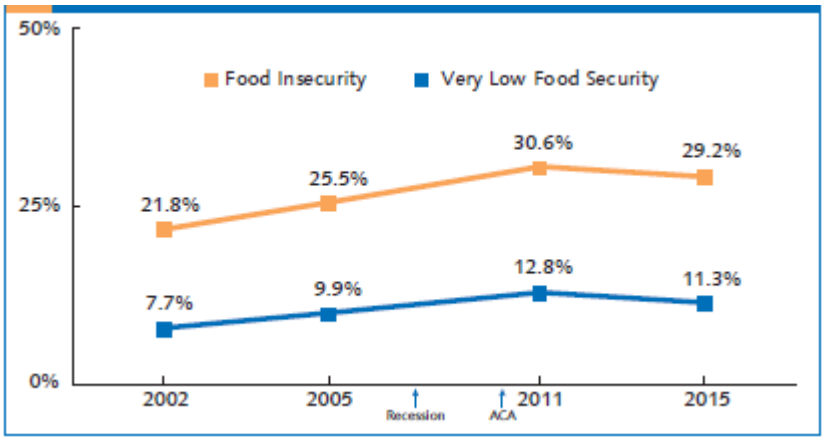
Secondary Data

LA Health: Food Insecurity in Los Angeles County

In September 2017, the County of Los Angeles Public Health department published an analysis on food insecurity in Los Angeles County. Using four cycles of the Los Angeles County Health Survey, from 2002 to 2015, households with incomes less than 300% of the federal poverty level (FPL) were trended and analyzed by demographics, healthcare access, chronic conditions and housing instability. The United States Department of Agriculture (USDA) considers a household to be food insecure if it experiences either:

1. *Low food security* – reports a reduction in the quality, variety, or desirability of diet with little to no indication of reduced food intake, or
2. *Very low food security* – reports of multiple indications of disrupted eating patterns and reduced food intake

Figure_Apx 24. Food Security Treands among Households <300% FPL, LACHS 2015



- Food Insecurity and very low food insecurity in Los Angeles County households with incomes less than 300% FPL have steadily increased between the years 2002 and 2011, followed by a leveling off between the years 2011 and 2015.

Figure_Apx 25. Percent of Households <300% FPL That Have Food Insecurity and Very Low Food Security, LACHS 2015

	Food Insecurity			Very Low Food Security		
	Percent	95% CI	Estimated #	Percent	95% CI	Estimated #
LA COUNTY HOUSEHOLDS	29.2%	27.1 - 31.3	561,000	11.3%	9.8 - 12.8	217,000
FEDERAL POVERTY LEVEL[5]						
0-99% FPL	41.1%	37.3 -44.9	307,000	17.5%	14.5 – 20.5	131,000
100%-199% FPL	25.4%	22.4 – 28.4	203,000	9.2%	7.1 - 11.3	73,000
200%-299% FPL	13.7%	10.2 - 17.2	51,000	3.6%	2.0 - 5.2	14,000
HOUSEHOLDS WITH CHILDREN						
Yes	27.7%	24.3 - 31.1	223,000	9.6%	7.2 - 11.9	77,000
No	30.4%	27.7 - 33.1	338,000	12.6%	10.6 - 14.6	141,000
SERVICE PLANNING AREA						
Antelope Valley	34.4%	27.5 - 41.3	27,000	16.3%	9.9 - 22.6	13,000
San Fernando	27.2%	22.7 - 31.6	96,000	10.5%	7.7 - 13.2	37,000
San Gabriel	21.8%	17.2 - 26.4	72,000	6.1%	3.4 - 8.8	20,000
Metro	32.0%	25.6 - 38.4	93,000	16.9%	11.4 - 22.4	49,000
West	30.5%	18.5 - 42.5	26,000	6.4%*	1.8 - 11.0	5,000
South	32.4%	27.3 - 37.6	71,000	12.9%	9.2 - 16.6	28,000
East	32.4%	26.2 - 38.6	79,000	12.4%	7.3 - 17.4	30,000
South Bay	30.3%	24.7 - 36.0	97,000	10.7%	6.9 - 14.4	34,000

- Los Angeles County households with incomes under 100% FPL had the highest proportion of households experiencing food insecurity and very low food security, followed by households with incomes between 100% and 200% FPL.

- Throughout the eight service planning areas in Los Angeles County, the South Bay Service Planning Area ranked 5th in proportion of households experiencing food insecurity and 4th in proportion of households experiencing very low food security.

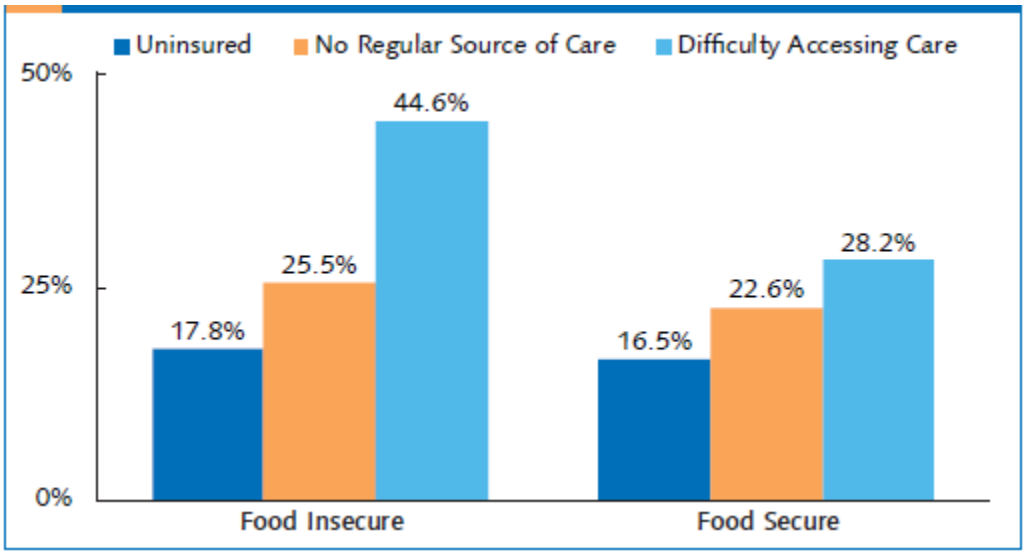
Figure_Apx 26. Demographic Characteristics of LA County Adults (ages 18+ years) with Household Incomes <300% FPL by Food Security Status, LACHS 2015

	Living in Food Insecure Household			Living in Food Secure Household		
	Percent	95% CI	Estimated #	Percent	95% CI	Estimated #
GENDER						
Male	42.1%	38.0 -46.1	499,000	46.4%	43.9 - 48.9	1,565,000
Female	57.9%	53.9 - 62.0	687,000	53.6%	51.1 - 56.1	1,810,000
AGE GROUP						
18-29	25.2%	21.3 - 29.2	299,000	29.9%	27.5 - 32.3	1,009,000
30-49	38.4%	34.5 - 42.4	456,000	35.9%	33.5 - 38.3	1,212,000
50-64	25.3%	22.1 - 28.5	300,000	19.4%	17.6 - 21.2	654,000
65 or over	11.0%	8.9 - 13.2	131,000	14.8%	13.5 - 16.2	500,000
RACE/ETHNICITY◊						
Latino	67.4%	63.8 - 71.0	799,000	54.4%	51.9 - 56.8	1,835,000
White	14.7%	12.1 - 17.2	174,000	17.9%	16.3 - 19.6	606,000
African American	10.9%	8.8 - 13.1	130,000	8.8%	7.7 - 10.0	299,000
Asian	6.6%	4.4 - 8.7	78,000	18.4%	16.3 - 20.6	621,000
Native Hawaiian and Other Pacific Islander	-	-	-	0.2%*	0.0 - 0.4	N/A
American Indian/ Alaskan Native	0.3%*	0.1 - 0.6	N/A	0.2%*	0.1 - 0.3	N/A
EDUCATION						
Less than high school	48.1%	44.0 - 52.2	569,000	30.2%	27.7 - 32.6	1,012,000
High school	23.6%	20.2 - 27.1	280,000	25.6%	23.5 - 27.8	860,000
Some college or trade school	20.4%	17.5 - 23.4	242,000	29.8%	27.6 - 32.1	1,000,000
College or post graduate degree	7.8%	6.1 - 9.5	92,000	14.4%	12.9 - 15.8	482,000
EMPLOYMENT STATUS						
Employed	40.5%	36.5 - 44.6	479,000	50.0%	47.5 - 52.5	1,679,000
Unemployed	17.7%	14.6 - 20.8	209,000	12.3%	10.7 - 13.9	412,000
Not in the labor force+	41.8%	37.8 - 45.8	494,000	37.7%	35.3 - 40.0	1,264,000

- Latinos make up over two-thirds (67.4%) of food insecure households in Los Angeles County.
- Age group “30 – 49” make up the largest proportion of food insecure households in Los Angeles County, closely followed by age groups “18 – 29” and “50 -64”.

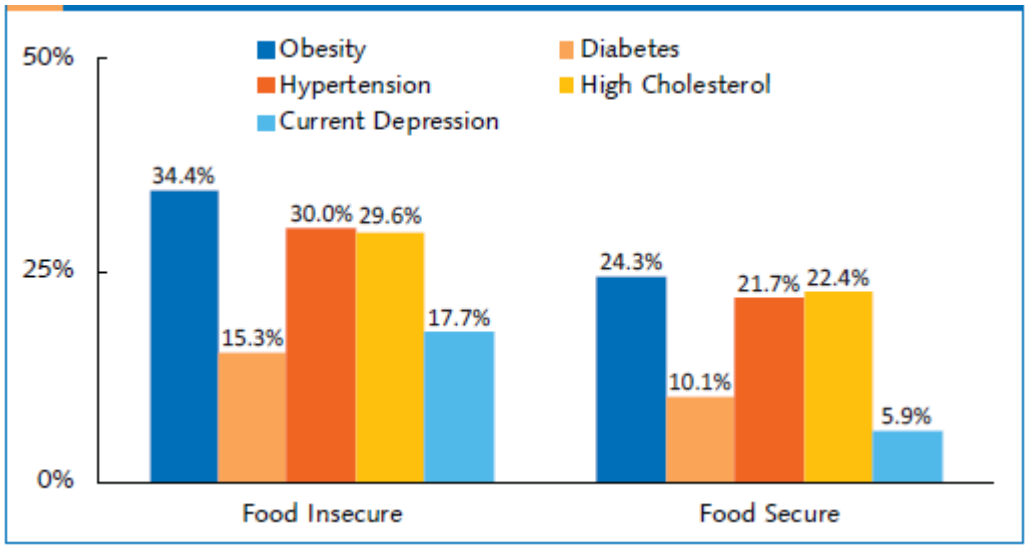
- Almost half of all adults living in food insecure households (48.1%) reported their education level to be less than high school.

Figure_Apx 27. Insurance and Access to Care for Adults in Households <300% FPL by Food Security Status, LACHS 2015



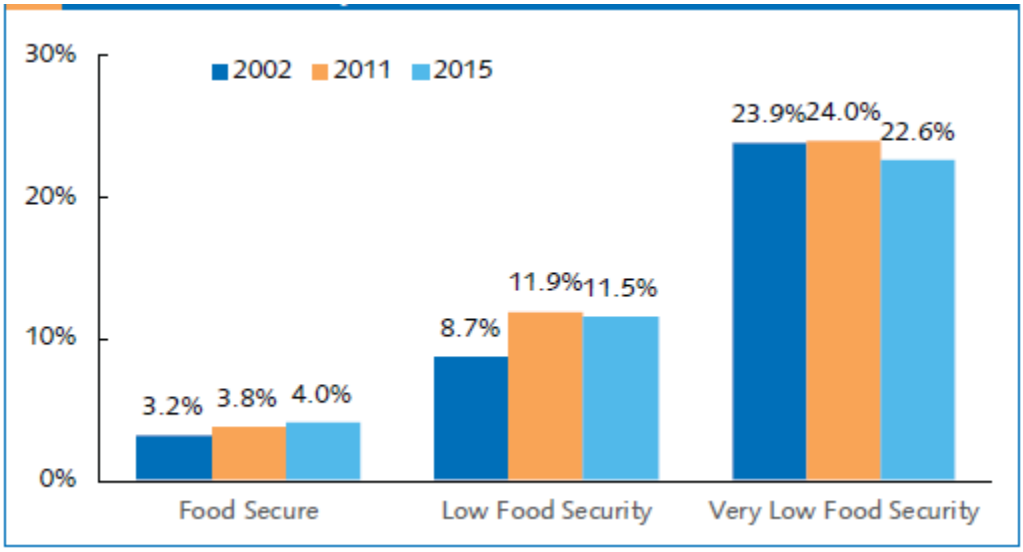
- When comparing adults in food insecure and food secure households with incomes below 300% FPL, we see that those in food insecure households have higher uninsured rates, reported higher rates of not having a regular source of care and a higher of proportion of food insecure households had difficulty accessing care.

Figure_Apx 28. Percent of Adults with Chronic Conditions in Households <300% FPL by Food Security Status, LACHS 2015



- The proportion of adults with chronic conditions was higher for those living in food insecure households compared to those living in food secure households.

Figure_Apx 29. Percent of Adults with Housing Instability in the Past 5 Years Households <300% FPL by Food Security Status, LACHS 2002-2015



- Housing instability was consistently highest among Los Angeles County households with very low food insecurity through every cycle of the Los Angeles County Health Survey.

Los Angeles County Department of Public Health Key Indicators

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

Table_Apx 11. Food Insecurity and Nutrition Related Indicators Prepared by the Los Angeles County Department of Public Health

Indicator	Community Benefit Service Area	Broader Service Area	Los Angeles County
Percent of households with incomes <300% Federal Poverty Level who are food insecure	32.1%	*17.0%	29.2%
Percent of children with excellent or good access to fresh fruits and vegetables in their community	75.6%	88.5%	75.0%
Percent of adults who consume five or more servings of fruits & vegetables a day	11.5%	18.8%	14.7%
Percent of children who drink at least one soda or sweetened drink a day	40.8%	34.8%	39.2%

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

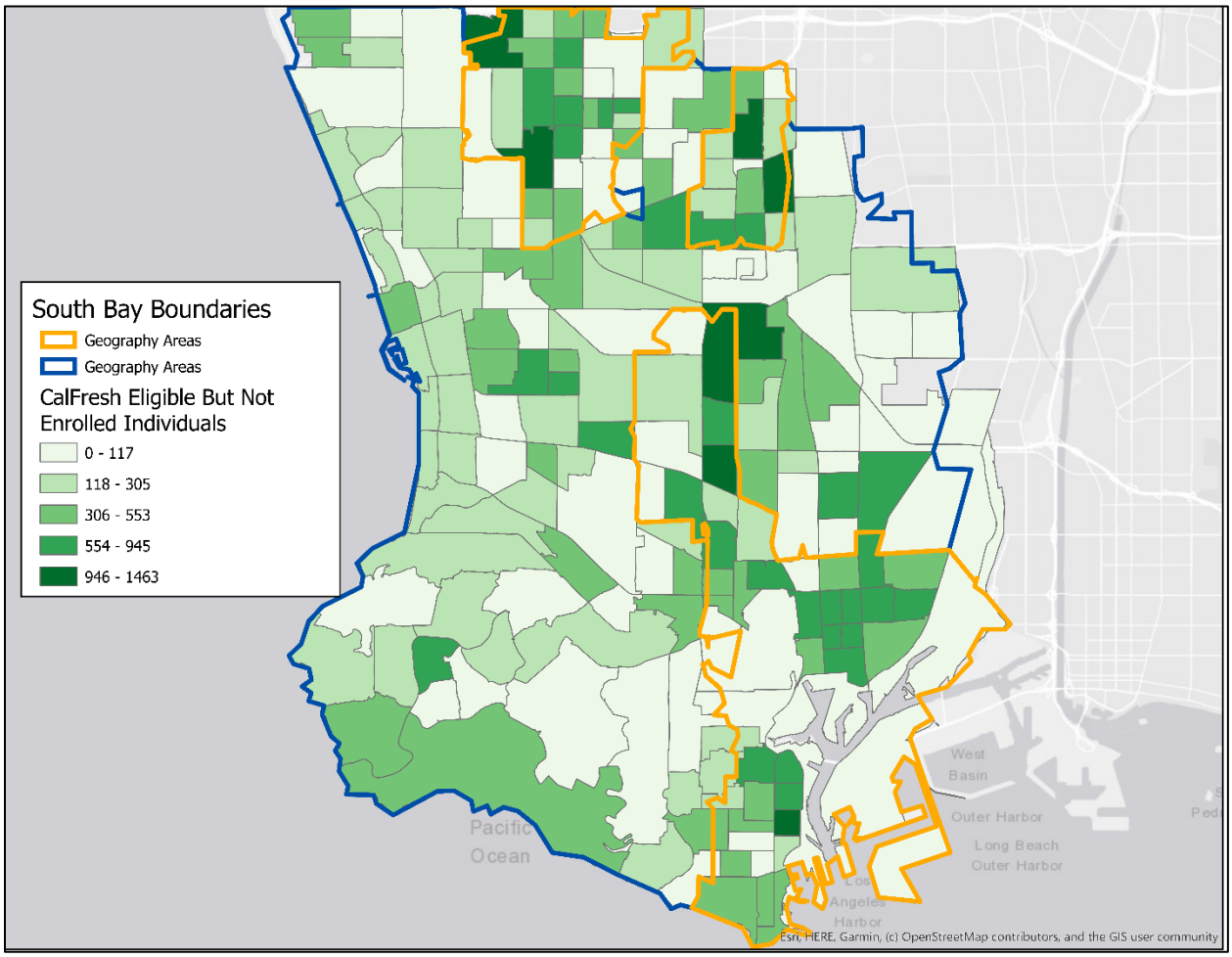
- The Community Benefit Service Area has a higher percentage of households who are both below 300% the Federal Poverty Level and are food insecure than the Broader Service Area. Additionally, both children and adults in the Community Benefit Service Area report worse access to fresh fruits and vegetables in their communities and poorer nutrition habits

CalFresh/Food Stamp Enrollment

Table_Apx 12. CalFresh Enrollment Indicator

Variable	Community Benefit Area	Broader Service Area	Los Angeles County
2013-2017 ACS Households Receiving Food Stamps/CalFresh	13,569 (11.39%)	6,370 (3.4%)	294,372 (8.93%)

Figure_Apx 30. CalFresh Eligible Individuals Not Receiving CalFresh Benefits



- In 2018, there were 24,697 CalFresh-eligible individuals who were not receiving benefits in the Broader Service Area. The Community Benefit Service Area had 38,707 CalFresh-eligible individuals who were not receiving benefits bringing the total of unenrolled but CalFresh-eligible individuals to 63,404 in the Providence Little Company of Mary service area.
- Of the 86 census tracts in the Community Benefit service area, the top ten census tracts in the Community Benefit Service Area by Eligible CalFresh Individuals makes up more than 25% of the total eligible individuals in the Community Benefit Service Area.

Homelessness and Housing Instability

Primary Data

Listening Sessions with Community Members

One listening session was conducted at Vasek Polak Health Clinic and two sessions were conducted at the Providence Wellness and Activity Center in Wilmington. Participants shared the following information:

Participants' vision for a healthy community includes affordable housing for all people

The community needs improved support services to address homelessness

- Increased shelters for people experiencing homelessness
- Increased services to address behavioral health needs of people experiencing homelessness

Community Stakeholder Listening Sessions and Interviews

Factors contributing to housing instability and homelessness

- Lack of affordable housing options
- Economic insecurity, including a lack of jobs that pay a living wage
- Mental health and substance use
- Lack of educational opportunities
- Domestic violence

> *"I think it goes back to income and lack of affordable housing. For the populations that I work with, most of them don't have an income or credit to be able to afford [housing] and then what they can afford it's really not necessarily the best housing situation for them." – Community stakeholder*

Barriers to addressing homelessness

- An unsustainable and fragmented approach to addressing homelessness: lack of a scalable model in place, with the current system of developing housing being too time intensive and costly to keep up with demand and be sustainable.
- Lack of emergency shelter beds

- Fear and mistrust preventing people experiencing homelessness from engaging with services
- "NIMBYism" (Not in My Backyard)

"I think people are willing to vote for the money to solve the problem with things like Measure H and {Proposition] HHH and Prop One and Two on California's ballot. But when it comes to trying to actually locate a shelter or permanent location for housing they don't want it in their own neighborhood because there's a lot of fear. Property costs. Crime, all those things." – Community stakeholder

- Lack of funding and flexibility in use of funds for affordable housing and services
- Lack of supportive services for people newly transitioned to housing

Groups disproportionately affected by homelessness

- Transitional age youth (named by all groups)
- Older adults (named by all groups)
- People with physical or developmental disabilities
- People who identify as LGBTQ
- Women
- People of color

Health effects of living unsheltered

- Diseases such as HIV and hepatitis
- Exacerbated mental illness, such as anxiety and depression
- Unmanaged chronic conditions
- Untreated dental problems

Effective strategies or actions for addressing homelessness

- Street-based outreach teams: Specifically, effective is engaging nurses and behavioral health professionals on the teams.
- Hospital navigators and increased communication between services providers: Having an onsite hospital navigator who can connect patients with community-based resources is an important step in ensuring patients experiencing homelessness are connected to the care and services they need.
- Homelessness prevention and diversion: Efforts to keep people housed and give them the tools to be self-sufficient.
- Community education to address NIMBYism and common misperceptions about homelessness
- Housing First with supportive services
- Implementing shared housing, such as two-bedroom apartments
- Building smaller sites to limit neighborhood impact

Community needs for addressing homelessness

- Collaboration and sharing between organizations, particularly related to post-discharge planning and warm handoffs from hospitals to social service organizations
- Leadership from stakeholders involved

- Advocacy from health care organizations that can leverage their authority and power to address homelessness
- Prevention efforts, such as investing in workforce development, job skill building, education and vocational opportunities
- Harm reduction strategies, such as needle exchanges
- Flexible funding to allow organizations to decide how best to spend money to meet clients' needs
- Recuperative care or transitional care for patients experiencing homelessness onsite at hospitals

Secondary Data

Greater Los Angeles Homeless Count

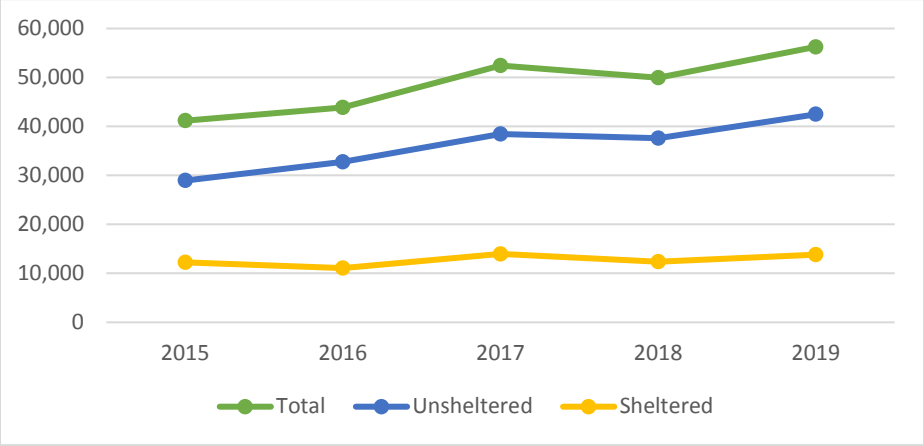
The Los Angeles Homeless Services Authority (LAHSA) conducts a yearly point-in-time count called the Greater Los Angeles Homeless Count. Moderated by the U.S. Department of Housing and Urban Development, LAHSA conducts the nation's largest homeless census count with the help of volunteers over the course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

The table below displays the results of the 2019 Greater Los Angeles Homeless Count with a focused look at the results of Service Planning Area 8, the Community Benefit Service Area and Broader Service Area.

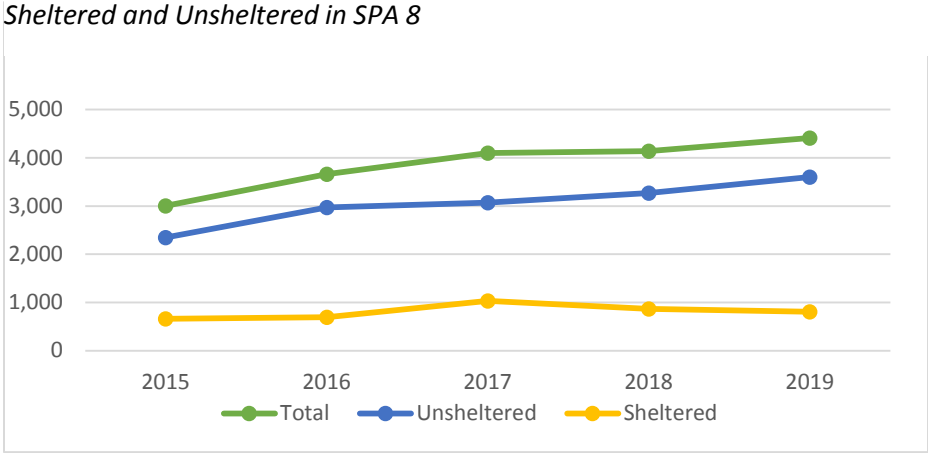
Table_Apx 13. 2019 Point-In-Time Homeless Count

Geographic Area	Sheltered	Unsheltered	Total	Percent Change 2018 - 2019
Los Angeles County	14,722	44,214	58,936	+12%
SPA 8	1,429	4,874	6,303	+5%
Broader Service Area	25	1,730	1,755	-3%
Community Benefit Service Area	198	1,859	2,057	+26%

Figure_Apx 31. Total Number of People Experiencing Homelessness, Living Sheltered and Unsheltered in LA County



Figure_Apx 32. Total Number of People Experiencing Homelessness, Living Sheltered and Unsheltered in SPA 8



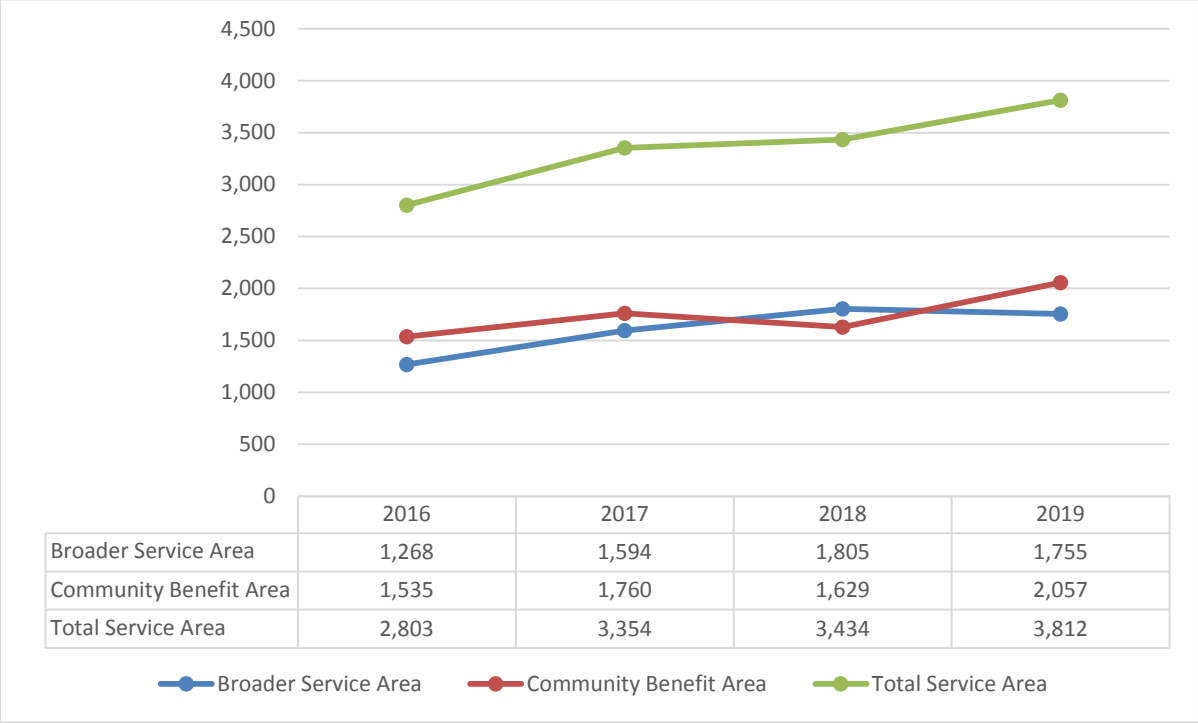
- SPA 8 had a change of 5% in total homeless population between 2018 and 2019. This was the fifth largest change of all Service Planning Areas in Los Angeles County.

- Of all 6,303 persons experiencing homelessness in SPA 8, 87% of those are individuals, 13% are family members and 0.1% are unaccompanied minors.

- Like Los Angeles County, the unsheltered homeless population for SPA 8 had an increasing trend between the years 2015 and 2019.

- SPA 8 has seen a decrease in the sheltered homeless population between the years 2017 and 2019.

Figure_Apx 33. LAHSA Homeless Count Results by Year and PLCM Service Area



	2016	2017	2018	2019
Broader Service Area	1,268	1,594	1,805	1,755
Community Benefit Area	1,535	1,760	1,629	2,057
Total Service Area	2,803	3,354	3,434	3,812

- Both the Broader Service Area and Community Benefit Service Area have been trending upwards in total homeless counts since the year 2016.

- The Broader Service Area saw a decrease in total homeless counts by 3% between the years 2018 and 2019 while the Community Benefit Service saw an increase of 26% in that same time. This has increase has been the largest yearly increase since 2016.

Table_Apx 14. LAHSA Homeless Count by City/Neighborhood

City/Neighborhood	2019 City Total	2018 City Total	% Difference
Carson	326	462	-29%
Harbor City	153	104	47%
Harbor Gateway	280	167	68%
San Pedro	615	497	24%
Wilmington	675	538	25%
Gardena	76	47	62%
Hawthorne	108	138	-22%
Hermosa Beach	25	23	9%
Inglewood	461	505	-9%
Lawndale	33	31	6%
Lomita	26	14	86%
Manhattan Beach	21	41	-49%
Palos Verdes Estates	0	0	0%
Rancho Palos Verdes	2	4	-50%
Redondo Beach	174	154	13%
Rolling Hills	0	0	0%
Rolling Hills Estates	0	0	0%
Torrance	226	188	20%
West Carson	96	200	-52%

- Carson, Hawthorne, Manhattan Beach and Palos Verdes were the only cities to see a decrease in the total count of persons experiencing homelessness between the years 2018 and 2019.
- The cities of Wilmington and San Pedro have a combined 1,290 individuals experiencing homelessness. This accounts for 33% of all persons in the Providence Little Company of Mary Service Area who are experiencing homelessness.
- There are 255 more people experiencing homelessness in Wilmington and San Pedro since the year 2018.
- Lomita, Harbor Gateway and Gardena all saw more than a 50% increase in persons experiencing homelessness between the years 2018 and 2019.

Table_Apx 15. 2019 Point-In-Time Homeless Count in SPA 8 by Race and Ethnicity

Race/Ethnicity	Sheltered	Unsheltered	Total	Prevalence of Homeless Pop.	Percent Change 2018-2019
American Indian/ Alaska Native	3	94	97	2%	+3,133%
Asian	2	44	46	1%	-19%
Black/African American	433	930	1,363	31%	-4%
Hispanic/ Latino	246	1,430	1,676	38%	+30%
Native Hawaiian/ Other Pacific Islander	3	51	54	1.2%	+59%
White	114	996	1,110	25%	-15%
Multi-Racial/Other	9	54	63	1%	+271%

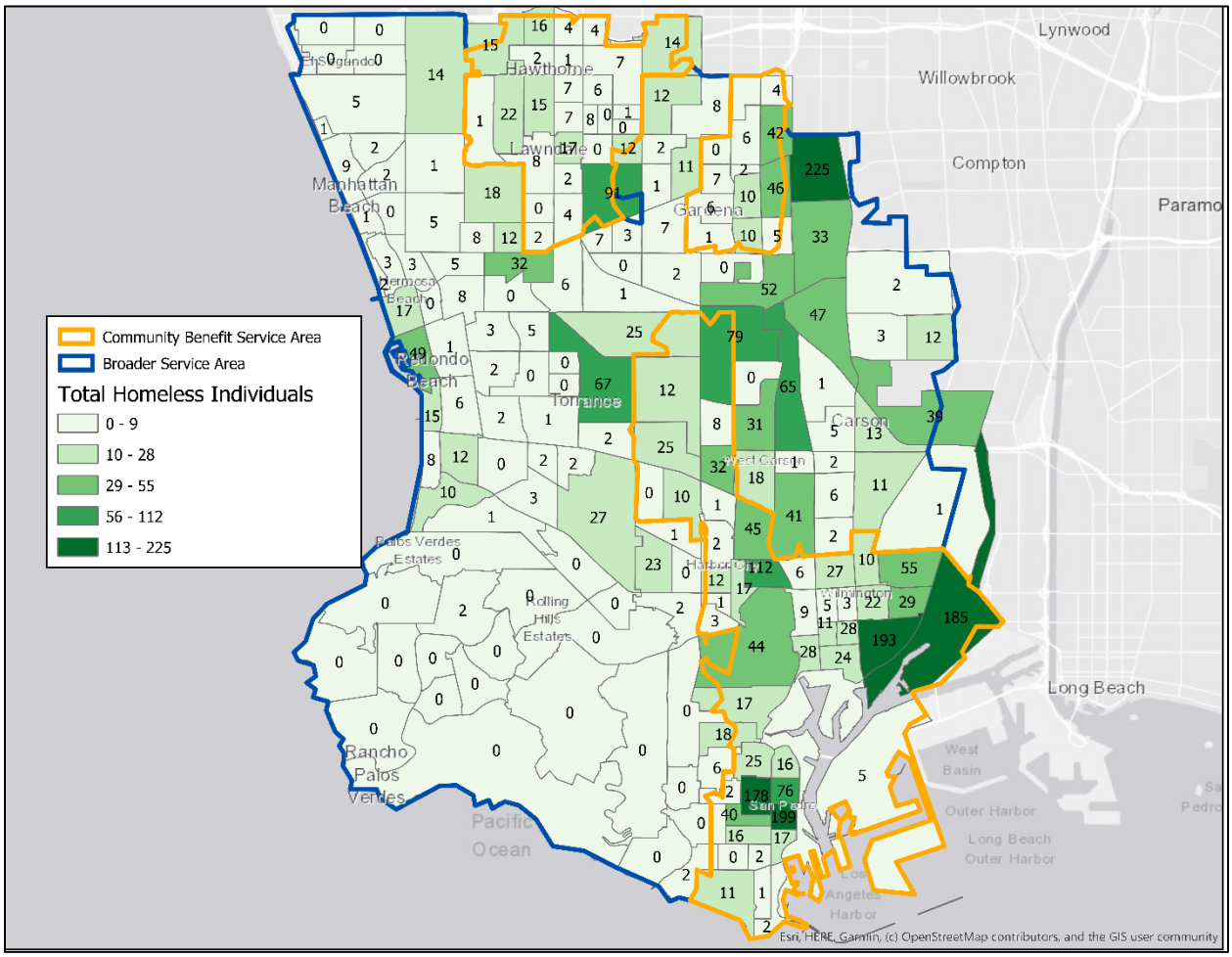
- 73% of all persons experiencing homelessness are men and when looking at race and ethnicity, the largest groups are Hispanic, Black/African American and White 38%, 31% and 25% respectively.

Table_Apx 16. 2019 Point-In-Time Homeless Count in SPA 8 by Age

Age Group	Sheltered	Unsheltered	Total	Prevalence of Homeless Population	Total Percent Change 2018 - 2019
Under 18	283	70	353	8%	-12%
18 - 24	56	73	129	3%	-1%
25 - 54	300	2,355	2,655	60%	+6%
55 - 61	107	625	732	17%	+10%
62 and Over	64	476	540	12%	+24%

- The largest age group for those experiencing homelessness are ages 25 – 55, making up 60% of all persons experiencing homelessness

Figure_Apx 34. 2019 Homeless Count by Census Tract for South Bay



- The largest concentrations of individuals experiencing homelessness by census tract are found in the cities of Wilmington, Carson and San Pedro.

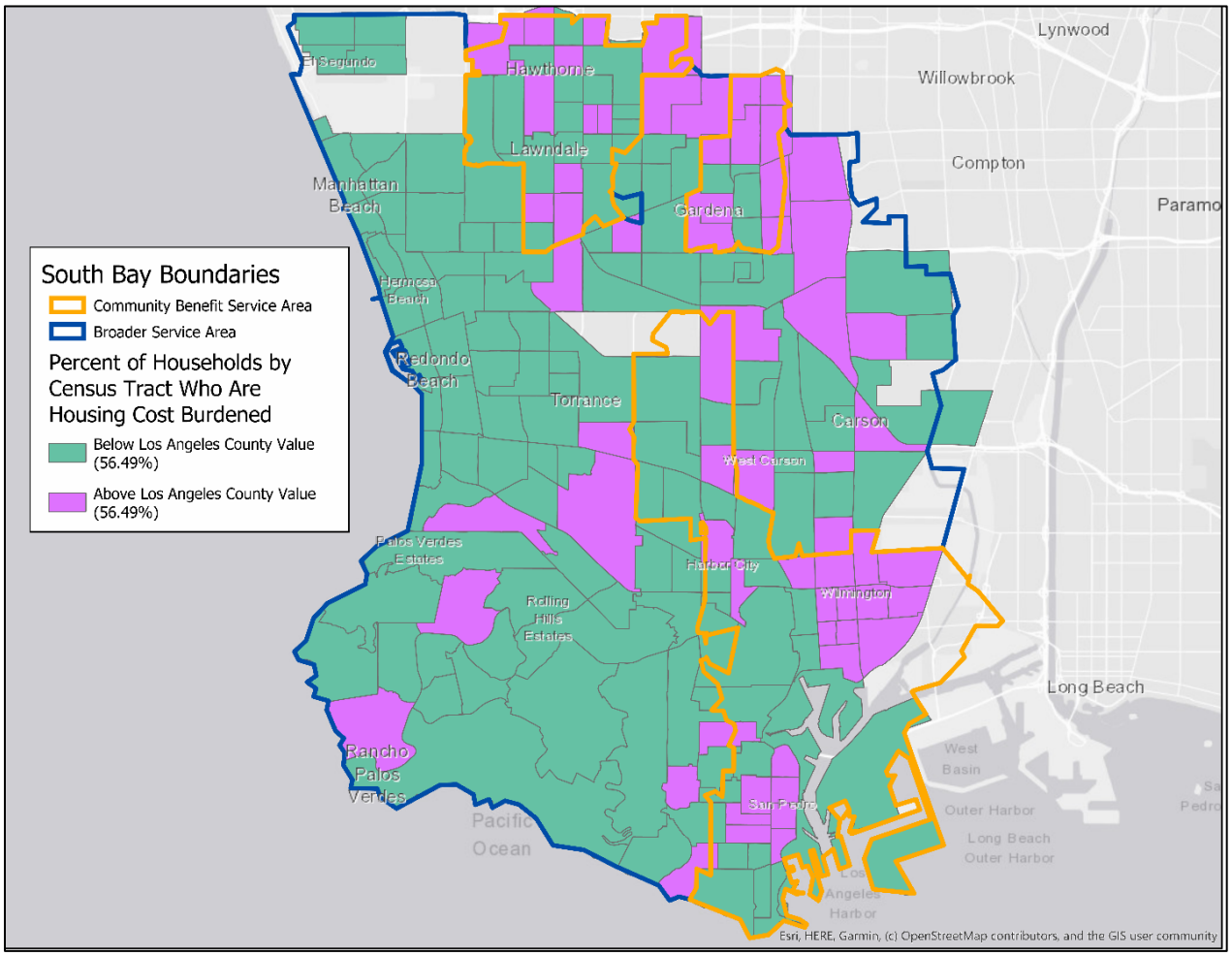
Housing-Cost Burden

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

Table_Apx 17. Housing-Cost Burden Indicators

Variable	Community Benefit Service Area	Broader Service Area	Los Angeles County
2013-2017 ACS Households: Renter Households That Are Housing-Cost Burdened (%)	42,560 (53.53%)	32,937 (46.05%)	1,006,798 (56.49%)
2013-2017 ACS Households: Renter Households That Are Severely Housing-Cost Burdened (%)	21,633 (28.73%)	15,814 (22.11%)	536,832 (30.11%)

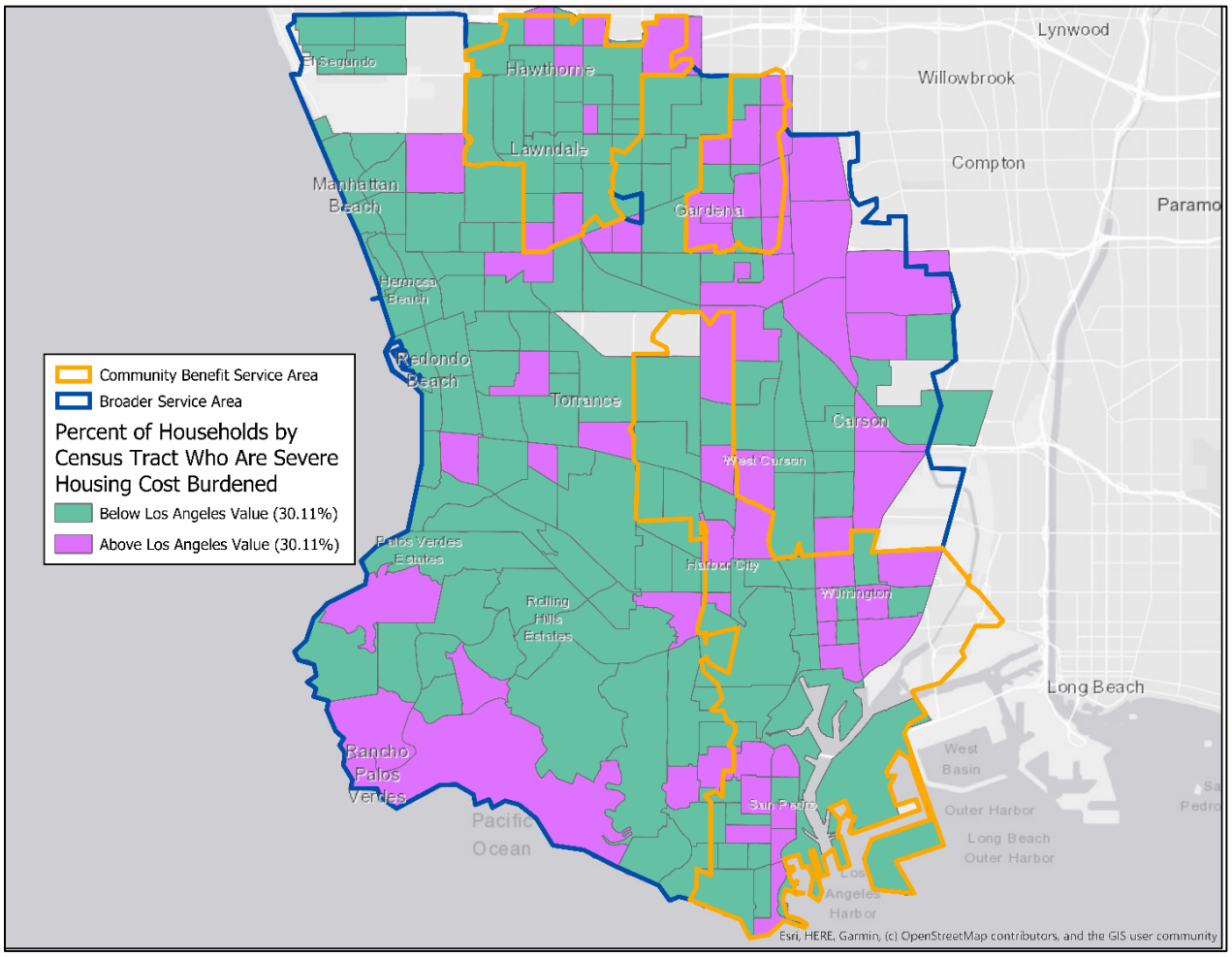
Figure_Apx 35. Renter Households Experiencing Housing-Cost Burden



When looking at the Community Benefit Service Area as a whole we see that 42,560 of renter households are housing cost burdened which equates to about 54% of the total households in the Community Benefit Service Area.

In looking at census tracts within the Community Benefit Service Area we are able to pinpoint communities with a high percentage of renters who are housing cost burdened. When comparing at the census tract level to Los Angeles County in terms of percent of renter households who are housing cost burdened we see that much of Wilmington, San Pedro, Gardena, Lawndale and Hawthorne have communities with values higher than the Los Angeles County value.

Figure_Apx 36. Renter Households Experiencing Severe Housing-Cost Burden



In the Community Benefit Service Area there are 21,633 renter households that are severe housing cost burdened which equates to about 29% of the total households in the Community Benefit Service Area. This value is slightly under what we see for Los Angeles County which is about 30%. The Broader Service Area has 22% of renter households severe housing cost burdened.

Communities in Wilmington, San Pedro, Gardena and Carson have higher rates of severe housing cost burdened as seen in the purple shaded census tracts in the figure above.
Overall, there are more census tracts in the Community Benefit Service Area with rates of renters households who are severe housing cost burdened higher than the Los Angeles County value than in the Broader Service Area.

Oral Health Care

Primary Data

Community Stakeholder Listening Session and Interviews

People experiencing homelessness are affected by untreated dental problems

Oral health is related to overall physical health. Stakeholders discussed how dental infections can lead to cardiac complications and make treating other health problems more challenging. They shared people experiencing homelessness may not have access to preventive care, leading to poorer oral health and ultimately their general wellbeing.

Secondary Data

Los Angeles County Key Indicators

Table_Apx 18. Oral Health Indicators

Indicator	Community Benefit Service Area	Broader Service Area	Los Angeles County
Percent of adults who did not see a dentist or go to a dental clinic in the past year	44.5%	27.4%	40.7%
Percent of children ages 3-17 years who did not obtain dental care (including check-ups) in the past year because they could not afford it	19.6%	*7.7%	11.5%

- Almost 1 out of every 5 children in the Community Benefit Service Area went without dental care in the past year because they could not afford it while almost 50% of adults did not see a dentist or go to a dental clinic in the past year.
- The percent of adults who did not see a dentist or go to a dental clinic in the past year was above that of Los Angeles County and almost double what is seen in the Broader Service Area.

California Health Interview Survey

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

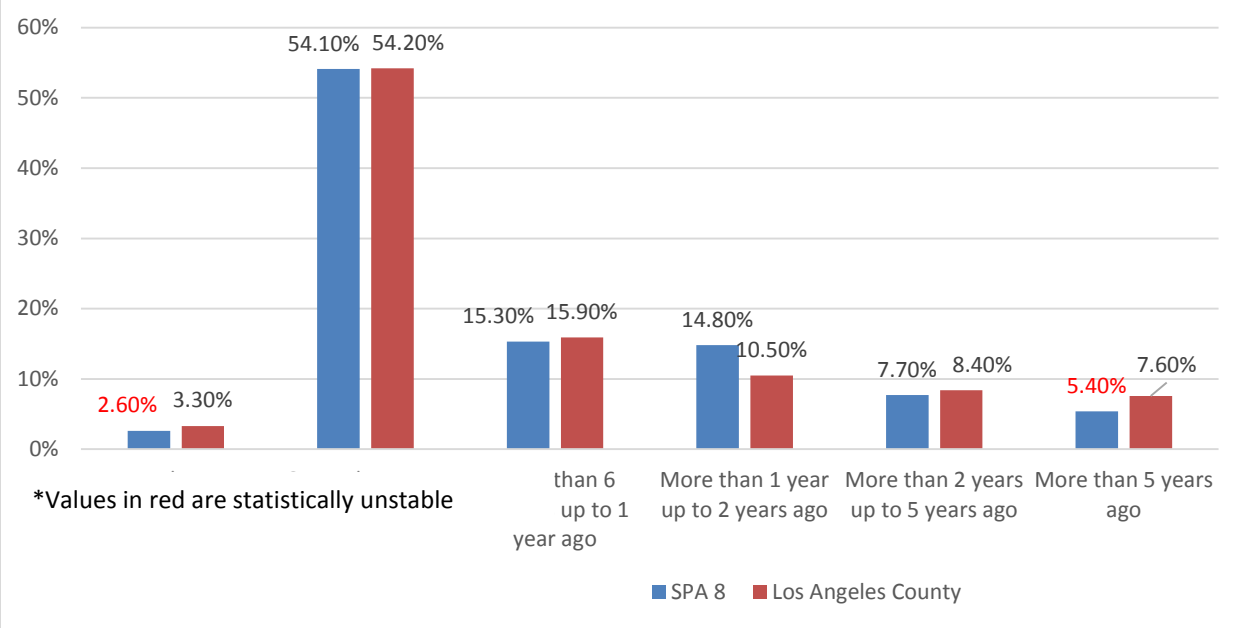
Table_Apx 19. Dental Insurance Indicators

Indicator	SPA 8	Los Angeles County
Adults who have insurance that pays for part or all of dental care(CHIS, 2017)	65.5%	61.1%
Children who have insurance that pays for part or all of dental care (CHIS, 2017)	79.7%*	86.1%

* Statistically unstable

- In SPA 8 over 30% of adults do not have insurance that pays for part or all of dental care.

Figure_Apx 37. Time Since Last Dental Visit (Adults, 2017)



- In 2017, about 30% of adults in SPA 8 did not have a dental visit within the past year

Table_Apx 20. Dental Insurance Payor

Who pays for dental insurance (CHIS, 2017)	%
Self or Family	30.3*
Respondents's/spouse's current or former employer or union	38.6%
Covered CA or someone else	-
Governmental programs	31.1*

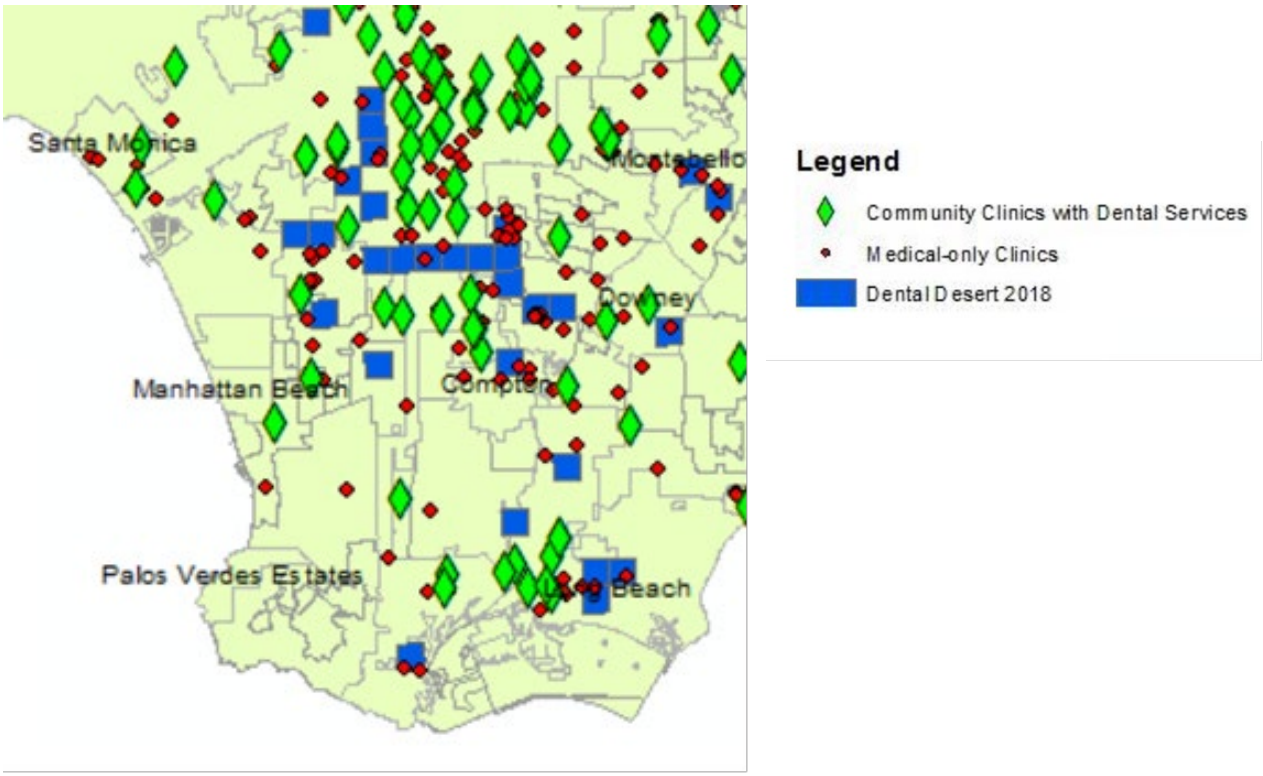
* = statistically unstable

- In 2017 respondents who have some type of dental insurance were asked who pays for their child's dental care. Almost 40% of respondents indicated that all of their dental care was paid by an employer or union leaving 60% of residents in SPA 8 to cover the remaining cost of dental care.

Dental Desert

The Los Angeles County Department of Public Health defines a dental desert as areas with a high population density, low-income and insufficient or no dental services. The definition used to define high population density is more than 10,000 people per square mile and for low-income its income below 138% of the Federal Poverty Level. For the analysis conducted by the Los Angeles County Department of Public Health the ratio of patients to dentists for defining insufficient dental services was 1 provider for every 4,000 patients. Below are the results of a mapping project conducted in 2018 by the Oral Health Program of the Los Angeles County Department of Public Health.

Figure_Apx 38. Dental Deserts in Los Angeles County



- Within the Providence Little Company of Mary service area there are three identified dental deserts as of the 2018 Oral Health Program analysis. Dental deserts exist in San Pedro, Hawthorne and Gardena which are all located in the Community Benefit Service Area.

Services for Seniors

Primary Data

Listening Sessions with Community Members

Community members want more resources for older adults at the Wellness and Activity Center

PaCrticipants shared they would like to see more classes designed for older adults, such as exercise and wellbeing classes.

Community Stakeholder Listening Sessions and Interviews

Older adults need housing support services

Older adults may experience financial insecurity, cognitive impairment, and social isolation which can all contribute to housing instability and homelessness.

Older adults need support accessing health care services

- High cost of care: Stakeholders shared even individuals with insurance struggle to afford the co-pays and bills associated with health care. Additionally, the high cost of medications makes managing chronic diseases or other conditions more challenging. The high cost of health care services and medications may disproportionately affect people with low incomes or individuals with incomes just above the poverty threshold, who may have insurance, but still not be able to afford the care they need. Older adults may also be disproportionately affected by challenges paying for care and medications.
- Transportation barriers: Getting to appointments is not always easy for people, particularly without a car. Older adults may be disproportionately affected by transportation barriers.

Secondary Data

Senior Population in Providence Little Company of Mary Service Area

Table_Apx 21. Senior Population in Providence Little Company of Mary Service Area, Projected for 2024

	Community Benefit Service Area	Broader Service Area
Population Age 55+ for Year 2019	84,097	173,363
Population Age 55+ for Year 2024	91,641	184,164
5 Year Increase for Population Age 55+ (%)	8.9%	6.2%
Population Age 65+ for Year 2019	43,419	97,061
Population Age 65+ for Year 2024	50,259	109,421
5 Year Increase for Population Age 65+ (%)	15.8%	12.7%

- The population for ages 55+ accounts for 22.6% of the total population in the Community Benefit Service Area and 33.1% of the total population in the Broader Service Area
- Over the next 5 years the age 55+ population is expected to grow by 8.9% in the Community Benefit Service Area and 6.2% in the Broader Service Area.
- The population for ages 65+ accounts for 11.7% of the total population in the Community Benefit Service Area and 18.6% of the total population in the Broader Service Area
- Over the next 5 years the age 65+ population is expected to grow by 15.8% in the Community Benefit Service Area and 12.7% in the Broader Service Area.

Los Angeles County Key Indicators

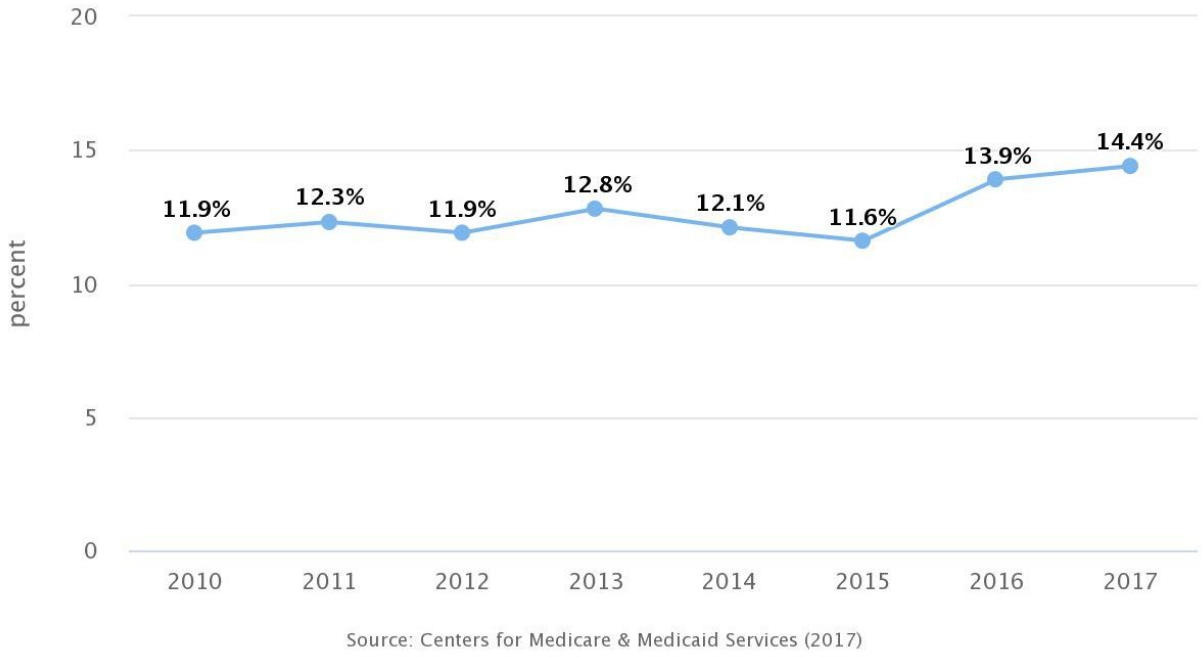
Table_Apx 22. LA County Key Indicators Related to Aging

Indicator	Community Benefit Service Area	Broader Service Area	Los Angeles County
Percent of adults ages 65+ years who have fallen in the past year	36.8%	23.1%	27.1%
Alzheimer's disease-specific death rate (per 100,000 population)	27.0	30.2	38.7

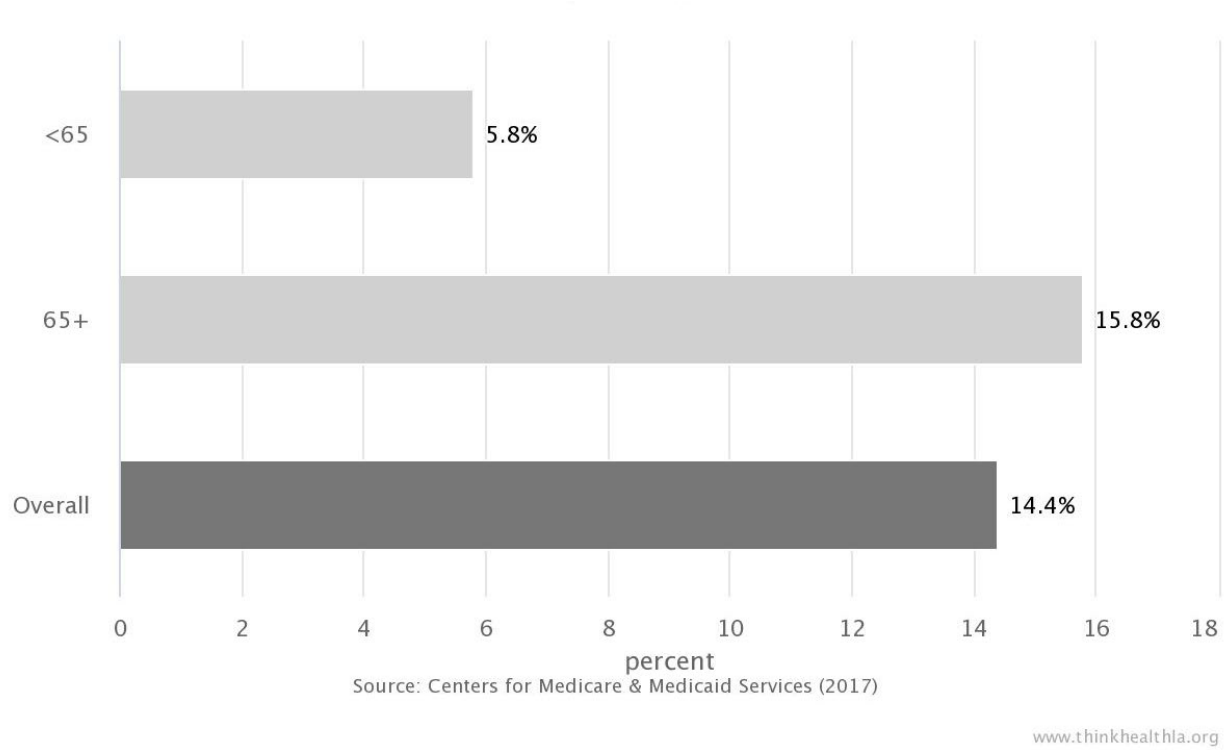
Alzheimer's and dementia

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

Figure_Apx 39. Alzheimer's Disease or Dementia in Medicare Population in LA County



Figure_Apx 40. Alzheimer's Disease and Dementia in Medicare Population by Age in LA County



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

Senior Homeless Population

Table_Apx 23. 2019 Point-In-Time Homeless County in SPA 8 by Age

Age Group	Sheltered	Unsheltered	Total	Prevalence of Homeless Population	Total Percent Change 2018 - 2019
55 - 61	107	625	732	17%	+10%
62 and Over	64	476	540	12%	+24%

- Individuals ages 55 and older made up 29% of all people experiencing homelessness during the 2019 LAHSA point-in-time count. Both age groups 55 – 61 and 62 and over have seen increases in total individuals experiencing homelessness between the years 2018 and 2019.

Changes to CalFresh Eligibility Requirements

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

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

Social Cohesion

Relationships are important for physical health and psychosocial well-being. Social cohesion refers to the strength of relationships and the sense of solidarity among members of a community.

Primary Data

Listening Sessions with Community Members

One listening session was conducted at Vasek Polak Health Clinic and two sessions were conducted at the Providence Wellness and Activity Center in Wilmington. Participants shared the following information:

Participants' vision of a healthy community includes community connectedness

- Participants expressed the importance of people helping and supporting each other in times of need

The Wellness and Activity Center improves people's mental health and connectedness

- Participants reported experiencing improved feelings of depression and social isolation since participating in programming at the Center
- The Center is a safe place where people feel loved and welcome
- The Center is a space to meet friends and engage with other community members
- Participants shared their cultures are celebrated at the Center, helping to build community and learn about one another
- The Welcome Baby and Building Stronger Families programs provide support for families and new parents

Participants would like more mental health services at the Wellness and Activity Center

- Mental health support groups and classes for young people
- Support groups for parents

Participants at Vasek Polak Health Clinic want more opportunities to meet community members

- Participants enjoyed the opportunity to meet their neighbors and hear from other individuals in the community

- They shared feelings of isolation and expressed interest in more forums to gather with other community members
- They would like to learn about local resources from others in their community

Community Stakeholder Interviews

Lack of supportive relationships contribute to housing instability for TAY population

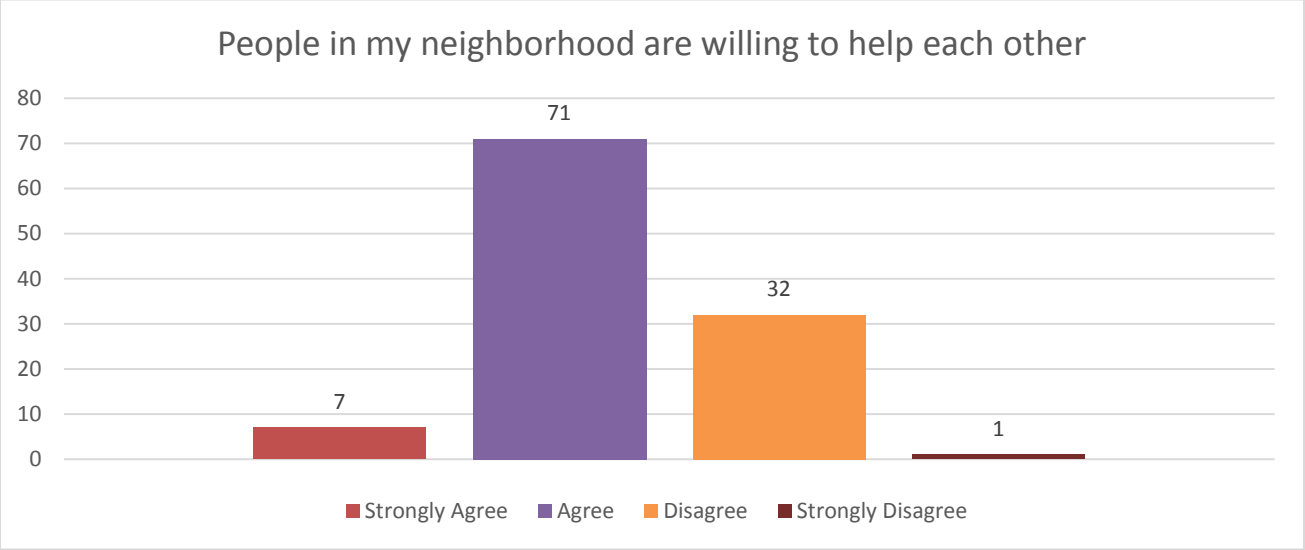
Young people between the ages of 16 and 24 transitioning from state or foster care are known as transitional age youth (TAY). These young people may be more at risk of experiencing homelessness because at 18 they no longer qualify for the support systems they rely on. Not having strong supportive relationships, a history of trauma, and lacking skills to navigate the responsibilities of adulthood may contribute to housing instability.

> *"Lack of supportive relationships for a lot of the TAY population that I've seen. They don't know who to go to for resources or they don't have anyone to ask questions or 'How do I go about doing this?' And so a lot of them are ending up couch surfing. Or sleeping in their cars."- Community stakeholder*

Abode Health Survey

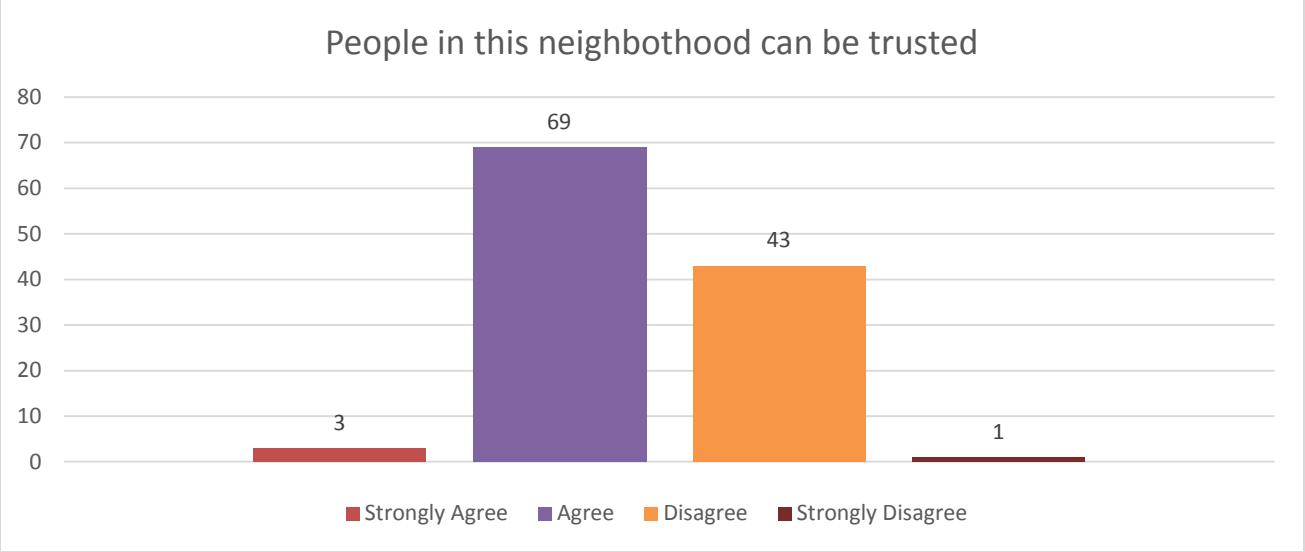
Providence Little Company of Mary partnered with Abode Communities, a nonprofit affordable housing provider, to administer health surveys to all new residents moving into Camino del Mar & Vista del Mar affordable homes located in the vicinity of the Providence Little Company of Mary Wellness and Activity Center. The health survey covered a wide range of topics including insurance status, self-reported health, chronic conditions, food insecurity and access, physical activity and social cohesion. Between January 2019 and July 2019, a total of 133 responses were received and analyzed.

Figure_Apx 41. Measure of Community Helpfulness from Abode Health Survey



- 80 residents (70%) either agreed or strongly agreed that people in their neighborhood are willing to help each other.

Figure_Apx 42. Measure of Community Trustworthiness from Abode Health Survey



- 72 residents (62%) either agreed or strongly agreed that people in their neighborhood can be trusted.

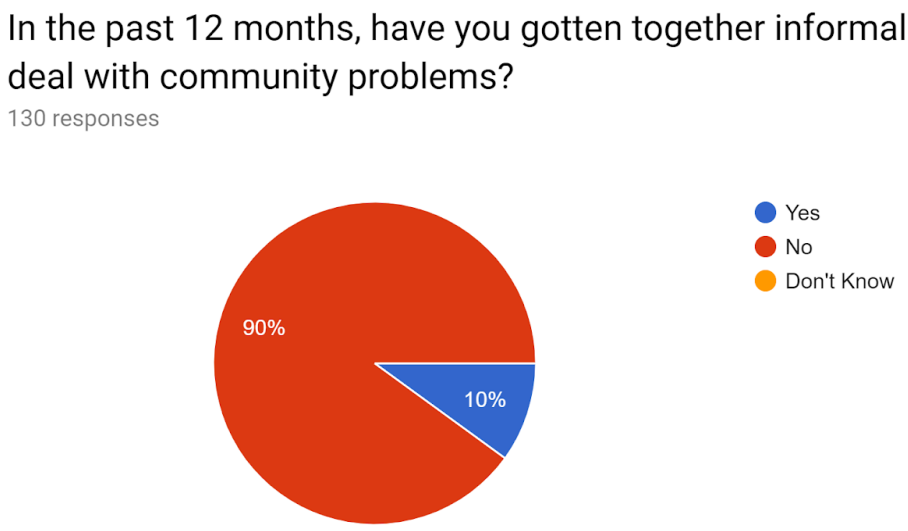
Figure_Apx 43. Volunteerism Responding to Community Problems from Abode Health Survey

- One in ten respondents (N= 129) stated that within the past 12 months, they had served as volunteer on any local board, council, or organizations that deals with community problems

Figure_Apx 44. Volunteerism or Community Service, Unpaid from Abode Health survey

- 23.5% of respondents (N = 132) stated that within the past 12 months, they had done volunteer work or community service for which they had not been paid.

Figure_Apx 45. Informal Work to Address Community Problems

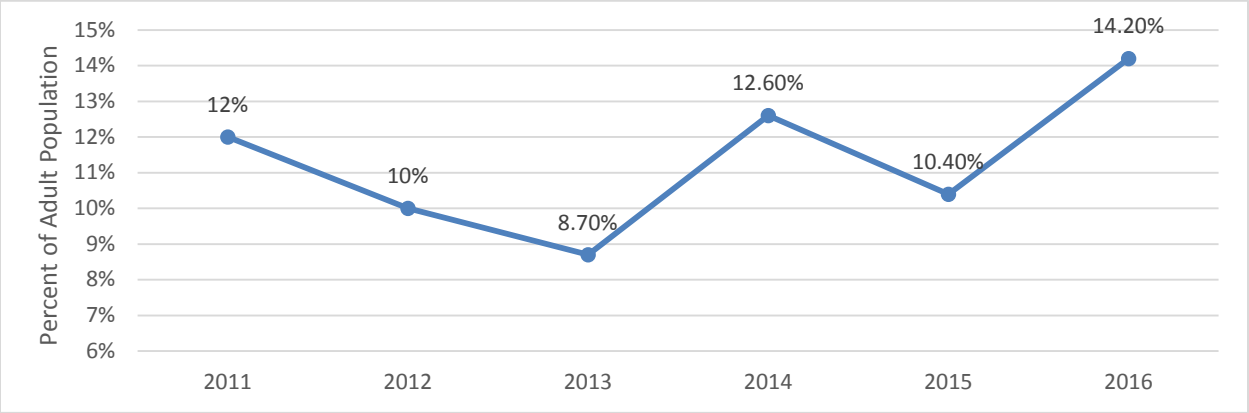


- 23.5% of respondents (N = 132) stated that within the past 12 months, they had gotten informally together with others to deal with community problems.
- A vast majority of new residents have not served as volunteers in the past 12 months and have not come together informally with others to deal with community problems.

Secondary Data

The following indicators are taken from the California Health Interview Survey (CHIS). CHIS is a health survey conducted on a continuous basis by the UCLA Center for Health Policy Research in collaboration with the Department of Health Care Services and the California Department of Public Health. Currently the most recent date for CHIS data through the self-service portal "AskCHIS" is from the year 2017 however data from previous years were used when service planning areas values were deemed statistically unstable or for examining trends. According to the following figure, community volunteerism has risen since the year 2013 for adults in Service Planning 8.

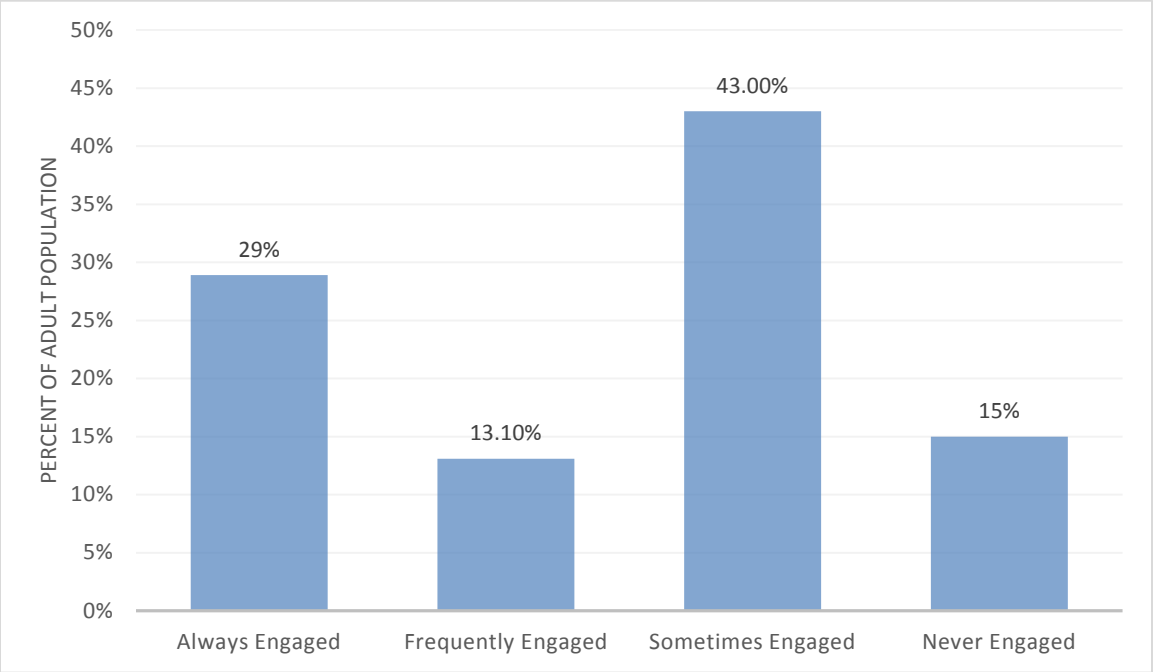
Figure_Apx 46. Percent of Adults in SPA 8 Who Have Engaged in Formal Volunteer Work for Community Problems in the Past Year



Source: California Health Interview Survey, self-service portal "AskCHIS"

Voters in SPA 8 appear to engage in various degrees with the national, state and local elections with only 15% reporting no engagement, and 29% of adults reporting being “always engaged.”

Figure_Apx 47. Voter Engagement in National, State and Local Elections for Adults in SPA 8



Source: California Health Interview Survey 2017, self-service portal "AskCHIS"

Appendix 2: Additional Quantitative Data

2019 CHNA Common Metrics - South Bay

Variable

Social Determinants, Poverty, and Environment

South Bay Community Benefit Service Area		South Bay Broader Service Area	Los Angeles County	California	United States
% Population below 200% FPL	**44.7%**	**19.2%**	**39.6%**	**35.2%**	**33.6%**
Language spoken at home other than English	**58.7%**	**35.8%**	**56.7%**	**44.0%**	**21.2%**
Top 5 Zip Codes					
90744	77.4%				
90745	63.6%				
90260	62.0%				
90250	59.5%				
90502	59.4%				
Bottom 5 Zip Codes					
90278	26.0%				
90245	19.6%				
90277	19.5%				
90266	14.8%				
90254	9.7%				

	South Bay Community Benefit Service Area	South Bay Broader Service Area	Los Angeles County	California	Jnited States
Median HH income	**$53,598**	**$98,724**	**$62,751**	**$69,051**	**$58,100**
Top 5 Zip Codes					
90274	$189,068				
90266	$157,003				
90275	$132,358				
90747	$124,338				

	90254	$124,084
Bottom 5 Zip Codes		
	90260	$56,271
	90731	$55,685
	90250	$51,940
	90247	$46,360
	90744	$43,716

	South Bay Community Benefit Service Area	South Bay Broader Service Area	Los Angeles County	California	Jnited States
% Population with at least a HS diploma	**75.4%**	**92.0%**	**78.4%**	**82.6%**	**87.7%**
Top 5 Zip Codes					
90254	99.1%				
90266	98.4%				
90274	98.2%				
90277	97.8%				
90275	96.7%				
Bottom 5 Zip Codes					
90731	78.2%				
90247	77.9%				
90250	76.0%				
90260	75.2%				
90744	56.7%				

	South Bay Community Benefit Service Area	South Bay Broader Service Area	Los Angeles County	California	Jnited States
% Labor force employed	**95.3%**	**96.6%**	**95.5%**	**95.3%**	**95.2%**
Top 5 Zip Codes					
90274	98.7%				
90266	98.2%				
90275	98.1%				
90254	98.0%				
90277	97.6%				
Bottom 5 Zip Codes					

90731	94.5%
90747	94.4%
90744	94.4%
90745	94.0%
90746	93.4%

	South Bay Community Benefit Service Area	South Bay Broader Service Area	Los Angeles County	California	Jnited States
Severe Housing Cost Burden	**28.8%**	**21.7%**	**30.6%**	**27.9%**	**24.1%**
Top 5 Zip Codes					
90747	33.3%				
90746	32.7%				
90247	32.2%				
90248	32.1%				
90744	31.0%				
Bottom 5 Zip Codes					
90249	19.4%				
90277	17.9%				
90266	15.6%				
90245	15.5%				
90254	14.1%				

	South Bay Community Benefit Service Area	South Bay Broader Service Area	Los Angeles County	California	Jnited States
Food insecurity/HH on SNAP	**11.6%**	**3.2%**	**9.0%**	**9.4%**	**13.1%**
Top 5 Zip Codes					
90744	18.6%				
90731	12.3%				
90250	11.3%				
90710	10.6%				
90501	9.4%				
Bottom 5 Zip Codes					
90277	2.0%				
90505	1.8%				

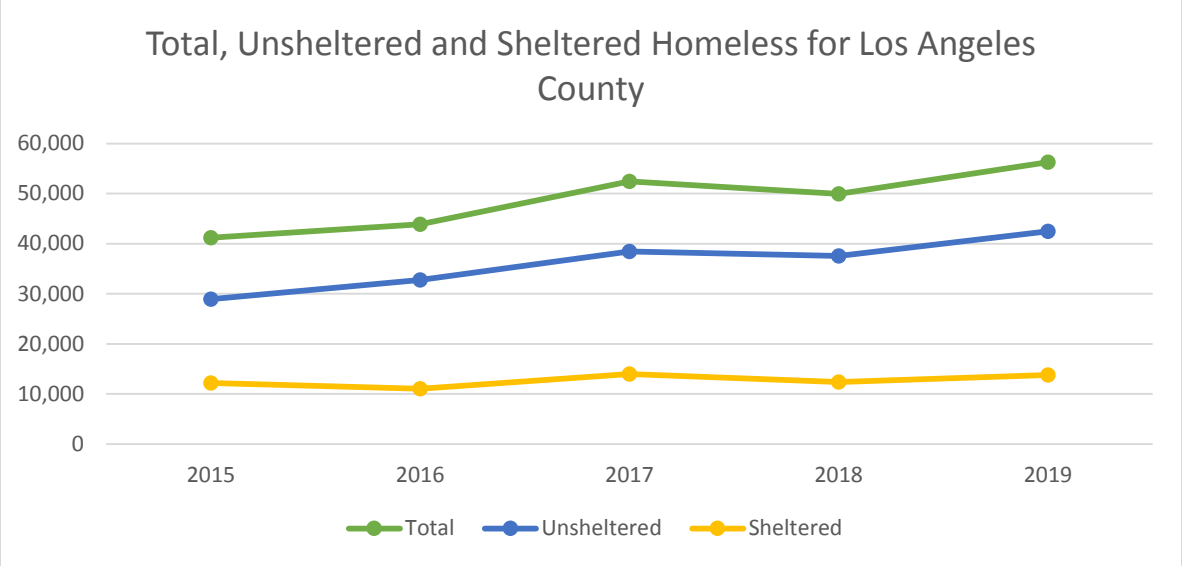
90254	1.6%
90266	0.8%
90274	0.2%

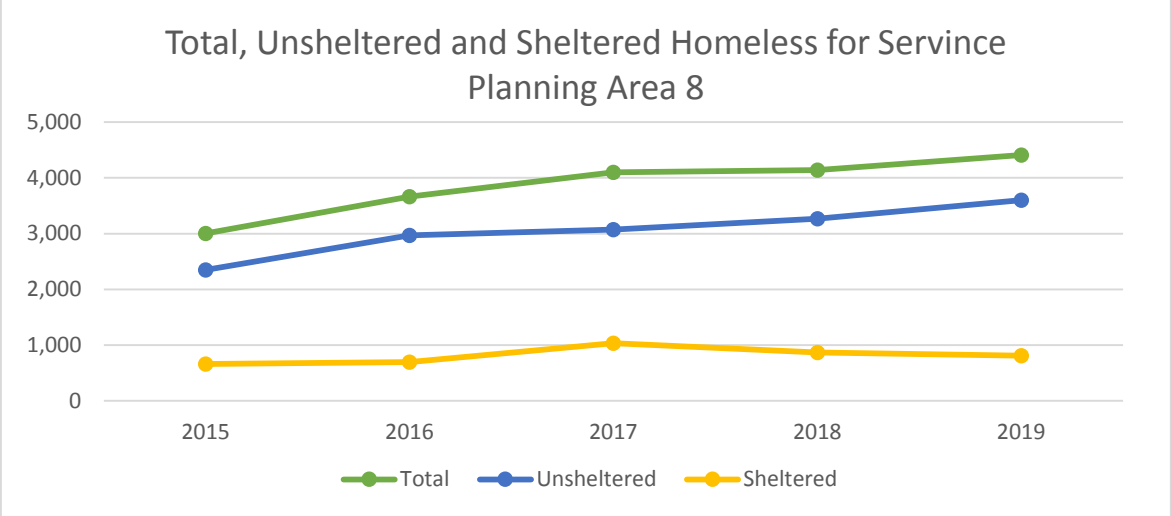
Chronic Homelessness				
2019 Point-In-Time Homeless County				
Geographic Area	**Sheltered**	**Unsheltered**	**Total**	**Percent Change 2018 - 2019**
Los Angeles County	14,722	44,214	58,.936	+12%
SPA 8	810	3,599	4,409	+7%

2019 Point-In-Time Homeless Count – Service Planning Area 8 Race and Ethnicity Table					
Race/Ethnicity	**Sheltered**	**Unsheltered**	**Total**	**Prevalence of Homeless Pop.**	**Percent Change 2018-2019**
American Indian/ Alaska Native	3	94	97	2%	3133%
Asian	2	44	46	1%	-19%
Black/African American	433	930	1,363	31%	-4%
Hispanic/ Latino	246	1,430	1,676	38%	30%
Native Hawaiian/ Other Pacific Islander	3	51	54	1.20%	59%
White	114	996	1,110	25%	-15%
Multi-Racial/Other	9	54	63	1%	271%

2019 Point-In-Time Homeless Count – Service Planning Area 8 Age Table					
Age Group	**Sheltered**	**Unsheltered**	**Total**	**Prevalence of Homeless Population**	**Total Percent Change 2018 - 2019**

Under 18	283	70	353	8%	-12%
18 - 24	56	73	129	3%	-1%
25 - 54	300	2,355	2,655	60%	6%
55 - 61	107	625	732	17%	10%
62 and Over	64	476	540	12%	24%



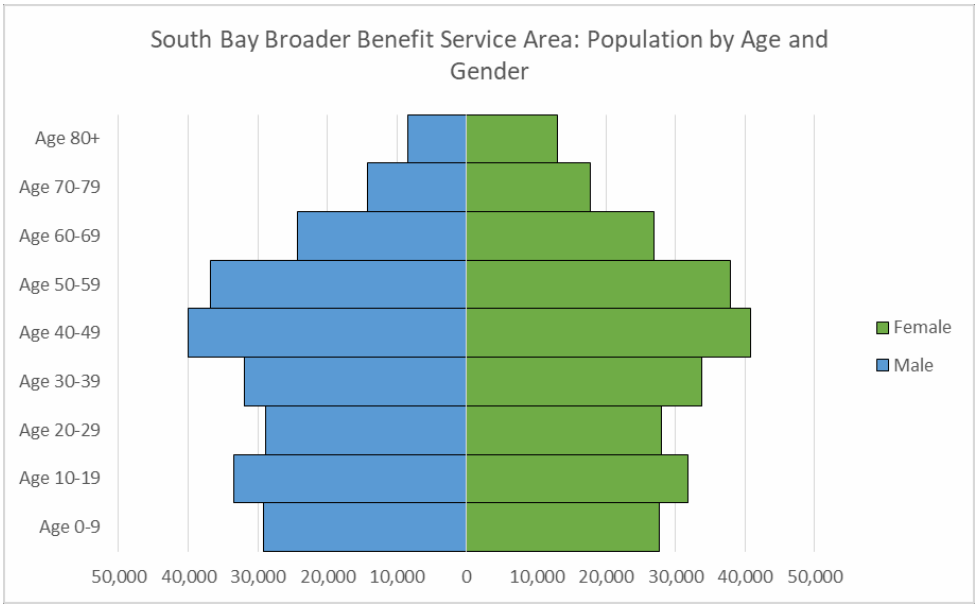


South Bay Broader Service Area Population by Race

Race	pulation Count	Population %
White	278,744	55.04%
Black	41,764	8.25%

American Indian	2,187	0.43%
Asian	114,731	22.65%
Pacific Islander	3,621	0.71%
Other Race	39,387	7.78%
Mulitple Races	26,009	5.14%
Total Population	**506,443**	**100%**

Hispanic Population	101,922	20.13%
Minority Population	279,193	55.13%



		Prevention Quality Inidcators (Per 1,000 Admissions) by Hospital Facility 2018												
Facility	Grouping	PQI #01 Diabetes Short term Complications Admission Rate	PQI #02 Perforated Appendix Admission Rate	PQI #03 Diabetes Long-Term Complications Admission Rate	PQI #05 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	PQI #07 Hypertension Admission Rate	PQI #08 Heart Failure Admission Rate	PQI #09 Low Birth Weight Rate	PQI #10 Dehydration Admission Rate	PQI #11 Community Acquired Pneumonia Admission Rate	PQI #12 Urinary Tract Infection Admission Rate	PQI #14 Uncontrolled Diabetes Admission Rate	PQI #15 Asthma in Younger Adults Admission Rate	PQI #16 Lower-Extremity Amputation Among Patients with Diabetes Rate
762 - PROVIDENCE LCM MED CENTER TORRANCE	Facility Level	7.35	3.19	8.02	16.22	4.37	36.14	52.00	6.17	13.11	18.20	5.76	2.68	1.23
772 - PROVIDENCE LCM MED CENTER SAN PEDRO	Facility Level	4.68	4.55	5.54	16.03	2.58	33.11	10.23	3.82	12.92	13.42	4.68	5.09	0.49
Southern California Average	Facility Level	4.95	3.82	6.62	17.47	2.94	35.09	38.89	5.20	13.22	12.71	4.03	3.32	1.17
Facility	**Age Group**													
762 - PROVIDENCE LCM MED CENTER TORRANCE	18 to 39 years	14.59	6.04	2.52	-	2.77	6.04	47.38	1.26	1.51	6.04	5.03	2.68	-
762 - PROVIDENCE LCM MED CENTER TORRANCE	40 to 64 years	10.45	5.22	14.18	13.54	5.60	33.95	51.02	2.05	11.94	11.94	7.65	-	1.49
762 - PROVIDENCE LCM MED CENTER TORRANCE	65 to 74 years	3.60	2.10	14.12	21.99	5.41	53.77	-	6.61	15.62	13.22	7.21	-	2.70
762 - PROVIDENCE LCM MED CENTER TORRANCE	75+ years	2.51	0.44	3.39	15.50	3.83	46.89	-	7.67	19.61	32.59	3.98	-	1.03
762 - PROVIDENCE LCM MED CENTER TORRANCE Total		**7.35**	**3.19**	**8.02**	**16.23**	**4.37**	**36.15**	**47.94**	**4.63**	**13.11**	**18.15**	**5.76**	**2.68**	**1.23**
772 - PROVIDENCE LCM MED CENTER SAN PEDRO	18 to 39 years	12.71	10.70	1.34	-	2.01	3.34	10.84	-	4.01	5.35	3.34	4.45	-
772 - PROVIDENCE LCM MED CENTER SAN PEDRO	40 to 64 years	2.85	4.43	8.23	16.42	3.80	25.95	-	3.16	6.01	7.28	4.43	-	0.95
772 - PROVIDENCE LCM MED CENTER SAN PEDRO	65 to 74 years	4.22	2.81	8.44	21.74	2.11	40.82	-	4.22	12.67	17.59	6.33	-	0.70
772 - PROVIDENCE LCM MED CENTER SAN PEDRO	75+ years	1.95	1.46	2.44	11.32	1.46	60.55	-	7.32	30.27	25.88	4.88	-	-
772 - PROVIDENCE LCM MED CENTER SAN PEDRO Total		**4.68**	**4.55**	**5.54**	**16.03**	**2.58**	**33.11**	**10.31**	**3.82**	**12.92**	**13.42**	**4.68**	**4.45**	**0.49**
Facility	**Gender**													
762 - PROVIDENCE LCM MED CENTER TORRANCE	FEMALE	5.56	2.69	4.21	16.59	4.21	27.7	58.55	4.29	10.27	22.31	4.8	1.78	2.53
762 - PROVIDENCE LCM MED CENTER TORRANCE	MALE	10.18	3.96	14.01	15.78	4.63	49.43	45.45	5.15	17.58	11.63	7.27	6.93	27.75
762 - PROVIDENCE LCM MED CENTER TORRANCE Total		**7.35**	**3.19**	**8.02**	**16.23**	**4.37**	**36.15**	**52**	**4.63**	**13.11**	**18.15**	**5.76**	**2.68**	**12.34**
772 - PROVIDENCE LCM MED CENTER SAN PEDRO	FEMALE	4.25	2.6	3.07	23.57	1.65	28.36	10	4.02	14.89	20.8	4.02	7.26	-
772 - PROVIDENCE LCM MED CENTER SAN PEDRO	MALE	5.14	6.68	8.22	8.53	3.6	38.27	10.47	3.6	10.79	5.39	5.39	-	10.27
772 - PROVIDENCE LCM MED CENTER SAN PEDRO Total		**4.68**	**4.55**	**5.54**	**16.03**	**2.58**	**33.11**	**10.23**	**3.82**	**12.92**	**13.42**	**4.68**	**4.45**	**4.92**
Facility	**Gender**													
762 - PROVIDENCE LCM MED CENTER TORRANCE	CAPITATION	-	2.59	10.36	15.71	2.59	49.22	-	2.59	12.95	5.18	-	-	-
762 - PROVIDENCE LCM MED CENTER TORRANCE	COMMERCIAL	9.13	6.85	6.85	6.48	2.66	11.98	41.17	5.52	5.14	3.61	4.76	2.30	0.57
762 - PROVIDENCE LCM MED CENTER TORRANCE	MEDICAID	14.92	4.30	7.17	16.93	5.16	26.39	75.91	5.45	11.47	11.47	8.03	3.02	0.57
762 - PROVIDENCE LCM MED CENTER TORRANCE	MEDICARE	4.24	0.71	8.78	19.37	5.04	52.36	-	6.86	18.06	29.36	5.95	9.80	1.92
762 - PROVIDENCE LCM MED CENTER TORRANCE	OTHER	-	-	-	-	-	-	-	-	-	-	-	-	-
762 - PROVIDENCE LCM MED CENTER TORRANCE	OTHER GOVERNMENT	-	-	-	18.52	7.94	31.75	-	15.87	31.75	-	-	-	-
762 - PROVIDENCE LCM MED CENTER TORRANCE	SELF PAY	3.55	10.64	14.18	5.52	3.55	21.28	20.83	3.55	-	7.09	-	-	-
762 - PROVIDENCE LCM MED CENTER TORRANCE Total	**All Payors**	**7.35**	**3.19**	**8.02**	**16.22**	**4.37**	**36.14**	**52.00**	**6.17**	**13.11**	**18.20**	**5.76**	**2.68**	**1.23**
772 - PROVIDENCE LCM MED CENTER SAN PEDRO	CAPITATION	-	-	21.74	65.22	-	43.48	-	-	-	-	-	-	-
772 - PROVIDENCE LCM MED CENTER SAN PEDRO	COMMERCIAL	2.80	12.59	3.50	7.65	4.20	15.38	17.24	4.20	6.99	4.20	0.70	7.81	-
772 - PROVIDENCE LCM MED CENTER SAN PEDRO	MEDICAID	7.95	3.79	5.30	18.90	2.27	20.83	9.29	0.76	6.06	7.95	5.30	4.00	0.38
772 - PROVIDENCE LCM MED CENTER SAN PEDRO	MEDICARE	3.16	2.11	6.33	17.10	1.85	49.05	-	5.80	20.83	21.10	6.07	-	0.79
772 - PROVIDENCE LCM MED CENTER SAN PEDRO	OTHER	-	-	-	-	-	83.33	-	-	-	27.78	-	-	-
772 - PROVIDENCE LCM MED CENTER SAN PEDRO	OTHER GOVERNMENT	-	-	-	-	-	-	-	-	-	9.52	-	-	-
772 - PROVIDENCE LCM MED CENTER SAN PEDRO	SELF PAY	13.16	13.16	13.16	-	26.32	13.16	-	13.16	-	-	-	27.03	-
772 - PROVIDENCE LCM MED CENTER SAN PEDRO Total	**All Payors**	**4.68**	**4.55**	**5.54**	**16.03**	**2.58**	**33.11**	**10.23**	**3.82**	**12.92**	**13.42**	**4.68**	**5.09**	**0.49**

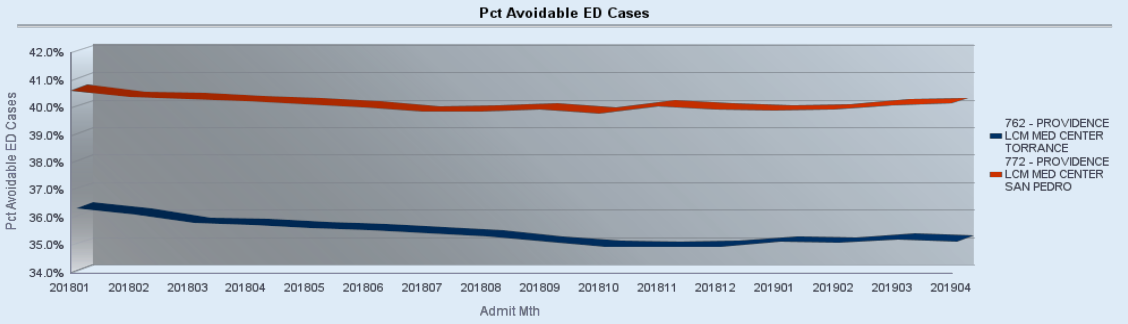
Avoidable ED Visits Detail Tables (May 2018 - April 2019)

Rolling Year Period Ending 201904

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

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

Enc Facility Desc	Pct Avoidable ED Cases	Avoidable ED Cases	Total ED Cases
710 - PROVIDENCE ST JOSEPH MEDICAL CENTER	36.0%	19,887	55,245
720 - PROVIDENCE HOLY CROSS MEDICAL CENTER	40.4%	35,012	86,763
725 - PROVIDENCE TARZANA MEDICAL CENTER	37.9%	15,498	40,896
735 - PROVIDENCE ST JOHNS HEALTH CENTER	34.2%	7,921	23,167
762 - PROVIDENCE LCM MED CENTER TORRANCE	35.1%	18,178	51,860
772 - PROVIDENCE LCM MED CENTER SAN PEDRO	40.1%	14,061	35,022



Pct Avoidable ED Cases	2018												2019			
Enc Facility Desc	2018 JAN	2018 FEB	2018 MAR	2018 APR	2018 MAY	2018 JUN	2018 JUL	2018 AUG	2018 SEP	2018 OCT	2018 NOV	2018 DEC	2019 JAN	2019 FEB	2019 MAR	2019 APR
762 - PROVIDENCE LCM MED CENTER TORRANCE	36.3%	36.0%	35.7%	35.7%	35.5%	35.5%	35.3%	35.2%	35.0%	34.9%	34.8%	34.9%	35.0%	35.0%	35.1%	35.1%
772 - PROVIDENCE LCM MED CENTER SAN PEDRO	40.6%	40.4%	40.3%	40.2%	40.1%	40.0%	39.8%	39.9%	39.9%	39.8%	40.1%	39.9%	39.9%	39.9%	40.1%	40.1%
Grand Total	**38.0%**	**37.8%**	**37.6%**	**37.5%**	**37.4%**	**37.3%**	**37.2%**	**37.1%**	**37.0%**	**36.9%**	**37.0%**	**36.9%**	**37.0%**	**37.0%**	**37.1%**	**37.1%**

Avoidable ED Cases	2018												2019			
Enc Facility Desc	2018 JAN	2018 FEB	2018 MAR	2018 APR	2018 MAY	2018 JUN	2018 JUL	2018 AUG	2018 SEP	2018 OCT	2018 NOV	2018 DEC	2019 JAN	2019 FEB	2019 MAR	2019 APR
762 - PROVIDENCE LCM MED CENTER TORRANCE	19,976	19,801	19,531	19,434	19,267	19,141	18,977	18,833	18,636	18,421	18,316	18,136	18,080	18,037	18,240	18,178
772 - PROVIDENCE LCM MED CENTER SAN PEDRO	14,964	14,855	14,796	14,741	14,618	14,494	14,427	14,386	14,345	14,208	14,285	14,062	13,884	13,886	14,059	14,061
Grand Total	**34,940**	**34,656**	**34,327**	**34,175**	**33,885**	**33,635**	**33,404**	**33,219**	**32,981**	**32,629**	**32,601**	**32,198**	**31,964**	**31,923**	**32,299**	**32,239**

Total ED Cases	2018												2019			
Enc Facility Desc	2018 JAN	2018 FEB	2018 MAR	2018 APR	2018 MAY	2018 JUN	2018 JUL	2018 AUG	2018 SEP	2018 OCT	2018 NOV	2018 DEC	2019 JAN	2019 FEB	2019 MAR	2019 APR
762 - PROVIDENCE LCM MED CENTER TORRANCE	55,093	54,958	54,678	54,505	54,219	53,965	53,688	53,452	53,196	52,819	52,566	52,005	51,606	51,535	51,928	51,860
772 - PROVIDENCE LCM MED CENTER SAN PEDRO	36,850	36,796	36,700	36,647	36,432	36,211	36,208	36,091	35,925	35,710	35,656	35,208	34,814	34,785	35,075	35,022
Grand Total	**91,943**	**91,754**	**91,378**	**91,152**	**90,651**	**90,176**	**89,896**	**89,543**	**89,121**	**88,529**	**88,222**	**87,213**	**86,420**	**86,320**	**87,003**	**86,882**

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

Providence Little Company of Torrance

Rank	MSDRG Code Desc	Cases	% of Total Cases
1	153 - OTITIS MEDIA & URI W/O MCC	2567	14.1%
2	690 - KIDNEY & URINARY TRACT INFECTIONS W/O MCC	1,596	8.8%
3	203 - BRONCHITIS & ASTHMA W/O CC/MCC	1,215	6.7%
4	603 - CELLULITIS W/O MCC	1,134	6.2%
5	103 - HEADACHES W/O MCC	1,013	5.6%
6	607 - MINOR SKIN DISORDERS W/O MCC	984	5.4%
7	552 - MEDICAL BACK PROBLEMS W/O MCC	928	5.1%
8	392 - ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	876	4.8%
9	897 - ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	860	4.7%
10	556 - SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	676	3.7%
11	149 - DYSEQUILIBRIUM	646	3.6%
12	880 - ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	423	2.3%
13	951 - OTHER FACTORS INFLUENCING HEALTH STATUS	413	2.3%
14	305 - HYPERTENSION W/O MCC	378	2.1%
15	125 - OTHER DISORDERS OF THE EYE W/O MCC	304	1.7%
16	195 - SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	301	1.7%
17	885 - PSYCHOSES	263	1.4%
18	639 - DIABETES W/O CC/MCC	253	1.4%
19	761 - MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC	241	1.3%
20	950 - AFTERCARE W/O CC/MCC	225	1.2%
	Top 20 MSDRGs Grand Total	15,296	84.1%

Providence Little Company of Torrance

Rank	Principal ICD Dx Sub Categorization	Cases	% of Total Cases
1	Acute upper respiratory infections	1973	10.9%
2	General symptoms and signs	1272	7.0%
3	Other diseases of the urinary system	1245	6.8%
4	Infections of the skin and subcutaneous tissue	1144	6.3%
5	Chronic lower respiratory diseases	1065	5.9%
6	Mental and behavioral disorders due to psychoactive substance use	940	5.2%
7	Other dorsopathies	922	5.1%
8	Other joint disorders	717	3.9%
9	Symptoms and signs involving cognition, perception, emotional state and behavior	682	3.8%
10	Diseases of middle ear and mastoid	530	2.9%
11	Symptoms and signs involving the skin and subcutaneous tissue	495	2.7%
12	Noninfective enteritis and colitis	445	2.4%
13	Other acute lower respiratory infections	421	2.3%
14	Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	403	2.2%
15	Hypertensive diseases	390	2.1%
16	Renal tubulo-interstitial diseases	375	2.1%
17	Influenza and pneumonia	354	1.9%
18	Diabetes mellitus	313	1.7%
19	Encounters for other specific health care	292	1.6%
20	Noninflammatory disorders of female genital tract	267	1.5%
	Top 20 ICD-10 Sub Categorizations Grand Total	14245	78.4%

Providence Little Company of Torrance

Rank	Principal ICD Dx Code Desc	Cases	% of Total Cases
1	J06.9 - Acute upper respiratory infection, unspecified	1139	6.3%
2	R51 - Headache	977	5.4%
3	N39.0 - Urinary tract infection, site not specified	667	3.7%
4	R42 - Dizziness and giddiness	640	3.5%
5	M54.5 - Low back pain	531	2.9%
6	J02.9 - Acute pharyngitis, unspecified	511	2.8%
7	K52.9 - Noninfective gastroenteritis and colitis, unspecified	444	2.4%
8	J20.9 - Acute bronchitis, unspecified	406	2.2%
9	I10 - Essential (primary) hypertension	381	2.1%
10	N30.00 - Acute cystitis without hematuria	319	1.8%
11	J40 - Bronchitis, not specified as acute or chronic	295	1.6%
12	R21 - Rash and other nonspecific skin eruption	278	1.5%
13	J45.901 - Unspecified asthma with (acute) exacerbation	276	1.5%
14	F10.129 - Alcohol abuse with intoxication, unspecified	275	1.5%
15	F41.9 - Anxiety disorder, unspecified	273	1.5%
16	R19.7 - Diarrhea, unspecified	226	1.2%
17	J18.9 - Pneumonia, unspecified organism	221	1.2%
17	N12 - Tubulo-interstitial nephritis, not specified as acute or chronic	221	1.2%
19	Z53.21 - Procedure and treatment not carried out due to patient leaving prior to being seen by health care provider	209	1.1%
20	M54.2 - Cervicalgia	208	1.1%
	Top ICD-10 Codes Grand Total	8497	46.7%

Providence Little Company of San Pedro

Rank	MSDRG Code Desc	Cases	% of Total Cases
1	1153 - OTITIS MEDIA & URI W/O MCC	2758	19.6%
2	2603 - CELLULITIS W/O MCC	1263	9.0%
3	3690 - KIDNEY & URINARY TRACT INFECTIONS W/O MCC	996	7.1%
4	4203 - BRONCHITIS & ASTHMA W/O CC/MCC	937	6.7%
5	556 - SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	777	5.5%
6	6552 - MEDICAL BACK PROBLEMS W/O MCC	769	5.5%
7	7607 - MINOR SKIN DISORDERS W/O MCC	756	5.4%
8	8103 - HEADACHES W/O MCC	620	4.4%
9	392 - ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	613	4.4%
10	897 - ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	433	3.1%
11	880 - ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	363	2.6%
12	12149 - DYSEQUILIBRIUM	297	2.1%
13	13125 - OTHER DISORDERS OF THE EYE W/O MCC	247	1.8%
14	14885 - PSYCHOSES	223	1.6%
15	15950 - AFTERCARE W/O CC/MCC	221	1.6%
16	761 - MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC	184	1.3%
17	17159 - DENTAL & ORAL DISEASES W/O CC/MCC	176	1.3%
18	18951 - OTHER FACTORS INFLUENCING HEALTH STATUS	175	1.2%
19	19639 - DIABETES W/O CC/MCC	160	1.1%
20	20305 - HYPERTENSION W/O MCC	159	1.1%
	Top 20 MSDRG Grand Total	12127	86.2%

Providence Little Company of San Pedro

Rank	Principal ICD Dx Sub Categorization	Cases	% of Total Cases
1	Acute upper respiratory infections	2351	16.7%
2	Infections of the skin and subcutaneous tissue	1274	9.1%
3	Other diseases of the urinary system	835	5.9%
4	Other joint disorders	796	5.7%
5	General symptoms and signs	750	5.3%
6	Other dorsopathies	743	5.3%
7	Chronic lower respiratory diseases	686	4.9%
8	Mental and behavioral disorders due to psychoactive substance use	473	3.4%
9	Other acute lower respiratory infections	452	3.2%
10	Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	385	2.7%
11	Diseases of middle ear and mastoid	369	2.6%
12	Symptoms and signs involving cognition, perception, emotional state and behavior	311	2.2%
13	Symptoms and signs involving the skin and subcutaneous tissue	298	2.1%
14	Symptoms and signs involving the digestive system and abdomen	236	1.7%
15	Noninfective enteritis and colitis	217	1.5%
16	Diabetes mellitus	202	1.4%
17	Noninflammatory disorders of female genital tract	192	1.4%
18	Renal tubulo-interstitial diseases	187	1.3%
19	Mood [affective] disorders	180	1.3%
20	Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	179	1.3%
	Top 20 ICD-10 Sub Categorizations Grand Total	11116	79.1%

Providence Little Company of San Pedro

Rank	Principal ICD Dx Code Desc	Cases	% of Total Cases
1	J06.9 - Acute upper respiratory infection, unspecified	1584	11.3%
2	R51 - Headache	593	4.2%
3	M54.5 - Low back pain	492	3.5%
4	J02.9 - Acute pharyngitis, unspecified	485	3.4%
5	J20.9 - Acute bronchitis, unspecified	435	3.1%
6	N39.0 - Urinary tract infection, site not specified	400	2.8%
7	R42 - Dizziness and giddiness	291	2.1%
8	R19.7 - Diarrhea, unspecified	222	1.6%
9	K52.9 - Noninfective gastroenteritis and colitis, unspecified	215	1.5%
10	F41.9 - Anxiety disorder, unspecified	201	1.4%
11	N30.00 - Acute cystitis without hematuria	199	1.4%
12	L03.116 - Cellulitis of left lower limb	191	1.4%
13	R21 - Rash and other nonspecific skin eruption	167	1.2%
14	I10 - Essential (primary) hypertension	161	1.1%
15	L03.115 - Cellulitis of right lower limb	158	1.1%
16	J45.901 - Unspecified asthma with (acute) exacerbation	156	1.1%
17	M25.562 - Pain in left knee	148	1.1%
18	L50.9 - Urticaria, unspecified	142	1.0%
19	J18.9 - Pneumonia, unspecified organism	138	1.0%
20	F32.9 - Major depressive disorder, single episode, unspecified	136	1.0%
20	M25.561 - Pain in right knee	136	1.0%
	Top 20 ICD-10 Codes Grand Total	6650	47.3%

Appendix 3: Qualitative Data – Community Input

Community Member Listening Sessions

Location	Date and Time	Language	Number of Participants
Vasek Polak Health Clinic	4/23/19, 10am	Spanish	12
Wellness and Activity Center	4/25/19, 10am	Spanish	19
Wellness and Activity Center	4/25/19, 5pm	English	6
		Total Participants	37

Stakeholder Listening Sessions

Location	Date and Time	Topic	Number of Participants
Kaiser Permanente's South Bay Medical Center	11/13/18, 10am	Food insecurity	11
Providence Wellness and Activity Center	1/31/19, 10am	Homelessness	18
		Total Participants	**29**

Stakeholder Interview Participants and Organizations

Organization	Name	Title	Sector
Behavioral Health Services, Inc.	Mike Ballue	Chief Strategy Officer	Community based organization, behavioral health
St. Joseph Church Hawthorn	Father Greg King	Pastor	Religious organization
Lawndale Elementary School District	Betsy Hamilton	Superintendent	School district, education
Harbor Community Clinic	Tamra King	Chief Executive Officer	Community based organization, health care
Boys & Girls Clubs of the Los Angeles Harbor	Mike Lansing	Executive Director	National organization, youth development
Behavioral Health Services, Inc.	Sara Myers	President and Chief Executive Officer	Community based organization, mental health, food insecurity, community wellbeing
St. Joseph Church Hawthorn	Stephanie Nishio	Director of Programs	State organization, food insecurity
Lawndale Elementary School District	Michael Parks	President and Chief Executive Officer	Community based organization, homelessness
Harbor Community Clinic	Juliette Stidd	Clinical Director	Community based organization, child abuse treatment and prevention
Boys & Girls Clubs of the Los Angeles Harbor	Nancy Wilcox	Co-chair	Coalition, homelessness

Food Insecurity Stakeholder Listening Session Participants

Organization	Name	Title	Sector
Black Women for Wellness	Jan Robinson Flint	Associate Director of Programs	Community-based organization, outreach, education, and policy
Children's Clinic	Jessica Hernandez	Health Education/Outreach, CalFresh Enrollment	Community-based organization, health care
Department of Public Social Services	DeLlora Ellis-Gant	CalFresh Nutrition Program Director	Government, health and social services

Everytable	Justin Jarman	Head of SmartFridge Growth	Community-based organization, food security
FEAST	Dana Rizer	Executive Director	Community-based organization, food security
Food Finders	Mayjane Canyon	Board Member	Community-based organization, food security
Hunger Action LA	Frank Tamborello	Executive Director	Community-based organization, food security
Providence Little Company of Mary	Jennifer Rodriguez	Supervisor for Community Health Insurance Program	Multi-state organization, health care
Robert F Kennedy Institute	Dominga Pardo	Director	Community-based organization, health and social services
	Peter Rivera	Executive Director	
Toberman Neighborhood Center	Michele Fallon	Director of Programs	Community-based organization, youth and family services

Homelessness Stakeholder Listening Session Participants

Organization	Name	Title	Sector
Beach Cities Health District	Melissa Andrizzi-Sobel	Director, Community Services	Government, public health
Beacon Light Mission and Doors of Hope Women's Shelter	Jerry Rilling	Executive Director	Community-based organization, homelessness
Center for the Pacific Asian Family	Jo Takarabe	Shelter Program Manager	Community-based organization, domestic violence
Century Villages at Cabrillo	Paige Pelonis	Multimedia Editor	Community-based organization, homelessness
Community's Child	Tara Nierenhausen	Founder	Community-based organization, homelessness, women and children
Doors of Hope Women's Shelter	Laura Scotvold- Lemp	Director of Operations	Community-based organization, homelessness, single women
El Camino College	Sharonda Barksdale	Foster Youth and Homeless Liaison	College, education
Harbor Interfaith Services	Jessica Bailey	Regional Hospital Liaison, Coordinated Entry System	Community-based organization, homelessness

LINC Housing Corporation	Nina Dooley	Vice President, Corporate Development	State-based organization, homelessness, affordable housing
Los Angeles Homeless Services Authority	Gary Mitchell	Homeless CalWORKs Families Project Manager	Government, homelessness
Mental Health America of Los Angeles	Laurie Ramey	Director of Outreach Services	Community-based organization, health and social services
NAMI South Bay	Paul Stansbury	President of South Bay Board	National organization, mental health
People Assisting the Homeless (PATH)	Courtney Reed	Associate Director	State-based organization, homelessness, affordable housing
Rainbow Services	Araceli Patino	Director of Housing Programs	Community-based organization, domestic violence
Salvation Army Torrance Stillman Sawyer Family Services Center	Ernesto Madrid	Social Service Manager	Community based organization, health and social services
San Pedro United Methodist Church	Lisa Williams	Pastor	Religious organization
South Bay Coalition to End Homelessness	Nancy Wilcox	Co-Chair	Coalition, homelessness
Torrance Unified School District	Nancy Gutierrez	Coordinator of Parent/Community Engagement, Homeless-Foster Liaison	Government, education

Qualitative Data Full Report

Prepared for Providence Little Company of Mary Medical Centers—Torrance and San Pedro
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Providence St. Joseph Health

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Findings—Community Member Listening Sessions

Vasek Polak Health Clinic Listening Session

One listening session was conducted in Spanish with community members from Vasek Polak Health Clinic, a Providence primary care clinic for uninsured and underinsured adults. Participants were asked to discuss what makes it easier or harder for them to access the health care services they need and to effectively utilize their health insurance benefits.

Demographics

Twelve adults participated in the listening session, nine of which identified as females. Half of the participants lived in Hawthorne, the same city as Vasek Polak Health Clinic, while the remaining lived in nearby cities: Wilmington, San Pedro, Inglewood, Gardena, and Lawndale. Seven participants were between the ages of 40-65, although participants' ages ranged from 18-79 years.
Following are the dominant themes expressed in the listening session.

Health care service utilization

Participants shared they seek medical services at a variety of locations including the following:

- Hospitals, including Providence Little Company of Mary Medical Centers—Torrance and San Pedro
- Emergency rooms
- Private doctors in the area
- Community clinics, such as Vasek Polak Health Clinic and Harbor UCLA

Participants explained their choice of where to receive services largely depended on their insurance status and type of insurance, with some participants saying they generally do not seek health care services. Participants spoke to primarily using the emergency room in the following situations:

- A true medical emergency, such as a high fever or sudden onset of pain
- Their doctor's office is closed, such as on an evening or weekend
- They need timely care, but appointments are being scheduled weeks or months in the future
- They do not have insurance or are enrolled in Emergency Medi-Cal only

One participant explained the wait time between scheduling an appointment and actually receiving care is so long a patient could die before their appointment date, emphasizing the dire need for more access to appointments. Participants also shared their choice to use the emergency room over other health care options depended on their insurance, with some individuals saying the emergency room is the only location covered by their insurance, Emergency Medi-Cal. This lack of comprehensive insurance also

contributed to some participants saying they do not have a regular primary care provider and do not seek preventive health services.

Barriers

Participants named two main barriers to seeking the health care services they need:

- **Lack of insurance and cost of care:** Lack of insurance was a main reason why participants did not seek medical care when they thought they needed it. Instead they waited until the point of emergency or unbearable pain to seek care. The cost of care, with or without insurance, including copays and a percentage of services, was also a deterrent.

- **Discrimination and fear:** Participants noted that even with insurance, specifically Medi-Cal, participants avoided seeking services for fear of discrimination. They shared stories of being treated rudely in a health care center and staff being unhelpful when they have questions or concerns. They felt the care they receive on Medi-Cal is of lower quality and they experience longer wait times than people on private insurance. They also shared they feel discriminated against for not speaking English. Additionally, fear of learning about their health problems and fear of not receiving good care contributed to avoiding seeking medical attention.

Participants did not think time was a barrier to accessing medical services, but thought that may be a challenge for individuals who work full time. Nine participants stated not working and three stated working part time.

Assets

Participants were asked to share what resources or supportive services assist them in accessing the care they need or in understanding their health insurance. While there were not many supports named, participants did agree the classes offered at Vasek Polak Health Clinic, especially related to diabetes and mental health, were useful. Additionally, the friendly, welcoming, linguistically appropriate services at Vasek Polak Health Clinic reduced their fear of seeking care there.

Needs

Participants uniformly agreed they need more information to help them access health care services and to understand their health insurance. Their needs were the following:

- More health related classes, including a class dedicated to explaining health insurance benefits
- A list of classes offered at Vasek Polak and other local partners (which was provided)
- A clear summary of health insurance benefits
- Opportunities for community members to share information with one another

Participants emphasized they not only need more information, but they need the information to be accessible, simple, and clear. Someone available to explain complicated topics such as health insurance would be valuable.

Additional Findings

Nine of the twelve participants were enrolled in health insurance. Despite this, many were confused about what kind of insurance they had and some were unsure if they were currently receiving benefits. This general lack of understanding of health insurance and the difference between Medi-Cal, Covered CA, and My Health LA (not a type of insurance), speaks to a need for clarification and further education.

Participants were also vocal about the benefit of having a forum to come together and meet their neighbors. They shared feelings of isolation and spoke to enjoying the opportunity to hear from other individuals in their community and to learn more about the services offered at the clinic. Many expressed interest in more opportunities to come together.

Wellness and Activity Center Listening Sessions

Two listening sessions were conducted at the Providence Wellness and Activity Center in Wilmington. One of the sessions was conducted in English with six participants and one was conducted in Spanish with 19 participants. The goal of the sessions was to better understand the health needs of community members in the South Bay and how the Wellness and Activity Center can better meet those needs.

Demographics

Twenty out of 25 participants chose to complete the demographics questionnaire. Of those 20 participants, 14 primarily spoke Spanish and 6 spoke English. Nineteen identified as female and all were parents. Participants ranged in age from 18-79, but a majority were between 55 and 79 years. Seven of the participants lived in the nearby Dana Strand apartments and the others lived in nearby neighborhoods.

Vision

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

- **People are exercising and participating in healthy activities:** Participants discussed the importance of outdoor space for people to participate in activities such as soccer. Additionally, in a healthy community there are opportunities for people of all ages to engage in exercise activities.

- **People have access to healthy, nutritious food:** Participants shared that in a healthy community people can buy healthy food locally and know how to cook healthy meals. They shared that farmers' markets are important for accessing fresh produce.

- **People can take care of their emotional health:** Participants shared that in a healthy community people have access to mental health services such as counseling. People have less stress and participate in stress-relieving activities such as meditation.

- **Housing is affordable:** Participants shared that housing needs to be affordable and accessible for all people in the community.

- **There are opportunities to learn and grow:** Community members discussed the importance of having opportunities to develop new skills and bring people's ideas together. They shared a healthy community has opportunities for learning, specifically classes aimed at children and classes to develop English and computer skills.

- **Themes unique to the session in English:** Participants from the English listening session emphasized the following themes that were not present in the Spanish listening session:

    - Community connectedness: Participants discussed the importance of people helping and supporting one another in times of needs.
    - Support for parents: Participants shared a healthy community cares for parents by providing classes for parents, prenatal support, the Women Infant and Child program, and child development information.

- **Themes unique to the session in Spanish—**Participants from the Spanish listening session emphasized the following themes that were not present in the English listening session:
    - Local, affordable health care services: Participants shared that a healthy community has low-cost or free health care services, in particular for people who are uninsured.
    - No crime
    - Clean streets
    - High graduation rates
    - Efficient public transportation

Needs

Participants were asked, "What are the most important issues that must be addressed to improve the health of your community?" Community members shared ways their community could improve to better meet their vision described above. The following paragraphs are the shared themes between the two listening sessions:

- **Healthier habits related to nutrition and exercise:** Participants said they would like to see their community members eat more nutritious foods and exercise more frequently. They particularly would like to see healthier habits in children as they are concerned about childhood obesity.

- **Reduced contamination from the refineries:** Participants were concerned about the health risks related to living so close to the refineries, in particular asthma and cancer. They would like to see the refineries held accountable for the contamination of their community.

- **Improved support services to address homelessness:** Participants shared they would like to see more support and shelters for people experiencing homelessness. They also expressed that there need to be increased services to address the mental health and substance use issues of people experiencing homelessness.

- **Clean streets free of abandoned cars and dumped goods:** Community members would like their community to be cleaner. They would like people to clean up after their dogs and stop dumping items in alleys. Additionally, they would like all the abandoned cars to be removed.

- **Themes unique to the session in English—** Participants from the English listening session emphasized the following theme that was not present in the Spanish listening session:
    - Improved outreach to the community to share opportunities and services provided by the Wellness and Activity Center

- **Themes unique to the session in Spanish—**Participants from the Spanish listening session emphasized the following themes that were not present in the English listening session:
    - More accessible and efficient public transportation

- More accessible mental health services: Participants would like to see counseling in schools as well as classes to help parents better meet the needs of their children. They also identified a need for more mental health professionals and appointment times.
- Opportunities to advance oneself, such as skill building and educational opportunities

Benefits

Participants were asked, "In what ways does the Wellness and Activity Center help you, your family, and your community be healthy?" The themes from their responses are as follow:

- **Increased knowledge of health and wellbeing:** Participants shared that they benefit from the many classes and resources at the Wellness and Activity Center. In particular, they have increased knowledge about nutrition, exercise, and managing chronic diseases such as diabetes and high blood pressure.

- **Improved mental health and reduced social isolation:** Multiple participants discussed how the Wellness and Activity Center has improved their symptoms of depression and social isolation. Participants described the Center as a safe place where they feel loved and welcome. They shared that the Center has helped them recognize their own talents and find their inner abilities.

- **Building community and social connections:** Participants described the Wellness and Activity Center as a space to meet friends and engage with the community. They described a sense of security and safety while at the center. They particularly appreciate the warm and welcoming staff. Additionally, people's cultures are celebrated at the Center and they appreciate the cultural activities available.

- **Support for families and new parents:** Participants discussed the benefits of the Welcome Baby and Building Stronger Families programs.

Opportunities

Participants were asked, "What additional services or activities would you like to see added at the Wellness and Activity Center to improve wellness for you, your family, and your community?" The themes from their responses are as follow:

- **Mental health support groups and classes, particularly for parents and young people:** Both groups of participants expressed interest in more mental health services at the Wellness and Activity Center. They shared a need for young people to have a safe space to express themselves and find support. They also expressed a need for support groups for parents with children with health challenges. Other ideas include meditation classes, 12-step programs, and grief support groups.

- **Health education classes for women and parents of children with health needs:** Participants shared they want more opportunities to learn about their health and provide guidance on healthy living. They would particularly like to see educational classes for parents of children with health needs and classes focused on women's health.

- **Arts and recreational activities, such as music, arts and crafts, and gardening:** Participants really appreciated all of the classes the Wellness and Activity Center offers. They would like to

see more classes for all ages. Some of their ideas include classes related to art and crafts, music, Tai Chi, and gardening.

- **Themes unique to the session in English**
    - Classes in English: Currently many of the classes at the Wellness and Activity Center are only offered in Spanish and participants would like to see more classes in English available.
    - Resources and classes specifically for older adults: Participants shared they would like to see more classes designed for older adults, such as exercise and wellbeing classes.

- **Themes unique to the session in Spanish**
    - Tutoring for young people: Participants expressed a need for free or low-cost tutoring services for their children after school.
    - Personal development: Participants want classes and groups that will help them grow as individuals and learn new skills. They offered these classes could be focused on work, family, education, and more.

Participants were asked, "Would you be interested in volunteering at the Center? If so, what types of volunteer opportunities would you be interested in participating in?" Many participants said they already volunteer with the Center, but those that do not already were eager to give of their time. They shared they would like to see volunteer opportunities to care for children while the parents are in classes and to teach art, music, and swimming classes.

Limitations

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

Note-takers were recording themes and information by hand in a fast-paced environment. Therefore, they may not have been able to capture all of the information shared in the sessions. To compensate for this, three sets of notes were collected. Additionally, because the note-takers were quickly documenting the themes, their own perspectives and biases may have influenced their interpretation of certain comments. Because of the fast-paced nature of the sessions, very few complete and reliable quotes were collected by the note-takers. Therefore, very few quotes are included in the findings. Additionally, for comments made in Spanish, some note-takers chose to translate in real-time, documenting their notes in English, while others took notes in Spanish and then were translated later. Real-time interpretation may be influenced by the note-takers' understanding of a comment or personal bias. Translation after the session may have lacked context.

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

Findings—Stakeholder Listening Sessions

Food Insecurity Listening Session

One listening session with representatives from community organizations and one stakeholder interview was conducted on the topic of food insecurity in the South Bay. Food insecurity is a state of lacking sufficient access to good quality, nutritious food. The findings from the interview were merged with those in the listening session.

Barriers

Participants acknowledged there are layers of factors that contribute to a community's access to high quality, affordable food. These factors range from the individual to the policy level and are often related. Participants spoke to barriers to food security in two categories:

- Accessing good quality, nutritious food
- Accessing and utilizing food assistance programs

Participants spoke to the many factors that make accessing good quality, nutritious food challenging for many of the communities they serve. Many low-income communities have **fewer grocery stores,** and the stores that are present typically have **poorer quality food**. Healthy food, such as produce, is sometimes more expensive than unhealthy food options. **Transportation barriers**, **stress**, and **busy schedules** also make accessing and cooking healthy food challenging compared to less expensive, faster, options close by, even though those options are often less healthy.

"I think yes, infrastructure is a problem. I think the quality of the food in poor communities is very different than the quality of food in more economic secure [communities]." – Listening session participant

Barriers to accessing and utilizing food assistance programs, such as CalFresh, generally revolved around **fear related to immigration**. Changing policies related to public charge and increased tension with immigration has resulted in individuals not wanting their names and information in a public database. Additional barriers, such as **long, complex CalFresh applications** and **stigma** around using public benefits were also noted. Participants shared that individuals receiving Supplemental Security Income (SSI) are not receiving sufficient food assistance due to **policies preventing them from qualifying for CalFresh**.

"From what we were told over and over again, people really didn't want their names being put into the system and didn't really know or trust what was going to happen if they did." –Listening session participant

Disproportionately Affected Groups

While many groups were implicitly mentioned in the barriers section, participants explicitly named the following groups as having less access to good quality, nutritious food:

- People with low-incomes
- People with incomes slightly above the threshold to qualify for assistance programs
- People with limited mobility
- People of color

- Undocumented immigrants

Health Effects

Participants noted several health effects related to food insecurity such as **obesity**, **diabetes**, and **high blood pressure**. Additionally, they noted negative effects on physical and mental **development for children**, as well as **problems with concentration** in school and **poor decision making**. One participant also noted anecdotally that their client population tends to report seemingly high incidents of cancer, learning disabilities, and autism, which may be associated with related environmental factors affecting residents in low-income areas.

"Kids in school have trouble concentrating or fall asleep because they haven't had breakfast or even dinner the night before." – Listening session participant

Effective Programs and Initiatives in the South Bay

Participants mentioned a wide variety of programs and initiatives in the South Bay that aim to reduce food insecurity. Participants spoke to efforts to provide free and low cost food to individuals with minimal barriers, such as food pantries which provide free food and require far less documentation than government assistance programs, and food banks that operate on a subsidized super market model.

"When you refer people to food pantries they feel more at ease to go there because they're not able to document information. Like they don't take their name, their social security number, or [information] like that." – Listening session participant

Community education and outreach, such as wellness fairs, cooking classes, and market demonstrations were also shared as important initiatives for helping individuals learn to shop for and cook healthier foods affordably. Participants noted that helping people not just access healthy food, but make the connection between food and health is important for changing the way people eat.

Market Match was cited as a successful program for both reducing the cost of food and incentivizing individuals to eat healthier, fresh food. Market Match, California's healthy food incentive program, helps food assistance dollars go further by matching customers' federal nutrition assistance benefits at farmers markets. For example, individuals using CalFresh benefits can spend $10 and get an additional $10 to buy food.

In medical settings, screening for food insecurity and connecting patients to health education teams aims to reduce barriers to getting individuals enrolled in food assistance programs.

"The doctors are actually identifying those that are faced with food insecurity and referring them down to a worker that is in the building that can take an application." – Listening session participant

To address the infrastructure barriers in the South Bay, the Los Angeles Food Policy Council implemented an initiative called the Healthy Neighborhood Market Network, which supports small businesses in low-income neighborhoods to bring healthy food to their customers through training, guidance, and store upgrades.

Grassroots initiatives that engage community members in change was mentioned as an important step in addressing food insecurity. One organization, Hunger Action LA, helps community members better understand the different issues related to the food systems and then engages them in advocacy for policy change.

"There's a lot of kind of grassroots movements that I do think… [are] essential for any of this to ultimately matter. Because like I was saying, you can increase food access, but if you don't have an engaged community… then it just doesn't go anywhere." –Listening session participant

Suggestions for Next Steps

Participants shared their thoughts about what local organizations, hospitals, and businesses can do to make it easier for people in the South Bay to get enough good quality, nutritious food. The conversation returned to the fear many of the community members are currently experiencing due to immigration status, the administration, and public charge. Participants suggested continuing to reach out to community members to build trust and educate them on resources and how the food they eat connects to their health, but to be mindful of the heightened fear when trying to enroll individuals in assistance programs.

Unexpected Findings

While no questions were asked specifically about immigration, participants' thoughts on how immigration status and fear is linked with food security were woven throughout the listening session. Participants shared that not only are they having a harder time enrolling clients in assistance programs, but individuals are choosing to withdraw from these programs. Heightened fear and mistrust of the current administration have made connecting with immigrant communities more challenging for service providers and left many of the participants unsure how to reassure their clients.

"I want to talk a little bit about this word 'enroll' in federal programs, et cetera. The people I know who are worried about immigration are not simply fearful. They are terrorized. I'm not trying to enroll people in anything. That's because I have no answers for them." – Listening session participant

Homelessness Listening Sessions

One listening session with representatives from community organizations were asked to respond to questions about homelessness in the communities they serve. Some of the questions were discussed in three small break-out groups and others were discussed as a larger group. Following are the dominant themes expressed in the listening session and interview.

Factors Contributing to Homelessness

Participants were asked, "What factors or conditions cause or contribute to homelessness in the communities you serve? What's the biggest influence?" Participants named the following factors as contributing to homelessness in the South Bay:

- **Lack of affordable housing options:** Participants discussed the high cost of housing in the South Bay, making rent unaffordable for many families. Gentrification may also contribute to higher rental costs in some areas, pushing out families who no longer can afford their home.
- **Economic insecurity:** Participants shared loss of income because of job elimination contributes to families not having sufficient income to cover their basic necessities. Additionally, lack of living wage jobs, coupled with high cost of living in the South Bay, means that people are not making enough money to cover their needs.

"I think it goes back to income and lack of affordable housing. For the populations that I work with, most of them don't have an income or credit to be able to afford [housing] and then what they can afford it's really not necessarily the best housing situation for them." – Listening session participant

- **Mental health and substance use:** Participants shared mental health challenges and substance use disorder can contribute to homelessness. They thought in particular trauma is a strong contributor to housing instability and homelessness.

"People don't recognize [mental illness]. It's not like cancer, it's not like diabetes where you walk in and they know these diseases, you know. They're chronic, they cost a lot of money for us, we ban together and we try to fix it together. But mental illness is hard to identify sometimes. It's complicated, there's not a lot of resources." – Listening session participant

- **Lack of educational opportunities:** Participants saw education as key for helping people access opportunities, such as better paying jobs and economic security. Therefore, people who may not have a strong educational background may be limited in their ability to better their circumstances, contributing to poverty and homelessness.
- **Domestic violence:** Participants shared people leaving violent situations may not have the resources or support to move into a stable living situation. Closely linked with trauma, mental health, and economic insecurity, domestic violence contributes to homelessness and housing instability for survivors of violence and their children.

Participants discussed factors that may make addressing homelessness more challenging in the South Bay, including barriers to moving people from living unsheltered to stable housing:

- **Lack of emergency shelter beds:** Participants discussed a need for more shelter beds in the South Bay. Currently individuals may have to travel to other areas for a shelter bed, which is an additional barrier.
- **Fear and mistrust preventing people experiencing homelessness from engaging with services:** People experiencing homelessness may be wary of accessing social services, such as shelters. Fear of their belongings being stolen or negative past experiences may contribute to this fear and mistrust.
- **NIMBYism:** The "not in my backyard" attitude creates a barrier to building more affordable housing in the South Bay. People may have misperceptions or concerns about how this housing could affect their community, creating resistance to developing much needed affordable housing units.

"I think people are willing to vote for the money to solve the problem with things like measure H and [Proposition] HHH and Prop One and Two on California's ballet. But when it comes to trying to actually locate a shelter or permanent location for housing they don't want it in their own neighborhood because there's a lot of fear. Property costs. Crime, all those things." – Listening session participant

- **Lack of funding and flexibility in use of funds for affordable housing and services:** Participants discussed needing more funding to address all of the needs of people experiencing homelessness. They shared that restrictions on how to use funding and very specific definitions for who qualifies as experiencing homelessness make providing services more challenging.
- **Lack of supportive services for people newly transitioned to housing:** Participants shared supportive services should not stop after individuals receive stable housing. Instead, once people

move from living unsheltered to sheltered, they are at a critical point of needing supportive services to address other needs such as employment, behavioral health, etc.

Disproportionately Affected Groups

Participants were asked, "Who or what groups in your community are most affected by homelessness? Why?" All three groups of participants named the following groups of people as being more affected by homelessness:

- Transitional age youth (TAY): Young people between the ages of 16 and 24 transitioning from state or foster care are known as transitional age youth. These young people may be more at risk of experiencing homelessness because at 18 they no longer qualify for the support systems they rely on. Not having strong supportive relationships, a history of trauma, and lacking skills to navigate the responsibilities of adulthood may contribute to housing instability.

"Lack of supportive relationships for a lot of the TAY population that I've seen. They don't know who to go to for resources or they don't have anyone to ask questions or 'How do I go about doing this?' And so a lot of them are ending up couch surfing. Or sleeping in their cars." – Listening session participant

- Older adults: Older adults may experience financial insecurity, cognitive impairment, and social isolation which can all contribute to housing instability and homelessness.

Two of the three participant groups identified the following people as most affected by homelessness:

- People with physical or developmental disabilities
- People who identify as LGBTQ
- Women
- People of color

Health Effects

Participants discussed how living unsheltered can reduce a person's life expectancy and lead to poor health outcomes. They noted several health effects related to homelessness:

- **Diseases such as HIV and hepatitis:** Participants discussed seeing high levels of HIV and hepatitis in the people they serve.

- **Exacerbated mental illness, such as anxiety and depression:** While mental illness can be a factor that contributes to homelessness, living homeless can also contribute to mental health challenges and make addressing behavioral health needs more challenging.

- **Unmanaged chronic conditions:** Participants shared accessing health care services can be more difficult for people experiencing homelessness. Individuals may not have the resources for necessary medications or nutritious foods.

"And then also folks who have chronic medical conditions, it's really hard to treat those or manage those conditions. For example, someone with diabetes, there's no place to refrigerate their insulin, to cleanly dispose of all their medications and then their needles get stolen." – Listening session participant

- **Untreated dental problems:** Oral health is related to overall physical health. Participants discussed how dental infections can lead to cardiac complications and make treating other health problems more challenging. They shared people experiencing homelessness may not have access to preventive care, leading to poorer oral health and ultimately their general wellbeing.

Listening session participants discussed the lack of preventive health care for many people experiencing homelessness. This contributes to people seeking care only in times of crisis and using the emergency room as their primary place of care.

Effective Strategies or Actions for Addressing Homelessness

Participants were asked, "Thinking about your own work and other work that's happening in the South Bay, what do you think are some effective strategies or actions for addressing homelessness?" Stakeholders shared the following insight:

- **Outreach teams:** With Measure H funding, organizations have been able to expand their street-based outreach teams. These teams have been especially helpful because they can establish caring relationships with people experiencing homelessness and they understand the available resources and how to navigate those systems. Specifically effective is engaging nurses and behavioral health professionals in the teams to better meet the needs of the people they are serving.

"Well it's that [outreach teams] seek to establish a relationship, and first of all they understand the individual, they understand the issue of homelessness better, and they're dealing with [people experiencing homelessness], and not just trying to, they're trying to get them help instead of just moving them along. So people kind of get that relationship developed." – Listening session participant

- **Hospital navigators and increased communication between services providers:** Participants spoke to the importance of having someone in the Emergency Department who can assess patients experiencing homelessness. Having an onsite hospital navigator who can connect patients with community based resources is an important step in ensuring patients experiencing homelessness are connected to the care and services they need.

- **Homelessness prevention and diversion:** Participants discussed the importance of more proactive strategies to address homelessness in the South Bay. They shared that providing subsidized food, educational and skill-building opportunities, and rental assistance can help keep people housed and give them the tools to be self-sufficient.

"We opened up a community center and really tried to focus on prevention… We do things like provide rental assistance… So I think there's some thought that needs to happen around preventing this. Like let's try and get in there before this happens. Right? Rather than treating it after the fact." – Listening session participant

- **Community education:** To address NIMBYism and common misperceptions about homelessness, participants said community education is critical. Showing elected officials low-

income housing units, conducting trainings with librarians, ride-alongs with police officers, and documentaries sharing the stories of people who are experiencing or formerly experienced homelessness are all ways of educating the public. By having these conversations, it helps to demystify homelessness and the barriers to moving people into housing.

- **Housing First with supportive services:** Participants shared that they have seen lives changed by having safe and stable housing. Bringing together stable housing and supportive services works to keep people from living homeless.

Measure H and Proposition HHH

Participants were asked, "How have Measure H and Proposition HHH affected homelessness in your community? In what ways do you expect them to affect homelessness in the coming years?" They shared Measure H has played an important role in increasing the number of street-based outreach teams. Additionally, it has helped improve collaboration and communication between service providers. Participants hoped that Proposition HHH will increase the amount of affordable housing in the City of Los Angeles in the future.

Needs

Participants were asked, "What else can organizations, hospitals, and businesses do to address and prevent homelessness? What else needs to change? At what level?" Participants noted needing more of the following:

- Collaboration and sharing between organizations, particularly related to post-discharge planning and warm handoffs from hospitals to social service organizations
- Leadership from stakeholders involved
- Advocacy from health care organizations that can leverage their authority and power to address homelessness
- Prevention efforts, such as investing in workforce development, job skill building, education and vocational opportunities
- Harm reduction strategies, such as needle exchanges
- Flexible funding to allow organizations to decide how best to spend money to meet clients' needs
- Recuperative care or transitional care for patients experiencing homelessness onsite at hospitals

Limitations

Community stakeholders were invited to participate in the listening sessions and those available attended. Only one listening session was conducted on each topic. Therefore, their voices do not represent the entire community and the data are not generalizable beyond the context in which it was gathered.

No notes were provided to the analyst and the analyst was not present at the session. Therefore, body language and energy of the room was not factored into the analysis. Additionally, the audio files included a lot of cross-talk and background noise making understanding certain comments challenging. The analysis was completed by only one analyst and is therefore subject to influence by the analyst's unique identities and experiences.

Finings—Community Stakeholder Interviews

Stakeholders were asked, "What are the most significant health issues or needs in the communities you serve, considering their importance and urgency?" As a follow-up, stakeholders were asked to elaborate on these needs by explaining contributing factors, groups most affected, and effective strategies for addressing these needs. Two issues stood out as high-priority with more than half of stakeholders identifying the need: access to care and mental health. Three issues were mentioned by multiple stakeholders and were categorized as medium priority needs: food insecurity and obesity, housing instability and homelessness, and substance use.

High Priority Health-Related Needs

Access to Care

Stakeholders shared the people they serve experience challenges accessing primary care and mental health care services for a variety of reasons:

- **Cost of care and medications:** Stakeholders shared even individuals with insurance struggle to afford the co-pays and bills associated with health care. Additionally, the high cost of medications makes managing chronic diseases or other conditions more challenging. The high cost of health care services and medications may disproportionately affect **people with low incomes** or **individuals with incomes just above the poverty threshold**, who may have insurance, but still not be able to afford the care they need. **Older adults** may also be disproportionately affected by challenges paying for care and medications.

- **Health literacy:** Stakeholders discussed how a lack of health literacy can prevent patients from accessing the care they need. Being able to navigate the complexity of the health care system and communicate effectively about one's needs are components of health literacy. Stakeholders shared a lack of case managers/ navigators, as well as culturally sensitive and bilingual providers make accessing high quality care more difficult. **Individuals with language or literacy barriers** may be disproportionately affected, particularly if they do not speak English and/or are not comfortable reading and writing.

- **Fear:** People may be afraid to seek health care services for a variety of reasons, including distrust of the health care system, fear related to immigration status, and fear of finding out about an illness. **People who are undocumented** may be disproportionately affected, as they may be afraid of having their immigration status reported or be afraid to seek health insurance due to the public charge rule.

- **Transportation:** Getting to appointments is not always easy for people, particularly without a car. **Older adults** may be disproportionately affected by transportation barriers.

- **Time of appointments:** For individuals who work during business hours they may not be able to take time off to go to an appointment. Additionally, they may need to prioritize making money over seeing a doctor. **Working individuals** may be disproportionately affected by the timing of appointments.

To address access to care challenges in the community, stakeholders suggested **increasing the number of medical homes** in the community which combine health education, medical care, and social-

emotional support. Other ideas included increasing **outreach and navigation** to help families learn about and then navigate the available resources in the community.

Mental health

Stakeholders shared mental health challenges as an urgent priority affecting many people in their communities. They shared the following contributing factors:

- **Challenges accessing care, including a lack of providers and mental health care centers:** Stakeholders shared they do not see mental health care services prioritized the same way physical health care services are prioritized. There are long wait times for mental health care appointments as most facilities face high patient volumes. Stakeholders shared challenges accessing mental health services disproportionately affect **young people** and **individuals with insurance other than Medicaid**. Stakeholders shared they typically have more options for referrals for people with Medicaid than those on other types of insurance.

- **Poverty and stress leading to lack of parental engagement:** Stakeholders discussed how chronic stress can contribute to mental health challenges. Stress from high housing costs, financial insecurity, and long work hours from multiple jobs puts strain on families. Stress and busy schedules contribute to lack of parental engagement and ineffective parenting, contributing to the mental health challenges stakeholders see in young people. Stakeholders shared **people of color**, particular **Latinx people**, and **immigrants** are disproportionately affected by poverty and stress contributing to poor mental health.

- **Screen time and social media addiction:** Stakeholders were particularly concerned about the high incidence of anxiety, stress, depression, and suicide they see in **young people**. They shared that along with ineffective parenting and stress in the home, high amounts of screen time and social media contribute to social isolation and poor sleeping habits, contributing to poor mental health.

- **Stigma around seeking mental health services:** A barrier to addressing mental health challenges in communities is stigma around utilizing services. Stakeholders shared parents do not always want their children to engage in mental health services for fear it will appear in their school or health records. Discussing mental health challenges or seeking services may not always be the norm in certain cultures as well.

To address mental health challenges in the community, stakeholders shared the following strategies:

- **Improve access to care:** To improve access to mental health care, stakeholders shared the following strategies: increase the available appointment times for mental health services, develop community partnerships to pool resources for funding services, and utilize mobile health vans to make services more accessible.

- **Invest in community based, preventive mental health services:** Implement group therapy or support groups for young people in community based settings.

Medium Priority Health-Related Needs

Food Insecurity and Obesity

Stakeholders expressed concern about poor access to healthy, affordable, good-quality food in the South Bay, which can contribute to obesity. They shared the following factors contributing to food insecurity and obesity in the community:

- **High cost of healthy foods and insufficient SNAP benefits:** Participants shared that healthy, good-quality food is often more expensive than unhealthy food options. High cost of rent and utilities means families may not be able to afford nutritious foods. Additionally, while the Supplemental Nutrition Assistance Program (SNAP) helps families afford food, it often is not sufficient to cover all of their dietary needs. **Families with low incomes** are disproportionately affected.

- **Fear related to public charge:** Undocumented immigrants, or immigrants with family members who are undocumented, may choose not to enroll in SNAP due to fear around public charge rules. **Undocumented immigrants** are disproportionately affected.

- **Poor quality food in low income neighborhoods:** Stakeholders shared there are fewer grocery stores in low-income neighborhoods and bringing farmers' markets to a low income neighborhood is challenging. Therefore, the availability of fresh, good-quality food in areas with poverty is generally lower than in higher income areas.

- **Lack of physical activity:** With busy schedules people have less time to exercise. Young people in particular may spend more time on screens than playing outside.

To address food insecurity, stakeholders suggested the following:

- **Provide free bags of food** to families on the weekends or at the end of the month at schools or community based organizations
- **Increase education** on how to buy healthy food on a budget, as well as health education related to obesity
- Work with community partners to **reduce cost** of healthy food
- Engage in **outreach** in communities to encourage enrollment in SNAP

Housing Instability and Homelessness

Stakeholders were concerned about the increasing number of people experiencing housing insecurity and homelessness in the South Bay. They shared the following as contributing to the problem:

- **An unsustainable and fragmented approach to addressing homelessness:** Stakeholders discussed that many of the current projects to address homelessness are "one offs," meaning there is not a structure or scalable model in place. The current system of developing housing is too time intensive and costly to be sustainable.

Individuals experiencing homelessness are disproportionately sleeping unsheltered compared to families experiencing homelessness.

To address housing instability and homelessness, stakeholders suggested the following:

- **Implement shared housing**: To address the needs of individuals experiencing homelessness, shared housing, meaning two bedroom apartments rather than a one bedroom might more effectively utilize space and be more cost effective.
- **Build smaller sites**: To limit neighborhood impact, stakeholders discussed building many smaller housing sites rather than a few really large sites.
- **Leverage influence and voices**: Health care systems should utilize their voice and resources to address homelessness.

Substance use

While substance use was mentioned as a community issue, stakeholders shared little about the complexity of the issue. They shared the following contributing factor:

- **Challenges accessing substance use treatment services:** Stakeholders shared there are a lack of providers available to provide substance use treatment, as well as few resources available to youth.

Stakeholders were particularly concerned about **young people** using substances. They shared the following strategy for addressing substance use in the community:

- **Youth led initiatives for substance use prevention and health promotion:** Implement a youth led initiative in schools and the community for substance use prevention and health promotion. Stakeholders shared an effective strategy for addressing substance use in young people is to engage young people in the solution.

Limitations

While stakeholders were intentionally recruited from a variety of types of organizations, there may be some selection bias as to who was selected as a stakeholder.

Multiple facilitators were used for the stakeholder interviews. Therefore, facilitators' emphasis on certain questions, examples given, and feedback (verbal or through body language) may have influenced the conversations. Note-takers were recording themes and information in a fast-paced environment. Therefore, they may not have been able to capture all of the information shared in the interviews. Additionally, because the note-takers were quickly documenting the themes, their own perspectives and biases may have influenced their interpretation of certain comments.

More information from the interviews was available for those with full transcriptions compared to those with notes, therefore, ideas from interviews that were recorded may be more detailed in the findings. The analysis was completed by only one analyst and is therefore subject to influence by the analyst's unique identities and experiences.

Appendix 4: Available Resources to Address Identified Needs

This section includes a description of the programs and services available in the Providence South Bay Community service area and that may be included in future Community Benefit Plan strategies or hospital partnerships and collaborations.

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

Health Need	Resources: Services, Programs and/or Community Efforts
Access to care	Community Clinic Association of Los Angeles County Vasek Polak Health Clinic Harbor Community Clinic The Children's Clinic, Serving Children and their Families
Dental	Assistance League of San Pedro- South
Food insecurity and obesity	Foodbank of Southern California (SoCal Foodbank) Providence Wellness and Activity Center Torrance Certified Farmers' Market Los Angeles County Department of Social Services (DPSS) Black Women for Wellness
Housing/Homelessness	Coordinated Entry System (CES) South Bay Coalition to End Homelessness (SBCEH)
Mental health	Catholic Charities of Los Angeles—St. Margaret's Center National Alliance on Mental Illness (NAMI) South Bay Families Connected South Bay Children's Health Center YMCA American Foundation for Suicide Prevention Didi Hirsch Mental Health Services Children's Institute Mental Health America Los Angeles (MHALA)
Substance use	Alcoholics Anonymous (AA) Al-Anon

Appendix 5: Evaluation of 2016 Community Health Improvement Plan Impact

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

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

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

Strategy 1: Improve Access to Health Care Services						
Measurable Objectives:	**Action Plan**	**Tactics**	**Progress in 2017**	**Progress in 2018**	**Benchmarks for 2019**	**Comments**
1) Increase enrollment in and utilization of health insurance *2) Increase the number of people with a primary care provider* *3) Increase the number of children who receive the recommended immunizations*	Increase enrollment in and utilization of health insurance	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	•2,517 individuals assisted with health insurance applications •2,264 individuals successfully enrolled into health insurance •2,001 applications assisted with Hospital Presumptive Eligibility Medi-Cal for ER Patients	•2,880 individuals assisted with health insurance applications •2,486 individuals successfully enrolled into health insurance •1,790 applications assisted with Hospital Presumptive Eligibility Medi-Cal •1,427 successful enrollments into Hospital Presumptive Eligibility Medi-Cal	•2,800 individuals assisted with health insurance applications •2,240 individuals successfully enrolled into health insurance •2,000 applications assisted with Hospital Presumptive Eligibility Medi-Cal •1,600 successful enrollments into Hospital Presumptive Eligibility Medi-Cal	
		Provide information and skills to newly insured adults on how to effectively utilize 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				
	Increase the number of people with a primary care provider	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	•1,368 patients seen at Vasek Polak Health Clinic •513 primary care appointments made for ER patients •127 high school students provided with sports physicals	•1,220 unique patients seen at Vasek Polak Health Clinic •848 primary care appointments made for ER patients •128 high school students provided with sports physicals	•1,800 unique patients seen at Vasek Polak Health Clinic •1,680 primary care appointments made for ER patients •125 high school students provided with sports physicals	
		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				
	Increase the number of children who receive the recommended	Partners for Healthy Kids: sustain operations of mobile pediatric clinic that offers free weekly immunizations at elementary, middle, and high schools	•1,211 immunization patient visits •439 people received doses of HPV vaccinations •Administered 374 doses of MCV4 vaccine	•1,399 immunization patient visits •571 people receive doses of HPV vaccinations •Administered 434 doses of MCV4	•1,400 immunization patient visits •600 people receive doses of HPV vaccinations •Administer 480 doses of MCV4	
		Promote HPV and meningococcal immunizations with local pediatricians and family practice physicians to encourage parents to have their children receive these vaccinations				

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

Community needaddressed: Prevention and Management of Chronic Diseases

Goal: To reduce the prevalence of diabetes and obesity

Strategy 2: Implement Prevention Interventions to Reduce the Prevalence or Progression of Chronic Disease						
Measurable Objectives:	**Action Plan**	**Tactic**	**Progress in 2017**	**Progress in 2018**	**Benchmarks for 2019**	**Comment**
1) Partner with local schools to reach the state-recommended standard of minutes of physical education instruction *2) Increase number of adults who meet the CDC recommended standard of physical activity*	Increase Physical Activity for Children and Adults	Sustain the delivery of the Creating Opportunities for Physical Activity (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	• COPA program sustained at 10 schools, impacting 243 teachers and 6,561 students •COPA expanded into two new schools in Watts, impacting 47 teachers and 1,269 students •326 Physical Activity related events hosted at the Providence Wellness and Activity Center in Wilmington	•COPA programming sustained at 12 schools impacting 291 teachers and 7,857 students •452 Physical Activity related events hosted at the Providence Wellness and Activity Center in Wilmington	•Sustain COPA programming at 9 schools for the 2019-2020 school year •450 Physical Activity related events hosted at the Providence Wellness and Activity Center in Wilmington	
3) Increase the number of structured movementactivities available for children and adults *4) Raise awareness of better eating habits through structured nutrition educationevents*	Promote Healthy Eating	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	•4 Fit Food Fairs with average attendance of 77 attendees per event • 2 Groceryships cohorts piloted with a total of 14 participants completing the program •1,194 households (1,529 individuals) assisted with CalFreshapplications	•Offered 3 Fit Food Fair events throughout the year 306 families attended. •3 FEAST (formerly Groceryships) cohorts offered in 2018 with an average of 16 participants in each cohort •1,052 households (1,659 individuals) assisted with CalFresh applications •Opened a weekly Farmer's Market in Wilmington at the Providence Wellness and Activity Center that accepts CalFresh as a form of payment in Fall 2018 •Opened a community teaching garden for vegetables at the Providence Wellness and Activity Center in Wilmington	•Continue to offer 4 Fit Food Fair events throughout the year. •Offer two FEAST classes in the South Bay •Assist 1,100 households (1,600 individuals) with CalFresh applications •Increase average CalFresh spending at Farmer's Market to average $150/week.	
5) Increase access to healthier foods in lower-income communities *6) Reduce the average A1C % of diabetic GOALprogramparticipants by 1.3%* *7) Implement a diabetes prevention*	Management Education	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 GOALclasses Adopt an evidence based curriculum for Pre-diabetic patients and work with hospital or community partner to strengthen the infrastructure of classes	•12 GOAL class series delivered in community sites •Average A1C of diabetic GOAL patients lowered from 8.0% to 6.7% (reduction of 1.3%) •179 patients referred to GOAL from Providence clinicians	•14 GOAL class series delivered in community sites •Average A1C of diabetic GOAL patients lowered by 0.87% •157 patients referred to GOAL from Providence clinicians •1 Diabetes Prevention Program cohort started in Fall of 2018	•12 GOAL class series delivered in community sites •Average A1C of diabetic GOAL patients lowered by 1.0% •200 patients referred to GOAL from Providence clinicians •Diabetes Prevention Program: Achieve CDC Preliminary Recognition	

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

Community needaddressed: Mental Health (including substance abuse treatment)

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

Strategy 3: Strengthen Community Based Mental Health Infrastructure to Better Align with Hospital-Based Mental Health Services						
Measurable Objectives:	**Action Plan**	**Tactic**	**Progress in 2017**	**Progress in 2018**	**Benchmarks for 2019**	**Comment**
1) Improve integration of mental health in primary care settings *2) Build resilience in children, teens,families and seniors*	Prevention	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	• 10 series of CHAT (Creating Healthier Attitudes Today) courses on coping skills and resiliency taught. 83 people completed the entire series. •35 mental health awareness presentations hosted at the Providence Wellness and Activity Center •58 Providence Community Health employees completed Mental Health First Aid •36 community members completed Mental Health First Aid	• 12 CHAT cohorts provided in the community, with 110 people completing the series •44 mental health awareness presentations hosted at the Providence Wellness and Activity Center	•Provide 10 CHAT courses in the community, with 90 people completing the series •40 mental health awareness presentations hosted at the Providence Wellness and Activity Center	We are currently seeking funding to train staff as Mental Health First Aid trainers
3) Reduce the stigma of mental illness *4) Reduce symptoms of depression and anxiety*	Treatment	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	•917 patients screened for anxiety and depression at Vasek Polak Health Clinic •58 patients enrolled into therapy sessions at Vasek Polak Health Clinic	•941 patients screened for anxiety and depression at Vasek Polak Health Clinic •52 patients enrolled into therapy sessions at Vasek Polak Health Clinic •18 participants enrolled into UCLA Alcohol Consumption ReductionStudy	•1,440 patients screened for anxiety and depression at Vasek Polak Health Clinic •80 patients enrolled into therapy sessions at Vasek Polak Health Clinic •Enroll 60 participants into UCLA Alcohol Consumption ReductionStudy	After exploring feasibilty of linkage to community resources for patients discharged from hospital settings, we have realized that we will first need to invest in a software system to track these referrals. Furthermore, we have come to the conclusion that a more appropriate location to pilot process this will be the Vasek Polak Health Clinic rather than the hospital settings.

Strategy 4: Develop Partnerships that Address Social Determinants of Health

Community need 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

Strategy 4: Develop Partnerships that Address Social Determinants of Health						
Measurable Objectives:	**Action Plan**	**Tactic**	**Progress in 2017**	**Progress in 2018**	**Benchmarks for 2019**	**Comment**
1) Reduce household food insecurity *2) Reduce social isolation by providing opportunities for residents to build social connections* *3) Increase breadth/diversity of programs provided at the Providence Wellness and Activity Center in Wilmington provided by community partners or volunteers* *4) Establish a subcommittee of the local coalition to end homelessness attended by area hospital representative who have*	Providence Wellness and Activity Center	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 healtheducation	• 854 events/classes/activities at the Wellness Center in 2017. 13,470 visits by community members •42 Community Leaders trained in Builidng Stronger Families. These leaders led 5 large outreach events and led 27 workshops in the community.	•Host 741 events/classes/activities at the Wellness Center. 9,788 visits by community members. •We have replicated Building Stronger Families community leaders training at the Lawndale Elementary School District, rebranded as Building Stronger Communities. We are seeking funding to build a Wellness Center site on one of the Lawndale school campuses.	•Host 800 events/classes/activities at the Wellness Center •Secure funding for a Wellness Center at Lawndale Elementary School District site or identify alternate site for collaborative Wellness Center with a local community based organization	We have replicated Building Stronger Families community leaders training at the Lawndale Elementary School District, rebranded as Building Stronger Communities.
		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	•Began discussions with local school district to provide services on one of their school campuses.			
	Strengthen Collaborative Organizational Partnerships	Host briefings for community leaders/stakeholders centered around violence, affordable housing and homelessness, or poverty and food insecurity	•Provided space for SART at both Providence Little Company of Mary Medical Center Torrance and PLCMMC San Pedro. 185 total forensic and suspect exams in 2017. •Began exploration of a partnership with other nonprofit hospitals and Charles Drew University to develop a Community Health Worker workforce development program	•Provided spaces at PLCMMC Torrance and PLCMMC San Pedro for Sexual Assault Response Teams. 200 total forensic and suspect exams in 2018. • We have submitted two proposals to fund a Community Health Worker Academy at Charles Drew University but have not yet found a funder for this project. Will continue to seek funding in 2019. • Hospital Liaison at Harbor Interfaith collaboratively funded by Providence, Torrance Memorial, and Kaiser who connects patients experiencing homelessness to housing resources.	•Continue to provide spaces at PLCMMC Torrance and PLCMMC San Pedro for Sexual Assault Response Teams • Find philanthropic seed funding for Community Health Worker workforce training program at Charles Drew University • Secure sustainable funding for Hospital Liaison position	
		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	Increase CalFresh enrollment through application assistance and work with local farmers markets to accept CalFresh as a form of payment	•1,529 individuals, 1,194 households assisted with CalFresh applications •Food service department partners with local non-profit, Food Finders, to donate leftovers to local food banks.	•1,052 households (1,659 individuals) assisted with CalFresh applications	•Assist 1,100 households (1,600 individuals) with CalFresh applications •Implement food insecurity screening at Vasek Polak Health Clinic and Wellness and Activity Center	See Strategy 2 regarding Farmer's Markets.
		Work with hospital departments to facilitate donations to local South Bay safety net organizations				

Appendix 6 – CHNA GOVERNANCE

Assessment Oversight Committee

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

First Meeting Date: 10/15/19 (Noon - 2pm) Second Meeting Date: 10/29/19 (Noon - 2pm)

Name	Internal/ External	Title	Organization	Community Representation
Dolores Bonilla-Clay	External	Chief Executive Officer	Wilmington Community Clinic	
Dipa Shah-Patel	External	Director, Nutrition and Physical Activity Program	Los Angeles County Department of Public Health	
Juliette Stidd	External	Clinical Director	Richstone Family Center	
Louie Mardesich	External	Community of Schools Administrator	LAUSD Local District South	
Tom Harney		Director, Food and Nutrition Services	Providence Little Company of Mary	
Gilberto Dorado	Internal	Director, Behavioral Health/Care Management	Providence Little Company of Mary	
Ted Wang	Internal	Chief Financial Officer	Providence Little Company of Mary	
Kathryn Webster	Internal	Director, Acute Care/Emergency Services	Providence Little Company of Mary	
Tim McOsker, Chair, Community Ministry Board Providence Little Company of Mary	External	CEO	AltaSea at the Port of Los Angeles	

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