Saint John's Health Center
PROVIDENCE Health & Services

Westside Service Area Community Health Needs Assessment 2016

Providence Saint John's Health Center

Santa Monica, Calif.

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Executive Summary

Providence Saint John's Health Center (PSJHC) completes a community health needs assessment of the Westside area every three years. As part of the process, both primary and secondary research is done to identify the high priority needs and issues facing the community. As part of this needs assessment process, input was sought from community leaders (e.g. the local Public Health Officer) and local residents using both phone and written surveys. Part of the primary data collection involved a collaborative relationship between PSJHC, UCLA Health System, Cedars-Sinai Medical Center, and Kaiser Permanente Medical Center West L.A. to conduct the interviews with community leaders. Secondary data review included information from multiple public and private sources on the targeted area.

Once the information was collected and analyzed on the community, members of the Providence Saint John's Community Advisory Committee were asked to help prioritize the needs identified through this process. Through discussion and rank voting, the following five key areas were identified as priorities for the organization to focus on over the next three years:

- Increase access to affordable primary and specialty care
- Offer programs and resources to better manage and prevent chronic illnesses
- Develop more programs focused on reducing obesity and improving nutrition in the community
- Improve access to affordable mental health and substance abuse programs
- Offer programs and services to assist the growing number of homeless persons living in the area

Many of the priority needs identified in this CHNA were similar themes from the assessment completed in 2013. The priorities identified in that study included:

- Access to mental health services
- Increase in the number of homeless patients utilizing the emergency department for non-emergent conditions
- Access to affordable and convenient primary and specialty care
- More health education and wellness promotion programs in the community

Since the completion of the last Community Health Improvement Plan, several positive outcomes have occurred to address the priority needs:

- PSJHC developed the Homeless Care Navigation Program to better meet the needs of patients coming to the emergency department
- The specialty care access hub was created in partnership with Venice Family Clinic to work with providers in the area to increase access to specialty care for those who are uninsured or on Medi-Cal
- A program to improve screening of children in preschool was implemented by the Providence Child and Family Development Center to identify and assist children who are at-risk for mental illness, and the Helen Reid Parenting Program was merged into CFDC
- PSJHC now has a contract with one of the Medi-Cal managed care plans and can serve patients at the hospital
- The Community Health Partnership Program has been developed by PSJHC to improve health education and screening programs offered in the community

As we begin to focus on the next three years, PSJHC developed five key strategies and seventeen metrics to address the priority health needs identified from this assessment process.

Assessment Overview

Providence Saint John's Health Center (PSJHC) began the community health needs assessment process in September 2015. The assessment included primary data collection that involved phone surveys with key community stakeholders and leaders and written surveys with community residents. Input was also provided from members of the Providence Saint John's Community Advisory Committee to help rank the priority needs identified through the various interviews and data analysis.

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 information from the Think Health L.A. Database, Community Commons Database, California Health Interview Survey Dataset, data from the L.A. County Department of Public Health, morbidity and mortality data from the State of California Department of Public Health, Community Need Index data from Truven Analytics/Dignity Health, community specific data from the City of Santa Monica, and clinical data from PSJHC's electronic health record system.

Prioritized Need #1 – Access to Care

Access to affordable primary and specialty care for those who are low-income or uninsured.

Data Point	Previous CHNA	Current CHNA
Access to obstetrical care for women on Medi-Cal living on the Westside.	No OB/GYNs accepted Medi-Cal at PSJHC	OB/GYNs in Laborist program will begin to accept Medi-Cal
Access to select specialists identified as priority from the area community clinics.	Access to specialty medical care was identified in the top 5 needs	Access to primary care improved with the expansion of Medi-Cal, but specialty care access for Medi-Cal patients is still very limited
Access to gastroenterology diagnostic testing and consults for the uninsured and patients on Medi-Cal.	Patients could be waiting for up to 6 months for G.I. diagnostics with County providers	Access to G.I. diagnostics is still a top need identified by the 3 local community clinics

Prioritized Need #2 – Chronic Disease

Better management and prevention of chronic illnesses such as heart disease, diabetes, arthritis and hypertension

Data Point	Previous CHNA	Current CHNA
More prevention and management resources for diabetes and hypertension.	Adults Diag. with Diabetes 6.3% Adults Diag. with Hypertension 22.1%	Adults Diag. with Diabetes 4.6% Adults Diag. with Hypertension 26.8%
More education and management programs for those dealing with arthritis and other mobility limiting chronic	Adults Diag. with Arthritis, Lupus,	Adults Diag. with Arthritis, Lupus,

conditions.	Gout or Fibromyalgia 22.4%	Gout or Fibromyalgia 20.3%
Improve community care management services for medically fragile seniors in the community.	Population age 65+: 14.9%	Population Age 65+: 16.3%

Prioritized Need #3– Disease Prevention and Health Promotion
More programs focused around good nutrition and reducing obesity.

Data Point	Previous CHNA	Current CHNA
Low participation in food assistance programs for households < 300% of the Federal Poverty Level.	5.8% of households < 300% of FPL receive food assistance	5.1% of households < 300% of FPL receive food assistance
Increasing number of adults 18+ who are overweight and obese.	41.2% of adults were overweight and obese	53.3% of adults were overweight and obese
Increasing number of teens who are overweight and obese.	23.4% of teens were overweight and obese	40.7% of teens were overweight and obese

Prioritized Need #4– Mental Health and Substance Abuse
Improved access to affordable mental health and substance abuse treatment programs.

Data Point	Previous CHNA	Current CHNA
Lack of access for adults to affordable mental health and substance abuse treatment programs in the area.	23.6% of adults needed help for mental health or substance abuse	20.0% of adults needed help for mental health or substance abuse
Increasing number of youth reporting experiencing significant periods of extreme sadness over the past year.	25.3% of school-aged youth in Santa Monica	26.3% of school-aged youth in Santa Monica
Significant number of youth reporting they have used substances over the previous months.	31.7% of youth in Santa Monica report using substances	26.1% of youth in Santa Monica report using substances

Prioritized Need #5– Homelessness
Growing rates of homelessness and housing instability due to higher housing costs in the Westside area and economic pressures.

Data Point	Previous CHNA	Current CHNA
Number of homeless persons utilizing the emergency departments at area hospitals for non-emergent conditions.	Approximately 203 homeless patients per month use PSJHC's E.D.	Approximately 175 homeless patients per month use PSJHC's E.D.
Lack of shelter beds, affordable housing and other resources in the area for the homeless.	12 recuperative care beds were available at OPCC	22 recuperative care beds are available at OPCC
Lack of hospice/palliative care services for homeless individuals with terminal illnesses.	12-15 homeless patients per year died without end of life care	22-25 homeless patients per year died without end of life care

Acknowledgements
Summary of Community Input

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

This section describes how Providence Saint John's Health Center took into account input from persons who represent the broad interests of the community. It summarizes in general terms input provided, including how and over what time period such input was provided.

Summary of phone interviews with select community leaders and stakeholders

From September to October 2015 phone interviews were conducted with key community leaders in the area. These individuals were from organizations and government agencies serving all sectors of the community, including those who are poor and vulnerable. The phone interviews were conducted in collaboration with Cedars-Sinai Medical Center, Kaiser Permanente West L.A., and UCLA Health System. Interviews were conducted with forty-one individuals from the area and included questions about top needs in the area and contributing factors impacting those needs. The following needs were identified by the group as the top priorities:

- Mental health treatment and suicide prevention programs
- Access to affordable medical care
- Substance abuse treatment and prevention programs
- Growing rate of homeless persons
- Chronic disease prevention and management
- Poor nutrition

The key contributing factors impacting the key needs in the community identified by this group included:

- High housing costs
- Lack of affordable nutritious foods
- Lack of specialty physicians taking Medi-Cal, Medicare, and other insurances
- Growing rate of poverty in the area
- Lack of affordable public transportation
- Lack of education

Summary of written surveys conducted with community residents

From February to April 2016, written surveys were distributed to local residents attending community health education forums to seek their input on the priority needs in the community. A total of eighty-five surveys were completed. The top priority needs identified from this survey included:

- Access to affordable medical care
- Growth of chronic diseases including diabetes, heart disease, arthritis and high blood pressure
- Disease prevention programs and services that are free/low cost
- Mental health conditions and increasing rate of suicides

- Growing homeless population
- Growing rate of substance abuse

The top contributing factor impacting the community needs that the community residents identified included:

- Lack of physicians who accept all insurance plans
- Increase in economic/financial pressures facing community residents
- Lack of free and affordable disease prevention programs in the area
- Lack of affordable housing in the area

When asked what Providence Saint John's should be doing to address the priority health needs in the community, the top three recommendations that the community residents provided included:

- Implement programs to address the community needs identified
- Work closer with community residents to address the needs
- Lead initiatives and projects in the community that will address the needs

Summary of discussion group session conducted with the Community Advisory Committee

A discussion was held as part of the Providence Saint John's Community Advisory Committee meeting held in May 2016, in which members of the group were asked for input on the priority needs and issues identified by both community stakeholders and area residents. This committee is comprised of twenty-two individuals (both external and internal leaders) who advise PSJHC on the programs and initiatives it develops for the community. Based on this discussion some of the key themes included:

- Access to specialty medical care for those persons who are uninsured or on Medi-Cal remains a key issue on the Westside
- Lack of affordable mental health services in the area and the availability of inpatient mental health services is a key issue
- Housing and services for the growing homeless population continues to be a key need in the community
- Many seniors in the community are facing multiple pressures including the loss of affordable (e.g. rent controlled) housing, declining physical health from chronic illness, and increased financial pressures for those on fixed incomes
- Increased use of drugs and alcohol from teens to adults is a growing concern in the community

Summary of comments regarding the last CHNA

Two questions were received from community residents on the last community health needs assessment conducted by Providence Saint John's Health Center. These questions were received at two community meetings held on the new development project the hospital is planning.

- Meeting on August 8, 2015: The question was regarding how PSJHC defined the area studied for the community needs assessment. The response provided was that the organization looks at the group of zip codes where approximately 70% of the patients served reside and matching this list with the Service Planning Area definitions established by the County of Los Angeles.

- Meeting on January 7, 2016: A question was asked by a local resident regarding how someone can access the complete community health needs assessment completed by PSJHC. The person was provided with the web address to access the full CHNA document.

Introduction

Creating healthier communities, together

As health care continues to evolve, Providence Saint John's Health Center is responding with dedication to its Mission and a desire to *create healthier communities, together*. Partnering with others of goodwill, we conduct a formal community health needs assessment to learn about the greatest needs and assets in our community, especially considering members of medically underserved, low-income, and minority populations.

This assessment helps us develop collaborative solutions to fulfill unmet needs while continuing to strengthen local resources. It guides our community benefit investments, not only for our own programs but also for many partners, toward improving the health of entire populations. Through strategic programs and donations, health education, charity care, medical research and more, Providence Health & Services provided $848 million in community benefit across Alaska, California, Montana, Oregon and Washington during 2014.

Serving Westside Communities

Providence Saint John's Health Center offers a comprehensive array of medical services (both inpatient and outpatient) to meet the health care needs of the Westside area. These services include cardiac/cardiovascular, neurosciences, orthopedics, obstetrics and women's health, general medicine/surgery, and a comprehensive cancer program and research center offered at the John Wayne Cancer Institute.

The Health Center also has a strong commitment to addressing the health needs in the community with special concern for the poor and vulnerable. The Providence Saint John's Child and Family Development Center offers comprehensive outpatient mental health services to low-income children and their families. PSJHC also provides a comprehensive community health education program for area residents through community forums and lectures. In 2015, the Health Center started the Homeless Care Navigation Program to assist homeless patients who utilize the emergency department by linking them with shelter/housing and other resources.

During 2015, PSJHC provided $44,386,407 in community benefit in response to unmet needs and to improve the health and well-being of those we serve in the Westside of Los Angeles County. Our service area includes:

- Providence Saint John's Health Center: A nationally renowned 266-bed hospital with physicians, nurses, volunteers and support staff who work as a team to provide the best possible medical care to its patients and the community.
- John Wayne Cancer Institute: A cancer treatment and research center affiliated with PSJHC providing the latest advances in treating this growing disease.
- Providence Medical Institute: A network of primary care and specialty physicians located in Santa Monica and the surrounding communities.
- Doctors of Saint John's: A group of primary care and specialty physicians affiliated with Providence Saint John's Health Center.
- Child and Family Development Center: A community mental health center serving low-income children and their families dealing with emotional and mental health issues.
- Freestanding Urgent Care Centers: Provided through a partnership with Exer Urgent Care.
- Trinity Care Hospice: Operated by Providence Health and Services to offer home hospice to the community.
- Institute for Human Caring: Operated by Providence Health and Services to provide palliative care education and services to the community.

Our Partners in the Community Health Needs Assessment

Cedars Sinai Medical Center, Los Angeles, CA
Kaiser Permanente Medical Center, West Los Angeles, CA
UCLA Health System, Westwood, CA

As part of the primary data collection process, Providence Saint John's Health Center worked in collaboration with our area hospitals to collect and analyze the information. Together, the four hospital systems collaborated on several components of the CHNA including:

- 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 for each hospital is completed, there are plans to look at each organizations' implementation strategies to identify the common priority needs across the respective hospitals. The hospitals intend to continue the collaborative efforts begun with the CHNA process to identify a common health need that they can work on together.

About us

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

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

Our Values
Respect, Compassion, Justice, Excellence, Stewardship

Our Vision
Simplify health for everyone

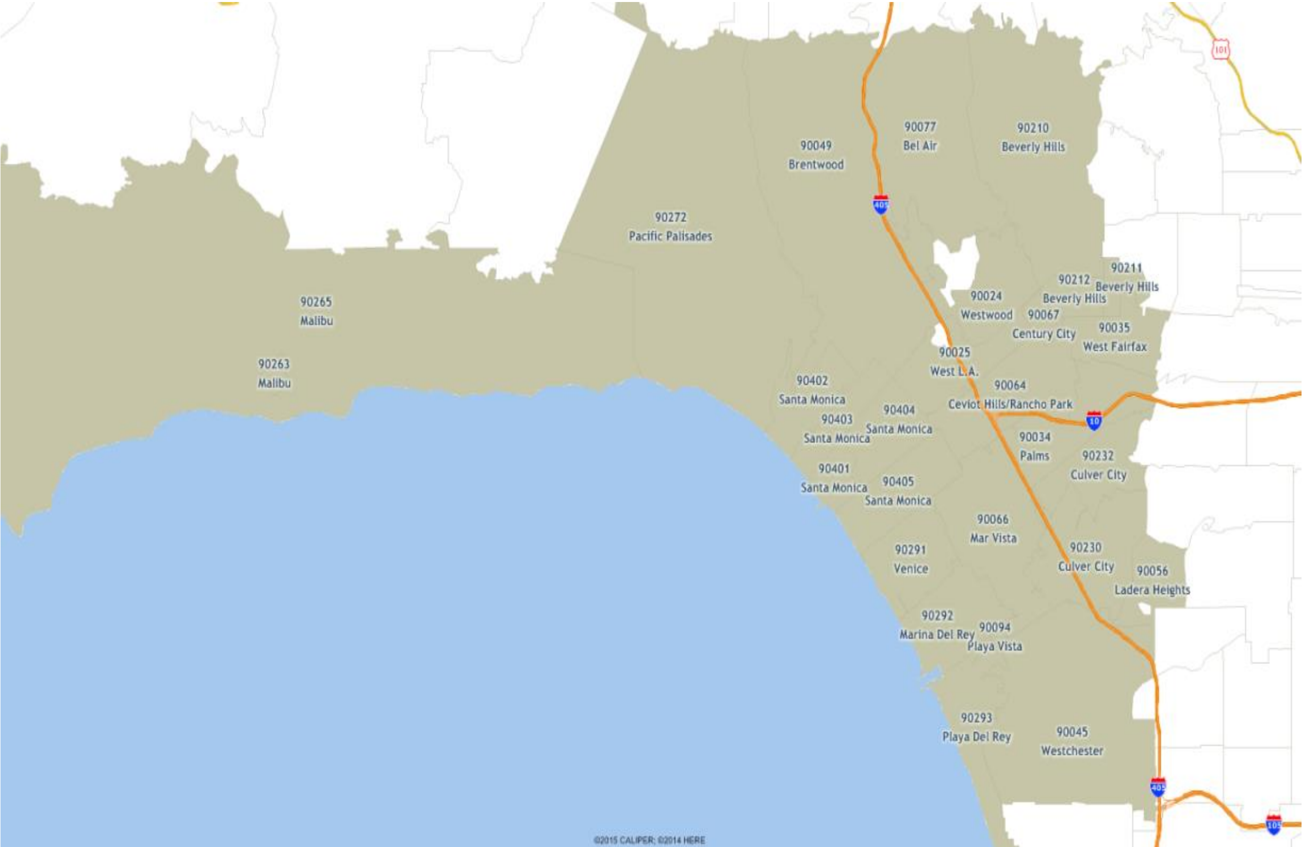
Our Promise
Together, we answer the call of every person we serve: Know me, Care for me, Ease my way. ®

Description of Community

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

The service area defined for the Providence Saint John's Health Center Community Health Needs Assessment includes the zip codes located within Service Planning Area (SPA) 5 of Los Angeles County. The planning area includes the communities located on the west side of the County, and represents the area where a significant portion (over 70%) of the patients served by the hospital resides. Since the service planning area matched closely with where a majority of PSJHC's patients reside, it was decided to use this geographic area for the CHNA. Using the SPA definition also helped with the collection of data from the L.A. County Department of Public Health and other governmental agencies that use these boundaries when conducting studies. The area includes 20 distinct communities and 30 zip codes.

Providence Saint John's Health Center
CHNA Service Area Map



Community Profile

The table provides a breakdown of the communities and zip codes that are part of the area studied as part of the community health needs assessment conducted by PSJHC.

Zip Code	Community	Community	Zip Code
90024	Westwood	Bel Air	90077
90025	West L.A.	Beverly Hills	90210
90034	Palms	Beverly Hills	90211
90035	West Fairfax	Beverly Hills	90212
90045	Westchester	Brentwood	90049
90049	Brentwood	Century City	90067
90056	Ladera Heights	Cheviot Hills/Rancho Park	90064
90064	Cheviot Hills/Rancho Park	Culver City	90230
90066	Mar Vista	Culver City	90232
90067	Century City	Ladera Heights	90056
90073	Veterans Admin/West L.A.	Malibu	90263
90077	Bel Air	Malibu	90265
90094	Playa Vista	Mar Vista	90066
90095	UCLA/Westwood	Marina Del Rey	90292
90210	Beverly Hills	Pacific Palisades	90272
90211	Beverly Hills	Palms	90034
90212	Beverly Hills	Playa Del Rey	90293
90230	Culver City	Playa Vista	90094
90232	Culver City	Santa Monica	90401
90263	Malibu	Santa Monica	90402
90265	Malibu	Santa Monica	90403
90272	Pacific Palisades	Santa Monica	90404
90291	Venice	Santa Monica	90405
90292	Marina Del Rey	Venice	90291
90293	Playa Del Rey	West Fairfax	90035
90401	Santa Monica	West L.A.	90025
90402	Santa Monica	West L.A./Veterans Admin.	90073
90403	Santa Monica	Westchester	90045
90404	Santa Monica	Westwood	90024
90405	Santa Monica	Westwood/UCLA	90095

Population and Age Demographics

Total population of the area in 2016 is 674,787 persons, which represents a 5 percent increase compared to the 2010 population or an additional 32,000 residents living in the area. A breakdown of the population by age/gender for the area include

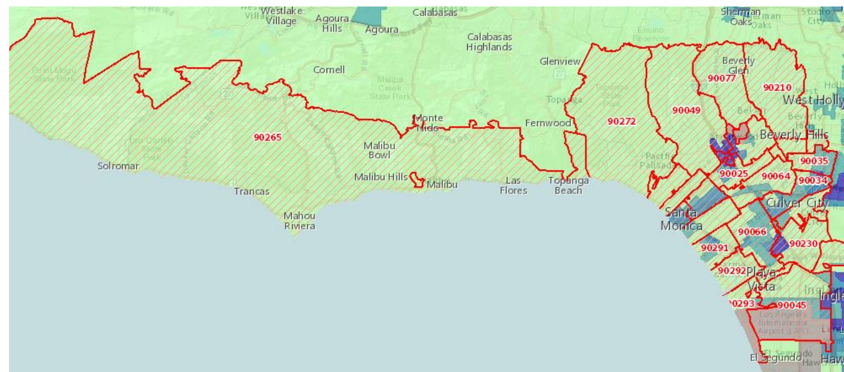
- 8.1 percent male youth (0-17 years)
- 7.8 percent female youth (0-17 years)
- 33.2 percent male adults (18-64 years)
- 34.7 percent female adults (18-64 years)
- 7.2 percent male senior adults (65+ years)
- 9.1 percent female senior adults (65+ years)

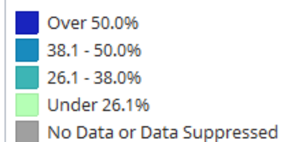
Ethnicity

Among Westside/SPA-5 residents in 2016, 68.5 percent were White, 13.4 percent Asian/Pacific Islander/Hawaiian, 0.43 percent were Alaska Native or American Indian, 6.0 percent were African American or Black, and 5.5 percent were of two or more races. In looking at the Latino population that resides in the area, approximately 15.4 percent of the residents identify themselves as being part of this group.

Income Levels and Housing

In 2016, the median household income of the area varied significantly from a low of $55,025 for the community of Westwood to $158,545 for the community of Bel Air. This difference in income was also reflected in average household income of the area with $78,891 in the community of Palms and $215,718 in the community of Bel Air. Although the Westside contains many affluent communities, the income data shows that there are areas within the service area with a higher portion of low-income households. Approximately, 24 percent of the population has annual incomes below 200% of the Federal Poverty Level compared to 41 percent in Los Angeles County as a whole.





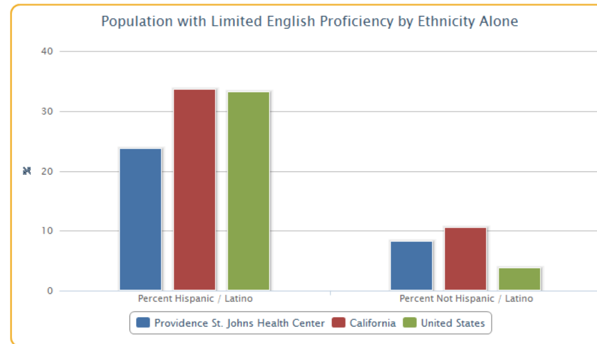
Education Level

While most of the adults age 25+ living in households on the Westside 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 Palms (90034) 11.5%, Mar Vista (90066) 11.5%, Culver City (90230) 12.1% and Culver City (90232) 10.2%.

Other Community Characteristics

The Westside area has some notable economic indicators. The unemployment rate in the area has been averaging around 4 percent. The number of owner occupied housing units in the area is 40.5 percent compared to 59.5 percent that are rented housing units. Of the occupied housing units, approximately 46 percent have one or more substandard conditions.

Within the Westside/PSJHC service area, approximately 10.8 percent of the general population aged 5 and older has limited English proficiency. Within the Latino population, 23.7 percent have limited English proficiency.



Health Care and Coverage

The share of Westside residents who are uninsured was 5.3 percent in 2016. Compared to L.A. County with 79.3 percent of the population insured, the Westside has a higher percentage insured (94.7 percent). For the same period, approximately 26.8 percent of area residents were covered by Medi-Cal. With the passage of the Affordable Care Act, more people in the area are now covered by health insurance. One of the major issues in the area is the lack of specialty care access for those covered by Medi-Cal due to few physicians in the area who accept this insurance. The most recent count shows that eighty-three specialty physicians located on the Westside accept Medi-Cal managed care patients.

Health and Wellbeing

The area has a large supply of physicians due in part because there is a large medical school and academic medical center in the vicinity. Compared to other parts of L.A. County, the Westside has a larger ratio of physicians to the population living in the area, especially specialty providers. The main issue is that a good portion of the physicians located on the Westside do not accept all insurance plans, including Medi-Cal and Medicare, which raises access issues with a significant number of residents.

Process, Participants and Health Indicators

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

Assessment process

Every three years, Providence Saint John's Health Center conducts a community health needs assessment (CHNA) for the Westside area/Service Planning Area 5. The CHNA is an evaluation of key health indicators of this targeted area. The assessment process includes a review of secondary data/studies completed on the area and primary research completed through telephone interviews with community stakeholders, written surveys of area residents, and in-person meetings with members of the Providence Saint John's Community Advisory Committee.

Participants

Telephone Survey with Key Community Leaders/Stakeholder from September to October 2015

Participant	Affiliated Organization	Area Representing
Elan Schultz	L.A. County Board of Supervisors	Health Deputy for District 3
Rosemary Veniegas	California Community Foundation	Funder of health projects
Elizabeth Forer	Venice Family Clinic	Federally Qualified Health Center (FQHC) serving the area
Yolanda Vera	L.A. County Board of Supervisors	Health Deputy for District 2
Kita Curry	Didi Hirsch Mental Health Center	Outpatient mental health services
Nina Vaccaro	Southside Coalition of Community Health Centers	Organization representing community health clinics
Laurel Rosen	Santa Monica Chamber of Commerce	Organization representing businesses in the area
Mary Odell	UniHealth Foundation	Funder of health projects
Deb Farmer	Westside Family Health Center	FQHC serving the area
Jeff Bujer	Saban Clinic	FQHC serving the area
Mark Mariscal	L.A. City Dept. of Parks and Rec.	Government agency
Susan Cohen	L.A. Gay and Lesbian Center	Organizations providing multiple services to LGBQT
Lucia Diaz	Mar Vista Family Center	Community center serving a low income housing project
Ivan Mason	U.S. Veteran's Initiative	Organization serving veterans
Maryjane Puffer	The L.A. Trust for Children's Health	Organization serving children
Armen D. Ross	Crenshaw Chamber of Commerce	Organization representing businesses
Richard Bruckner	L.A. County Dept. of Planning	Government organization
Nolan Rollins	Los Angeles Urban League	Civil rights organization

Participant	Affiliated Organization	Area Representing
Vivian Sauer	Jewish Family Services	Organization providing social and community services
Connie Chung	Korean American Family Services	Organization providing social and community services
Liz Romo	South L.A. Women, Infants & Child.	Serves pregnant women, new mothers and their infants
David Giugni	City of West Hollywood	Government organization
Loretta Jones	Healthy African American Families	Provides health and social services
Lora Morn	Santa Monica-Malibu Unified School District	Oversees public schools in Malibu and Santa Monica
Alison Herrmann	UCLA Kaiser Permanente Center for Health Equity	Conducts research on health disparities in the area
Dr. David Carlisle	Charles R. Drew University of Medicine and Science	Medical school located in the area
Dr. John King	City of L.A. Housing Authority	Government agency overseeing housing issues
Veronica Lewis	Homeless Outreach Program Integrated Care System	Provides social services to those who are homeless
Heather Hays	First African American Episcopal Church of L.A.	Religious institution
Tunua Thrash-Ntuk	West Los Angeles Community Development Corp.	Organization focusing on economic and community development
John Maceri	Ocean Park Community Center	Organization providing shelter & other services for homeless
Maureen Cyr	L.A. County Dept. of Mental Health	Government organization providing mental health svcs.
Grace Cheng Braun	WISE and Healthy Aging	Organization providing social and other services to seniors
Tod Lipka	Step Up on Second	Organization providing services to the homeless
Dr. Kimberly Uyeda	Los Angeles Unified School District	Oversees health services for the District
Dr. Patrick Dowling	UCLA David Geffen School of Med.	Major medical school in the area
Louise Jaffe	Santa Monica College	Community college in the area
Msgr. Lloyd Torgerson	St. Monica Church	Religious institution
Chris Baca	Meals on Wheels West	Organization providing free and low-cost meals
Leticia Segura	L.A. Care Health Plan	Major Medi-Cal managed care plan in the area
Dr. Jan King	L.A. County Department of Public Health	Public Health Officer for the area

Community Resident Input

A written survey was distributed at four community education forums to solicit input from community residents regarding the key health needs and contributing factors impacting the area. These community forums had representation from a broad sector of the community and were conducted on February 23 and 24 and April 12 and 13 in 2016. There were a total of eighty-five residents who completed the surveys at these community events.

Providence Saint John's Health Center

The Providence Saint John's Health Center Mission reaches out beyond the walls of care settings to touch lives in the places where relief, comfort and care are needed. One important way we do this is through community benefit spending. PSJHC programs and funding not only enhance the health and well-being of our patients, but the whole community. Providence is committed to supporting broader determinants of health beyond clinical care. Providence's community benefit connects families with preventive care to keep them healthy, fills gaps in community services, addresses mental health issues, offers services to assist those who are homeless, and provides opportunities that bring hope in difficult times.

When the Sisters of Providence began our tradition of caring nearly 160 years ago, their ministry greatly depended on partnering with others in the community who were committed to doing good. Today, we collaborate with social service and government agencies, charitable foundations, community organizations/nonprofits, religious institutions, clinics, schools and universities, other health care providers, and many other partners to identify the greatest needs and create solutions together. PSJHC makes a significant investment in the work of these organizations through community benefit grants and other funding. During 2016, the Health Center provided over $1.6 million in funding to support the work of our community partners in improving the health and well-being of the service area.

Data collection

Primary Data (new)

As part of the CHNA data collection, Providence Saint John's Health Center partnered with the three other hospital systems in the area to identify key sectors in the community to seek input and those community stakeholders representing these areas. A list of questions was developed in collaboration with the other hospitals and forty-one individuals were selected to be interviewed via phone. These individuals included representation from local government, education, public health, health care providers, social services, mental health, community development, faith-based institutions, foundations, homeless agencies, programs serving the elderly, and organizations serving children. A copy of the questions that were asked in the telephone surveys is included in Appendix III of this report.

Secondary Data (existing)

The following table provides a breakdown of the secondary data sources used for the community health needs assessment.

Type of Data	Data Sources	Reason for Including
Demographic Data	Think Health L.A. Database Claritas Data	These data sources provided the most current demographic

Type of Data	Data Sources	Reason for Including
	American Community Survey	data for the area at a zip code level.
Health Status Data	Community Commons Dataset Ask CHiS Database	These databases include a comprehensive set of data elements looking at the population's health status.
Disease and Illness Estimates	Epic Medical Record Data Community Commons Dataset Truven Health Analytics Los Angeles County Department of Public Health	These datasets included both internal information from PSJHC's medical records and external data looking at diseases/illnesses in the area.
Mortality and Morbidity Data	Los Angeles County Department of Public Health State of California Department of Public Health	Public health databases were reviewed to look at morbidity and mortality rates of the area.
Community Need Measure/Indices	California Environmental Screen Index Community Need Index Score Health Disparity Index SocioNeeds Index Score	These four indices of need were measured at a census tract or zip code level to help identify areas of the Westside with the highest level of need.
Economic Data	American Community Survey Community Commons Dataset Think Health L.A. Database U.S. Bureau of Labor Statistics	These datasets provided the most recent information on unemployment and other economic indicators for the area.
Other Community Level Data	LAHSA 2016 Homeless Count Santa Monica 2014 Youth Wellbeing Report Card L.A. DPH Community Health Needs Assessment	These studies provided more in-depth data on the homeless, low-income populations, and issues facing children and youth in the area

Community and stakeholder input

In order to get community input regarding the needs and issues impacting the Westside area, a written survey was developed to use with local residents. The survey was one page in length and asked for input on what the residents saw as the key needs facing the area, what contributing factors they felt impacted these needs, and what opportunities they saw for PSJHC to address the needs. The surveys were distributed at four community forum events to approximately 350 people and eighty-five people completed the surveys. A copy of the survey instrument is included in Appendix III.

Based on community feedback the key needs/issues identified in the area included:

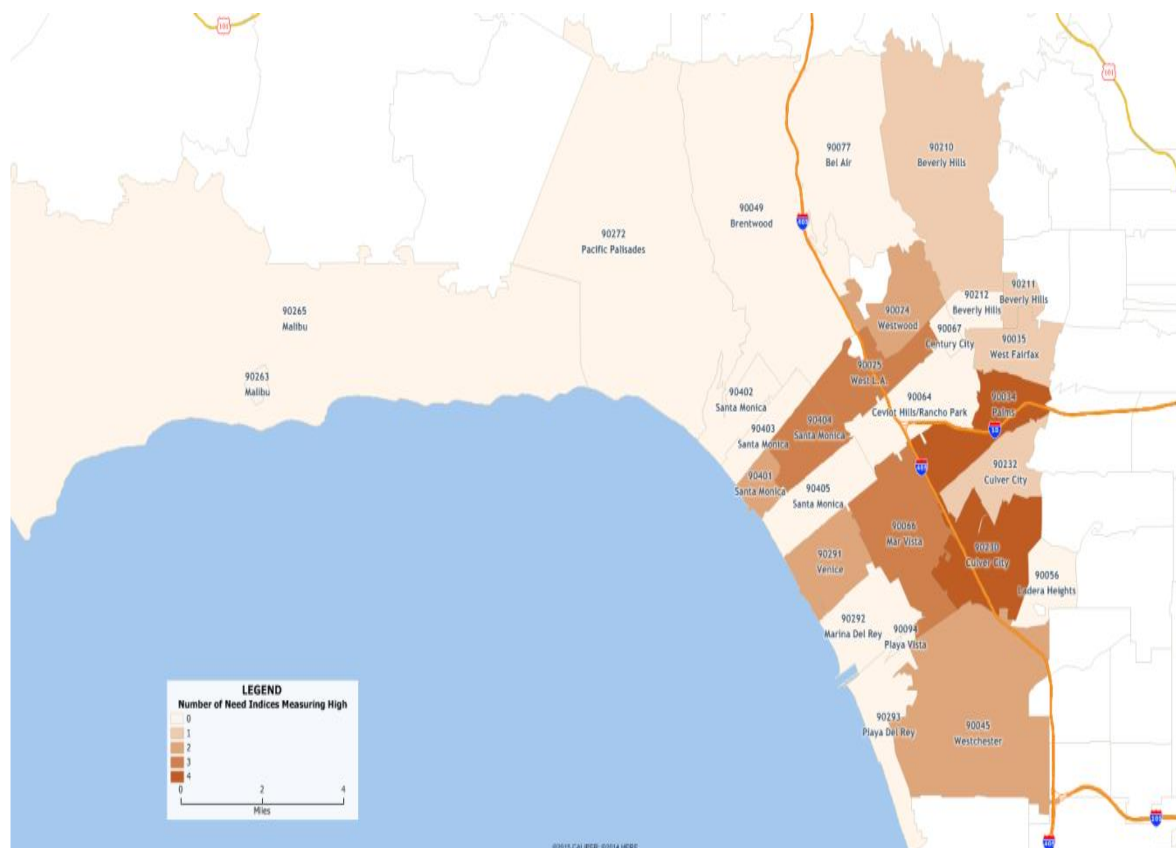
- Access to affordable, quality medical care
- Growth of chronic illnesses such as heart disease, stroke, diabetes, etc.
- Need for more disease prevention programs
- Growing need for more mental health and suicide prevention programs
- Growth of homelessness and lack of affordable housing
- Need for more programs around substance use/addiction

The area residents surveyed identified the following contributors as impacting the growing needs in the community:

- Lack of physicians in the community who accept all insurance plans
- Increase in economic pressures in the area
- Lack of affordable housing
- Lack of affordable/free health promotion and disease prevention programs
- Increase in drug and alcohol use among the population
- Educational barriers
- Growing poverty
- Lack of adequate paying jobs
- Lack of affordable nutritious foods
- Increase in peer and family pressures

Identification of Significant Health Needs

In looking at areas of the Westside with significant health, social and other needs, several composite measurements of need were utilized. These indices looked at multiple factors to measure the level of need in the community including number of persons who were uninsured, household income level, unemployment rate, levels of poverty, education level, English proficiency, home ownership, environmental risk factors, and components identified with the social determinants of health. These measurements calculated need at a local level either at a census tract or zip code breakdown. The measurements used to identify higher need communities include the Community Need Index, SocioNeeds Index, Health Disparity Index, and the California Environmental Screen Index. Based on these four composite measures, we were able to identify areas that scored high in three or more of the indices. These areas included zip codes 90025 (West Los Angeles), 90034 (Palms), 90066 (Mar Vista), 90230 (Culver City), and 90404 (Santa Monica).



Health Indicators and Trends

As mentioned earlier, several secondary data sources were used to identify the health and social needs of the community. A summarized break down is provided of the data that was analyzed as part of this community health needs assessment. The data is divided based on indicators focused on disease and health access, nutrition, fitness, mental health status, and economic indicators for the Westside/SPA-5 area.

Disease Estimates and Health Access Data

- Approximately 47.9 percent of adults were not vaccinated for the flu in the past 12 months
- Within the area it is estimated that 46 percent of adults have pre-diabetes
- Adults diagnosed with high blood pressure represent 26.8 percent of the population
- Approximately 10 percent of the area's population rank their health status as fair to poor
- Adults and children who have no regular source of medical care represent 9 percent of the area's population
- The top leading causes of death in SPA-5 include coronary artery disease, stroke, Alzheimer's disease, lung cancer, and chronic obstructive pulmonary disease
- The top leading rates of communicable/reportable diseases in the area include Campylobacteriosis (33.7 cases/100,000 pop.), Salmonellosis (11.4 cases/100,000 pop.) and Giardiasis (7.6 cases/100,000 pop.)
- Respiratory related illnesses were in the top six diagnoses of patients seen in the emergency department at PSJHC for the age group under 18 and 18-64

Nutrition Needs/Issues

- Within the targeted area, approximately 20 percent of children have consumed at least one soda in the past day
- Teens living in the area who eat less than five fruits or vegetables a day represent 63 percent of the total youth population
- Approximately 17 percent of residents in the area report that fresh fruits and vegetables are sometimes or never affordable in their neighborhood
- Over 11 percent of the area population report that fast food was eaten at least four times over the past week
- Only 5.1 percent of households in SPA-5 with annual incomes below 300% of the federal poverty level are receiving food assistance from the government
- The number of adults reporting to be food insecure in the area represented 43.5 percent of the total adult population

Physical Fitness Issues

- The number of adults who are overweight or obese represent 53.3 percent of the total adult population in the area
- The number of teens who are overweight or obese represent 40.7 percent of the total teen population in SPA 5
- Approximately 42 percent of children between the ages of 5-11 years are physically active for at least one hour per day only two days per week or less on the Westside
- Approximately 37.6 percent of teens are physically active for at least one hour per day only two days per week or less in the area

Mental Health and Substance Use Issues/Needs

- Approximately 41 percent of adults living on the Westside report having been involved in binge drinking
- The number of adults in the area needing help for emotional/mental health issues or alcohol/drug issues represent 23.6 percent of the total adult population
- The number of teens in the area needing help for emotional/mental health issues or alcohol/drug issues represent 21.6 percent of the total teen population
- Adults in the area who reported thinking about committing suicide in the past year represented 9.0 percent of the total adult population
- Adults reporting having taken medications for emotional/mental health issues in the past two weeks represent 10 percent of the total adult population in the Westside area
- The number of adults who were dealing with psychological distress and unable to work more than three months during the year represented 26 percent of the adult population in SPA-5
- Depression and anxiety were the top ten and eleven diagnoses based on patient visits to the emergency department at PSJHC for the age group 18-64
- Suicidal ideation was the top nine diagnosis for patients seen in the emergency department at PSJHC for the age group 65+
- Suicide and drug overdose were the second and third leading causes of premature death in SPA-5

Economic Indicators/Issues

- Service Planning Area 5 has approximately 4,659 homeless individuals, with 3,608 persons who are unsheltered, and includes 11 percent of the homeless population in L.A. County
- Approximately 24 percent of individuals living in the area report annual incomes below 200% of the federal poverty level
- Of the occupied housing units in the area, approximately 60 percent are rented
- The unemployment rate of the area is averaging around 4 percent
- Approximately 48 percent of the households in the area spend 30 percent or more of their monthly income on housing costs
- There are wide household income variations in the SPA with some areas having the highest levels of wealth in L.A. County while other areas have higher rates of poverty

See Appendix I for all health indicators utilized in this assessment.

Identified Priority Health Needs

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

Prioritization process and criteria

Based on a review of both primary and secondary data, five key priority health issues were identified to focus on over the next several years. Input from key community stakeholders representing different sectors of the community was crucial in helping to identify the key health needs. Also, input from local residents living in the community was helpful in highlighting areas of concern and needs that people felt should be addressed.

Taking the information gathered through research of existing data and the feedback provided from the community, PSJHC then worked with the members of the Community Advisory Committee (see the list of individuals on this group in Appendix II) to develop the list of high priority needs. Through in-depth discussion and rank voting with this group, the list of priorities was developed.

Priority health issues and baseline data

Priority Health Issue	Rationale/contributing factors
1. Access to affordable primary and specialty care	• There are few physicians on the Westside who accept Medi-Cal and a limited number accepting Medicare • The number of persons covered by Medi-Cal in the area has increased by over 55,000 persons with the expansion of the ACA • Close to one out of ten people living in the area report having no regular source of medical care
2. Better management and prevention of chronic illnesses	• The senior population is growing in the area with over 16 percent of the population now 65 or over • Heart disease and stroke remain the leading causes of death in the area • Approximately 46 percent of adults in the area are estimated to have pre-diabetes
3. Need for more prevention programs focused on reducing obesity and improving nutrition	• Obesity rates are on the rise in the area with 53.3 percent of adults being overweight and obese and 40.7 percent of teens being overweight and obese • The number of adults reporting to be food insecure in the area is estimated to be approximately 43 percent • Estimates show that only 5 to 6 percent of those individuals eligible for food assistance benefits take advantage of it
4. Improve access to affordable mental health and substance abuse programs	• There are limited inpatient mental health beds, especially programs serving youth, in the Westside area • Area residents expressed concern over the growing use of drugs and alcohol and the impact economic and social pressures have on their use • Approximately 23.6 percent of adults and 21.6 percent of

Priority Health Issue	Rationale/contributing factors
	teens living in the area have expressed a need for mental health and/or substance abuse services
5. Growing number of homeless persons living in the area	• Individuals with annual incomes below 200% of the Federal Poverty Level represent 24 percent of residents living in the area • Approximately 48 percent of households in the area spend more than 30 percent of their monthly income on housing costs • A mild climate, expanded services for the homeless, and increase development in the downtown L.A. area have resulted in more homeless persons coming to the Westside • With new development increasing in the area there has been a reduction in the available supply of affordable housing

Included in Appendix I of this report is a more detailed listing of the data that supports the identification of these five areas as a focus of the 2016 CHNA, and some of the key factors that contribute to the growing needs. Community resident and local stakeholder input was also very helpful in identifying some of the underlying factors that are contributing to these growing needs in the Westside area.

Addressing Identifed Needs

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

Plan development

Providence Saint John's Health Center reviewed the prioritized health needs identified through this community health needs assessment and has developed strategies to address each need. These strategies will be documented in a community health improvement plan (CHIP). The CHIP will describe how PSJHC plans to address the health needs. If Providence does not intend to address a need, the CHIP will explain why[1].

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

The implementation strategies were approved by the Providence Saint John's Community Ministry Board on December 16, 2016. The implementation strategies will be included in the CHIP attached to this community health needs assessment report in Appendix IV.

Providence Saint John's Health Center implementation strategies

Implementation Plan

Strategy	Need Addressed	Metric	Target Completion Date
Improve access to specialty care on the Westside for Medi-Cal and uninsured patients	Access to affordable primary and specialty care	Work in partnership with PMI, MDSJ, Venice Family Clinic and Westside Family Health Ctr to serve Medi-Cal patients for OB and GI Expand access to 2-3 more medical specialties	1st Quarter 2017 1st Quarter 2018
Develop education, screening and support programs to help address chronic disease in the area	Better management and prevention of chronic illnesses	Develop key partnerships with 8-10 area churches Develop 3-4 chronic disease support groups Conduct 4 community education forums on select chronic diseases Conduct ongoing blood pressure, BMI and glucose screenings Implement program for medically fragile seniors with WISE and Healthy Aging	4th Quarter 2018 2nd Quarter 2018 2nd Quarter 2019 4th Quarter 2017 3rd Quarter 2017

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

Implementation Plan (continued)

Strategy	Need Addressed	Metric	Target Completion Date
Provide programs and improve access to resources focused on better nutrition in the community	More programs focused on reducing obesity and improving nutrition	Implement 8 healthy eating education programs in the community Link 300 eligible people/families with SNAP benefits Partner with 3 area grocery stores to conduct nutrition education programs	4th Quarter 2018 4th Quarter 2019 4th Quarter 2017
Expand mental health and substance abuse services in the community to vulnerable populations	Improve access to affordable mental health and substance abuse programs	Expand preschool consult program at CFDC with 17 new sites Expand outreach at CFDC to new mothers dealing with post-partum depression Provide grant funding to area organizations addressing substance abuse treatment for low-income residents	4th Quarter 2017 3rd Quarter 2018 3rd Quarters 2017, 2018 and 2019

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Implementation Plan

Strategy	Need Addressed	Metric	Target Completion Date
Expand services and outreach to homeless patients coming to PSJHC and to those living in the community	Growing number of homeless persons living in the area	Expand the Homeless Care Navigation Program at PSJHC by adding a second full-time coordinator Get an approved license to be able to access the Coordinated Entry System database to help direct homeless patients to the correct resources Work with OPCC on the development of their comprehensive wellness program for their homeless clients In collaboration with UCLA and Trinity Care Hospice, develop a hospice for the homeless on the Westside	2nd Quarter 2017 1st Quarter 2017 4th Quarter 2017 4th Quarter 2018

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Evaluation of Impact From 2013 Community Health Improvement Plan

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

Following the prior CHNA, Providence Saint John's Health Center collaborated with community partners to develop a community health improvement plan (CHIP) to address the needs identified below. The top health issues for the 2013 CHNA/CHIP were:

1. Access to mental health services
2. Increase in number of homeless patients utilizing the emergency department for non-emergent conditions
3. Access to affordable and convenient primary and specialty care
4. Lack of health education and wellness promotion programs in the community

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

Prioritized Need #1: Access to affordable mental health services

Data Point	Previous CHNA	Current CHNA
Continue to support the Child and Family Development Center	Assess need to implement screening at area preschools for at-risk children	Implemented outreach screenings to 17 preschool sites
	Work with at-risk parents in low income neighborhoods	Adopted the Helen Reid Parenting Program
Maintain grant funding to local community organizations providing mental health and violence prevention services	Approximately $43,700 provided in grants	Approximately $74,000 provided in grants

Subsidized programs and services

Providence Saint John's Health Center provides subsidized programs and services through regular operations. These are clinical and social services provided by Providence despite a financial loss because it meets an identified community need that is not met elsewhere in the community. Programs and services that address mental health needs include:

- Child and Family Development Center: Using evidenced based practices, the CFDC provides comprehensive outpatient mental health services to low income children and their families. In addition to counseling, the CFDC offers a therapeutic preschool, on-site counseling at area schools and nonprofits, screening for children at-risk for behavioral and other issues, and a training site for graduate students to obtain their clinical hours.

Community investment funding support

Often there are organizations that provide services in the community that address community needs. Rather than duplicate services, Providence Saint John's partners with these organizations to ensure community needs are served. Organizations that have received community investments and funding support from Providence to address mental health, violence and substance abuse include:

- Pico Youth and Family Center: Education and violence prevention programs to serve at-risk youth in the community
- OPICA: Program serves those dealing with dementia and Alzheimer's disease
- Saint Anne School: Funding from PSJHC helps to provide school counseling on campus
- Safe Place for Youth: Funding supports mental health counseling at their drop-in center for homeless youth
- Westside Domestic Violence Network: Funding to maintain ongoing membership by PSJHC in the collaborative network

Prioritized Need #2: Increase number of homeless patients utilizing the E.D. for non-emergent conditions

Data Point	Previous CHNA	Current CHNA
Implement program in the emergency department to better serve this population	Pilot project started with OPCC	Full-time Community Care Coordinator hired to work with these patients in E.D.
Continue partnerships with local agencies to provide appropriate respite care and shelter	Support of $160,000 provided to area organizations	Support of $349,325 provided to area organizations
Continue to provide medical detoxification to homeless patients as required	Assess needs of E.D. staff in helping to deal with this patient population	E.D. staff trained in local resources and shelters available to refer patients

Other Providence programs and services that benefit community

Providence Saint John's Health Center provides programs and services that meet community needs, but are not categorized as "subsidized" or as "community benefit" by IRS definition as no unreimbursed costs are incurred in the delivery of the service. Of these programs and services, those that address the increasing number of homeless patients include:

- Homeless Care Navigation Program: Providence Saint John's Health Center now supports a full-time Community Care Coordinator in the emergency department to work with the homeless patient population and get them connected to shelter/housing and other resources. This person has been successful in placing close to 50 percent of the patients into appropriate shelters.

Community investment funding support

Often there are organizations that provide services in the community that address community needs. Rather than duplicate services, Providence Saint John's partners with these organizations to ensure community needs are served. Organizations that have received community investments and funding support from Providence to address the increasing number of homeless patients include:

- OPCC: The largest homeless serving agency in the area, offers a respite medical program that receives referrals from PSJHC
- Upward Bound House: PSJHC provides funding to this organization to assist homeless families in obtaining temporary and permanent housing
- St. Joseph Center: PSJHC works in partnership with this organization to assist homeless patients needing shelter and other services. PSJHC is a major funder of their Bread and Roses Café to provide both food and training to those who are homeless
- Westside Coalition: PSJHC supports the work of this organization by serving on committees and also supporting their annual fundraising event. This organization helps to coordinate housing and shelter resources in the area.

Prioritized Need #3: Access to affordable and convenient primary and specialty care

Data Point	Previous CHNA	Current CHNA
Continue to provide financial support to area clinics	$260,000 in funding provided to area clinics	$638,517 in funding provided to area clinics
Develop specialty care hub to provide increased access to care for those on the Westside	Collaborative established to explore developing the specialty network	Specialty hub funded by PSJHC and in operation
Establish mechanism to treat Medi-Cal patients	Explore opportunity to have a contract with PSJHC to treat these patients	Managed care contract with L.A. Care Health Plan is currently in place

Other Providence programs and services that benefit community

Providence Saint John's provides programs and services that meet community needs, but are not categorized as "subsidized" or as "community benefit" by IRS definition as no unreimbursed costs are incurred in the delivery of the service. Of these programs and services, those that address primary and specialty access include:

- Free Imaging and Laboratory Services: PSJHC provides free imaging and laboratory services to uninsured patients referred from Venice Family Clinic and Westside Family Health Center

Community investment funding support

Often there are organizations that provide services in the community that address community needs. Rather than duplicate services, Providence Saint John's partners with these organizations to ensure community needs are served. Organizations that have received community investments and funding support from Providence to address primary and specialty care access include:

- Venice Family Clinic: PSJHC funded the specialty care access hub being operated by Venice Family Clinic. The Health Center also supports their homeless health care program
- Westside Family Health Center: PSJHC supports the diabetes management and pediatrics program operated by this primary care clinic
- Claris Health: PSJHC supports their obstetrical clinic for low income patients

Prioritized Need #4: More health education and wellness promotion programs

Data Point	Previous CHNA	Current CHNA
Continue community health education classes targeting major diseases	PSJHC offers five community health forums per year	In addition to the community forums, PSJHC is now doing targeted education on-site at four churches and one local non-profit
Offer community screening events	Mammogram screenings have been done in the past	Implemented the lung cancer screening program
Work with new partners to address public health concerns	Identified key partners to work with	Collaborative relationship being built with UCLA, Cedars and Kaiser around a community health issue

Other Providence programs and services that benefit community

Providence Saint John's provides programs and services that meet community needs, but are not categorized as "subsidized" or as "community benefit" by IRS definition as no unreimbursed costs are incurred in the delivery of the service. Of these programs and services, those that address the health education and wellness promotion need include:

- Flora Thornton Community Education Program: This program offers 4-5 community education forums per year focusing on health issues and diseases of concern to the community. Sessions are usually well attended with over 100 people coming to the forums
- Community Health Partnership Program: This program uses a team of Community Health Promoters and Faith Community Nurses to bring health education, information and screening programs into the community. Currently, four faith communities and two non-profits are working together with this program to expand health education

Community investment funding support

Often there are organizations that provide services in the community that address community needs. Rather than duplicate services, Providence partners with these organizations to ensure community needs are served. Organizations that have received community investments and funding support from Providence to address the health education and wellness promotion need include:

- OPCC: Funding provided by PSJHC will help to develop a comprehensive wellness program for homeless clients of OPCC including a smoking cessation component
- WISE and Healthy Aging: Funding from PSJHC will help to develop their evidence-

based health promotion and disease prevention program

- Boys and Girls Club of Santa Monica: Funding from PSJHC supports their Healthy Lifestyles Program for youth who participate in their programs
- Pico Youth and Family Center: Funding provided by PSJHC is being used to support their three-point focused wellness program including fitness, health education classes, and mental wellness services

Resources Potentially Available to Address the Significant Needs Identified Through the CHNA

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

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

Organization or Program	Description	Associated Community Need
Achievable Foundation	Operates a health care clinic for the clients served by the organization who have special needs.	Access to Medical Care
Claris Health	Provides medical and counseling services to women who are pregnant.	Access to Medical Care
Venice Family Clinic	The largest Federally Qualified Health Center in the area providing primary and specialty care to low-income residents who are uninsured and on Medi-Cal.	Access to Medical Care
Westside Family Health Center	A community clinic located in Santa Monica providing women's health, pediatric and primary care medical services to the community.	Access to Medical Care
Catholic Charities	Provides social services, food and other services to those who are poor and vulnerable in the area.	Services to Assist the Homeless
OPCC	The main homeless serving agency in the area providing shelter, housing, medical care, counseling and social services to this population.	Services to Assist the Homeless
Safe Place for Youth	Provides a drop-in center for homeless youth in the area including food, clothes, counseling, medical care, social services, and job training.	Services to Assist the Homeless
Step Up on Second	Provides counseling, shelter, housing and other services to the homeless including substance abuse treatment.	Services to Assist the Homeless Access to Substance Abuse Services
St. Joseph Center	Provides social services, housing assistance, food, job training and other resources for the homeless.	Services to Assist the Homeless
Upward Bound House	Offers services to assist homeless families including shelter, housing, case management services, food, and other resources.	Services to Assist the Homeless
Westside Coalition	Assists the homeless by coordinating housing and shelter resources available in the area.	Services to Assist the Homeless
Clare Foundation	Provides outpatient and residential treatment to those dealing with substance abuse.	Access to Mental Health & Substance Abuse Services
Didi Hirsch	Provides quality mental health and substance abuse	Access to Mental

Mental Health Services	services to those where stigma or poverty limit access.	Health & Substance Abuse Services
Exodus Recovery	Provides outpatient, 23-hour and inpatient mental health services to those who are low-income. Also offers chemical dependency treatment services.	Access to Mental Health & Substance Abuse Services
Los Angeles County Department of Mental Health	Provides comprehensive mental health services including counseling, crisis response, chemical dependency treatment services, and other resources.	Access to Mental Health & Substance Abuse Services
National Alliance on Mental Illness	The local chapter is part of a national association who work in local communities to raise awareness and provide support and education around mental illness and substance abuse.	Access to Mental Health & Substance Abuse Services
Alzheimer's Association	Offers education, outreach and support to those dealing with dementia and Alzheimer's disease and their families/caregivers.	Management and Prevention of Chronic Illness
American Cancer Society	Provides educational, support and other services to those diagnosed with cancer and offers resources targeted to the prevention of this disease.	Management and Prevention of Chronic Illness
American Heart Association	Offers education, outreach, and other services targeted to the prevention of heart disease.	Management and Prevention of Chronic Illness
American Lung Association	Offers services and resources to those dealing with lung disease and also provides education and outreach to prevent respiratory illnesses.	Management and Prevention of Chronic Illness
American Stroke Association	Provides education, outreach and other services targeted to the prevention of stroke, and offers services to assist those who have suffered from a stroke.	Management and Prevention of Chronic Illness
OPICA	Provides resources and services to those dealing with dementia and Alzheimer's disease.	Management and Prevention of Chronic Illness
WISE and Healthy Aging	Provides classes, support groups, and case management services to mature adults dealing with chronic illnesses.	Management and Prevention of Chronic Illness
Boys and Girls Club of Santa Monica	Provides fitness, nutrition and recreational services to underserved youth in the community.	Expand Nutrition & Health Promotion Programs
City of Santa Monica, Community Services Dept.	Provides programs and funding focused around improving health and physical activity within the City of Santa Monica.	Expand Nutrition & Health Promotion Programs
Culver City Senior Center	Offers fitness, health education, nutrition, and recreational programs to seniors.	Expand Nutrition & Health Promotion Programs
Meals on Wheels West	Provides home delivered nutritious meals to seniors and vulnerable populations in the community.	Expand Nutrition & Health Promotion Programs
Pico Youth and Family Center	Provides fitness and recreational programs to at-risk youth in the community.	Expand Nutrition & Health Promotion Programs
YMCA of Santa Monica	Provides fitness programs, recreational activities, and health promotion classes to the community.	Expand Nutrition & Health Promotion Programs

2016 CHNA approval

This community health needs assessment was adopted on December 16, 2016 by the Providence Saint John's Health Center Community Ministry Board. The final report was made widely available[2] on December 31, 2016.

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[2] Per § 1.501(r)-3 IRS Requirements

Appendices

Appendix I – Demographics, Health Indicators, and Other Data

Data Category: Demographics

Providence Saint John's Health Center

Community Health Needs Assessment 2016

Demographic Data: Population Over 25 Years, Education Level Below H.S. Graduation, Median and Average HH Income Level

Zip Code	Total Population Years 25+	Pop. 25+ Less Than H.S. Grad.	% of Pop. 25+ Less H.S. Grad.	Median HH Income	Average HH Income	Average HH Income White	Average HH Income African Am.	Average HH Income Native Amer.	Average HH Income Asian	Average HH Income HI/Pac Is.	Average HH Income Hisp/Latino
90024	25,444	848	3.33%	$55,025	$101,074	$96,686	$82,137	$50,379	$53,508	$91,667	$80,304
90025	35,643	2,604	7.31%	$75,919	$104,937	$92,722	$81,583	$62,006	$106,895	$98,750	$72,694
90034	45,192	5,207	11.52%	$58,167	$78,891	$80,012	$57,403	$54,806	$76,669	$98,705	$59,423
90035	21,600	1,506	6.97%	$74,765	$110,404	$100,656	$66,554	$54,008	$107,644	$96,667	$96,203
90045	27,753	1,779	6.41%	$78,037	$104,687	$105,581	$68,667	$43,554	$106,960	$87,222	$99,390
90049	29,283	651	2.22%	$114,218	$170,484	$133,938	$69,820	$50,625	$142,048	$54,231	$149,761
90056	6,028	188	3.12%	$88,393	$119,242	$105,988	$110,625	$44,167	$74,293	$25,000	$52,192
90064	19,562	954	4.88%	$86,000	$131,683	$113,711	$106,929	$46,929	$98,388	$70,000	$94,482
90066	42,395	4,859	11.46%	$69,211	$101,340	$96,337	$77,217	$61,563	$94,365	$47,500	$72,445
90067	2,515	74	2.94%	$96,161	$149,425	$121,358	$40,833	$152,500	$111,364	$250,000	$155,221
90073	2	0	0.00%	$0	$0	$0	$0	$0	$0	$0	$0
90077	7,213	146	2.02%	$158,545	$215,783	$159,819	$110,300	$78,438	$152,490	$71,250	$205,907
90094	5,200	75	1.44%	$76,169	$129,131	$113,460	$68,444	$63,500	$113,429	$35,833	$82,758
90095	0	0	0.00%	$0	$0	$0	$0	$0	$0	$0	$0
90210	17,520	676	3.86%	$130,251	$191,615	$143,258	$74,952	$80,000	$116,029	$65,000	$129,445
90211	6,533	398	6.09%	$69,441	$99,701	$89,339	$106,396	$108,571	$95,186	$55,000	$114,121
90212	8,980	447	4.98%	$81,971	$123,553	$107,478	$80,275	$74,286	$100,121	$71,000	$99,239
90230	24,250	2,922	12.05%	$74,805	$104,571	$105,158	$70,130	$66,326	$108,968	$82,596	$68,445
90232	12,312	1,258	10.22%	$70,155	$95,694	$89,102	$76,591	$65,357	$96,271	$79,022	$68,716
90263	555	26	4.68%	$148,936	$190,608	$156,591	$180,357	$87,500	$163,182	$250,000	$262,574
90265	13,741	419	3.05%	$127,743	$183,165	$140,970	$144,167	$53,333	$139,772	$98,636	$177,226
90272	17,294	261	1.51%	$146,742	$210,459	$153,589	$97,059	$77,222	$151,042	$92,083	$157,517
90291	23,516	1,650	7.02%	$80,969	$112,933	$104,117	$65,569	$50,625	$94,098	$59,063	$86,649
90292	21,438	395	1.84%	$102,691	$135,300	$119,474	$107,296	$54,650	$105,192	$43,654	$123,966
90293	10,933	278	2.54%	$89,333	$117,600	$106,766	$66,787	$70,000	$125,833	$91,667	$114,991
90401	6,962	338	4.85%	$65,037	$100,062	$91,182	$53,180	$79,167	$73,329	$141,071	$94,116
90402	8,989	166	1.85%	$127,487	$187,789	$137,016	$81,930	$90,750	$188,625	$60,357	$131,190
90403	21,007	698	3.32%	$76,700	$111,554	$97,695	$73,543	$74,712	$104,547	$65,625	$106,153
90404	17,633	1,517	8.60%	$63,351	$84,724	$84,506	$51,521	$81,633	$75,272	$68,158	$72,745
90405	22,903	1,066	4.65%	$74,398	$108,630	$100,105	$62,245	$50,363	$94,354	$63,900	$98,611
	502,396	31,406	6.25%								

Source: ThinkHealthLA.org/Claritas

Note: Zip codes 90073 and 90095 are the Veterans Administration complex and the University of California Los Angeles campus so that is why demographics are not reported for these areas

Providence Saint John's Health Center

Community Health Needs Assessment 2016

Demographic Data: Population by Age

Zip Code	Total Population	Median Age	Age <18	% of Zip Code Pop.	Age 18-64	% of Zip Code Pop.	Age 65+	% of Zip Code Pop.	Males <18	Males 18-64	Males 65+	Females <18	Females 18-64	Females 65+
90024	50,284	25.40	4,213	8.38%	39,595	78.74%	6,476	12.88%	2,107	18,837	2,713	2,106	20,758	3,763
90025	43,543	37.40	5,818	13.36%	32,045	73.59%	5,680	13.04%	2,978	16,269	2,448	2,840	15,776	3,232
90034	59,301	35.30	10,210	17.22%	43,202	72.85%	5,889	9.93%	5,189	21,812	2,516	5,021	21,390	3,373
90035	29,272	38.70	5,973	20.41%	18,759	64.09%	4,540	15.51%	3,029	8,967	1,838	2,944	9,792	2,702
90045	41,622	37.10	7,505	18.03%	28,551	68.60%	5,566	13.37%	3,798	13,763	2,463	3,707	14,788	3,103
90049	38,015	43.20	6,158	16.20%	24,014	63.17%	7,843	20.63%	3,055	11,117	3,604	3,103	12,897	4,239
90056	7,878	50.00	1,214	15.41%	4,666	59.23%	1,998	25.36%	615	2,047	830	599	2,619	1,168
90064	26,552	41.80	5,178	19.50%	16,678	62.81%	4,696	17.69%	2,645	8,167	2,034	2,533	8,511	2,662
90066	56,196	39.60	10,459	18.61%	37,681	67.05%	8,056	14.34%	5,374	19,210	3,530	5,085	18,471	4,526
90067	2,731	66.90	176	6.44%	1,077	39.44%	1,478	54.12%	93	488	637	83	589	841
90073	2	65.00	0	0.00%	1	50.00%	1	50.00%	0	1	1	0	0	0
90077	9,868	49.80	1,870	18.95%	5,499	55.73%	2,499	25.32%	971	2,605	1,261	899	2,894	1,238
90094	6,569	34.80	1,107	16.85%	4,929	75.03%	533	8.11%	566	2,342	223	541	2,587	310
90095	5	21.70	0	0.00%	5	100.00%	0	0.00%	0	2	0	0	3	0
90210	23,659	48.50	4,256	17.99%	13,417	56.71%	5,986	25.30%	2,150	6,244	2,828	2,106	7,173	3,158
90211	8,752	42.50	1,430	16.34%	5,788	66.13%	1,534	17.53%	737	2,599	672	693	3,189	862
90212	11,860	43.00	1,809	15.25%	7,909	66.69%	2,142	18.06%	919	3,470	936	890	4,439	1,206
90230	33,742	40.60	6,900	20.45%	21,391	63.40%	5,451	16.15%	3,534	10,288	2,124	3,366	11,103	3,327
90232	16,236	40.70	2,793	17.20%	10,997	67.73%	2,446	15.07%	1,401	5,445	1,002	1,392	5,552	1,444
90263	1,559	22.00	136	8.72%	1,299	83.32%	124	7.95%	72	584	60	64	715	64
90265	19,628	46.90	3,013	15.35%	12,655	64.47%	3,960	20.18%	1,625	6,181	1,963	1,388	6,474	1,997
90272	24,975	48.70	5,470	21.90%	13,695	54.83%	5,810	23.26%	2,785	6,419	2,695	2,685	7,276	3,115
90291	28,709	40.30	3,972	13.84%	21,396	74.53%	3,341	11.64%	2,010	11,348	1,587	1,962	10,048	1,754
90292	24,575	43.70	2,571	10.46%	17,337	70.55%	4,667	18.99%	1,280	8,617	2,263	1,291	8,720	2,404
90293	12,794	43.10	1,515	11.84%	9,175	71.71%	2,104	16.45%	768	4,476	954	747	4,699	1,150
90401	7,819	40.70	564	7.21%	5,991	76.62%	1,264	16.17%	289	3,250	530	275	2,741	734
90402	12,438	48.30	2,509	20.17%	7,060	56.76%	2,869	23.07%	1,212	3,368	1,303	1,297	3,692	1,566
90403	25,442	43.50	3,371	13.25%	17,437	68.54%	4,634	18.21%	1,758	8,183	1,932	1,613	9,254	2,702
90404	22,313	40.40	3,070	13.76%	15,837	70.98%	3,406	15.26%	1,576	7,938	1,299	1,494	7,899	2,107
90405	28,448	43.40	3,980	13.99%	19,663	69.12%	4,805	16.89%	2,079	9,752	2,103	1,901	9,911	2,702
	674,787		107,240	15.89%	457,749	67.84%	109,798	16.27%	54,615	223,789	48,349	52,625	233,960	61,449
								% of Total	8.09%	33.16%	7.17%	7.80%	34.67%	9.11%

Source: ThinkHealthLA.org/Claritas

Providence Saint John's Health Center
Community Health Needs Assessment 2016
Demographic Data: Population by Race and Ethnicity

Zip Code	Total Population	White	% of Zip Code	African American	% of Zip Code	Am Ind./ AK Native	% of Zip Code	Asian/PI/ Haw. I.	% of Zip Code	Other Race	% of Zip Code	2 or More Races	% of Zip Code	Hispanic/ Latino	% of Zip Code	Not Hisp/ Latino	% of Zip Code
90024	50,284	30,405	60.47%	1,140	2.27%	95	0.19%	13,456	26.76%	2,129	4.23%	3,059	6.08%	4,802	9.55%	45,482	90.45%
90025	43,543	27,553	63.28%	1,288	2.96%	221	0.51%	8,980	20.62%	2,928	6.72%	2,573	5.91%	6,507	14.94%	37,036	85.06%
90034	59,301	30,020	50.62%	5,279	8.90%	546	0.92%	12,095	20.40%	8,044	13.56%	3,317	5.59%	17,176	28.96%	42,125	71.04%
90035	29,272	22,237	75.97%	2,197	7.51%	107	0.37%	1,945	6.64%	1,399	4.78%	1,387	4.74%	3,052	10.43%	26,220	89.57%
90045	41,622	24,128	57.97%	6,382	15.33%	183	0.44%	5,388	12.95%	2,626	6.31%	2,915	7.00%	7,796	18.73%	33,826	81.27%
90049	38,015	31,026	81.62%	879	2.31%	61	0.16%	3,559	9.36%	638	1.68%	1,852	4.87%	2,153	5.66%	35,862	94.34%
90056	7,878	834	10.59%	6,094	77.35%	20	0.25%	248	3.15%	201	2.55%	481	6.11%	504	6.40%	7,374	93.60%
90064	26,552	18,004	67.81%	754	2.84%	96	0.36%	4,752	17.90%	1,352	5.09%	1,594	6.00%	3,767	14.19%	22,785	85.81%
90066	56,196	34,957	62.21%	2,206	3.93%	438	0.78%	8,392	14.93%	7,018	12.49%	3,185	5.67%	15,999	28.47%	40,197	71.53%
90067	2,731	2,326	85.17%	20	0.73%	3	0.11%	297	10.88%	12	0.44%	73	2.67%	92	3.37%	2,639	96.63%
90073	2	1	50.00%	1	50.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	2	100.00%
90077	9,868	8,282	83.93%	126	1.28%	13	0.13%	800	8.11%	153	1.55%	494	5.01%	502	5.09%	9,366	94.91%
90094	6,569	3,725	56.71%	940	14.31%	13	0.20%	1,257	19.14%	149	2.27%	485	7.38%	560	8.52%	6,009	91.48%
90095	5	2	40.00%	0	0.00%	0	0.00%	2	40.00%	0	0.00%	1	20.00%	0	0.00%	5	100.00%
90210	23,659	20,165	85.23%	508	2.15%	24	0.10%	1,448	6.12%	315	1.33%	1,199	5.07%	1,176	4.97%	22,483	95.03%
90211	8,752	6,608	75.50%	222	2.54%	17	0.19%	1,144	13.07%	187	2.14%	574	6.56%	604	6.90%	8,148	93.10%
90212	11,860	9,270	78.16%	370	3.12%	31	0.26%	1,323	11.16%	154	1.30%	712	6.00%	791	6.67%	11,069	93.33%
90230	33,742	17,800	52.75%	3,280	9.72%	207	0.61%	5,322	15.77%	5,053	14.98%	2,080	6.16%	11,016	32.65%	22,726	67.35%
90232	16,236	9,970	61.41%	928	5.72%	81	0.50%	2,571	15.84%	1,560	9.61%	1,126	6.94%	3,897	24.00%	12,339	76.00%
90263	1,559	1,174	75.30%	81	5.20%	4	0.26%	171	10.97%	37	2.37%	92	5.90%	151	9.69%	1,408	90.31%
90265	19,628	17,117	87.21%	395	2.01%	40	0.20%	853	4.35%	438	2.23%	785	4.00%	1,452	7.40%	18,176	92.60%
90272	24,975	22,179	88.80%	192	0.77%	38	0.15%	1,457	5.83%	184	0.74%	925	3.70%	1,165	4.66%	23,810	95.34%
90291	28,709	22,305	77.69%	1,377	4.80%	191	0.67%	1,408	4.90%	2,009	7.00%	1,419	4.94%	5,108	17.79%	23,601	82.21%
90292	24,575	18,692	76.06%	1,290	5.25%	75	0.31%	2,528	10.29%	679	2.76%	1,311	5.33%	2,304	9.38%	22,271	90.62%
90293	12,794	9,403	73.50%	754	5.89%	39	0.30%	1,450	11.33%	322	2.52%	826	6.46%	1,379	10.78%	11,415	89.22%
90401	7,819	5,669	72.50%	494	6.32%	34	0.43%	943	12.06%	238	3.04%	441	5.64%	771	9.86%	7,048	90.14%
90402	12,438	10,692	85.96%	157	1.26%	19	0.15%	894	7.19%	169	1.36%	507	4.08%	621	4.99%	11,817	95.01%
90403	25,442	20,665	81.22%	552	2.17%	43	0.17%	2,292	9.01%	528	2.08%	1,362	5.35%	1,951	7.67%	23,491	92.33%
90404	22,313	14,582	65.35%	1,715	7.69%	154	0.69%	2,699	12.10%	1,966	8.81%	1,197	5.36%	5,081	22.77%	17,232	77.23%
90405	28,448	22,350	78.56%	968	3.40%	129	0.45%	2,423	8.52%	1,201	4.22%	1,377	4.84%	3,695	12.99%	24,753	87.01%
	674,787	462,141	68.49%	40,589	6.02%	2,922	0.43%	90,097	13.35%	41,689	6.18%	37,349	5.53%	104,072	15.42%	570,715	84.58%

Source: ThinkHealthLA.org/Claritas

Providence Saint John's Health Center

Community Health Needs Assessment 2016

Demographic Data: Population Size, Gender, and Number of Households

Zip Code	Total Population	% of Pop Of Area	Males	Females	% Pop. Growth 2010 to 2016	Total Households	% of HH Of Svc. Area	% HH Growth 2010 to 2016	Average HH Size	Total Housing Units
90024	50,284	7.45%	23,657	26,627	5.39%	19,021	6.24%	5.46%	2.03	21,115
90025	43,543	6.45%	21,695	21,848	4.48%	21,902	7.18%	4.61%	1.97	23,732
90034	59,301	8.79%	29,517	29,784	3.07%	26,344	8.64%	3.20%	2.22	27,990
90035	29,272	4.34%	13,834	15,438	2.75%	13,075	4.29%	2.65%	2.21	14,289
90045	41,622	6.17%	20,024	21,598	5.03%	16,041	5.26%	4.86%	2.38	16,986
90049	38,015	5.63%	17,776	20,239	3.46%	17,484	5.73%	3.30%	2.11	18,959
90056	7,878	1.17%	3,492	4,386	0.72%	3,359	1.10%	1.36%	2.34	3,510
90064	26,552	3.93%	12,846	13,706	4.35%	11,569	3.79%	4.90%	2.27	12,189
90066	56,196	8.33%	28,114	28,082	2.87%	24,416	8.01%	3.06%	2.28	25,692
90067	2,731	0.40%	1,218	1,513	10.25%	1,649	0.54%	7.29%	1.66	1,949
90073	2	0.00%	2	0	0.00%	0	0.00%	0.00%	0.00	0
90077	9,868	1.46%	4,837	5,031	4.39%	3,828	1.26%	3.49%	2.56	4,114
90094	6,569	0.97%	3,131	3,438	23.34%	3,135	1.03%	9.12%	2.10	3,342
90095	5	0.00%	2	3	0.00%	0	0.00%	0.00%	0.00	0
90210	23,659	3.51%	11,222	12,437	3.51%	9,560	3.14%	4.53%	2.46	10,484
90211	8,752	1.30%	4,008	4,744	3.92%	3,830	1.26%	4.19%	2.29	4,167
90212	11,860	1.76%	5,325	6,535	3.83%	5,791	1.90%	4.70%	2.05	6,404
90230	33,742	5.00%	15,946	17,796	6.89%	13,495	4.43%	5.98%	2.49	13,976
90232	16,236	2.41%	7,848	8,388	3.33%	7,168	2.35%	4.41%	2.24	7,536
90263	1,559	0.23%	716	843	7.37%	288	0.09%	14.74%	2.34	342
90265	19,628	2.91%	9,769	9,859	6.43%	7,520	2.47%	8.12%	2.37	9,302
90272	24,975	3.70%	11,899	13,076	9.52%	9,722	3.19%	5.85%	2.56	10,333
90291	28,709	4.25%	14,945	13,764	1.81%	14,613	4.79%	2.89%	1.92	16,612
90292	24,575	3.64%	12,160	12,415	9.54%	14,063	4.61%	8.14%	1.75	16,206
90293	12,794	1.90%	6,198	6,596	8.89%	6,732	2.21%	6.82%	1.89	7,122
90401	7,819	1.16%	4,069	3,750	14.06%	4,860	1.59%	14.54%	1.50	5,367
90402	12,438	1.84%	5,883	6,555	2.98%	5,410	1.77%	2.79%	2.30	6,024
90403	25,442	3.77%	11,873	13,569	3.68%	14,323	4.70%	3.10%	1.76	15,547
90404	22,313	3.31%	10,813	11,500	5.36%	10,608	3.48%	5.93%	1.99	11,384
90405	28,448	4.22%	13,934	14,514	4.57%	15,064	4.94%	4.60%	1.87	16,076
	674,787		326,753	348,034		304,870				330,749

Source: ThinkHealthLA.org/Claritas

Adults Diagnosed With Diabetes

Los Angeles County Service Planning Areas (SPA) (West Area)

Ever diagnosed with diabetes	%	95% CI	Population
Diagnosed with diabetes	4.6*	1.2 - 7.9	24,000
Never diagnosed with diabetes	95.4*	92.1 - 98.8	503,000
Total	100.0%	-	528,000

Source: 2014 California Health Interview Survey

Adults Ever Diagnosed with High Blood Pressure

Los Angeles County Service Planning Areas (SPA) (West Area)

Ever diagnosed with high B.P.	%	95% CI	Population
Has/had high BP	26.8%	17.7 - 35.8	141,000
Doesn't have/never had high BP	73.2%	64.2 - 82.3	386,000
Total	100.0%	-	528,000

Source: 2014 California Health Interview Survey

Health Status Self Rating Total Population

Los Angeles County Service Planning Areas (SPA) (West Area)

Health status	%	95% CI	Population
Excellent	27.2%	19.6 - 34.7	170,000
Very good	41.7%	32.0 - 51.3	261,000
Good	21.3%	14.2 - 28.3	133,000
Fair	8.3*	2.1 - 14.6	52,000
Poor	1.5*	0.0 - 3.5	10,000
Total	100.0%	-	627,000

Source: 2014 California Health Interview Survey

Leading Causes of Death in Service Planning Area 5

Los Angeles County, Department of Public Health 2012 Data

Rank	Cause of Death	Number of Deaths
1.	Coronary Heart Disease	822
2.	Stroke	236
3.	Alzheimer's Disease	225
4.	Lung Cancer	207
5.	COPD	156

Total Deaths in SPA-5: 4,050

Leading Causes of Premature Death

Los Angeles County, Department of Public Health 2012 Data

Rank	Cause of Premature Death	Years of Life Lost
1.	Coronary Heart Disease	2,542
2.	Suicide	1,819
3.	Drug Overdose	1,386
4.	Lung Cancer	1,189
5.	Liver Disease/Cirrhosis	934

Total number of years of life lost due to premature death in SPA 5: 20,267 years

Body Mass Index - Adults

Asked of respondents who are 18 years or older

Los Angeles County Service Planning Areas (SPA) (West Area)

Body Mass Index - 4 level (adult only)	%	95% CI	Population
0 - 18.49 (Underweight)	0.3*	0.0 - 0.8	2,000
18.5 - 24.99 (Normal)	46.3%	36.9 - 55.8	244,000
25.0 - 29.99 (Overweight)	38.8%	27.9 - 49.7	205,000
30.0 or higher (Obese)	14.5*	5.6 - 23.5	77,000
Total	100.0%	-	528,000

Source: 2014 California Health Interview Survey

Body Mass Index - Teens

Los Angeles County Service Planning Areas (SPA) (West Area)

Body Mass Index - 4 level (teen only)	%	95% CI	Population
Underweight (within lowest 5th percentile)	-	-	-
Normal weight (5th up to 85th percentile)	59.3*	27.7 - 90.8	35,000
Overweight (85th up to 95th percentile)	24.0*	0.0 - 50.5	14,000
Obese (highest 5th percentile)	16.7*	0.0 - 40.6	10,000
Total	100.0%	-	59,000

Source: 2014 California Health Interview Survey

Providence Saint John's Emergency Dept. Top Diagnoses for 2015

Source: EPIC

Under 18 years		
ICD9_CODE	HAR_COUNT	ICD9 CODE definition
465.9	10573	Acute upper respiratory infections of unspecified site
780.60	6205	Fever, unspecified
382.9	6074	Unspecified Otitis Media
V64.2	5679	Surgical or other procedure not carried out because of patient's decision
787.03	3652	Vomitting alone
959.01	3199	Head injury, unspecified
462	2992	Acute pharyngitis, unspecified
079.99	2529	Viral and chlamydial infection in conditions classified elsewhere and of unspecified site
558.9	2438	Other and unspecified noninfectious gastroenteritis and colitis.
464.4	2096	Croup
789.00	2027	Abdominal pain, unspecified site
486	1785	Pneumonia, organism unspecified
599.0	1736	Other disorders of urethra and urinary tract
493.92	1665	Abcess, unspecified type, with (acute) exacerbation
466.0	1652	Acute bronchitis, unspecified

18-64 years		
ICD9_CODE	HAR_COUNT	ICD9 CODE definition
883.0	6655	Closed dislocation of carpal bone
490	6592	Bronchitis, nonspecified as acute or chronic
780.4	6426	Dizziness and giddiness
466.0	6146	Acute bronchitis, unspecified
845.00	5862	Ankle sprain
486	5789	Pneumonia, organism unspecified
729.5	5763	Pain in limb
789.06	5742	Abdominal pain, epigastric
787.01	5600	Nausea with vomitting
311	5462	Depressive disorder, not elsewhere classified
300.00	5444	Anxuety state, unspecified
682.6	5276	Cellulitis or abcess of leg, other than foot
493.92	5265	Abcess, unspecified type, with (acute) exacerbation
920	4939	Contusion of face, scalp and neck, except eyes
305.00	4733	Alcohol abuse, unspecified

65+ years		
ICD9_CODE	HAR_COUNT	ICD9 CODE definition
784.7	2724	Epistaxis (bloody nose)
427.31	2678	Atrial fibrilation
780.39	2622	Other convulsions
789.01	2587	Abdominal pain, right upper quadrand
034.0	2538	Actinomycosis
535.5	2529	Unspecified gastritis and gastroduodenitis.
574.2	2485	Calculus of gallbladder without mention of cholecystiti
782	2376	Symptoms involving skin and other integumentary tissue
V62.84	2374	Suicidal ideation
372.3	2354	Other and unspecified conjunctivitis
338.29	2339	Other chronic pain
595	2326	Cystitis
850	2304	Consussion with no loss of consciousness
491.21	2304	Obstructive chronic bronchitis with (acute) exacerbation

Data Category: Mental Health Measures

Adults Needed Help for Emotional/Mental Health Problems Or Use of Alcohol/Drugs

Los Angeles County Service Planning Areas (SPA) (West Area)

Needed help for emotional/mental health problems or use	%	95% CI	Population
Needed help	23.6%	16.9 - 30.4	124,000
Did not need help	76.4%	69.6 - 83.1	402,000
Total	100.0%	-	526,000

Source: 2012 California Health Interview Survey

Adults Ever Seriously Thought About Committing Suicide

Los Angeles County Service Planning Areas (SPA) (West Area)

Ever seriously thought about committing suicide	%	95% CI	Population
Thought about committing suicide (2009)	11.4%	5.5 - 17.3	58,000
Thought about committing suicide (2011)	7.8%	5.0 - 10.6	38,000
Thought about committing suicide (2012)	9.3%	4.1 - 14.5	49,000
Thought about committing suicide (2013)	9.0*	3.1 - 15.0	46,000
Thought about committing suicide (2014)	6.9*	2.0 - 11.7	36,000
Never thought about committing suicide (2009)	88.6%	82.7 - 94.5	448,000
Never thought about committing suicide (2011)	92.2%	89.4 - 95.0	454,000
Never thought about committing suicide (2012)	90.7%	85.5 - 95.9	477,000
Never thought about committing suicide (2013)	91.0*	85.0 - 96.9	461,000
Never thought about committing suicide (2014)	93.1*	88.3 - 98.0	490,000
Total (2009)	100.0%	-	506,000
Total (2011)	100.0%	-	493,000
Total (2012)	100.0%	-	526,000
Total (2013)	100.0%	-	507,000
Total (2014)	100.0%	-	527,000

Source: 2014 California Health Interview Survey

Teens Needed Help for Emotional/Mental Health Problems

Asked of all adolescents

Los Angeles County Service Planning Areas (SPA) (West Area)

Teen needed help for emotional/mental health problems	%	95% CI	Population
Yes needed help	18.7*	0.0 - 49.3	6,000
No did not need help	81.3*	50.7 - 100.0	24,000
Total	100.0%	-	30,000

Source: 2012 California Health Interview Survey

Santa Monica Cradle to Career 2014 Youth Wellbeing Report Card

Indicator (Santa Monica Area Only)	2012/13	2014
Youth who report they experienced significant periods of extreme sadness and hopelessness in the past 12 mo.	25.3%	26.3%
Youth who report they have used alcohol over the past month	28.6%	21.0%
Youth who report they have used substances over the past month	31.7%	26.1%

Data Category: Access

	Providence Saint John's Health Center Health Insurance Estimates								
ZIP Code	2016 Adjusted Population								
	Total	Medicaid	Medicaid Expansion	Medicare	MedicareDual Eligible	Private - Direct	Private - ESI	Private - Exchange	Uninsured
90024	50,284	18,623	6,987	4,141	1,985	1,203	7,970	3,496	5,878
90025	43,543	7,528	3,538	3,596	1,777	3,005	19,149	2,918	2,032
90034	59,301	13,164	5,954	3,701	1,870	3,522	23,020	4,466	3,604
90035	29,272	5,822	2,610	2,883	1,412	1,722	11,223	1,970	1,631
90045	41,622	6,915	3,367	3,534	1,731	2,949	18,617	2,492	2,016
90049	38,015	4,370	2,151	5,027	2,393	2,917	18,012	1,834	1,311
90056	7,878	895	461	1,279	611	562	3,434	351	285
90064	26,552	4,134	1,944	2,994	1,449	1,783	11,482	1,578	1,189
90066	56,196	9,617	4,594	5,115	2,506	3,734	24,251	3,725	2,653
90067	2,731	421	130	959	439	73	447	119	143
90073	2	0	0	1	0	0	1	0	0
90077	9,868	735	354	1,613	751	829	4,975	358	252
90094	6,569	975	519	332	172	515	3,363	441	251
90095	5	0	0	0	0	1	4	0	0
90210	23,659	4,205	1,724	3,855	1,808	1,314	8,217	1,163	1,373
90211	8,752	1,564	717	979	472	548	3,475	543	453
90212	11,860	2,025	892	1,366	660	771	4,845	715	585
90230	33,742	4,910	2,490	3,457	1,700	2,395	15,396	1,981	1,414
90232	16,236	3,072	1,381	1,550	764	1,010	6,502	1,094	862
90263	1,559	42	57	78	39	196	1,082	47	18
90265	19,628	2,517	1,238	2,542	1,204	1,494	8,982	823	827
90272	24,975	2,159	1,047	3,732	1,765	2,056	12,523	941	752
90291	28,709	5,393	2,482	2,110	1,051	1,878	12,277	2,146	1,373
90292	24,575	3,323	1,576	2,984	1,432	1,765	11,143	1,458	895
90293	12,794	1,522	725	1,336	654	1,025	6,365	755	412
90401	7,819	2,400	884	804	391	267	1,746	665	661
90402	12,438	1,541	731	1,840	874	881	5,518	551	502
90403	25,442	4,594	2,044	2,950	1,434	1,549	9,929	1,713	1,228
90404	22,313	5,597	2,298	2,157	1,065	1,061	6,892	1,685	1,558
90405	28,448	6,291	2,627	3,056	1,490	1,495	9,691	2,043	1,754
	674,787	124,355	55,522	69,972	33,900	42,521	270,532	42,072	35,912

Data Source: Truven Analytics

Note: Zip codes 90073 and 90095 are the Veterans Administration complex and the University of California Los Angeles campus so that is why numbers are not reported for these areas

Population With Usual Place to go to When Sick Or Need Health Advice

Los Angeles County Service Planning Areas (SPA) (West Area)

Have usual place to go to when sick or need health advice	%	95% CI	Population
Has usual source of care	91.1*	85.6 - 96.7	571,000
Does not have usual source of care	8.9*	3.3 - 14.4	55,000
Total	100.0%	-	627,000

Source: 2014 California Health Interview Survey

Population < 300% of FPL Currently Receiving Food Stamps

Asked of all people in a household with total annual household income less than 300% of the Federal

Los Angeles County Service Planning Areas (SPA) (West Area)

Currently receiving Food Stamps	%	95% CI	Population
Currently receiving Food Stamps (2003)	5.1*	0.5 - 9.6	12,000
Currently receiving Food Stamps (2005)	6.2*	0.0 - 14.3	11,000
Currently receiving Food Stamps (2007)	0.6*	0.0 - 1.4	1,000
Currently receiving Food Stamps (2009)	5.2*	0.0 - 11.3	13,000
Currently receiving Food Stamps (2011)	5.8*	0.0 - 12.0	14,000
Currently receiving Food Stamps (2012)	8.5*	0.0 - 17.5	18,000
Currently receiving Food Stamps (2013)	5.1*	0.0 - 12.5	11,000
Currently receiving Food Stamps (2014)	3.0*	0.0 - 7.6	6,000
Not currently receiving Food Stamps (2003)	94.9*	90.4 - 99.5	225,000
Not currently receiving Food Stamps (2005)	93.8*	85.7 - 100.0	171,000
Not currently receiving Food Stamps (2007)	99.4*	98.6 - 100.0	195,000
Not currently receiving Food Stamps (2009)	94.8*	88.7 - 100.0	241,000
Not currently receiving Food Stamps (2011)	94.2*	88.0 - 100.0	223,000
Not currently receiving Food Stamps (2012)	91.5*	82.5 - 100.0	190,000
Not currently receiving Food Stamps (2013)	94.9*	87.5 - 100.0	208,000
Not currently receiving Food Stamps (2014)	97.0*	92.4 - 100.0	205,000
Total (2003)	100.0%	-	237,000
Total (2005)	100.0%	-	182,000
Total (2007)	100.0%	-	196,000
Total (2009)	100.0%	-	255,000
Total (2011)	100.0%	-	236,000
Total (2013)	100.0%	-	219,000

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Type of Usual Source of Medical Care Adults & Children

Los Angeles County Service Planning Areas (SPA) (West Area)

Type of usual source of care	%	95% CI	Population
Doctor's office/HMO/Kaiser	71.3%	61.8 - 80.9	447,000
Community clinic/government clinic/community hospital	15.2%	6.6 - 23.8	95,000
Emergency room/Urgent care	2.1*	0.0 - 5.0	13,000
Some other place/No one place	2.5*	0.0 - 6.0	15,000
No usual source of care	8.9*	3.3 - 14.4	55,000
Total	100.0%	-	627,000

Source: 2014 California Health Interview Survey

Teens Having Five or More Servings of Fruits/Vegetables Daily

Los Angeles County Service Planning Areas (SPA) (West Area)

Five-a-day (Five or more servings of fruits/vegetables daily)	%	95% CI	Population
Eat 5+ servings of fruits/vegetables daily (2003)	26.5%	12.9 - 40.1	12,000
Eat 5+ servings of fruits/vegetables daily (2005)	31.5*	9.5 - 53.5	15,000
Eat 5+ servings of fruits/vegetables daily (2007)	29.5*	10.9 - 48.0	15,000
Eat 5+ servings of fruits/vegetables daily (2009)	23.3*	3.6 - 43.0	12,000
Eat 5+ servings of fruits/vegetables daily (2011)	27.1*	0.0 - 55.1	13,000
Eat 5+ servings of fruits/vegetables daily (2012)	20.6*	0.0 - 64.2	6,000
Eat 5+ servings of fruits/vegetables daily (2013)	18.9*	0.0 - 41.2	13,000
Eat 5+ servings of fruits/vegetables daily (2014)	37.0*	1.9 - 72.2	22,000
Eat less than 5 servings of fruits/vegetables daily (2003)	73.5%	59.9 - 87.1	33,000
Eat less than 5 servings of fruits/vegetables daily (2005)	68.5*	46.5 - 90.5	33,000
Eat less than 5 servings of fruits/vegetables daily (2007)	70.5*	52.0 - 89.1	35,000
Eat less than 5 servings of fruits/vegetables daily (2009)	76.7*	57.0 - 96.4	41,000
Eat less than 5 servings of fruits/vegetables daily (2011)	72.9*	44.9 - 100.0	34,000
Eat less than 5 servings of fruits/vegetables daily (2012)	79.4*	35.8 - 100.0	24,000
Eat less than 5 servings of fruits/vegetables daily (2013)	81.1*	58.8 - 100.0	54,000
Eat less than 5 servings of fruits/vegetables daily (2014)	63.0*	27.8 - 98.1	37,000
Total (2003)	100.0%	-	45,000
Total (2005)	100.0%	-	48,000
Total (2007)	100.0%	-	50,000
Total (2009)	100.0%	-	53,000
Total (2011)	100.0%	-	47,000
Total (2012)	100.0%	-	30,000
Total (2013)	100.0%	-	67,000
Total (2014)	100.0%	-	59,000

Source: 2012 California Health Interview Survey

Children and Teen Soda Consumed Yesterday

Asked of children 2 years or older and all adolescents

Los Angeles County Service Planning Areas (SPA) (West Area)

Soda consumed yesterday	%	95% CI	Population
Did not drink yesterday	80.0*	56.2 - 100.0	72,000
Drank one glass	20.0*	0.0 - 43.8	18,000
Drank two or more glasses	-	-	-
Total	100.0%	-	90,000

Source: 2014 California Health Interview Survey

Number of Days Physically Active At Least One Hour (typical week)

Children 5-11 years

Los Angeles County Service Planning Areas (SPA) (West Area)

Number of days physically active at least one hour (typical week)	%	95% CI	Population
0 day	-	-	-
1 day	20.6*	0.0 - 51.6	4,000
2 days	21.4*	0.0 - 66.5	5,000
3 days	26.0*	0.0 - 73.7	6,000
4 days	22.6*	0.0 - 70.8	5,000
5 days	6.4*	0.0 - 16.8	1,000
6 days	-	-	-
7 days	-	-	-
Total	100.0%	-	22,000

Source: 2014 California Health Interview Survey

Number of Days Physically Active At Least One Hour (typical week)

Teens

Los Angeles County Service Planning Areas (SPA) (West Area)

Number of days physically active at least one hour (typical week)	%	95% CI	Population
0 day	-	-	-
1 day	14.4*	0.0 - 44.4	9,000
2 days	23.2*	0.0 - 48.6	14,000
3 days	5.2*	0.0 - 12.7	3,000
4 days	12.4*	0.0 - 30.8	7,000
5 days	3.1*	0.0 - 9.5	2,000
6 days	7.5*	0.0 - 18.9	4,000
7 days	34.2*	3.8 - 64.7	20,000
Total	100.0%	-	59,000

Source: 2014 California Health Interview Survey

Number of Times Fast Food Eaten in Past Week

Asked of respondents 2 years or older

Los Angeles County Service Planning Areas (SPA) (West Area)

Fast food eaten how many times in past week	%	95% CI	Population
No times (2012)	45.9%	38.2 - 53.6	279,000
No times (2013)	50.7%	42.2 - 59.2	313,000
No times (2014)	47.0%	36.4 - 57.7	291,000
One time (2012)	25.4%	18.7 - 32.1	154,000
One time (2013)	21.6%	14.1 - 29.2	134,000
One time (2014)	23.1%	15.1 - 31.2	143,000
Two times (2012)	9.9%	5.1 - 14.8	60,000
Two times (2013)	14.8%	8.3 - 21.4	92,000
Two times (2014)	12.2%	5.3 - 19.2	76,000
Three times (2012)	8.7%	3.8 - 13.5	53,000
Three times (2013)	6.6*	2.1 - 11.0	40,000
Three times (2014)	6.4*	1.1 - 11.7	39,000
Four or more times (2012)	10.1%	4.6 - 15.6	61,000
Four or more times (2013)	6.3*	1.7 - 10.8	39,000
Four or more times (2014)	11.2*	4.1 - 18.3	69,000
Total (2012)	100.0%	-	608,000
Total (2013)	100.0%	-	617,000
Total (2014)	100.0%	-	618,000

Source: 2012 California Health Interview Survey

Data Category: Community Need Indices

Providence Saint John's Health Center
Community Health Needs Assessment
Index Scores Measuring Level of Need

Zip Code	Community	Community Need Index Score 1 (Low Need) to 5 (High Need)	SocioNeeds Index Score 1 (Low Need) to 100 (High Need)	Health Disparity Index (70% or Above)	California Environ. Screen Index (4th Quartile)
90024	Westwood	3.8	16.3	C.T. 265202 79.3% C.T. 265305 85.8% C.T. 265304 95.3% C.T. 265303 86.0%	
90025	West L.A.	3.4	15.0	C.T. 267300 75.9%	C.T. 267300 41.53
90034	Palms	4.0	49.0	C.T. 269601 85.3%	C.T. 269601 49.06
90035	West Fairfax	3.4	16.8		
90045	Westchester	3.2	16.0		C.T. 277400 43.70
90049	Brentwood	2.6	1.4		
90056	Ladera Heights	2.8	7.4		
90064	Cheviot Hills/Rancho Park	3.0	5.5		
90066	Mar Vista	3.6	27.6	CT 7272201 70.9 CT 7272202 72.0 CT7275200 71.2	
90067	Century City	3.0	3.5		
90073	Veterans Admin/West L.A.	N/A	N/A	N/A	N/A
90077	Bel Air	1.6	0.3		
90094	Playa Vista	3.0	4.3		
90095	UCLA/Westwood	N/A	N/A	N/A	N/A
90210	Beverly Hills	2.8	1.3	C.T. 700801 75.9%	
90211	Beverly Hills	2.8	25.3		
90212	Beverly Hills	3.0	12.0		
90230	Culver City	3.8	28.6	C.T. 275102 85.3% C.T. 275500 75.7% C.T. 275603 76.6%	C.T. 275500 41.51
90232	Culver City	3.4	22.9		
90263	Malibu	2.0	1.2		
90265	Malibu	2.4	1.3		

90272	Pacific Palisades	1.8	0.5		
90291	Venice	3.4	17.9	C.T. 273502 76.3%	
90292	Marina Del Rey	3.0	4.1		
90293	Playa Del Rey	2.6	5.9		
90401	Santa Monica	3.2	17.1	C.T.701902 88.5%	
90402	Santa Monica	2.4	0.7		
90403	Santa Monica	2.8	6.6		
90404	Santa Monica	3.6	44.3		C.T. 701801 47.17
90405	Santa Monica	3.0	11.3		

*C.T. – Census Tract
Highlighted zip codes represent areas scoring high in one or more indices of need

Source:
Community Need Index – Developed by Dignity Health and Truven Analytics
SocioNeeds Index – Developed by the Healthy Communities Institute (2016)
Health Disadvantage Index - Tool to identify disadvantaged communities statewide based on factors influencing health, development and wellbeing (Social Determinants of Health) developed by the Public Health Alliance of Southern California
California Environmental Screen- Tool to help CalEPA target cleanup/remediation resources statewide by identifying communities with multiple pollution burdens developed by the CalEPA’s Office of Environmental Health Hazard Assessment (OEHHA)

Appendix II – Partners in the Community Health Needs Assessment

Community Advisory Committee participants in 2016 community health needs assessment

Name	Title	Organization	Community Representation
Nicolas Vrataric	Executive Director	The Clare Foundation	Agency represents those dealing with mental health and substance abuse issues
Julie Rusk	Assistant Director, Community Services	City of Santa Monica	Represents local government
John Maceri	Executive Director	OPCC	Largest homeless organization in the area
Oscar de la Torre	Executive Director	Pico Youth and Family Center	Organization serves at-risk youth in the area
Laurel Rosen	President/CEO	Santa Monica Chamber of Commerce	Represents local businesses
Julie Neveau	Director, Community Relations	Santa Monica College	Represents education
Lora Morn	Student Services Nurse Coordinator	Santa Monica-Malibu Unified School District	Represents education
Jessica Cuellar	Development Director	Saint Anne School	Represents private education
Msgr. Lloyd Torgerson	Pastor	St. Monica Church	Represents faith based institutions
Michele Bonat	Director, Community Health Education	Saint John's Health Center	Internal representative
Va Lecia Adams Kellum	Executive Director	St. Joseph Center	Social service and housing agency

Name	Title	Organization	Community Representation
Tod Lipka	CEO	Step Up on Second	Agency serving homeless with substance use and mental health issues
Christine Mirasy-Glasco	CEO	Upward Bound House	Serves homeless families
Elizabeth Forer	CEO	Venice Family Clinic	Largest Federally Qualified Health Center in the area
Debra Farmer	Executive Director	Westside Family Health Center	Primary care medical clinic serving low income and uninsured
Grace Cheng Braun	Executive Director	WISE and Healthy Aging	Serves seniors with education, social service, nutrition, case mgt. and other services
Chris Baca	Executive Director	Meals on Wheels West	Provides food/nutrition to low income and seniors
Rebecca Refuerzo	Executive Director	Providence Saint John's Child and Family Development Center	Provides mental health services to low-income children and their families
Elan Shultz	Health Deputy	Los Angeles County Board of Supervisors	Represents local government
Janet Turner	Field Deputy	U.S. Representative Ted Lieu	Represents government
Stephanie Cohen	Senior Field Representative	Assemblymember Richard Bloom	Represents State government
Dr. David Tam	C.O.O.	Providence Saint John's Health Center	Internal representative

Appendix III – Community Assessment Survey Tools

CHNA 2016

Interview Protocol (Stakeholder Phone Interviews)

Introduction:
Providence Saint John's Health Center is in the process of conducting their 2016 Community Health Needs Assessment. We are talking to health experts to obtain their perspective on the most important health issues facing the local community and to identify areas of need as well as the availability of services to meet those needs. All the information collected will help Providence Saint John's Health Center better serve the community. The information you provide is confidential and will not be associated with your name and will only be reported in an aggregated manner.

Familiarity with Medical Center:

Area of Expertise:

Primary Service Area:

Primary Population Served:

COMMUNITY HEALTH NEEDS AND ASSOCIATED DRIVERS

1. What are some of the **major health issues** affecting individuals in the community?

2. What are the most important socio-economic, behavioral, environmental or clinical factors contributing to poor health in the community?

3. As a result of our review of community data, we have identified some significant health needs.

   I am going to review this list of identified health needs and would like you to discuss your perspective on the issues surrounding each of the needs, and what you consider to be the challenges and barriers people face in addressing these health needs.

   Understanding the resources available to address health needs is an important part of the needs assessment process, I'd also like you to identify the services, programs and community efforts you are aware of that are available to address each of the health needs.

Health Needs	**Issues/Challenges/Barriers** Are there specific sub-populations (seniors, youth, others) and areas in the community that are most affected by this need? Has the health need gotten better or worse over the past 2-3 years?	**Resources: Services, Programs and/or Community Efforts** Where do community residents go to receive help or obtain information for this health need? In your experience, what are the most effective program /service delivery models for addressing this need?
Access to care: primary care, specialty care, medications, health insurance (Prompt: How has the Affordable Care Act (ACA) impacted community members' ability to access care and other services?)		
Cancer		
Chronic disease (asthma, diabetes, heart disease, HIV/AIDS, others)		

Community safety		
Dental care		
Homelessness / Housing		
Mental health		
Overweight/Obesity		
Preventive practices and services		
Substance abuse		
Other needs identified in question #1		

ACCESS TO CARE

4. What health or social services are **most difficult to access or are missing** in the community? *[DO NOT SAY ALOUD: This could include access to medical care that is affordable or free, health education workshops, dental care, vision care, substance abuse services, mental health care, etc.]*

    a. Are there socio-economic, behavioral, environmental or clinical factors that contribute to this?

    b. Does this affect certain sub-populations more than others?

COLLABORATION

5. What are the potential areas for **collaboration or coordination** among hospitals, community organizations, and/or businesses (i.e. health or social providers, local government, etc.) to address community health needs or specific socio-economic, behavioral, environmental or clinical factors?

COMMUNICATION

6. What would be the most efficient **ways to provide information** to community members about the availability of health and other services?

RANKING OF HEALTH NEEDS AND FACTORS/DRIVERS OF HEALTH

7. I would like to ask you to **rank the identified community health needs** on a scale of 1 to 5 according to severity where 1 is least severe and 5 is most severe.
   Note to facilitator: severity is defined as the level a health issue or health factor/driver that affects the health and lives of those in the community.
8. Thinking of these health needs, I would like to ask you to prioritize each by indicating the level of importance that **the hospital** should place on addressing them; on a scale of 1 to 5, where 1 is not important to address and 5 is very important to address.

Health Needs	Severity 1-5	Importance 1-5
Access to care		
Asthma		
Cancer		
Community safety		
Dental care		
Diabetes		
Heart Disease		
HIV/AIDS		
Homelessness / Housing		
Mental health		
Overweight /Obesity		
Preventive practices and services		
Substance abuse		
Other needs identified in question #1		

9. What would be the best way to share the findings of this **community health needs assessment**?

10. Before we end the interview, is there anything else you would like to add?

Your responses have been very helpful.
Thank you for your time.

The Flora L. Thornton Community Health Education Program
Community Needs Assessment Survey of Residents

Dear Community Resident,

Providence Saint John's Health Center (PSJHC) is in the process of conducting an assessment of the community to identify the priority health and social needs of the residents living in the area. As part of this assessment process, we would value your input to help us identify the key needs in the community. This information will help PSJHC as it plans for future programs and services to improve the health of the community. Please take a few minutes to answer the following questions.

1. What zip code do you live in? ________________________
2. Of the key community needs listed below, please rank them in order of priority/importance (e.g. 1 = most important and 6 = less important).
   ____ Access to affordable, quality medical care
   ____ Chronic illnesses (e.g. heart disease, diabetes, high blood pressure, arthritis, etc.)
   ____ Disease prevention practices and programs (e.g. nutrition programs, physical activity programs, etc.)
   ____ Homelessness/ Stable Housing
   ____ Mental Health/Suicide
   ____ Substance Abuse/Addiction

3. Are there other key needs in your community that you feel are missing from the list above? If so, please list them.

4. What 3 key factors (place a check next to them) do you feel are key contributors to the community needs that you prioritized above?
   □ Increase peer and family pressures
   □ Increase economic pressures
   □ Lack of affordable housing
   □ Lack of affordable nutritious food
   □ Lack of adequate paying jobs
   □ Lack of education
   □ Increase drug/alcohol use
   □ Poverty
   □ Lack of physicians who accept all insurance plans (e.g. private insurance, Medicare and Medi-Cal)
   □ Lack of affordable/free health promotion and disease prevention programs
   □ Other? ____

5. What do you feel that Providence Saint John's Health Center should be doing to help address the priority community needs (please check your top 2 recommendations)?
   □ Implementing programs to address the priority needs
   □ Providing funding to area nonprofits to address the needs
   □ Leading initiatives/projects in the community to address the needs
   □ Collaborating more with local nonprofits, education, faith and government organizations
   □ Working closer with community residents to address the priority needs
   □ Other? ____

Community Health Improvement Plan

[2017-2019]

Providence Saint John's Health Center

Santa Monica, California

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2017 to 2019

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Executive summary

In 2016, Providence Saint John's Health Center (PSJHC) completed a community health needs assessment of the Westside area of Los Angeles County. As part of this process, both primary and secondary data were reviewed to identify the priority needs and issues facing the community. With input from local residents, community leaders and area stakeholders the needs identified through the assessment process were prioritized. The five key areas that PSJHC will focus on over the next three years include:

- Increase access to affordable primary and specialty care
- Offer programs and resources to better manage and prevent chronic illnesses
- Develop more programs focused on reducing obesity and improving nutrition in the community
- Improve access to affordable mental health and substance abuse programs
- Offer programs and services to assist the growing number of homeless persons living in the area

This Community Health Improvement Plan (CHIP) was developed to provide a framework for focusing resources and programs to address the priority needs from the CHNA. This plan will assist PSJHC as it moves from the assessment stage to the implementation phase. Providence Saint John's Health Center plans to address the priority needs through a detailed implementation plan included in this document. The key strategies that are part of this implementation plan include:

- Improve access to specialty care on the Westside for Medi-Cal and uninsured patients
- Develop education, screening and support programs to help address chronic disease in the area
- Provide programs and improve access to resources focused on better nutrition in the community
- Expand mental health and substance abuse services in the community to vulnerable populations
- Expand services and outreach to homeless patients coming to PSJHC and to those living in the community

Each of these strategies has specific metrics to measure the progress in addressing the needs and a timeframe for completion.

The accomplishment of these key strategies will be achieved through:

- Expanding existing programs offered by Providence Saint John's Health Center
- Developing new programs to address the priority needs identified
- Strengthening existing partnerships in the community to address community needs
- Developing new partnerships with key stakeholders
- Providing grant funding to local organizations focused on addressing the priority needs identified in the CHNA

As part of the CHNA process, issues were identified that PSJHC is unable to address due to resource constraints or the lack of expertise in dealing with these issues. The four key needs that PSJHC is unable to address at this time include the development of more affordable and low income housing in the area, the need for more workforce development and employment programs, growing rate of poverty in the area, and the need for more affordable and reliable transportation options to help address traffic and mobility in the area. In collaborating with our community partners focused on these needs, PSJHC will support their efforts to address these four key areas that were identified as part of the CHNA process.

Providence Saint John's Health Center looks forward to working in collaboration with our community partners, and bringing its resources and expertise to the table to address the priority needs identified as part of the CHNA process. This Community Heath Improvement Plan will help to provide the framework to direct programs and resources aimed at improving the health and wellbeing of the area residents with special concern for those who are poor and vulnerable.

Introduction

CREATING HEALTHIER COMMUNITIES, TOGETHER

As health care continues to evolve, Providence is responding with dedication to its Mission and a core strategy to *create healthier communities, together*. Partnering with others of goodwill, we conduct a formal community health needs assessment to learn about the greatest needs and assets from the perspective of some of the most marginalized groups of people in communities we serve. This assessment helps us develop collaborative solutions to fulfill unmet needs while continuing to strengthen local resources. It guides our community benefit investments, not only for our own programs but also for many partners, toward improving the health of entire populations. Through strategic programs and donations, health education, charity care, medical research and more, Providence Health & Services provided $951 million in community benefit across Alaska, California, Montana, Oregon and Washington during 2015.

Serving the Westside of Los Angeles County

Providence Saint John's Health Center (PSJHC) serves the Westside area of Los Angeles County. During 2016, PSJHC provided $66,424,279 in community benefit in response to unmet needs and to improve the health and well-being of those we serve on the Westside. Providence facilities serving the area include:

- Providence Saint John's Health Center: A nationally renowned 266-bed hospital with physicians, nurses, support staff and volunteers who work as a team to provide the best possible medical care to its patients and the community.
- John Wayne Cancer Institute: A cancer treatment and research center affiliated with PSJHC providing the latest advances in treating this growing disease.
- Providence Medical Institute: A network of primary care and specialty physicians located in Santa Monica and the surrounding communities.
- Doctors of Saint John's: A group of primary care and specialty physicians affiliated with PSJHC.
- Child and Family Development Center: A community mental health center serving low income children and their families dealing with emotional and mental health issues.
- Freestanding Urgent Care Centers: Provided through a partnership with Exer Urgent Care.
- Trinity Care Hospice: Operated by Providence Health and Services to offer home hospice to the community. This program is one of the few home hospices to offer services to children with terminal illnesses.
- Institute for Human Caring: Operated by Providence Health and Services to provide palliative care education and services to the community.

About us

Providence Health & Services is a not-for-profit Catholic health care ministry committed to providing for the needs of the communities it serves – especially for those who are poor and vulnerable. Providence's

combined scope of services includes 34 hospitals, 475 physician clinics, senior services, supportive housing and many other health and educational services. The health system and its affiliates employs more than 76,000 people across five states – Alaska, California, Montana, Oregon and Washington – with its system office located in Renton, Washington. Our community health activities are rooted in the charitable work the Sisters of Providence started nearly 160 years ago when they answered a call for help from a new pioneer community in the West.

Mission

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

Vision

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

Values

Respect, Compassion, Justice, Excellence, Stewardship

Purpose of this plan

In 2016, Providence Saint John's Health Center conducted a community health needs assessment. This community health improvement plan is designed to address key health needs identified in that assessment. The prioritized needs were chosen based on a review of primary and secondary data on the community. As part of this process, input was sought from community residents, leaders, and key stakeholders to help identify the top priority health issues facing the area. In identifying these top priorities we determined that emphasis on these needs would have the greatest impact on the community's overall health, and offer opportunities for collaboration with private and public sector partners.

Providence prioritized needs
PRIORITY #1 IMPROVE ACCESS TO AFFORDABLE PRIMARY AND SPECIALTY CARE. PRIORITY #2 BETTER MANAGEMENT AND PREVENTION OF CHRONIC ILLNESSES. PRIORITY #3 NEED FOR MORE PREVENTION PROGRAMS FOCUSED ON REDUCING OBESITY AND IMPROVING NUTRITION. PRIORITY #4 IMPROVE ACCESS TO AFFORDABLE MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMS. PRIORITY #5 SERVICES TO ADDRESS THE GROWING NUMBER OF HOMELESS PERSONS LIVING IN THE AREA.

Our overall goal for this plan

As we work to create healthier communities, together, the goal of this community health improvement plan is to measurably improve the health of individuals and families living in the communities served by Providence Saint John's Health Center. The plan's target population includes the community as a whole, and specific population groups including minorities, those living in poverty, and other underserved demographics.

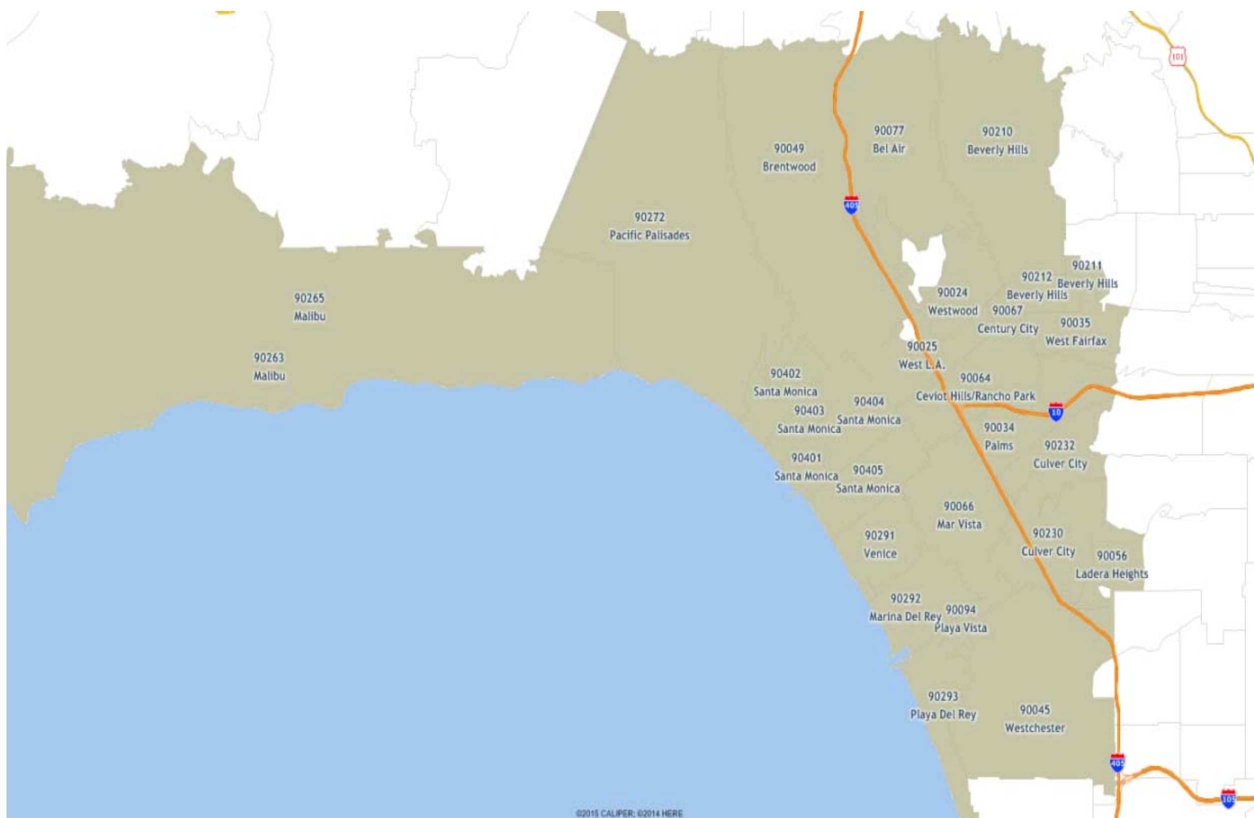
This plan includes components of education, prevention, disease management and treatment, and features collaboration with other agencies, services and area providers. The oversight, implementation, and monitoring of the plan will be the responsibility of the Community Health Partnership Department of the hospital with assistance from key staff in various departments and through input from the Community Advisory Board.

Community Profile

The service area defined for the Providence Saint John's Health Center Community Health Needs Assessment includes the zip codes located within Service Planning Area (SPA) 5 of Los Angeles County. The planning area includes the communities located on the Westside of Los Angeles County and represents the area where a significant portion (over 70%) of the patients served by the hospital reside. Since the service planning area matched closely with where a majority of PSJHC's patients reside, it was decided to use this geographic area for the CHNA. The area includes 20 distinct communities and 30 zip codes.

Providence Saint John's Health Center

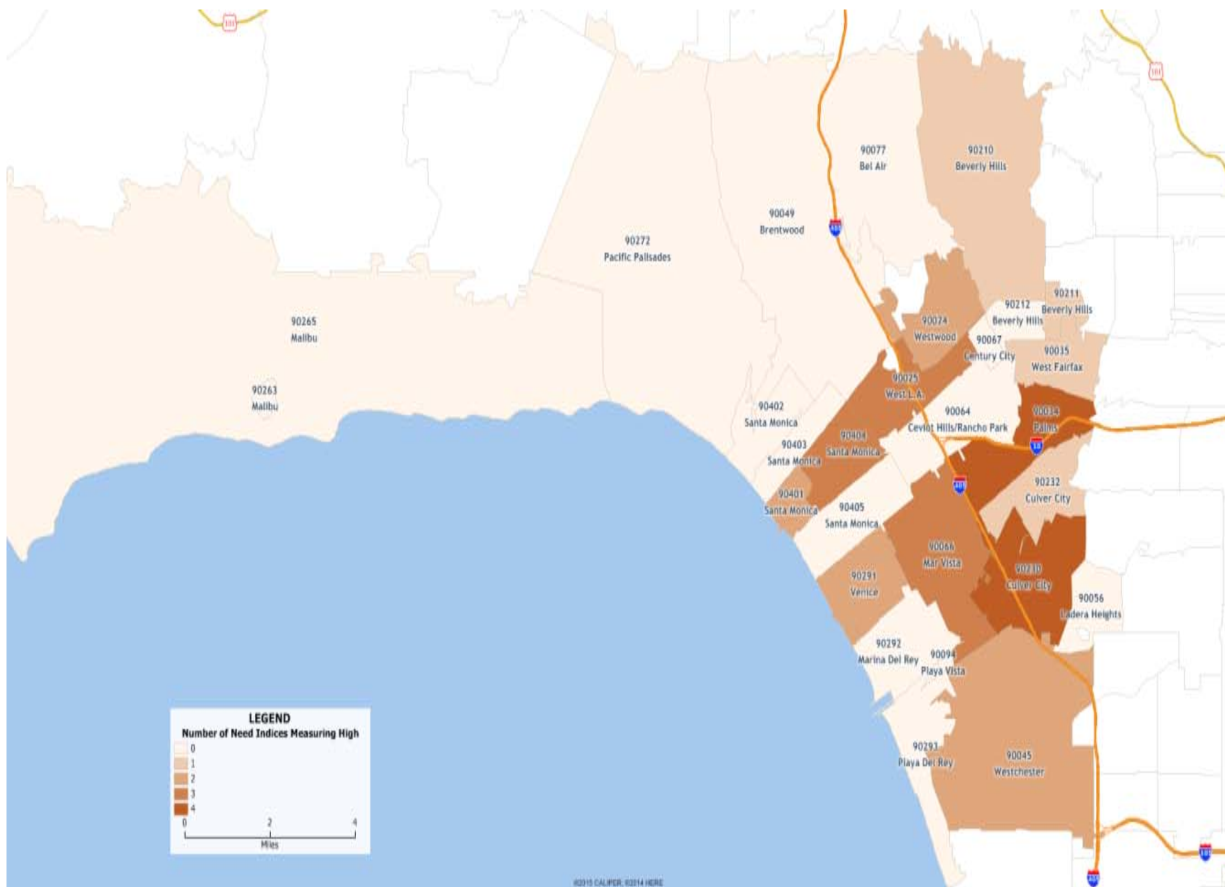
Community Needs Assessment Service Area Map



In looking at areas of the Westside with significant health, social, economic and other needs there were several composite measurements of needs utilized. These indices looked at multiple factors to measure the level of need in the community including the number of persons who were uninsured, household income level, unemployment rate, levels of poverty, education level, English proficiency, home ownership rate, environmental risk factors, and data elements identified with the social determinants of health. These measurements calculated need at a local level either at a census tract or zip code breakdown. The measurements used to identify higher need communities include the Community Need Index, SocioNeeds Index, Health Disparity Index, and the California Environmental Screen Index. Based on these four composite measures the following areas scored high in three or more of the indices:

- West Los Angeles (zip code 90025)
- Palms (zip code 90034)
- Mar Vista (zip code 90066)
- Culver City (zip code 90230)
- Santa Monica (zip code 90404)

As part of this community health improvement plan, PSJHC plans to target programs and services to these higher need areas to address the priority health issues.



POPULATION AND AGE DEMOGRAPHICS

The total population of the area in 2016 was 674,787 persons which represent a 5 percent increase compared to the population in 2010, or an additional 32,000 residents living in the area. A breakdown of the population by age/gender for the area shows:

- 8.1 percent male youth (0-17 years)
- 7.8 percent female youth (0-17 years)
- 33.2 percent male adults (18-64 years)
- 34.7 percent female adults (18-64 years)
- 7.2 percent male senior adults (65+ years)
- 9.1 percent female senior adults (65+ years)

ETHNICITY

Among Westside/SPA-5 residents in 2016, 68.5 percent were White, 13.4 percent Asian/Pacific Islander/Hawaiian, 0.43 percent were Alaska Native or American Indian, 6.0 percent were African American or Black, and 5.5 percent were of two or more races. In looking at the Latino population that resides in the area, approximately 15.4 percent of the residents identify themselves as being part of this group.

INCOME LEVELS AND HOUSING

In 2016, the median household income of the area varied significantly from a low of $55,025 for the community of Westwood to $158,545 for the community of Bel Air. This difference in income was also reflected in average household income of the area with the average being $78,891 in the community of Palms and $215,718 in the community of Bel Air. Although the Westside contains many affluent communities, the income data shows that there are areas within the service area with a higher portion of low-income households. Approximately, 24 percent of the population has annual incomes below 200% of the Federal Poverty Level compared to 41 percent in Los Angeles County as a whole.

EDUCATION LEVEL

While most of the adults age 25+ living in households on the Westside have at least graduated from high school, there are several zip codes that had a higher percentage of adults who did not compete high school. These zip codes include Palms (90034) 11.5%, Mar Vista (90066) 11.5%, Culver City (90230) 12.1% and Culver City (90232) 10.2%.

HEALTH CARE AND COVERAGE

The share of Westside residents who are uninsured was 5.3 percent in 2016. Compared to the entire Los Angeles County with 79.3 percent of the population insured, the Westside has a higher percentage of insured (94.7 percent). For the same period, approximately 26.8 percent of area residents were covered by Medi-Cal. The increase in the number of people insured in the area is due in large part to

the passage of the Affordable Care Act. One of the major health care access issues in the area is the lack of specialty care for those persons covered by Medi-Cal due to the low number of physicians in the area who accept this insurance. The most recent count identified that eighty-three specialty physicians in the Westside area accept Medi-Cal managed care patients.

Health and Wellbeing

The Westside area has a large supply of physicians due in part because there is a large medical school and academic medical center in the vicinity. The increase number of physicians is also due to the fact that many of the communities in the area include higher income neighborhoods and residents with more generous health coverage benefits. One of the major issues impacting the area is that a good portion of the physicians located on the Westside do not accept all insurance plans, including Medicare and Medi-Cal. This problem of limited access to physicians for those covered by these plans raises access issues with a significant number of local residents.

The City of Santa Monica is taking a more active role in trying to improve the health and wellbeing of its residents. The City recently completed a survey of its residents to get input on issues of concern regarding health and wellbeing. As part of this process, the City has created the Office of Civic Wellbeing to become more involved in this aspect of making the community a better place to live and work. Providence Saint John's Health Center will be working with staff from this new City office to identify areas of collaboration and opportunities to coordinate activities.

Summary of Providence prioritized needs and associated action plans

In completing the community health needs assessment for the Westside area, Providence Saint John's Health Center utilized both primary and secondary data sources to identify the priority issues facing the community. Primary data sources for the study included:

- Phone interviews with forty-one community stakeholders representing different sectors (e.g. health, government, public health, social services, etc.) conducted in collaboration with three other hospitals/health systems in the area (Kaiser West L.A., UCLA Health System and Cedars-Sinai Medical Center).
- Written surveys distributed to 350 people at four community events to get input from a broad sector of the community regarding key needs of the area.
- Meetings held with PSJHC's Community Advisory Committee to look at the issues identified as part of the CHNA process and to help prioritize the needs.

Several sources of secondary data were used as part of the CHNA process to identify key needs facing the Westside area. These data sources included hard copy reports, online databases, community need indices, data collected by our county and state public health departments, Federal data, and demographic databases. The secondary data analyzed for the study included:

- Demographic data
- Health status data
- Disease and illness estimates for the area
- Mortality and morbidity data
- Community need measures/indices
- Economic data
- Other community level data

From a review of both the primary and secondary data, the following major categories of need were identified along with the contributing factors impacting those needs.

ACCESS TO CARE

- Lack of specialty physicians in the area who accept Medi-Cal
- Lack of physicians in the area who accept Medicare
- Lack of hospitals in the area accepting Medi-Cal insurance

Growth of Chronic Illnesses

- Lack of free health promotion and disease prevention programs in the area

- Lifestyle factors that contribute to the growing rates of chronic disease
- Education and language barriers impacting compliance with managing chronic illness
- Increasing health care and pharmaceutical costs

Mental Health and Substance Abuse

- Increase peer and family pressures
- Increase economic pressures in the area
- Limited affordable substance abuse treatment programs in the area
- Lack of mental health beds on the Westside, especially for children and adolescents
- Access to prescription drugs leading to substance abuse issues

Obesity and Nutrition

- Lack of affordable nutritious food in the area
- Low number of eligible recipients taking advantage of government food assistance programs
- Availability of free educational programs around healthy eating and physical fitness
- Reduced physical activity among residents

Homelessness

- Lack of affordable housing and reduction in rent controlled units in the area
- Growing rate of poverty
- Lack of adequate paying jobs
- Increase in mental health issues and lack of affordable treatment
- Displacement of homeless from other areas of Los Angeles due to gentrification of areas
- Attractiveness of Westside area for the homeless population due to weather and availability of services

Based on the priority community health needs identified as part of the CHNA, following is a breakdown of each need and the implementation strategies and measurable metrics that PSJHC will be pursuing over the next three years to address these needs.

Community Need Addressed - Access to Care

Limited access to affordable primary and specialty care.

Strategy

Work with physicians and community partners to improve access to specialty care on the Westside for Medi-Cal and uninsured patients.

Metrics

Metric	Target Completion Date
Work in partnership with Providence Medical Institute, Doctors of Saint John's, Venice Family Clinic, and Westside Family Health Center to serve Medi-Cal patients for Obstetrical care and G.I. services.	1st Quarter 2017
Expand access to 2-3 more medical specialties for Medi-Cal and uninsured patients residing on the Westside by working with physicians on the medical staff at PSJHC.	1st Quarter 2018

Partners in Collaboration

- Venice Family Clinic
- Westside Family Health Center
- The Achievable Foundation
- Providence Medical Institute
- Doctors of Saint John's

Measurement of Progress

- Number of successful referrals to specialty care
- Number of specialty physicians willing to accept Medi-Cal patients
- Patient satisfaction measures with referral process
- Number of O.B. patients admitted through the Emergency Dept. versus through the regular admission process
- Amount of free diagnostic testing done by PSJHC for uninsured patients referred from the three area community clinics

Community Need Addressed - Chronic Disease

Growing rate of chronic diseases impacting the Westside area.

Strategy

Develop and expand education, screening and support programs to help address chronic disease in the area.

Metrics

Metric	Target Completion Date
Develop key partnerships with PSJHC and 8 to 10 area churches on the Westside to implement chronic disease education and screening programs.	4th Quarter 2018
Develop 3 to 4 chronic disease support groups for residents of the Westside area.	2nd Quarter 2018
Conduct 4 community education forums on select chronic diseases serving 800 people.	2nd Quarter 2019
Implement ongoing free blood pressure, body mass index, and glucose screenings at least six sites in the community.	4th Quarter 2017
Develop program for medically fragile seniors with WISE and Healthy Aging to improve their outcomes and functioning serving at least 100 patients/yr.	3rd Quarter 2017

Partners in Collaboration

- St. Monica Church
- St. Anne Church
- St. Clement Church
- Mount Olive Lutheran Church
- St. Timothy Church
- St. Thomas the Apostle Church
- YMCA of Santa Monica
- WISE and Healthy Aging
- City of Santa Monica Office of Civic Wellbeing

Measurement

- Number of people receiving free screenings
- Number of people participating in the support groups and educational classes
- Satisfaction scores from participants attending the community education forums
- Number of people with abnormal screening results referred for medical care
- Number of new community partnerships developed
- Number of support group participants successfully managing their chronic illnesses
- Senior patients' readmission rates to the hospital within a month of discharge

Community Need Addressed – Obesity & Nutrition

Growing rate of obesity and poor nutrition in the area

Strategy

Provide programs and improve access to resources focused on better nutrition and reducing obesity in the community.

Metrics

Metric	Target Completion Date
Implement eight healthy eating education programs in the community serving 125 people/yr.	4th Quarter 2018
Link 300 eligible people/families with government food assistance benefits.	4th Quarter 2019
Partner with three area grocery stores to conduct nutrition education programs.	4th Quarter 2017
Develop walking groups at three partnering church locations.	1st Quarter 2018

Partners in Collaboration

- Meals on Wheels West
- St. Joseph Center
- Pico Youth and Family Center
- Boys and Girls Club of Santa Monica
- YMCA of Santa Monica
- City of Santa Monica Office of Civic Wellbeing
- Three Local Grocery Stores (to be selected)
- St. Anne School

Measurement

- Number of people enrolled in SNAP/CalFresh
- Number of participants in nutrition education classes
- Measure of knowledge gained in classes based on pre and post-test measures
- Client satisfaction survey results
- Improvement in diet based on self-reported tracking from clients

Community Need Addressed – Mental Health/Substance Abuse

Growing need for access to affordable mental health and substance abuse treatment programs.

Strategy

Expand mental health and substance abuse services in the community to vulnerable populations.

Metrics

Metric	Target Completion Date
Expand the preschool consultation program administered by the Child and Family Development Center to seventeen new sites.	4th Quarter 2017
Expand the Child and Family Development Center program for new mothers dealing with post-partum depression, with a focus on Venice Family Clinic and Westside Family Health Center patients.	3rd Quarter 2018
Provide at least two community benefit grants per year to local nonprofit organizations addressing substance abuse treatment and mental health needs for low-income residents.	3rd Quarters 2017, 2018, and 2019

Partners in Collaboration

- Santa Monica Malibu Unified School District
- Area Preschools
- Venice Family Clinic
- Westside Family Health Center
- Safe Place for Youth
- Step Up on Second

Measurement

- Number of preschool children identified at-risk for behavioral or mental health disorders
- Number of patients identified with post-partum depression referred for treatment
- Amount of grant funding distributed to local nonprofit partners
- Number of clients served by the grant funded nonprofit partners
- Impact measures from the organizations receiving grant funds from PSJHC

Community Need Addressed - Homelessness

Growing number of homeless persons living in the Westside area.

Strategy

Expand services and outreach to homeless patients coming to Providence Saint John's Health Center and to those living in the community.

Metrics

Metric	Target Completion Date
Expand the Homeless Care Navigation Program at PSJHC by adding a second full-time Community Care Coordinator and serving an additional 350 pts/yr.	2nd Quarter 2017
Get an approved license to allow PSJHC to access the Coordinated Entry System database to help direct homeless patients to available resources.	1st Quarter 2017
Work with The People Concern/OPCC on the development of their comprehensive wellness program for their homeless clients.	4th Quarter 2017
In collaboration with UCLA Santa Monica and Trinity Care Hospice, develop hospice services for the homeless residents with terminal illnesses living on the Westside targeting 15 to 20 patients/yr.	4th Quarter 2018

Partners in Collaboration

- The People Concern/OPCC
- Upward Bound House
- Venice Family Clinic Homeless Care Medical Program
- Trinity Care Hospice
- UCLA Santa Monica Medical Center
- Westside Coalition
- St. Joseph Center

Measurement

- Number of homeless patients served by the Homeless Care Navigation Program
- Number of successful shelter/housing placements made by the Community Care Coordinators
- Successful training of staff on the Coordinated Entry System database
- Number of new community partnerships to serve homeless patients
- Patient and staff feedback results to measure satisfaction with the Homeless Care Navigation Program
- Measure reduction of length of stay in the Emergency Dept. for homeless patients
- Number of homeless patients successfully referred for hospice services

-

Healthier Communities Together

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

As part of the community health needs assessment process, Providence Saint John's identified a list of key issues facing the community. While PSJHC is committed to addressing five of the major needs impacting the Westside area, there are several needs that the organization is unable to address at this time. These needs identified through a review of the primary and secondary data include:

- Need for more affordable and low-income housing in the area
- Need for more workforce development and employment programs
- Growing rate of poverty in the area
- More affordable and reliable transportation options to help ease traffic congestion and improve mobility in the area

While PSJHC is not able to address these needs at this time due to resource constraints and lack of expertise is some of these areas, the organization will participate in collaborative projects and work with our community partners to help them address these issues. One example of this type of collaboration is through a grant that PSJHC gives to Upward Bound House to help support their transitional housing program for homeless families.

Providence Saint John's Health Center and partners cannot address the significant community health needs independently. Improving community health requires collaboration across community stakeholders. Below outlines a list of community resources/agencies potentially available to address the identified community needs.

Organization or Program	Description	Associated Community Need
Venice Family Clinic	Federally qualified health center providing medical services to the low-income, Medi-Cal recipients and the homeless	Access to care Growing # of homeless Mental health
Westside Family	Federally qualified health center providing medical services to	Access to care

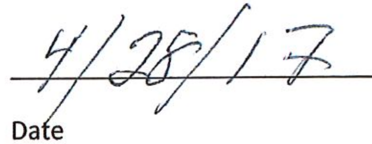
Organization or Program	Description	Associated Community Need
Health Center	the low-income and Medi-Cal recipients	Mental health
The Achievable Foundation	Federally qualified health center providing medical services to the low-income and Medi-Cal recipients	Access to care
Providence Medical Institute	Medical foundation including primary and specialty care physicians	Access to care
Local Churches	Faith communities to partner with PSJHC to focus on reducing chronic illnesses and assist those to better manage their disease	Chronic illness Obesity and nutrition
YMCA of Santa Monica	The YMCA offers programs to reduce the risk for chronic diseases such as diabetes	Chronic illness Obesity and nutrition
WISE and Healthy Aging	WISE and Healthy Aging offers programs to reduce and manage chronic illnesses and offers community case management for at-risk seniors	Chronic illness
City of Santa Monica Office of Civic Wellbeing	The Office of Civic Wellbeing is taking a more proactive approach to develop citywide initiatives to focus on improving residents' health status	Chronic illness Obesity and nutrition
Meals on Wheels West	This programs offers nutritious meals to those who are homebound and on fixed incomes	Obesity and nutrition
St. Joseph Center	This organization provides a food pantry and prepared meal program to the homeless and those who are living in poverty	Obesity and nutrition Homelessness
Pico Youth and Family Center	This organization is incorporating fitness and nutrition education into its mix of programs for adolescents and young adults	Obesity and nutrition
Boys and Girls Club of Santa Monica	Programs geared to youth including a focus on improving nutrition and physical activity for this population	Obesity and nutrition
St. Anne School	Program focused on healthy eating to be offered to the students	Obesity and nutrition
Safe Place for Youth	Organization offers counseling services to homeless youth	Mental health
Step Up on Second	Program offers substance abuse treatment services to the homeless	Substance abuse
Santa Monica Malibu Unified School District	The Child Family Development Center partners with the School District to provide early intervention services to at-risk children	Mental health
The People Concern/OPCC	Provides shelter, housing and wrap around services to homeless persons	Homelessness
Upward Bound House	Provides housing and transitional shelter to homeless families living on the Westside	Homelessness
Trinity Care Hospice	Provides hospice services to patients including those who are low-income	Homelessness
Westside Coalition	Coordinates housing and other resources for the homeless living on the Westside	Homelessness
UCLA Santa Monica Medical Center	The hospital is helping to lead a collaborative project addressing the need of homeless patients with terminal illnesses needing hospice care	Homelessness
Local Preschools	The Child Family Development Center is working in partnership with the School District and local preschools to identify children at risk for behavioral and mental health issues	Mental Health

Next steps

Now that Providence Saint John's Health Center completed the community health needs assessment of the Westside area, the organization is moving forward with developing programs and partnerships to address the identified needs. This community health improvement plan provides a roadmap for the organization to begin to address the identified needs and to establish measures to monitor success and target dates for completion. Moving forward, the organization will closely monitor the progress in addressing the priorities identified in the CHNA. The key to success in addressing these needs will be through the strong community partnerships that PSJHC has developed in the past, in addition to developing new partnerships as we move forward.

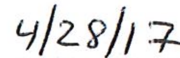
PSJHC hopes to share best practices with our local hospital partners and those across Providence St. Joseph Health to gain knowledge on what approaches work best to meeting the health needs we've identified. As part of the strategic focus of "creating healthier communities, together", PSJHC is committed to being a leader in improving the health status and wellbeing of the residents living on the Westside of Los Angeles County with special concern for those who are poor and vulnerable.

Plan Approval



Marcel Loh
Westside Service Area Chief Executive
Providence Saint John's Health Center

Date



Tom C. Geiser
Chair
Providence Saint John's Health Center Community Board

Date

Joel Gilbertson
Senior Vice President
Community Partnerships and External Affairs
Providence St. Joseph Health

Date

The implementation strategies and metrics were adopted on: December 16, 2016

This Community Health Improvement Plan was adopted on: April 26, 2017

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