2022

COMMUNITY HEALTH NEEDS ASSESSMENT

Providence Little Company of Mary Medical Center San Pedro

Providence Little Company of Mary Medical Center Torrance

Providence

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

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MESSAGE TO THE COMMUNITY

Since our first beginnings, Providence Little Company of Mary has been committed to investing in the health and wellbeing of the South Bay community. It's a calling that is embedded in our Mission — to serve all, especially the poor and vulnerable — and sustained by our community partnerships and community health investment programs.

Like our foundresses before us, we work alongside like-minded organizations to address the community's most pressing needs and help achieve our vision of health for a better world. This includes offering grants and financial resources to local organizations and partnering with nonprofits that deliver vital services to residents.

Last year alone, our community benefit totaled more than $90 million between our San Pedro and Torrance locations.

But to ensure we are meeting ever-shifting needs and providing meaningful impact to our community, we deploy a formal Community Health Needs Assessment every three years. This exercise helps us consider 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 that look to Providence Little Company of Mary for support. After all, we know that this Mission-driven work would not be possible without our local partners.

Since our last Community Health Needs Assessment, our medical centers have navigated through possibly the worst pandemic of our lifetimes. While it brought out incredible demonstrations of fortitude and courage from our caregivers and physicians, it also reaffirmed how special and supportive our community is. From meals to personal protective supplies and handwritten notes, we were humbled by such an overwhelming show of support over the last three years. We are truly blessed to serve and be supported by the South Bay community.

Now, as we begin our next Community Health Needs Assessment, we look forward to repaying the kindness that was extended to us, in part, by continuing this spirit of collaboration for decades to come and working toward cultivating a healthier community.

Thank you and stay well,

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

ACKNOWLEDGEMENTS

Providence Little Company of Mary Medical Center Torrance and Providence Little Company of Mary Medical Center San Pedro participated in a collaborative Community Health Needs Assessment process, which included Torrance Memorial Medical Center in the community input process.

EXECUTIVE SUMMARY

Understanding and Responding to Community Needs

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

The 2022 CHNA was approved by the Mission Community Health Committee on behalf of the Providence Little Company of Mary Community Ministry Board on September 13, 2022 and made publicly available by December 28, 2022.

Gathering Community Health Data and Community Input

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

- The pandemic exacerbated mental health needs, adding stress to a system already unable to meet the demand.
- Barriers to accessing health care included the complicated health care system, language, lack of culturally responsive providers, lack of childcare, and the cost of care.
- During the pandemic, some patients delayed accessing routine primary care and chronic disease management. As patients are returning for care, it takes months to get an appointment and, in many instances, there are not enough local providers.
- Oil refineries, multiple freeways, and the Port of Los Angeles negatively impact air quality and chronic diseases.
- The high cost of housing makes it difficult to be economically stable, resulting in overcrowded housing.

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

Identifying Top Health Priorities

Through a collaborative process engaging local community members, external partners, and Providence leadership, the Mission Community Health Committee of the Providence Little Company of Mary Community Ministry Board identified three priority areas (listed in priority order):

PRIORITY 1: ACCESS TO HEALTH CARE & PREVENTIVE CARE

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

PRIORITY 2: HOMELESSNESS & HOUSING INSTABILITY

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

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

PRIORITY 3: BEHAVIORAL HEALTH (MENTAL HEALTH AND SUBSTANCE USE/MISUSE)

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

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

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

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

This report evaluates the impact of the 2020-2022 CHIP. Providence Little Company of Mary Medical Centers responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices. In addition, we have leveraged these investments to secure numerous external grants that support our Community Health programs established in response to service gaps in our community that historically has had an underdeveloped safety net infrastructure.

We invited written comments on the 2019 CHNA and 2020-2022 CHIP, made widely available to the public. No written comments were received on the 2019 CHNA and 2020-2022 CHIP.

INTRODUCTION

Who We Are

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

Our Vision Health for a Better World.

Our Values Compassion — Dignity — Justice — Excellence — Integrity

Providence Little Company of Mary Medical Center Torrance is located at 4101 Torrance Boulevard, Torrance, CA, 90503. It is an acute care hospital with 327 licensed beds founded in 1960. In addition to excellent general medical, surgical and critical care services, the hospital offers a number of specialty programs and services including advanced robotic surgery with da Vinci for gynecologic, urologic and cardiac procedures; a Heart Center; and a state of the art obstetrical unit complete with the county's first single family Level III Neonatal Intensive Care Unit (NICU). Other services offered are related to bariatric wellness, cancer care, stroke and neurosciences, diabetes and nutrition, emergency care, home care, maternity, medication management, men's health, orthopedics, pediatric care, pelvic floor disorders, pharmacy, rehabilitation, spine, surgery, transitional care, and women's health.

Providence Little Company of Mary Medical Center San Pedro is located at 1300 West Seventh Street, San Pedro, CA, 90732. It is an acute care hospital with 231 licensed beds founded in 1925. The hospital offers a variety of services related to the following areas: bariatric wellness, behavioral health, cancer care, aging care, diabetes and nutrition, emergency care, heart and vascular, medication management pharmacotherapy, men's health, orthopedics, rehabilitation and recovery, stroke and neurosciences, sub-acute care, and surgery.

These two Providence South Bay community medical centers share a common service area because of their proximity to each other.

Our Commitment to Community

Providence Little Company of Mary Medical Centers dedicate resources to improve the health and quality of life for the communities we serve. During 2021, Providence Little Company of Mary Medical Centers provided $90 Million in Community Benefit[1] in response to unmet needs and to improve the health and well-being of those we serve in the South Bay community.

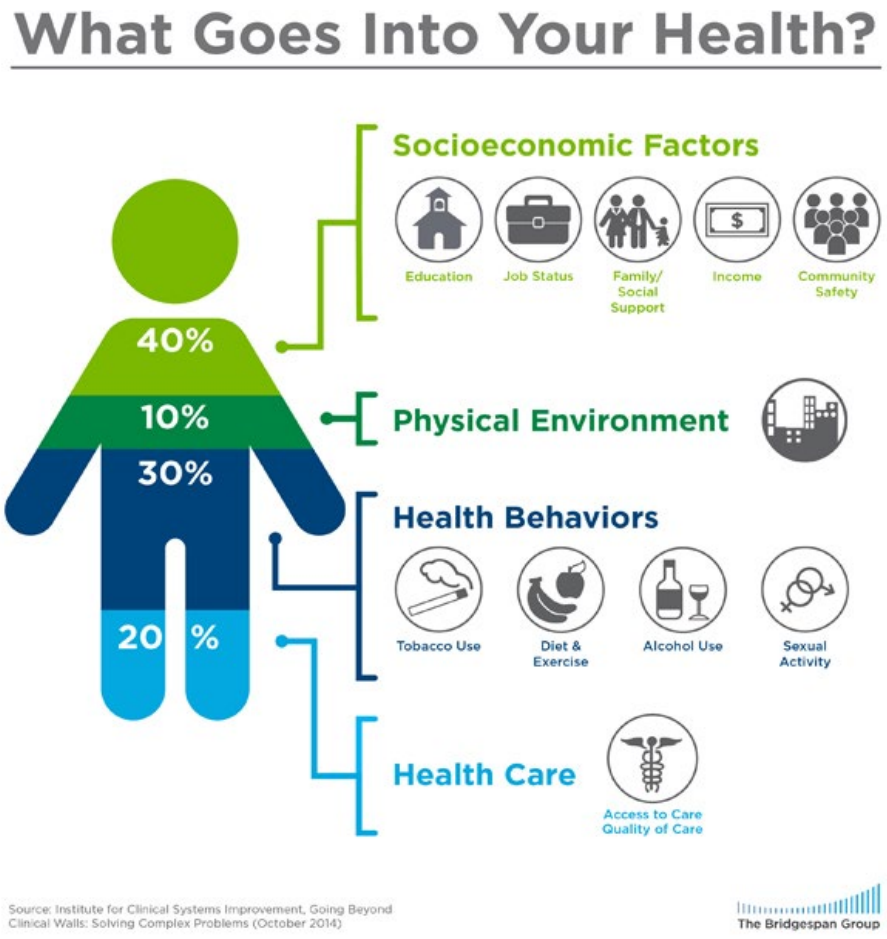
Providence Little Company of Mary Medical Centers further demonstrate organizational commitment to community health through the allocation of staff time, financial resources, participation, and collaboration to address community identified needs. The hospitals' Regional Director, Community Health Investment and the Director, Community Health are responsible for ensuring the compliance of

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

State and Federal 501r requirements. They also ensure community and hospital leaders, physicians, and others work together to plan and implement the resulting Community Health Improvement Plan (CHIP).

Health Equity

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



Factors contributing to overall health and well-being

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

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

Health Equity

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

Health Disparities

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

Definitions of key terms

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

Approach

Explicitly name our commitment to equity

Take an asset-based approach, highlighting community strengths

Use people first and non-stigmatizing language

Community Engagement

Actively seek input from the communities we serve using multiple methods

Implement equitable practices for community participation

Report findings back to communities

Quantitative Data

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

Disaggregate data when responsible and appropriate

Acknowledge inherent bias in data and screening tools

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

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

Collaboration

Providence Little Company of Mary Medical Center Torrance and Providence Little Company of Mary Medical Center San Pedro participated in a collaborative process for the stakeholder interviews, which included Torrance Memorial Medical Center. Given that these partners share an overlapping service area, a collaborative effort to identify and reach out to key stakeholders increased primary data collection efficiency and reduced redundancies.

Project Oversight

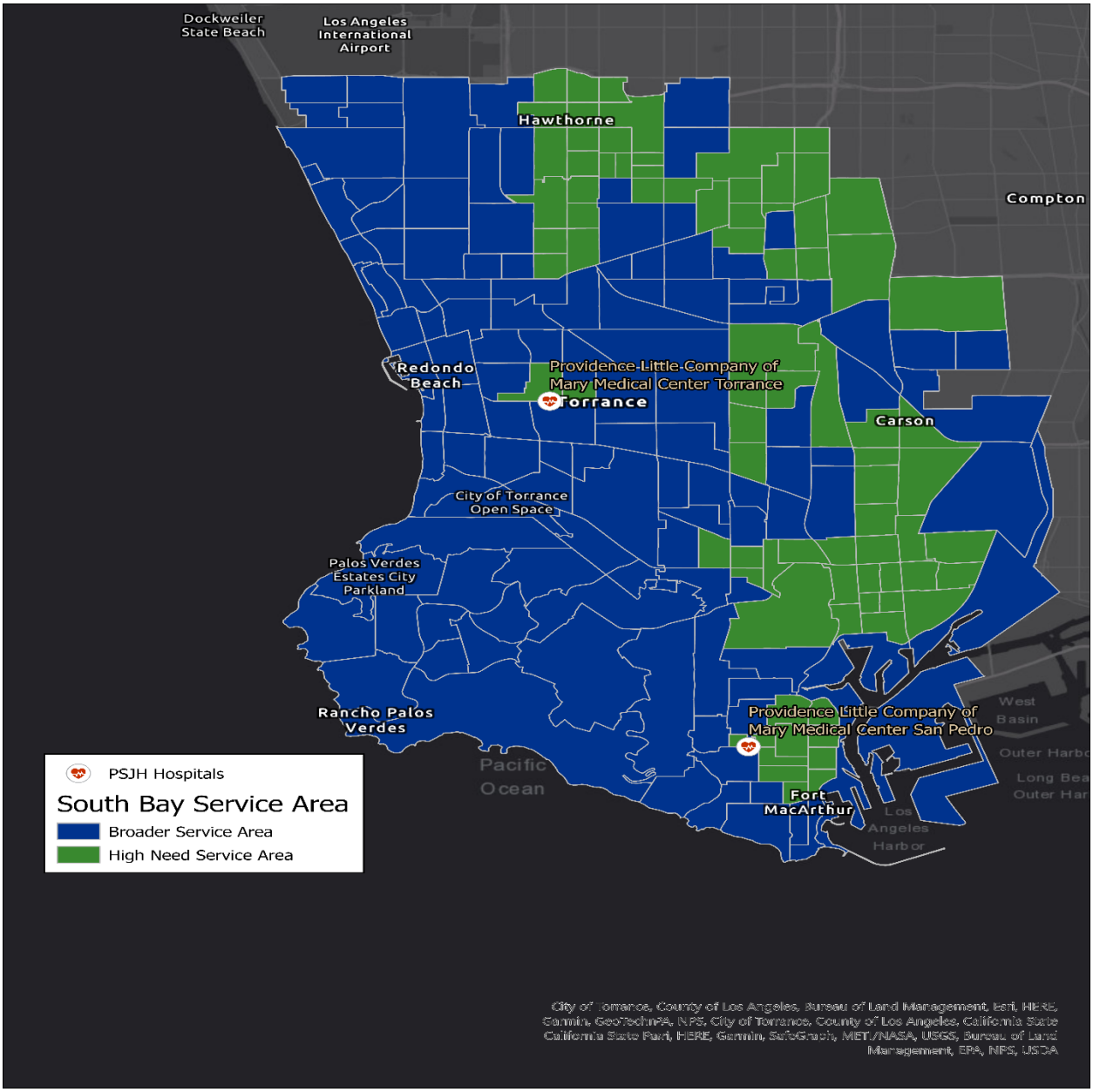
The Community Health Needs Assessment process was overseen by:
Justin Joe, MPH
Director, Community Health
Providence Little Company of Mary Medical Center Torrance
Providence Little Company of Mary Medical Center San Pedro

Consultant

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

OUR COMMUNITY

Hospital Service Area and Community Served



Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance share a common geographic service area because of their close proximity to each other. Based on the availability of data, geographic access to these facilities, and other hospitals in neighboring counties, the South Bay, as outlined in the map, serves as the boundary for the service area.

The South Bay Service Area is composed of 16 distinct municipalities and is a demographically and geographically diverse region stretching from El Segundo (North), to Carson (East), to the Port of Los Angeles (South), to the Pacific Ocean (West).

Providence Need Index

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

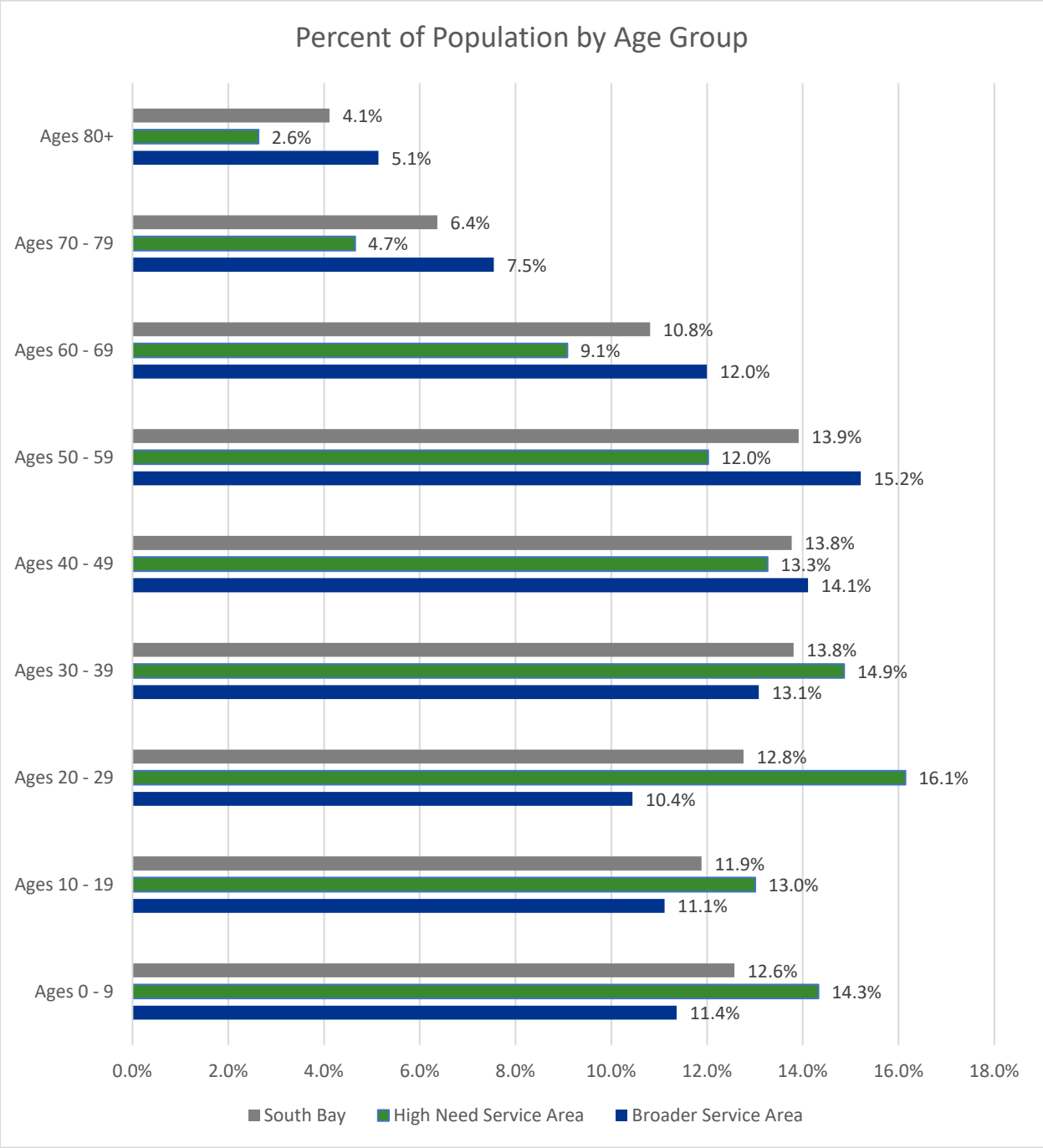
- Population below 200% the Federal Poverty Level (American Community Survey, 2019)
- Percent of population with at least a high school education (American Community Survey, 2019)
- Percent of population, ages 5 Years and older in Limited English Households (American Community Survey, 2020)
- Life expectancy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

For this analysis, census tracts with more people below 200% FPL, fewer people with at least a high school education, more people in limited English households and a lower life expectancy at birth were identified as "high need." All variables were weighted equally, and the average value of the population was assigned to census tracts that did not have an estimated life expectancy at birth. Ultimately, the census tracts were given a score between 0 and 100 where 0 represents the best performing census tract and 100 is the worst performing census tract according to the criteria. Census tracts that scored higher than the average were classified as high need service areas and are depicted in green. In the South Bay service area, 80 of 199 census tracts (40.2%) scored above the average of 33.3 on the PNI, indicating a high need.

Community Demographics

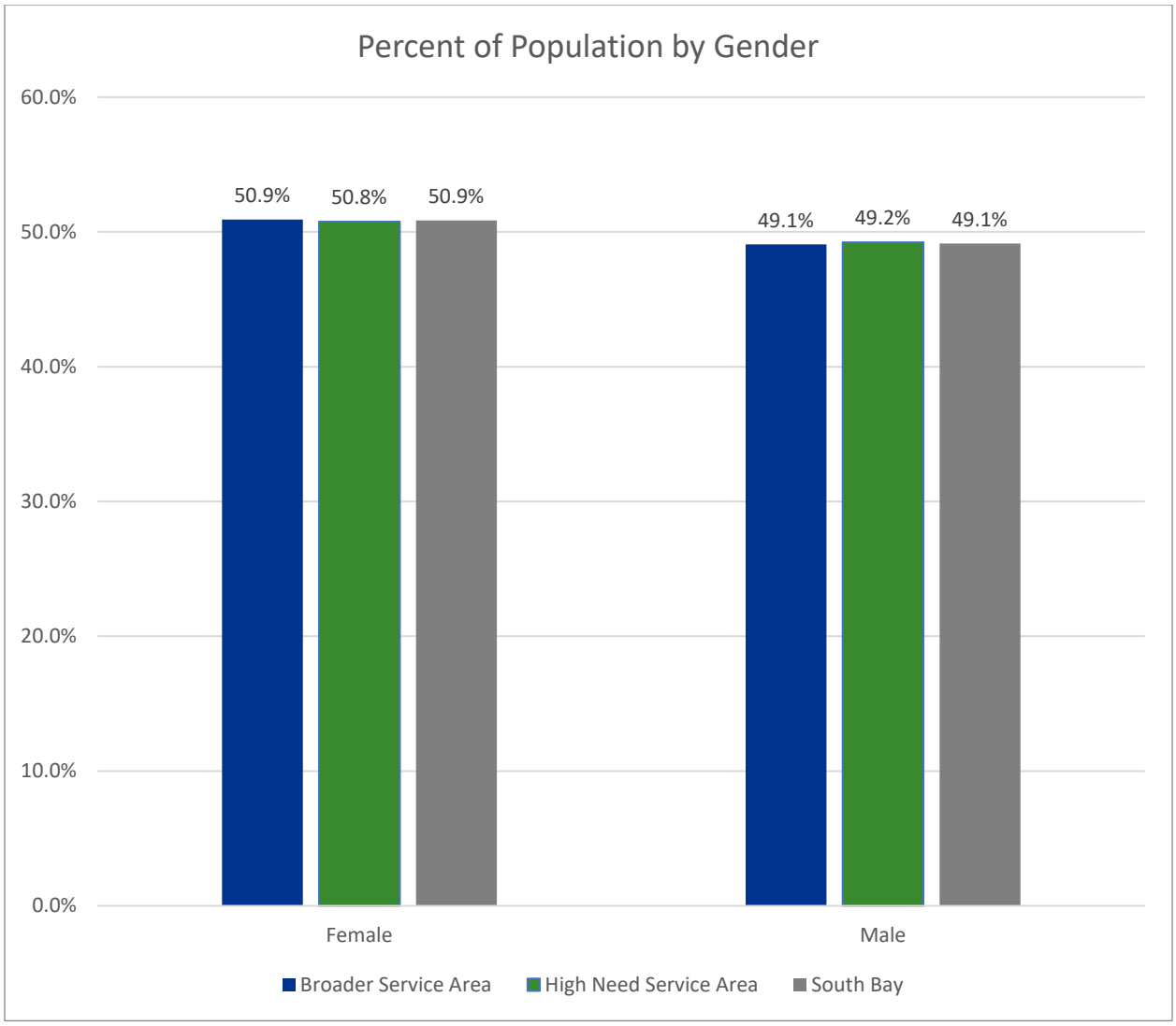
The tables and graphs below provide basic demographic and socioeconomic information about the service area and how the high need area compares to the broader service area. We have developed a dashboard that maps each CHNA indicator at the census tract level. The dashboard can be found here:

https://experience.arcgis.com/experience/9030a390834c4e70b7c66ac87161eb37/



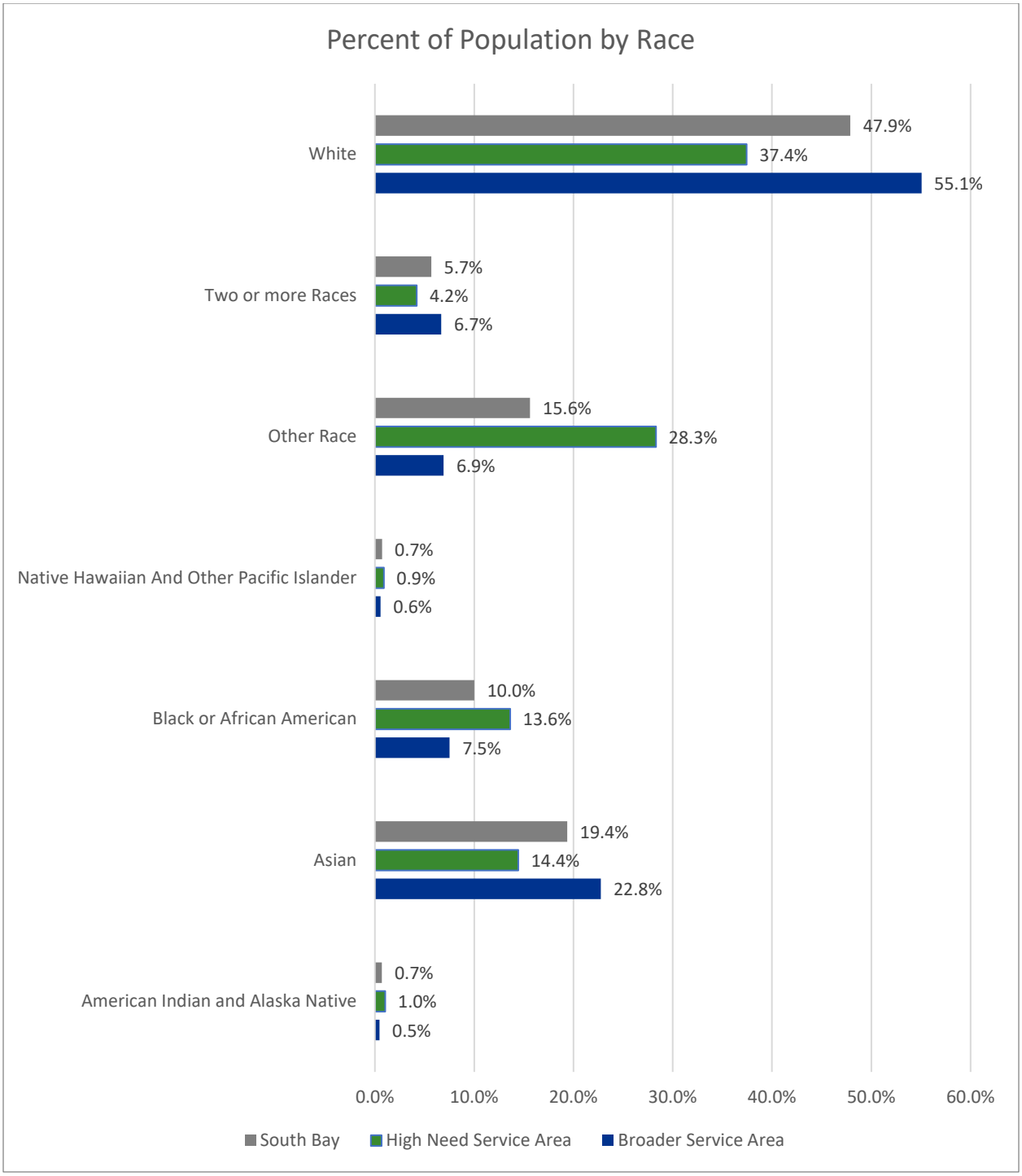
Population by Age Groups by Geography

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



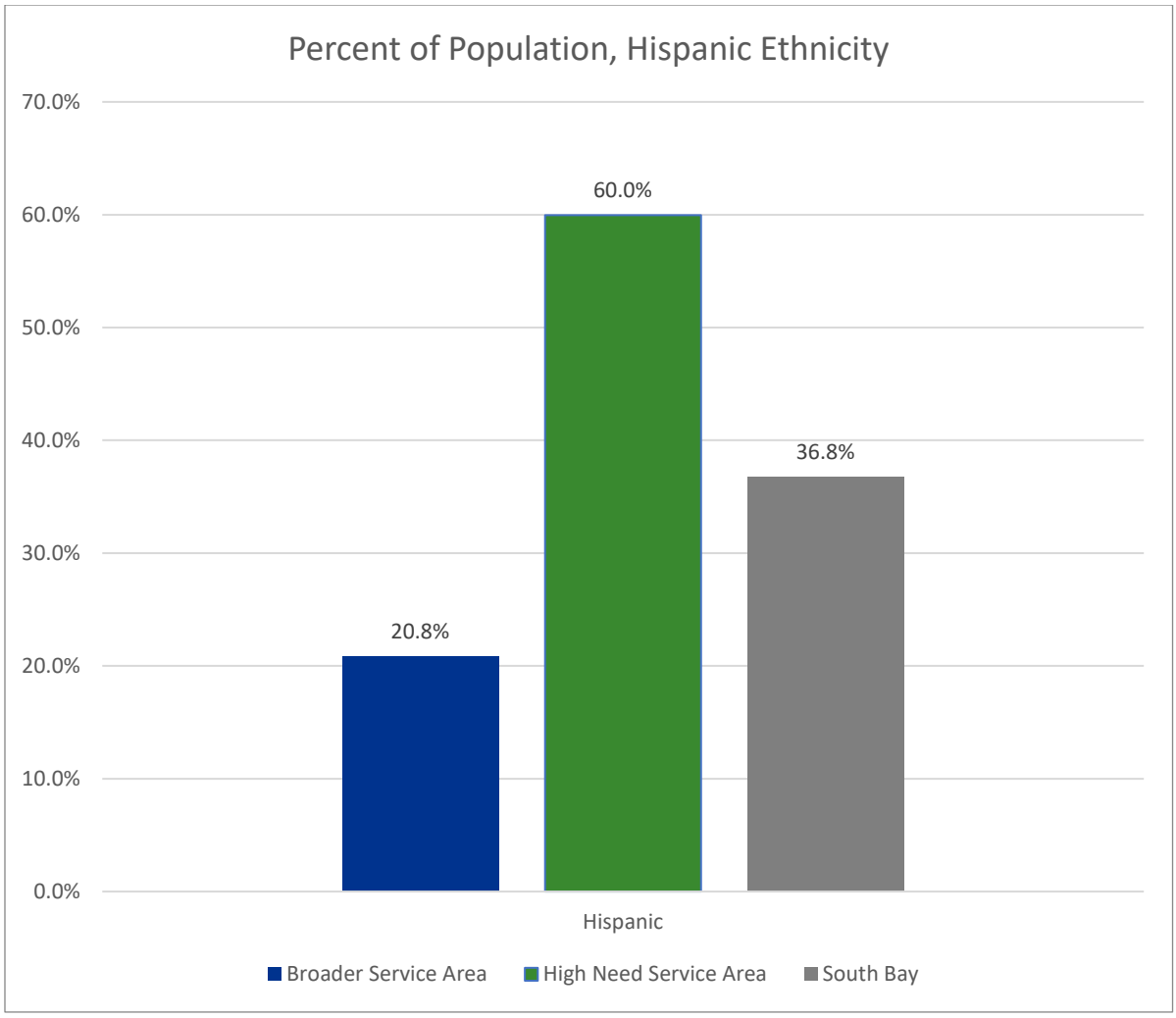
Population by Gender by Geography

The population in the South Bay is split fairly even by sex, with males making up 49% of the population and females 51%.



Population by Race by Geography

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



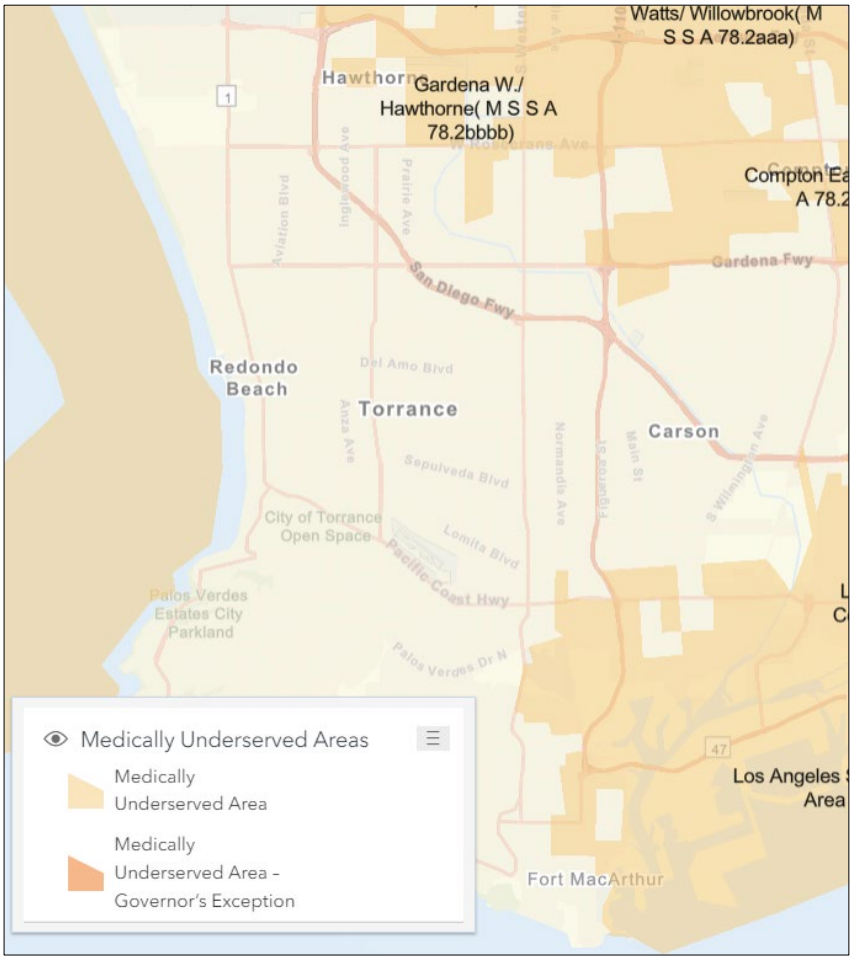
Population by Hispanic Ethnicity by Geography

The Hispanic population is over-represented in the high need service area, with 60% of the high need service area identifying as Hispanic compared to 20.8% in the broader service area and 36.8% in the South Bay overall.

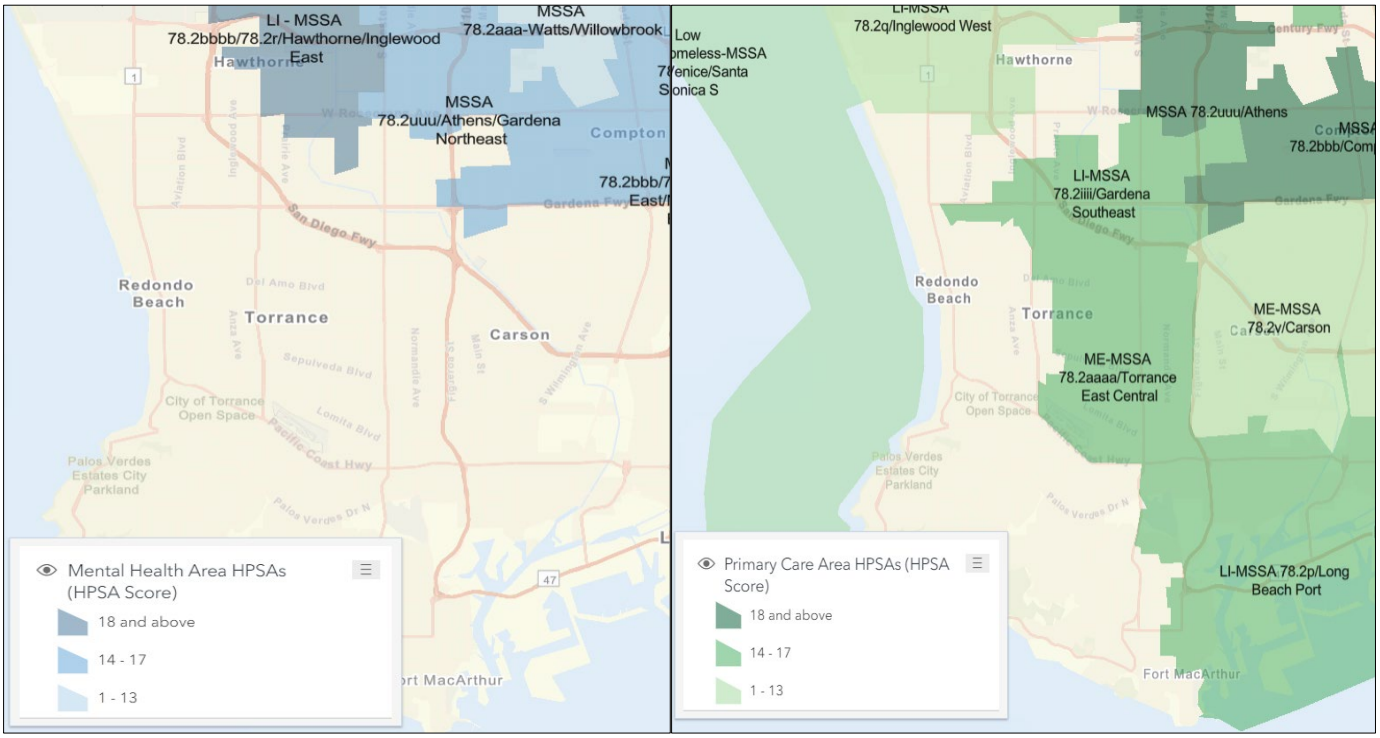
HEALTH PROFESSIONAL SHORTAGE AREA

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

Medical Service Study Areas (MSSAs) are geographic areas viewed at the Census Tract level and used to organize and display population, demographic, and physician data. The five MSSAs that are designated as MUAs, located within or partially within the service area, include: Gardena W/Hawthorne, Watts/Willowbrook, Compton East, Long Beach Port, and a portion of the service area that covers the Port of Los Angeles.



The three MSSAs that are designated as Mental Health HPSAs, located within or partially within the service area, include: Hawthorne/Inglewood East, Watts/Willowbrook, and Athens/Gardena Northeast. The seven MSSAs that are designated as Primary Care HPSAs, located within or partially within the service area, include: Inglewood West, Athens, Gardena Southeast, Carson, Torrance East Central, Long Beach Port, and a portion of the service area that covers the Port of Los Angeles.


LI - MSSA
78.2bbbb/78.2r/Hawthorne/Inglewood East
MSSA
78.2aaa-Watts/Willowbrook
MSSA
78.2uuu/Athens/Gardena Northeast
Hawthorne
Compton
Redondo Beach
Torrance
Carson
San Diego Fwy
Del Amo Blvd
Sepulveda Blvd
Lomita Blvd
Pacific Coast Hwy
Palos Verdes Dr N
City of Torrance Open Space
Palos Verdes Estates City Parkland
Mental Health Area HPSAs (HPSA Score)
18 and above
14 - 17
1 - 13
LI-MSSA
78.2q/Inglewood West
MSSA 78.2uuu/Athens
LI-MSSA
78.2iiii/Gardena Southeast
ME-MSSA
78.2v/Carson
ME-MSSA
78.2aaaa/Torrance East Central
LI-MSSA 78.2p/Long Beach Port
Fort MacArthur
Primary Care Area HPSAs (HPSA Score)
18 and above
14 - 17
1 - 13

OVERVIEW OF CHNA FRAMEWORK AND PROCESS

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

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

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

Data Limitations and Information Gaps

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

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

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

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

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

HEALTH INDICATORS

Please refer to the South Bay Data Hub 2022 to review each of the following health indicators mapped at the census tract level:
https://experience.arcgis.com/experience/9030a390834c4e70b7c66ac87161eb37/.
The hub provides data on each indicator in the South Bay, high need and broader need service areas, Los Angeles County, and California, as well as information about the importance of each indicator (homelessness data are not included in the hub).

Health Insurance, Uninsured

	South Bay	High Need	Broader Need	Los Angeles County
Uninsured	7.6%	12.4%	4.3%	9.6%

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

Chronic Diseases

	South Bay	High Need	Broader Need	Los Angeles County
Asthma prevalence	7.5%	8.2%	7.0%	7.5%
Cancer prevalence	5.6%	4.3%	6.6%	5.0%
Chronic kidney disease prevalence	2.7%	3.0%	2.5%	3.0%
Chronic Obstructive Pulmonary Disease prevalence	4.3%	4.7%	3.9%	4.3%
Coronary heart disease	4.5%	4.6%	4.5%	4.8%
Diabetes prevalence	9.7%	11.3%	8.6%	11.1%

Source: Behavioral Risk Factor Surveillance System Survey, 2019.

Physical Inactivity and Obesity

	South Bay	High Need	Broader Need	Los Angeles County
Physical inactivity	22.1%	28.4%	17.8%	25.1%
Obesity	25.2%	29.4%	22.3%	27.7%

Source: Behavioral Risk Factor Surveillance System Survey, 2019.

Mental Health

	South Bay	High Need	Broader Need	Los Angeles County
Mental health distress (14 or more days in past 30 days with poor mental health)	11.9%	14.4%	10.2%	12.4%
Depression	14.4%	15.1%	14.0%	21.6%

Source: Behavioral Risk Factor Surveillance System Survey, 2019.

Substance Use

	South Bay	High Need	Broader Need	Los Angeles County
Binge drinking	16.9%	16.6%	17.2%	16.8%
Smoking	10.8%	13.4%	8.9%	10.9%

Source: Behavioral Risk Factor Surveillance System Survey, 2019.

Persons Experiencing Homelessness, 2018-2020 Comparison*

	SPA 8		Los Angeles City/County CoC	
	2018	2020	2018	2020
Total homeless count	4,138	4,560	49,955	63,706
Sheltered	21.0%	23.0%	24.8%	27.7%
Unsheltered	79.0%	77.0%	75.2%	72.3%
Individual adults	83.5%	80.6%	84.1%	80.4%
Families/family members	16.4%	19.2%	15.8%	19.5%
Unaccompanied minors (<18)	0.1%	0.2%	0.1%	0.1%

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

Persons Experiencing Homelessness, Subpopulations*

	SPA 8		Los Angeles City/County CoC	
	2018	2020	2018	2020
Individuals, chronically homeless	21.6%	43.0%	25.6%	36.2%
Family members, chronically homeless	1.9%	2.1%	1.0%	2.2%
Brain injury	0.8%	3.0%	3.5%	3.5%
Chronic illness	15.4%	12.6%	23.2%	17.0%
Domestic violence experience	17.2%	25.7%	26.8%	28.8%
Persons with HIV/AIDS	0.0%	0.8%	1.4%	1.8%
Physical disability	12.2%	21.5%	13.5%	17.0%
Serious mental illness	19.8%	17.9%	24.2%	22.2%
Substance use disorder	11.2%	31.0%	13.4%	23.9%
Veterans	8.8%	9.2%	7.1%	5.8%

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

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

Hospital Utilization Data

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

Avoidable Emergency Department Cases

Emergency department cases for Providence Little Company of Mary San Pedro Medical Center and Providence Little Company of Mary Torrance Medical center have declined since 2019. There has been a 19.5% reduction in emergency department cases between the two medical centers from 2019 through 2021. In this same time period, the number of avoidable emergency department cases dropped by 32.6%. Overall, the percentage of emergency department cases that were avoidable visits declined from 37.0% in 2019 to 31.0% in 2021. Utilization of the emergency department was significantly impacted at the height of the COVID-19 pandemic.

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

- Combined across both medical centers there was a higher percentage of avoidable ED visits for patients who self-reported their race as Black or African American (32.9%) compared to the total patient population (31.0%)

- Combined across both medical centers there was a higher percentage of avoidable ED visits for patients who self-reported their ethnicity as Hispanic or Latino (31.6%) compared to the total patient population (31.0%).

- 25.6% of avoidable visits across both medical centers in 2021 were from diagnoses related to urinary tract infections (10.0%), skin infections (8.6%) and bronchitis (7%) and other upper respiratory disease.

- Substance use disorder accounted for 6.2% of the avoidable visits seen at both medical centers in 2021.

Behavioral Health Emergency Department Cases

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

- Behavioral health related diagnoses as a portion of all emergency department visits increased from 4.5% in 2019 to 5.7% in 2021 of all emergency department visits across both medical centers.

- The two most common diagnoses grouping for behavioral health related emergency department visits in 2021 at both medical centers were substance use disorder and anxiety and personality disorders. Substance use disorder and anxiety and personality disorder accounted for 36.1% and 22.8%, respectively, of all behavioral health related ED visits.

COMMUNITY INPUT

Summary of Community Input

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance in partnership with Torrance Memorial Medical Center, conducted 37 stakeholder interviews with representatives from community-based organizations during November 2021 to January 2022 and 4 listening sessions with 31 community members were conducted in June 2022. During the interviews and listening sessions, community members and nonprofit and government stakeholders, including a representative from Los Angeles County Department of Public Health, discussed the issues and opportunities of the people, neighborhoods, and cities of the service area. Below is a high-level summary of the findings of these sessions. Using the notes from the interviews and listening sessions, analysts identified themes related to community needs and the associated gaps in services, barriers, and affected populations. A listing of the interview and listening session participants are provided in Appendix 2. Detailed listening session and stakeholder interview responses are available in Appendix 3.

Vision for a Healthy Community

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

- **Safety**: In a healthy community, people feel safe to walk around and know their children are safe. This means there is not a lot of crime and violence.
- **Community engagement and helping one another:** In a healthy community people are engaged in initiatives and volunteering. They help one another, check in on their neighbors, and work together. The community supports and accepts everyone, including immigrants.
- **Accessible mental health services for everyone:** Mental health services are accessible for everyone, but especially children. People's emotional well-being is care for and people are happy.
- **Opportunities for recreation and physical activity:** There are outdoor activities and green spaces where children can play.

Community Needs

Listening session participants and key community stakeholders were asked to identify the most important community needs. Listening session participants discussed a variety of needs, but most frequently discussed 1) overweight and obesity, including recreational opportunities and safe, clean

green spaces, and 2) food insecurity. Feedback from the listening sessions and interviews is summarized below.

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

Homelessness and housing instability	Stakeholders noted the rising costs associated with housing are the biggest challenges for families. Stakeholders fear families are falling behind in rent and will be unable to catch-up and may be forced into dwelings that aren't meant for habitation. **Persons who are undocumented, adults, ages 65 and older, special needs adults**, and those with **chronic and long-term disabilities** are especially vulnerable to housing insecurity and economic instability. Listening session participants were particularly concerned about the high cost of rent affecting older adults and families. Stakeholders spoke to the importance of recognizing that the **persons experiencing homelessness are not a uniform group:** some are invisible, living in their car, or multiple generations are living in the same household, some are mentally ill or have substance use issues, while others recently lost their jobs due to the pandemic and need a hand-up. More people are experiencing homelessness **on a daily basis** than the programs can handle. Assistance programs may have **years-long wait lists**, and once people are housed, **the system can still fail them**. Understanding the **nexus between homelessness and mental health** is critical.
Behavioral health (mental health and substance use/misuse)	The pandemic **exacerbated mental health needs**, adding stress to a system already **unable to meet the demand**. There is concern about **students, individuals experiencing homelessness, those experiencing domestic violence**, and **senior adults, age 65 and older**. Being away from school for almost two years, kids are struggling to return to school and adjust. Students are exhibiting **social-emotional challenges, outbursts, struggling with structure, and fighting**. Listening session participants were particularly concerned about the social-emotional well-being of children, noting a need for more mental health professionals in schools to address the mental health and behavioral challenges educators are seeing. Senior adults are demonstrating **worry, anxiety, and panic**, in addition to the impact of **prolonged isolation**. Challenges include **accessing services, the availability of practitioners, a lack of integration of the body and mind in health care, and limitations with health insurance**. A **decrease in stigma** around mental health occurred during the pandemic. COVID-19 reduced the face-to-face aspect with telehealth services, and now, people often **prefer telehealth services**. Drug and alcohol consumption habits have changed. People are **self-medicating** with substances as a way to feel numb and cope. People need help in recognizing better ways to cope. Listening session participants discussed the importance of helping people develop skills for managing stress.

Access to health care and preventive care	**Transportation and health insurance** were the main barriers discussed by stakeholders across the community. Barriers to access health care include the **complicated health care system, language, culture, lack of childcare, and the cost of care**. Certain populations face more difficulty navigating the health care system to access high-quality, respectful care: **individuals experiencing homelessness, special needs adults, people of color, those who speak languages other than English, and mixed status families**. Telehealth has been a positive change but not everyone is able to engage successfully using telehealth. **Co-locating services** in the community, **meeting people where they are** and feel comfortable, will allow people to more easily access care. During the pandemic, **some patients delayed accessing routine primary care and chronic disease management**. As patients are returning for care, it **takes months to get an appointment** and, in many instances, there are **not enough local providers**. Preventable conditions that are preventable, treatable, and detectable will be exacerbated. Listening session participants were also concerned about long wait times for appointments, noting a need for easier access to health care.
Chronic diseases	**Oil refineries, multiple freeways, and the Port of Los Angeles** negatively impact air quality and chronic diseases. Listening session participants shared a need to better regulate refineries and oil wells, which can contribute to asthma and other health problems. **Trauma and adverse childhood experiences** impact overall health. There is a **lack of integrating primary care, substance use, and dental care into treatment plans for chronic conditions.** Telehealth has helped many people to manage their chronic conditions, but there are still **technological challenges and barriers** for many community members to access care remotely.
Economic insecurity	Economic insecurity is connected to **housing and food insecurity**. Populations disproportionately impacted by economic insecurity include **mixed status families who may not qualify for assistance, young families, and people, ages 65 and older, on limited incomes**. The high cost of housing makes it difficult to be economically stable, resulting in **overcrowded housing.** There are numerous resources in the community, but barriers include **language, a lack of public awareness about existing resources, and a need for effective outreach and communication plans to reach those most in need**. Listening session participants would like to see more resources to support older adults and people with disabilities, including educational classes. Employers are having difficulty hiring staff for childcare sites, senior programs, and health care centers. **Higher wages for entry level jobs are a hardship for businesses.** Concurrently, **education levels, a disconnect with jobs available and the skill sets of the unemployed, and better paying jobs located outside the community that require reliable transportation**, were all identified as barriers to gainful employment. Listening session participants want to see more local hiring and internship opportunities for students.

Food insecurity	Food insecurity became more pronounced during the pandemic. Populations disproportionately impacted by food insecurity included: **mixed status families who may not qualify or feel safe applying for food assistance programs, unhoused families living in hotels without kitchens, and people, ages 65 and older, on limited incomes. Cumbersome application processes, stigma about receiving benefits, and a lack of transportation** may cause barriers to accessing consistent, nutritious, and affordable foods. Listening session participants noted a need for more local grocery stores that have healthier food options, including prepared foods, as well as community gardens for growing vegetables. They shared there are too many fast food restaurants. **Supply chain issues** and more recently, **inflation,** are causing food prices to escalate. To assist, many organizations have taken on food distribution because there is such a great need, and that **need has not dissipated**.
Overweight and obesity	The biggest barrier to healthy weight is the **lack of opportunities for physical activity and access to healthy foods**. There is an increase in **student obesity** and **childhood diabetes** because of the pandemic. Access to **safe streets, and walkable, green space** are critical to alleviating community obesity. Listening session participants emphasized wanting safer and cleaner streets, including more school crossing guards and safer driving near schools. They also noted a need for more free recreational activities, especially for children, such as dance, swimming,etc. **Those who are experiencing homelessness or are housing insecure** may not have access to a kitchen or cooking opportunities; they may rely on fast food or processed food that is more easily consumed. **Healthier choices are often more expensive**, and with inflation, healthy food is more unattainable.
Dental care	Dental care is often **viewed as a luxury.** For persons with limited resources, they address other needs and health issues before they consider dental care. Populations of particular concern included: **adults, ages 65 and older, people who are experiencing homelessness, and people with low incomes**. The pandemic resulted in **reduced access to dental care, reduced capacity for some dental providers, and fewer providers accepting Denti-Cal**.

SIGNIFICANT HEALTH NEEDS

Significant Community Health Needs

Eight significant community health needs were identified for a prioritization process by the Mission Community Health Committee through a review of the secondary health data collected and based on qualitative data collected from interviews and listening sessions. The identified needs (listed in alphabetical order) include:

- Access to Health Care and Preventive Care
- Behavioral Health (Mental Health & Substance Use/Misuse)
- Chronic Diseases
- Dental Health
- Economic Insecurity
- Food Insecurity
- Homelessness & Housing Instability
- Overweight/obesity

Prioritization Process and Criteria

The Mission Community Health Committee (MCHC) of the Providence Little Company of Mary Community Ministry Board is responsible for the oversight of the ministry's Community Health Needs Assessment and the prioritization of the identified significant community needs. The Committee is composed of external stakeholders and PLCM leadership (see Appendix 5). The MCHC met on July 12, 2022, and September 13, 2022, to review key findings from the data collected and select the top three priority needs.

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

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

2022 Priority Needs

PRIORITY 1: ACCESS TO HEALTH CARE & PREVENTIVE CARE

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

PRIORITY 2: HOMELESSNESS & HOUSING INSTABILITY

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

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

PRIORITY 3: BEHAVIORAL HEALTH (MENTAL HEALTH AND SUBSTANCE USE/MISUSE)

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

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

Potential Resources Available to Address Significant Health Needs

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

EVALUATION OF 2020-2022 CHIP IMPACT

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

In 2019, the hospitals conducted the previous CHNA. Significant needs were identified from issues supported by primary and secondary data sources gathered for the CHNA. The hospitals' 2020-2022 CHIP associated with the 2019 CHNA addressed the following needs through a commitment of community benefit programs and resources: homelessness and housing insecurity, access to health care, behavioral health, economic insecurity and workforce development, food insecurity, services for seniors, chronic diseases, early childhood development, and social cohesion.

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

Focus Population	Strategies	Progress
Persons experiencing homelessness or at risk of becoming homeless	CHW Homeless Navigators are hospital emergency department-based Community Health Workers that assist patients experiencing homelessness with discharge to shelter or homeless service providers.	904 screened for homelessness. 885 linked to homeless services or housing resources. 358 placed in shelter or housing.
	The Coordinated Entry System Hospital Liaison Collaborative is a workgroup of private non-profit hospitals in the South Bay having a direct, single point of contact with the local lead homeless service agency to coordinate referrals and educate hospital staff on changing resources.	205 clients referred and served by the Hospital Liaison.
	Implement screening for risk of homelessness and identify public and private funded resources that focus on prevention.	In 2020, in emergency response to COVID-19, $1,004,600 in grants were given to homeless service providers and LA County for support of the Project Room Key sites--vacant hotels and motels converted into interim housing. In 2021, $1,500,000 in grants made to local organizations for homeless services. Services funded by grants included

Focus Population	Strategies	Progress
		support services at interim housing and development of a street medicine clinic.
	Improve the infrastructure of available recuperative care/interim shelter for patients experiencing homelessness who are not medically stable enough to be discharged back to the streets.	Providence participated in the UniHealth Foundation's Recuperative Care Advisory Group to develop recommendations for strengthening the infrastructure of recuperative care in Los Angeles County. $100,000 grant made to National Health Foundation to support increased access to recuperative care.

Initiative 2: Improve Access to Health Care Services

Focus Population	Strategies	Progress
Uninsured and underinsured populations in low-income communities	Vasek Polak Health Clinic provides an alternative to the emergency room for people who do not have insurance or have Medi-Cal. The clinic provides access to primary care and also acts as a walk-in clinic for treating uncomplicated minor illnesses.	6,037 medical visits. 38% of patients screened for anxiety and depression in 2020, 43% of patients screened in 2021. 447 persons enrolled in mental health therapy.
	Partners for Healthy Kids is a mobile pediatric clinic that offers free weekly immunizations at elementary schools as well as health insurance enrollment and navigation assistance.	2,889 immunizations given in 2020. In 2021, administered 8,857 doses of COVID-19 vaccine and 175 doses of other immunizations (flu, Tdap, HPV).
	Emergency Department Community Health Workers assist uninsured patients in the emergency department, helping them with affordable care options, applications for enrollment in eligible health insurance programs, and coordination of follow-up visits at a clinic in their community.	3,483 primary care appointments made.
	Health Insurance Enrollment Assistance utilizes community health workers to provide education about affordable health care options and assistance with health insurance and CalFresh applications.	Assisted with 3,319 health insurance applications.

Focus Population	Strategies	Progress
	The Sexual Assault Response Team is a multidisciplinary team providing survivor-centered response and high-quality care to survivors of sexual assault	Conducted 290 sexual assault exams.

Initiative 3: Expand Community-Based Wellness Activity Centers

Focus Population	Strategies	Progress
Residents in Wilmington and Lawndale.	Wilmington Wellness and Activity Center gives children and adults in the Wilmington area a physical space to participate in free programs run by Providence, local volunteers and community partners that promote social connections among neighbors and help improve the health of the community.	43 visits by unduplicated registered Wellness Center members/month. 288 events at the Wellness and Activity Center. Served as a COVID-19 testing and vaccination site during pandemic (7,200 tests provided). Hosted free grocery distributions for food insecure families. Continued hosting of weekly Wilmington Certified Farmer's Market All events to the public at the Center were shut down in March 2020 due to the COVID-19 pandemic.
	Construct a new Wellness and Activity Center in the city of Lawndale in partnership with the Lawndale Elementary School District	Design completed and proposed plans submitted to CA Division of the State Architect for approval. CEQA exemption approved. Key contacts established with California Conservation Corps and Los Angeles Conservation Corps regarding potential participation in project.

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

Focus Population	Strategies	Progress
Workforce development for persons without	Create a Community Health Workers Academy In collaboration with Charles Drew University.	Recruitment and curriculum design for CHW Academy was completed in 2020. Go-live of the first cohorts training was

Focus Population	Strategies	Progress
a college degree, services for residents of low-income neighborhoods, especially Spanish speaking communities.		postponed to January of 2021 as adaptations were needed to teach the course online. First cohort in 2021 had 13 Community Health Workers enrolled. 11 of the 13 CHW interns from cohort 1 completed their six-month internships. A second cohort of 16 CHW interns began in August and graduated in February 2022.
	The Community Health Insurance Program utilizes community health workers to provide education about affordable health care options and assistance with health insurance and CalFresh applications.	Assisted with 3,159 health insurance applications. Assisted with 1,665 CalFresh applications.
	Health educators and CHWs teach free community-based courses in English and Spanish on mental health awareness and coping skills.	376 participants completed Mental Health First Aid. 116 participants completed Creating Healthier Attitudes Today.
	Health educators and CHWs teach free community-based courses in English and Spanish to persons who have been diagnosed with diabetes or pre-diabetes.	18 participants completed Diabetes Prevention Program. 98 participants completed Get Out and Live (GOAL).
	CHWs promote information on COVID-19 prevention, testing, and vaccinations. The program focuses on local communities with low vaccination rates and high rates of COVID-19 transmission.	127,482 outreach contacts made in 2021.

Addressing Identified Needs

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

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

2022 CHNA GOVERNANCE APPROVAL

This Community Health Needs Assessment was adopted by the Mission Community Health Committee on behalf of the Providence Little Company of Mary Community Ministry Board on September 13, 2022. The final report was made widely available by December 28, 2022.

Garry Olney 9/13/2022
Chief Executive, Providence Little Company of Mary Medical Centers San Pedro, and Torrance

Suzi Gulcher 9/13/2022
Mission Community Health Committee Chairperson, Community Ministry Board of Directors, South Bay

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

APPENDICES

Appendix 1: Quantitative Data

DEMOGRAPHIC DATA

Demographic Profile for the South Bay Service Area

Indicator	South Bay	Broader Service Area	High Need Service Area
Population by Age Groups			
Total Population	884,116	524,107	360,009
Population Ages 0 - 9	111,150	59,564	51,586
Population Ages 10 - 19	105,067	58,234	46,833
Population Ages 20 - 29	112,848	54,726	58,122
Population Ages 30 - 39	122,078	68,563	53,515
Population Ages 40 - 49	121,718	73,958	47,760
Population Ages 50 - 59	123,009	79,728	43,281
Population Ages 60 - 69	95,562	62,865	32,697
Population Ages 70 - 79	56,285	39,544	16,741
Population Ages 80+	36,399	26,925	9,474
% Population Ages 0 - 9	12.6%	11.4%	14.3%
% Population Ages 10 - 19	11.9%	11.1%	13.0%
% Population Ages 20 - 29	12.8%	10.4%	16.1%
% Population Ages 30 - 39	13.8%	13.1%	14.9%
% Population Ages 40 - 49	13.8%	14.1%	13.3%
% Population Ages 50 - 59	13.9%	15.2%	12.0%
% Population Ages 60 - 69	10.8%	12.0%	9.1%
% Population Ages 70 - 79	6.4%	7.5%	4.7%
% Population Ages 80+	4.1%	5.1%	2.6%
Population by Gender			
Female Population	449,670	266,923	182,747

Indicator	South Bay	Broader Service Area	High Need Service Area
Male Population	434,446	257,184	177,262
% Female Population	50.9%	50.9%	50.8%
% Male Population	49.1%	49.1%	49.2%
Population by Race			
American Indian and Alaska Native	6,202	2,449	3,753
Asian Population	171,247	119,258	51,989
Black or African American Population	88,551	39,468	49,083
Native Hawaiian and Other Pacific Islander Population	6,305	3,020	3,285
Other Race Population	138,212	36,291	101,921
Two or more Races Population	50,232	35,048	15,184
White Population	423,367	288,573	134,794
% American Indian and Alaska Native	0.7%	0.5%	1.0%
% Asian Population	19.4%	22.8%	14.4%
% Black or African American Population	10.0%	7.5%	13.6%
% Native Hawaiian and Other Pacific Islander Population	0.7%	0.6%	0.9%
% Other Race Population	15.6%	6.9%	28.3%
% Two or more Races Population	5.7%	6.7%	4.2%
% White Population	47.9%	55.1%	37.4%
Population by Ethnicity			
Hispanic Population	325,069	109,165	215,904
% Hispanic Population	36.8%	20.8%	60.0%

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

POPULATION LEVEL DATA

	South Bay	High Need	Broader Need	Los Angeles County
Population below 200% of Federal Poverty Level	25.9%	41.7%	15.0%	34.9%
Language proficiency limited English	8.3%	12.7%	5.3%	10.8%
Population with a High School diploma	84.7%	72.1%	93.5%	79.1%
Households without Internet access	10%	14.9%	6.6%	12.6%
Labor force, unemployed	5.1%	6.1%	4.4%	6.1%
Households receiving SNAP (Supplemental Nutrition Assistance Program) benefits	6.9%	12.5%	3.1%	8.7%
Household median income	$80,546	$56,484	$106,070	$67,817

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

HEALTH PROFESSIONAL SHORTAGE AREA

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

MEDICALLY UNDERSERVED AREA/MEDICAL PROFESSIONAL SHORTAGE AREA

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

Appendix 2: Community Input

Listening Sessions

Community Input Type and Population	Location of Session	Date	Language
Listening session with adults (40-70 years) that attend classes at or visit the Wellness and Activity Center	Wellness and Activity Center	6/2/2022	Spanish
Listening session with residents in Wilmington	Zoom	6/2/2022	Spanish
Listening session with elementary school teachers from Wilmington, San Pedro and Lawndale	Zoom	6/13/2022	English
Listening session with elementary school parents from Lawndale	Zoom	6/15/2022	Spanish

Key Community Stakeholder Participants

Name	Title	Organization
Name	**Title**	**Organization**
Melissa Andrizzi-Sobel, MSW	Director of Community Services	Beach Cities Health District
Michael Ballue, CADC II, BSBA	Chief Strategy Officer Executive Director	Behavioral Health Services, Inc. National Council on Alcoholism and Drug Dependence of the South Bay (NCADD)
Dolores Bonilla	Chief Executive Officer	Wilmington Community Clinic
Kelly Bruno, DSW	President & Chief Executive Officer	National Health Foundation
Roxanne S. Chang, MD	Consulting Pediatrician	Community's Child
Lisa Daggett-Cummings, MBA	Development Director	South Bay Children's Health Center
Ghislaine Davis	Founder and Chief Executive Officer	South Bay Village
Yolanda De La Torre, MBA	Program Executive Director	Wilmington YMCA
Dr. Luis Dorado	Interim President	Los Angeles Harbor College
Benicio Espitia	Director, Workforce Development	Goodwill Industries
Mike Estes	Director of Community Services	City of Lawndale
Officer Nickolas Ferrara	Police Officer	Los Angeles Police Department
Amy Grat, MBA, MA	Chief Executive Officer	EXP The Opportunity Engine
Jann Hamilton Lee	President and Chief Executive Officer	South Bay Family Health Care
Tahia Hayslet	Executive Director	Harbor Interfaith Services
Dora Jacildo, MA	Executive Director	Child Lane
Gretchen Janson	Assistant Superintendent, Business Services	Lawndale Elementary School District
Mike Lansing, MSA	Chief Executive Officer	Boys & Girls Clubs of the Los Angeles Harbor

Name	Title	Organization
Ed Long, JD	Community Activist	Co-Founder of Healthcare and Elder Law Programs Corporation (HELP); Co-Founder of Caring House
Steve MacAller	Executive Director	YMCA of Metropolitan Los Angeles
Lou Mardesich	Administrator, San Pedro Community of Schools	Los Angeles Unified School District, San Pedro Community of Schools
Christine Martinez	Administrative Program Director	Mychal's Learning Place
Sarah Myers	President and Chief Executive Officer	Volunteer Center South Bay-Harbor-Long Beach
Candace Nafissi	Manager, Community Resource Center, Wilmington	Blue Shield Promise/L.A. Care Health Plan
Tara Nierenhausen	Founder and Executive Director	Community's Child
Daniel Ortiz Reti	Healthcare Integration Coordinator	Los Angeles Homeless Services Agency (LAHSA)
June Pouesi	Executive Director	Office of Samoan Affairs
Marc Schenasi	Chief Executive Officer	South Bay Children's Health Center
Juliette Stidd, LMFT	Chief Clinical and Programs Officer	Richstone Family Center
Lindsey Strata	Public Health Officer	Los Angeles County Department of Public Health
Lihn Tran	Manager III, Product Solutions	L.A. Care Health Plan
Amanda Valorosi, MSG	Senior Assisted Living Coordinator, Human Services	City of Carson
Jennifer Vanore, PhD	President and Chief Operating Officer	UniHealth Foundation
Rosemary C. Veniegas, PhD	Senior Program Officer, Health	California Community Foundation
Yolanda Wilburn, MLIS	City Librarian	City of Torrance
Lisa Williams	Pastor	San Pedro United Methodist Church

Appendix 3: Findings from Listening Sessions and Interviews

FINDINGS FROM COMMUNITY LISTENING SESSIONS

High priority community needs identified from listening sessions

- **Overweight and obesity:** This need encompassed both safety and recreation. Listening session participants discussed the importance of safe and clean streets to allow families to spend time outside. They noted needing more school crossing guards and safer driving near schools. They also suggested increased free activities to help people, especially children, be more active. These activities include dance classes, swimming, and more. Participants noted the importance of clean green spaces to allow for families to play.
- **Food insecurity:** Listening session participants want to see grocery stores with healthier food options, including prepared foods. They also noted there are too many fast-food options and unhealthy restaurants in the community. Participants shared they would like to see community gardens to teach people how to grow vegetables and to support better eating habits of children.

Medium priority community needs identified from listening sessions

- **Access to health care and preventive care:** Listening session participants were concerned about long wait time for appointments and would like easier access to health care services.
- **Economic insecurity:** Listening session participants would like to see more resources to support older adults and people with disabilities, including educational classes. They were particularly concerned about older adults and families experiencing economic insecurity because of the high cost of rent. Listening session participants want to see more local hiring and internship opportunities for students.
- **Homelessness and housing instability:** Participants would like to see more housing assistance for older adults experiencing homelessness. The high cost of housing in the area has led some families to move. Participants would like to see more affordable rent.
- **Behavioral health (mental health and substance use/misuse):** Listening session participants were particularly concerned about the mental health of school age children. They shared a need for more social and emotional resources for young people, as well as more mental health professionals on school campuses. As a result of mental health challenges, educators are seeing more behavioral challenges. Listening session participants discussed the importance of helping people develop skills for managing stress.
- **Chronic diseases:** Listening session participants shared a need to better regulate refineries and oil wells, which can contribute to asthma and other health problems.

FINDINGS FROM STAKEHOLDER INTERVIEWS

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

- Mental health and dental care. For our community, it is often difficult for them to get any health care. Most patients have HMO insurance, which can make it more difficult to navigate the system.
- Because people do not have access to insurance, they do not have access to adequate health care.
- There are not enough Medi-Cal physicians and dentists who specialize in pediatrics. For mental health, there is more need than there are providers, at any income level.
- Childhood obesity and lack of health care services.
- Housing, job development, mental health, and access to health care.
- In Wilmington, it is access to health care, mental health, and chronic illnesses.
- ADL (activities of daily living) deficits and chronic diseases that require significant management.
- Since the pandemic, a lot of seniors have been stuck indoors and even with the lift of restrictions, they are too nervous to leave the house.
- Diabetes, hypertension, and obesity. But the one issue that has been exacerbated the most is mental health.
- We work with students, so we see obesity and a spike in diabetes. Also, food insecurity and supporting families so that they have sufficient healthy foods in their home.
- We serve persons who are homeless so access to health care and access to health insurance.
- Mental health is a real crisis for us. Housing insecurity and other issues that stem from or are related to housing insecurity.
- There is more food insecurity and a lot of patients with diabetes and heart disease that were controlled prior to the pandemic but have now become uncontrolled during the last year or so. Immunizations were missed and preventive and emergency needs continue to be in high demand.
- We need access to quick and responsive mental health services as well as occupational therapy, physical therapy, and speech therapy.
- We have a lot of uninsured community members so even getting a flu shot is difficult. The more complicated the process, the more difficult it gets to access care. The pandemic exacerbated that access even more.
- We have a significant need to improve the connection of hospital patients to care facilities that match their needs.
- Housing insecurity and food insecurity. And affordable housing.
- COVID-19, diabetes and obesity are huge issues. Also, mental health in the schools is an issue.
- Chronic disease, substance use and mental health.
- There is a large number of people who live in poverty in our community.
- Food insecurity and mental health, particularly for our youth and the ability to access affordable health care resources.
- The neighbors in our community, the unhoused, are dealing with substance use, mental health, and anger management.
- There are a lot of issues in the community related to pollution, environmental hazards, and homelessness.

- The continuing pandemic and how it's affecting residents. Serving those who are homeless or housing unstable as the economic crisis continues. Food insecurity has increased over the past 18 months.
- There is a heightened need for behavioral health and substance use services. We need integrated care and to be more tuned in with the social determinants of health. Also, there is a need for access to specialty timely, quality specialty care.
- The biggest needs among seniors are social isolation and loneliness and menta health. Housing is also an issue. Some seniors may decide to move into assisted living but that is only financially feasible for those in the highest financial brackets.
- Drugs, drug addiction, overdoses among the homeless population are untreated and growing in size.
- Mental health, nutrition, and accessing health care. We've seen a rise in cancer and that is due to the shutdown of health care and delayed care.
- Kids are behind in their vaccines because the clinics were closed, and no one is getting dental care. It was a problem before the pandemic, and it has gotten worse.
- Obesity, diabetes, dialysis, hypertension, stroke, and gout. These are food-related diseases.

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

- Tooth decay has increased for our communities. Our kids are at higher risk for dental decay. Some factors include income, families that had jobs before the pandemic and lost their jobs, kids are at home snacking more, families were afraid to take them in for preventive care. These factors increased dental decay.
- A lot of kids are just struggling in life. Kids going back to school don't know what is coming at them, they are afraid if they get a cold, it is COVID-19. Parents are fighting about whether kids should wear masks, parents are extremely stressed with their income and job loss.
- For kids, there is a lack of activity, reduction of physical education classes in schools, use of mobile devices, lack of parental supervision, parents working until late at night and kids in an empty home playing video games and eating poorly.
- Genetics. The population I work with is special needs, especially adults with developmental disabilities.
- We are in a community that doesn't have access to health insurance. We also do not have much information on how to get services that are low cost so people will wait and delay care and then go to the ED for services.
- One of the worst things the pandemic did for seniors was isolate them. It adds fear to the equation of leaving your house and it led to more health issues because people couldn't get to a doctor.
- The area is very built out, so there is very little open space and limited grocery stores with fresh fruit and vegetables and organic choices. There are lots of small stores that serve less healthy options.
- Among persons who are homeless, their health plays a big role in their ability to survive. And they have a lot of unmet needs.
- The high cost of housing and wages not keeping up with the cost of living.

- Isolation for seniors that is a direct result of the pandemic and likewise for teens. These are the two populations I'm worried about.
- The geographic location of the city itself makes transportation to access services an issue with families.
- COVID-19 and a lot of instability with people's health and some of that has led to lost income and lost jobs and housing.
- Families live with a great deal of stress and sometimes children's issues aren't detected early enough.
- The system can be very cumbersome to get a referral, or an intervention plan, especially if the child has special needs. Parents have a hard time navigating a system that is designed to minimize the number of consumers.
- It may be uncomfortable for health care providers to talk to families about life expectancy and families may be uncomfortable talking to hospital staff about it.
- It is difficult to build affordable housing due to zoning issues, NIMBYism, and structural racism.
- There is a lack of knowledge around the COVID-19 vaccine and our community has a lot of contributory factors that can make them more susceptible to side effects.
- Poverty limits one's access to quality food and access to enough food. So, there is food insecurity in families.
- COVID-19 hit hard and the inability to find good paying jobs contributes to the ability to afford food.
- The mental health situation among our youth includes stress, pressure of life and school and the disconnection from people.
- The ability to get affordable health insurance and mental health providers who don't have long wait lists and will accept new clients are also issues.
- Economics and racial/ethnic demographics lead to differences in life span and health conditions. There is an historical disinvestment in housing infrastructure, particularly in SPA 6. This makes it hard to access specialty care as it requires travel.
- We've seen an increase in cognitive impairments and caregiver burnout and the impact on their overall wellbeing. Rising costs and inflation are impacting those who live paycheck to paycheck. We've seen 10-15% increases in rent and seniors are struggling financially and being pushed out.
- COVID-19, unemployment, poverty, and there is a subset of people who are hesitant to access safety net services.

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

- Low-income neighborhoods are highly impacted. including ethnic racial minorities. Latino and Black families are disproportionately impacted.
- Elementary and middle school students.
- Special needs populations.
- We still see Wilmington as an immigrant community. Residents are afraid to seek out services because of their immigration status.
- Older adults, anyone with chronic health issues.

- Students and their families.
- Low income, persons who are homeless and the working poor.
- People of color, women of color, and all low-income individuals.
- There are people who are working well past their retirement age because they are trying to supplement their incomes in order to survive and be able to get health care. The same with young adults. Many young adults continue to live at home.
- Low income, vulnerable families are really impacted. It is difficult to take a bus to go to your doctor's appointment. As a result, people are skipping their appointments. Seniors are skipping appointments for the same reason.
- The greatest concern for those with limited resources is how they struggle to navigate a complicated system.
- Primarily Latinos, low-income families, and single household families. They may be employed, but they do not have employment-based benefits.
- Anyone who has been hospitalized with serious illnesses.
- Brown and Black communities and homeless communities. Seniors are the fastest growing population of the unhoused. They are the largest unhoused population of homeless because there is nowhere for them to go.
- BIPOC (Black, Indigenous and People of Color) groups that are more impacted with mental health challenges than other groups and low-income populations.
- Those with private insurance struggle to find access to care more than those with Medi-Cal. For persons with private insurance, there is a shortage of professionals.
- Residents who are Black, Latinx, Native Hawaiians, and Asian are all affected. Native Hawaiians are disproportionately impacted by the pandemic, and they are already suffering with health conditions.
- Immigrant populations with low educational attainment. They are working hard but have fewer job skills. Families who were making ends meet, prior to the pandemic, they were living marginally. With COVID-19 came job loss and they were heavily impacted. Many in the food industry were impacted.
- The elderly with existing co-morbidities.

What health inequities have you observed and what solutions do you believe are needed to address those inequities?

- We see income inequities especially for moderate to middle income families who do not qualify for Medi-Cal but do not earn enough to pay out-of-pocket for co-pays for mental health professionals. Often, insurance does not offer mental health coverage at all, or the co-pays are very high, or practitioners are not taking new clients.
- Free recreation programs for families are needed. People can’t afford them. We used to have more physical education opportunities than we have now, it used to be more of a priority. We need recreation activities in the community that everyone can freely access.
- Individuals who lack capacity to advocate for themselves. It is difficult to get the services they need if they are not strong advocates for themselves or have someone advocating for them to connect

them to the resources they require.

- The fact that many don't have access to health insurance creates issues. For solutions, we need more community education.
- There is no system of care for those who need long term support, especially for those who are homeless with ADL deficits.
- There are so many health concerns. A lot of seniors live alone. They often need assistance with eating, going to a doctor's appointment, and grocery shopping. Some are too embarrassed to ask us to bring them groceries, so they start eating frozen food with no nutrition.
- The pandemic has pointed out who has and doesn't have Internet at home. Without the Internet, people cannot access telehealth services.
- We see inequities related to opportunities to participate in physical activities outside of school.
- The primary inequity I see is a lack of access to readily accessible health care services in the form of community centers or more localized opportunities for health care services.
- If you do not have housing or all your money goes to housing, you cannot afford to go to the doctor. The homeless need health care, they have swollen feet and open wounds and sores that don't heal because they are not in an environment where they can heal. And with food, it is whatever you can get and prepare on the street.
- Transportation is an issue. There are very few dentists here. And very few accept Medi-Cal.
- Sometimes it can be a long wait for specialty services. Others who have insurance may be able to gain services more quickly.
- The misinformation that is out there. People not trusting governmental entities. We need more outreach and provide information, and the right information.
- Patients who show up who are homeless, and they are unidentified - they appear to be homeless, and they are found on the street. But they may have people who will speak for them and love them and that is a real problem because they are unidentified.
- I work with families who are not documented, so they don't have access to any kind of medical care. When they do seek care, they go to the ED, and they receive bills that are thousands of dollars that they can't pay.
- Housing is health. You cannot be healthy if you are unhoused. Do you have grocery stores, transportation, parks, and places for kids to play so they are healthy? It all relates at the core to having affordable housing and a community that has those resources.
- We are seeing issues around access to care but more specifically to accessibility to health care. There is health care available, but it is accessing it via transportation, culture, and language that becomes the problem. You see these issues more in low-income, minority populations such as Black people/African Americans and monolingual Spanish speaking populations. Immigration status also adds to that inequity. Some of our South Asian communities, Pacific Islanders in SPA 8, particularly, they are impacted culturally.
- In a lot of communities, people don't have access to facilities like an athletic field and places where young can be physically fit and healthy.

- High poverty levels lead to a lack of access to tools and resources. Immigrants may not trust persons who are giving help and may not want to talk about mental health.
- When someone goes to the hospital and they have an illness and we put them back on the street without any assistance, they will continue to come back to the hospital. I know the hospitals are working hard to not do that and make sure everyone discharged is safe and they are getting assistance, which has been improving over the last couple of years. But I've seen people discharged and die a week later.
- The challenge with urban development, pollution and environmental issues are that they are very complex systems, and it takes a long time to get advocacy and policy to come to fruition.
- For some families there is generational addiction and a lack of awareness and treatment once they are chronically addicted.
- There are no dental services for low-income populations. It could be because of a lack of insurance, cultural trauma, or distrust of the system, but they are not accessing services that they could be accessing.
- We are seeing children who have developmental disabilities and their families who have been very impacted with schools closing. It is difficult to Zoom for kids with developmental disabilities and ADHD.

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

- The needs are stronger, but the care isn't stronger. We see a domino effect. With the pandemic, we started to see other issues arise that may impact low-income families. What was once a secondary need became a primary need and moderate-income families that lost jobs had no choice but to go on Medi-Cal.
- It has made it significantly worse. People stayed at home, played video games, and used their mobile device and it had a negative impact.
- Because we've been so focused on COVID-19, other things have not been addressed like Alzheimer's care, the Stroke Center, the Diabetes Program, and our Fall Risk Program. We are not running these programs or the flu clinic. Everything is now focused on COVID-19.
- Some needs significantly worsened during the pandemic, particularly issues around mental health. There was already a shortage of mental health resources for all individuals, let alone those with developmental disabilities.
- So many people became ill and didn't know how to get medical help or vaccines. Also, the fact that there is so much misinformation out there on vaccines, people consequently don't believe they need the vaccine, or they refuse to get one.
- It highlighted the needs, and nothing has changed. Many agencies have stepped up to the plate who previously never did. The pandemic is a mixed blessing, it resulted in many partnerships that wouldn't have existed before.
- Physical activity was already a concern, and it has become a greater concern. The pandemic hit our area pretty significantly and when schools re-opened, only 20% of families chose to have their kids

return to school, so there was not much physical activity in the community going on.

- We have all had to adjust, adapt, and operate in different times. A lot of things have been done virtually and persons who are homeless do not have that luxury.
- It completely stopped people from accessing health care other than getting a vaccination.
- It seemed that things were getting better with the big push to get the unhoused into housing. What we are seeing now is more people who are unhoused. That population is growing again. Fewer people are being placed in hotels and the rent moratorium is over. people are struggling. People who can't work, then they become unhoused and when they try to get work, they can't because who will hire someone who hasn't bathed or washed their clothes? It becomes a vicious cycle. This is happening to a number of people.
- The limited lifestyle has led to more cases of youth obesity due to inactivity over the last couple of years.
- Many people were already in a very tenuous situation with their jobs, and they did not have a lot of time off or sick time. When the pandemic hit, they found themselves without employment because their only form of transportation, the bus, had shut down. And they needed someone to stay home with the kids and help with schooling so that reduced people's income. We had high positivity rates. Families lost loved ones or they themselves were ill and out of the workforce or confined to their home for weeks on end.
- It has made it even harder for families to keep routine appointments with providers who were providing support services, like the pediatrician, the regional centers, the school district. For many kids, they are not able to get speech and language support. For some children, that increases their level of anxiety and their inability to self-regulate.
- Hospitals had to delay care for patients. I think there were a lot of people that had serious health issues and they didn't go to the hospital. People were hospitalized and never saw their families again. That had a huge impact on those families.
- It rose to the surface how fragile folks are and how fiscally unstable people are.
- We continue to see the number of cases of COVID-19 increase predominately in the Latinx and African American communities. It has given us a stronger picture of the differences in health, economic and social inequities when it comes to our minorities.
- Overall, having youth stay inside made them less physically active and a lot of them put on weight and there is a spiral impact where there are feelings of isolation and people continue to struggle with mental health issues. Also, it gave people license to do unhealthy things like overeat and drink more and get involved in drugs.
- Right now, we are seeing people leave the workforce. The need for food increased by almost 50% and we continue to have waiting lists. We are seeing people who put off routine care and now are experiencing the impacts of delaying care for cancer and diabetes.
- I think that it has created some awareness in the community to understand the needs and become more educated on what can be done to help people.
- How does a person decide about a vaccine when the information is only available in English and Spanish?

- Exacerbation of food insecurity. It's a fundamental human right that's been impacted. Both access to food and housing impact health.
- Three is more substance use and more death on the streets, and younger people dying on the streets.
- One improvement has been the switch to telehealth. It provides a more convenient option. People don't have to take time off work, find childcare, or arrange transportation. With behavioral health telehealth, there have been fewer no shows.
- We weren't equipped for this. There is a general escapism. People are depressed and anxious and have turned to drugs and alcohol. Alcohol purchases went up 200-300% and it is to escape depression.
- It exacerbated old existing problems and magnified disparities. And there is a trust issue. There is a polarization, and it goes to other areas of health services, not just vaccines.
- The foundation of the pandemic was fear and that caused a lot of upheaval and uncertainty. So much information is coming out and people do not know what is true and what is not. We see information from responsible agencies, and we see that experts counter it, and they are being blocked by the media and there is a sense of what is the actual truth.

Appendix 4: Community Resources Available to Address Significant Health Needs

Providence Little Company of Mary Medical Center, San Pedro and Providence Little Company of Mary Medical Center, Torrance cannot address all the significant community health needs. Improving community health requires collaboration with community stakeholders. The table below lists community resources potentially available to address identified community needs. This is not a comprehensive list of all available resources. For additional resources refer to https://www.211la.org/.

Community Resources Available to Address Significant Health Needs

Significant Needs	Community Resources
Access to Health Care and Preventive Care	Beach Cities Health District, CalAIM, Children's Institute, Community's Child, Harbor Community Clinic, Harbor Regional Center, L.A. Care Community Resource Center, LA Christian Health Centers, Office of Samoan Affairs, Pediatric Therapy Network, Planned Parenthood, Saban Community Clinic, South Bay Children's Health Clinic, South Bay Family Health Care, The Children's Clinic, Venice Family Clinic, Wilmington Health Center
Chronic diseases	Beach Cities Health District, Community's Child, Harbor Community Clinic, Smart Air LA, South Bay Children's Health Center, Venice Family Clinic, Wilmington Health Center
Dental health	American Dental Association, Community's Child, South Bay Children's Health Center
Economic insecurity	Economic Development & Policy Committee for the San Pedro Chamber of Commerce, El Camino College, EXP The Opportunity Engine, Goodwill Industries, LA Harbor College, Long Beach City College, Mychal's Learning Place, Pilipino Workers Center, Pop Up LA, Rancho Los Amigos, Social Justice Learning Institute, Southern California Crossroads, The Volunteer Center South Bay - Harbor - Long Beach, Toberman Neighborhood Center
Food insecurity	Boys and Girls Clubs, Carson Essentials to Go, Community's Child, House of Yahweh, Los Angeles Regional Food Bank, Meals on Wheels, Salvation Army, Second Chance Breakfast, St. Luke's Presbyterian Church, St. Peter's by the Sea, Trader Joe's, YMCA
Homelessness & Housing Instability	1736 Family Crisis Center, Century Villages at Cabrillo, City of Carson Homeless Task Force, DMH Enriched Residential Care Program, Family Promise, Harbor Interfaith Services, Home for Good, Housing Authority of City of Los Angeles (HACLA), Housing for Health, Los Angeles Homeless Outreach Portal (LA-HOP), Los Angeles Homeless Services Authority (LAHSA), Moving on Program, National Health Foundation, Rainbow Services, Salvation Army, South Bay Coalition to End Homelessness, South Bay COG: Council of Government, The People Concern
Mental health	Bayfront Youth and Family Services, Children's Institute, Community's Child, Creating Healthier Attitudes Today, Didi Hirsch, Richstone Family Center, DMH Enriched Residential Care Program, GENESIS Geriatric Services Intervention Support Programs, Heritage Clinic, Kedren Health, Mychal's Learning Place, National Alliance on Mental Illness, Pediatric Therapy Network, South Bay Families Connected, South Bay Family Health Care, Ties for Families, Toberman Neighborhood Center

Significant Needs	Community Resources
Overweight/obesity	Beach Cities Health District, Community's Child, Harbor Community Clinic, Creating Opportunities for Physical Activity, Smart Air LA, South Bay Children's Health Center, South Bay Family Health Care, Venice Family Clinic, Wilmington Health Center, YMCA
Substance use	Al-Anon, Alcoholics Anonymous, Asian American Christian Counseling Service, Exodus Recovery, Medication-Assisted Recovery Anonymous (MARA), Narcotics Anonymous, National Council of Alcoholism and Drug Dependence, Southern California Crossroads, St. Francis Recovery Center, Tarzana Treatment Center, Ties for Families, Toberman Neighborhood Center

Appendix 5: Mission Community Health Committee

The Mission Community Health Committee oversees the CHNA process.

Mission Community Health Committee Members

Name	Title	Organization
Jordan Abushawish	Director, Public Affairs	Providence
Richard Afable, MD	Board Member	PLCM Community Ministry Board
Emily Blue	Community Member	
Randy Bowers	Board Member	PLCM Community Ministry Board
Jan Brandmeyer	Community Member	
Rev. Andrew Campbell	Chaplain	Providence
Scott Ciesielski	Chief Nursing Officer	Providence
Thomas Connaghan	Board Member	PLCM Community Ministry Board
Dr. Michele DelVicario	Board Member	PLCM Community Ministry Board
Ed Derenzis	Community Member	
Kathie Eckert	Chair	PLCM Foundation Board
Thelma Gonzalez	Director of Student Support Services	Lawndale School District
Suzi Gulcher	Board Member	PLCM Community Ministry Board
Jim Hartman	Community Member	
Justin Joe	Director, Community Health	Providence
Sr. Nancy Jurecki	Chief Mission Integration Officer	Providence
Glen Komatsu, MD	Chief Medical Officer	Trinity Care Hospice
Jerry Kouzmanoff	Board Chair	PLCM Community Ministry Board
Jennifer Kozakowski	Chief Mission Integration Officer South Bay	Providence
Phyllis Monroe, MD	Board Member	PLCM Community Ministry Board
Bishop Dean Nelson	Board Member	PLCM Community Ministry Board
Lori Nolan, RN	Philanthropy Officer	PLCM Foundation
Stephanie Nolan	Exec. Dir. Acute Care Svs.	Providence
Garry Olney	Chief Executive So. Bay	Providence
Jeff Parker	Community Member	Kaufman, Dolowich, Voluck, LLP
Mark Paullin	Treasurer	PLCM Foundation Board
Dr. Karen Pavic-Zabinski	Regional Ethicist	Providence
Amber Sheikh	Community Member	Sheikh Impact
Sr. JoAnn Showalter	Board Member	PLCM Community Ministry Board
Msgr. David Sork	Community Member	St. John Fisher Catholic Church
Jim Tehan	Regional Director, CHI	Providence
Mary Ann Walker	Vice-Chair	PLCM Foundation Board
Candice Washilewski	Exec. Dir. Acute Care Svs.	Providence
Paul White	Mgr, Spiritual Care	Providence
Veronica Williams	Associate Marriage & Family Therapist	Richstone Family Center
Rabbi Gordon Zalman	Community Member	Jewish Community Ctr.