PROVIDENCE
Health & Services

San Fernando Valley Community
Joint Community Health Needs Assessment 2016

Providence Holy Cross Medical Center
Mission Hills, Calif.

Providence St. Joseph Medical Center
Burbank, Calif.

Providence Tarzana Medical Center
Tarzana, Calif.

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Creating healthier communities, together

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

Defining the community

The Total Service Area for the Providence San Fernando Valley Community is composed of the total service areas for Providence Holy Cross Medical Center (Mission Hills), Providence St. Joseph Medical Center (Burbank), and Providence Tarzana Medical Center (Tarzana).

For purposes of this CHNA, the Total Service Area for the Providence San Fernando Valley Community is divided into six distinct areas using the Community Need Index (CNI) mapping tool from Dignity Health and Truven Health Analytics. There are three community benefit areas, one for each hospital and three Broader Service Areas, one for each hospital. All communities defined as “Community Benefit Service Areas” have a rounded score of 4 or greater on the scale. The communities defined as “Broader Service Areas” are the communities within the Total Service Area remaining after application of the Community Need Index. These areas are more resource rich with a population on the higher end of the socioeconomic spectrum. Through use of this tool, six distinct areas emerge as subcategories within the Providence San Fernando Valley Community:

- Holy Cross Community Benefit Service Area
- St. Joseph Community Benefit Service Area
- Tarzana Community Benefit Service Area
- Broader Holy Cross Service Area
- Broader St. Joseph Service Area
- Broader Tarzana Service Area

Our starting point: Gathering community health data and input

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

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

vulnerable populations.

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

Identified Community Health Needs in 2016

Priority Health Issue	Rationale/contributing factors
Access to healthcare and resources • Enrollment services • Health navigators • Culturally sensitive services • Affordable housing and homelessness*	• Issues with access to care, navigating the system, or other social resources were among the top barriers mentioned by key informants, focus group participants, and community based organizations. • Key informants consistently cited a need for more health education and outreach to ensure client access to and use of services. The need for health navigator type services in combination with medical care was also expressed. • Cultural and language barriers to obtaining health care was the top issue for children and adults and second top issue for seniors, selected by partners on the Community Based Organizations Survey. • Language barriers and services for undocumented populations was mentioned frequently by key informants. • Housing cost burden is about 56 percent across all three Community Benefit Service Areas. In comparison, about 50 percent of households across the Broader Service Areas spend 30 percent or more of their income on housing. • Safe and affordable housing was mentioned by both focus group participants and key informants as a major social issue in our community. • SPA 2 (San Fernando Valley) has the third largest homeless population, in comparison to the other SPAs. • The 2016 Greater Los Angeles Homeless count estimated a total of 7,094 total homeless persons on a night in 2016. 1,431 were sheltered (20%) and 5,663 (80%) were unsheltered. • From 2015 to 2016, SPA 2 experienced a 36% growth in the number of homeless.
Crime and community safety	• The most frequently mentioned aspects of a community which contribute to people's health in a negative way were crime including bullying, graffiti, speeding, and youth safety. • Key informants and focus group participants frequently

Priority Health Issue	Rationale/contributing factors
	mentioned unsafe environments, improper dumping and cleanliness, and access to safe and supportive spaces as drivers of health in our region. • 19.4 percent of adults living in the Broader St. Joseph service area, 18.4 percent of adults living in the St. Joseph Community Benefit service area, and 17.6 percent of adults living in the Broader Holy Cross service area have experienced some form of intimate partner violence. In comparison, 13.4 percent of adults throughout LA County reported experiencing intimate partner violence.
Low educational attainment and income • Early childhood education • Workforce development	• The need for education around financial literacy, resources, job training and quality child care/youth development programs was expressed by key informants, focus group members, and partners through the CBO survey. • Financial resources and chronic illness were the most frequently mentioned health and social issues by key informants. Housing, sufficient resources, and livable wages were also mentioned. • The need for quality child care and youth development programs was expressed by key informants, focus group members, and partners through the CBO survey. The focus group responses provided awareness of services and resources and no childcare during the programs as the barriers for reaching the needs in the community.
Mental health (including substance abuse treatment)	• Mental health was one of the most frequently mentioned health need by key informants, focus group participants, and community based organizations. All participants noted a need for more specialty (substance, trauma, coping skills) and integrated services for all age levels. • Binge drinking among adults was highest in Holy Cross's community benefit service area (16.5 percent), followed by Tarzana's community benefit service area (15.8 percent) and the Broader Tarzana service area (15 percent). In comparison, the percentage of adults throughout LA County reporting engaging in binge drinking is 15.9 percent. • 12.8 percent of adults living in the St. Joseph community benefit service area and 12.3 percent of adults living in the Broader Tarzana service area are at risk for major depression. In comparison, 11.8 percent of adults throughout LA County are at risk for major depression.

Priority Health Issue	Rationale/contributing factors
Poverty and food insecurity	• Poverty and the associated consequences were mentioned frequently by key informants. • An average 20 percent of households across the Community Benefit Service Areas and an average of 9.5 percent of households across the Broader Service Areas are living below the federal poverty level. In comparison, 18 percent of households throughout LA County are living below the federal poverty level. • All three Community Benefit Service Areas had rates for food insecurity above the County estimate and estimates for Broader Service Areas.
Prevention and management of chronic diseases • Diabetes • Obesity • Physical activity • Nutrition • Health education	• The need for health education on obesity, diabetes, and nutrition were mentioned by key informants as needs among clients. • Access to healthy foods and safe places to play were mentioned by both key informants and focus group participants as needs in the community. • The availability of green space is lowest in Tarzana's community benefit service area, in comparison to other areas in the region. For example, there are 0.57 acres of park areas per 1,000 people in Tarzana's community benefit service area. In comparison, the Broader Tarzana service area has 20.15 acres of park acres per 1,000 people.
Senior care and resources	• Generational differences in asking for assistance and accessing resources were noted as challenges by key informants, when helping seniors obtain health care. • In consideration of health and social needs of the community, focus group participants noted a need for better communication, awareness of resources and connection to those resources, access to transportation for handicapped and elderly people, food delivery for homebound, and access to a trainer for exercise and proper weight training as concerns for older adults. • The St. Joseph total service area has the highest percentage of adults age 65 and older who have fallen in the past year in comparison to other areas (45.1 percent in the community benefit service area and 39.2 percent in the Broader St. Joseph service area). In comparison, 27.1 percent of adults age 65 and older throughout LA County have fallen in the past year.

Note: *Members of the Oversight Committee suggested and adopted "affordable housing and homelessness" as part of an overall strategy to address "access to health care and resources".

Identifying top health priorities, together

The Oversight Committee for Providence Holy Cross, St. Joseph, and Tarzana Medical Centers met two times in 2016 to learn about the key findings from the CHNA and determine the priority health needs for the 2017-2019 cycle. The first meeting provided an in depth walk through indicators related to social determinants of health in our communities. During the second meeting, Board members reviewed the list of top identified health needs and associated CHNA results to determine the final list of priority health needs for 2017-2019. Committee members used a curated list of IRS criteria and tailored criteria developed in partnership with experts at Providence Health and Services and HC^2 Strategies, Inc:

- Attorney General requirements regarding the effect of the change in control and governance of St. Joseph Health System and Providence Health and Services on the availability and accessibility of healthcare services to the communities served by Providence Holy Cross, St. Joseph, and Tarzana Medical Centers
- Input from community
- Mission alignment and resources of hospital
- Severity and magnitude
- Addresses disparities of subgroups
- Existing resources and programs
- Opportunity for partnership

On November 10, 2016, board members of the Oversight Committee met to debrief on the findings of the CHNA and prioritize the identified needs. Members used a priority matrix with pre-determined weights and criteria to determine the final prioritized list of needs for the 2017-2019 cycle. Committee members were provided the rankings for input from the community (primary data), severity and magnitude (secondary data), and programs required by the Attorney General. Committee members were broken into three separate groups and asked to rank the remaining four criteria based on their expertise, using a scale of 1 (strongly disagree) to 4 (strongly agree). Three facilitators helped participants reach a ranking for each of the eight identified priority issues.

The rankings for each group were scored and the scores were tallied for each priority health need. The final ranked list: 1) Access to health care and resources 2) Prevention and management of chronic diseases 3) Senior care and resources 4) Mental health services 5) Poverty and food insecurity 6) Low educational attainment and unemployment 7) Crime and community safety 8) Affordable housing and homelessness.

After tallying the results, there was discussion on the placement of Affordable Housing and Homelessness. Many Committee members felt that this should be among the top needs addressed by the hospitals. Thus, it was decided to include “Affordable Housing and Homelessness” as a health need that falls under “Access to health care and resources.”

Providence top priority health needs for 2017-2019

1. **Access to health care and resources**
2. **Prevention and management of chronic diseases**
3. **Senior care and resources**
4. **Mental health services**
5. **Poverty and food insecurity**

Measuring our success: Results from our 2014 CHNA

Based on a review of the primary and secondary data collected as part of the community needs assessment process, a group of community stakeholders (both within and outside the organization) were invited to review these needs to help the Medical Centers identify the key priority issues. The key needs/issues identified through the assessment and prioritization steps include the following (listed in priority order):

Providence Holy Cross Medical Center

1. Expanded primary care capacity.
2. Obesity prevention programs, including more community based nutrition and physical activity programs.
3. Free, low-cost, and culturally/language appropriate health education programs.
4. Diabetes, heart disease, and hypertension prevention and management programs.
5. Affordable and accessible mental health services.

Providence St. Joseph Medical Center

1. Affordable and expanded services for a growing senior population.
2. Access to affordable primary and specialty care.
3. Expanded primary care capacity.
4. Access to affordable mental health services.
5. Coordination of existing programs and services that are culturally and language appropriate.
6. Heart disease, diabetes, hypertension, and cancer screening and prevention programs.

Providence Tarzana Medical Center

1. Affordable and accessible mental health services.
2. Diabetes and hypertension screening, management, and prevention programs.
3. Access to affordable primary and specialty care.
4. Affordable and expanded services for a growing senior population.
5. Alcohol and drug abuse treatment and prevention programs.

The Medical Centers identified specific multi-year community benefit strategies to direct its resources and work with others in achieving unmet needs in the area. Tables that provide an update on progress made over the past year in meeting the measurable metrics targeted for 2015 and 2016 are provided later in the document.

Acknowledgements
Summary of community input

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

From July to September 2016, on behalf of Providence Holy Cross, St. Joseph, and Tarzana Medical Centers, HC2 Strategies, Inc. conducted multiple focus groups, key informant interviews, and an internet based survey for community partners. 70 people were surveyed to obtain input from the community in the form of 13 key informant interviews, five focus groups (37 people), and 20 people responded to the community based organization survey.

Summary of Key Informant Interviews

Key informant interviews comprised key leaders in our community from an array of agencies, including social service agencies, safety-net providers, home based care and outreach for seniors, local government, funders, not-for-profits, researchers, and public health practitioners.

Summary of Focus Groups

Participants in the focus groups were end-users who are currently receiving programming and services from Providence Holy Cross, St. Joseph, or Tarzana Medical Center. Focus group types included those participating in the coping skills, resilience, Welcome Baby program, outreach program for seniors, and school principals.

Summary of Community-Based Organization Survey

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

Summary of Written Comments

Providence Holy Cross, St. Joseph, and Tarzana Medical Centers each solicited written comments on the latest CHNA through a link on their hospital's websites; however, no feedback was received.

Providence Holy Cross
Medical Center
15031 Rinaldi Street
Mission Hills, CA 91345

Providence St. Joseph
Medical Center
501 S Buena Vista St,
Burbank, CA 91505

Providence Tarzana
Medical Center
18321 Clark St,
Tarzana, CA 91356

Introduction

Creating healthier communities, together

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

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

Serving San Fernando Valley Community

The geographic region served by the Providence Medical Centers is referred to as the San Fernando and Santa Clarita Valleys. The governance structure for the three Medical Centers is referred to as the Valley Service Area Community Ministry Board (VSA). During 2015, the VSA provided $70,808,207 in community benefit in response to unmet needs and improve the health and well-being of those we serve in the San Fernando Valley. That same year, the California region, which included two medical centers in the South Bay and one medical center on the Westside, provided $169,027,860 in community benefits. The VSA includes:

- 3 Hospitals:
  - Providence Holy Cross Medical Center
  - Providence Saint Joseph Medical Center
  - Providence Tarzana Medical Center

- 1 Home health provider:
  Providence Home Care

- 1 Long-term care, assisted living and adult day centers:
  - Providence St. Elizabeth Care Center

About us

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

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

Our Values
Respect, Compassion, Justice, Excellence, Stewardship

Our Vision
Simplify health for everyone

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

Description of community

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

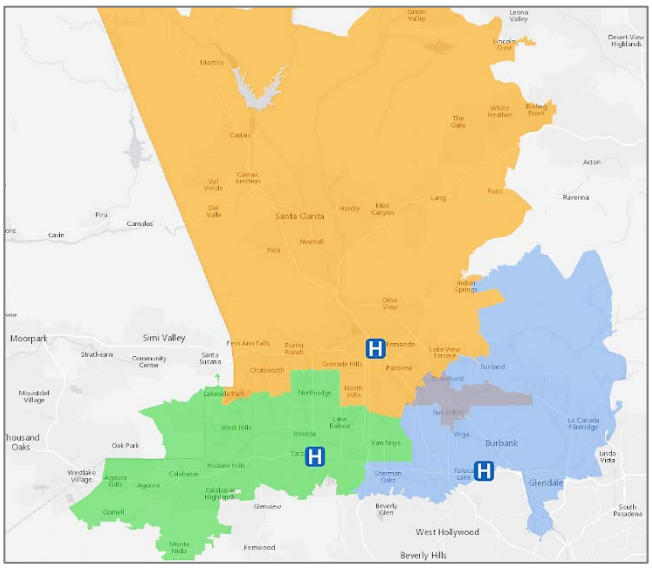
Community profile

Providence San Fernando Valley Community encompasses the San Fernando/Santa Clarita Valley Region of Southern California. The San Fernando Valley is a dynamic and diverse area with a population that spans the socioeconomic spectrum. Neighborhoods include the more resource rich and affluent areas such as Porter Ranch, Calabasas, and Studio City and other areas experiencing various barriers, including but not limited to, the neighborhoods and surrounding areas of San Fernando, Pacoima, Sylmar, Canoga Park, Reseda, North Hills, and North Hollywood.

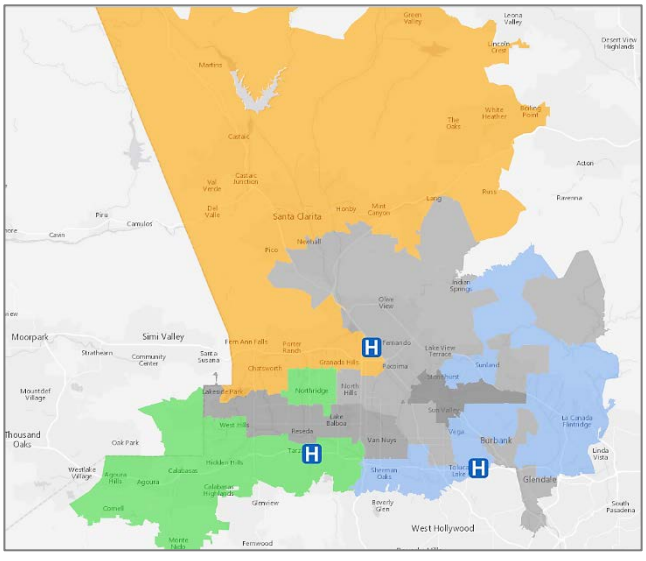
The Total Service Area for the Providence San Fernando Valley Community is composed of the total service areas for Providence Holy Cross Medical Center (Mission Hills), Providence St. Joseph Medical Center (Burbank), and Providence Tarzana Medical Center (Tarzana).

For purposes of this CHNA, the Total Service Area for the Providence San Fernando Valley Community is divided into six distinct areas using the Community Need Index (CNI) mapping tool from Dignity Health and Truven Health Analytics. There are three community benefit areas, one for each hospital and three Broader Service Areas, one for each hospital. All communities defined as "Community Benefit Service Areas"

Providence San Fernando Valley Region



Providence San Fernando Valley Region with Community Benefit Service Areas Shaded



have a rounded score of 4 or greater on the scale. The communities defined as “Broader Service Areas” are the communities within the Total Service Area remaining after application of the Community Need Index. These areas are more resource rich with a population on the higher end of the socioeconomic spectrum. Through use of this tool, six distinct areas emerge as subcategories within the Providence San Fernando Valley Community:

- Holy Cross Community Benefit Service Area
- St. Joseph Community Benefit Service Area
- Tarzana Community Benefit Service Area
- Broader Holy Cross Service Area
- Broader St. Joseph Service Area
- Broader Tarzana Service Area

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

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

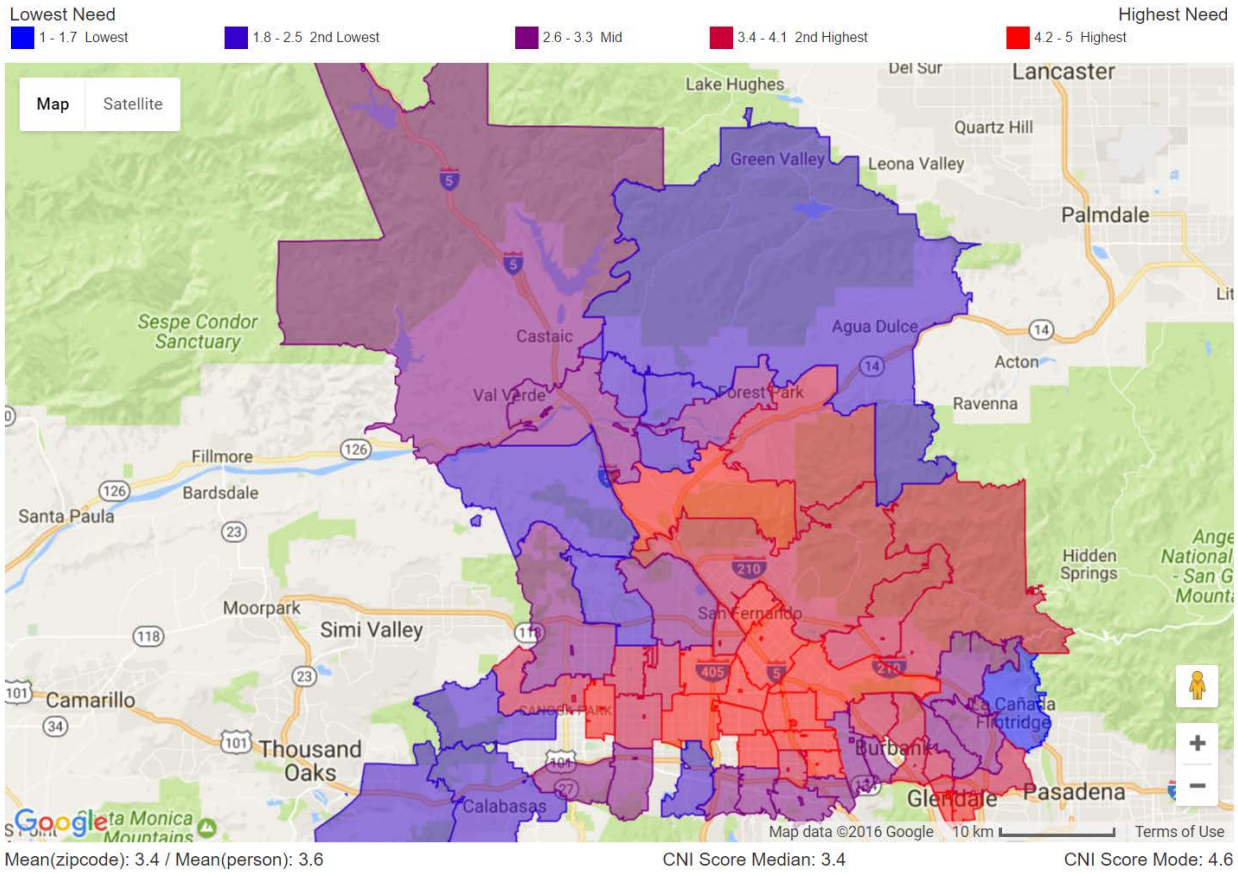
2. Cultural Barrier
    - Percentage of population that is minority (including Hispanic ethnicity)
    - Percentage of population over age 5 that speaks English poorly or not at all

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

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

5. Housing Barrier
    - Percentage of households renting their home

Community Need Index



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

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

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

Once each ZIP code is assigned its barrier scores from 1 to 5, all five barrier scores for each ZIP code are averaged together to yield the CNI score. Each of the five barrier scores receives equal weight (20 percent each) in the CNI score. A score of 1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with the most need. Zip codes for each service area and associated CNI score can be found in the appendix of this document.

Population and age demographics

According to the latest US Census Bureau estimates, the total population for the Total Service Area is 2,220,756, with an average annual growth rate of about 0.7% percent in 2016. Age demographics are 78 percent of the population are age 18 or older, and the median age is 37.2, compared to a U.S. median age of 38. In 2016 the population comprised:

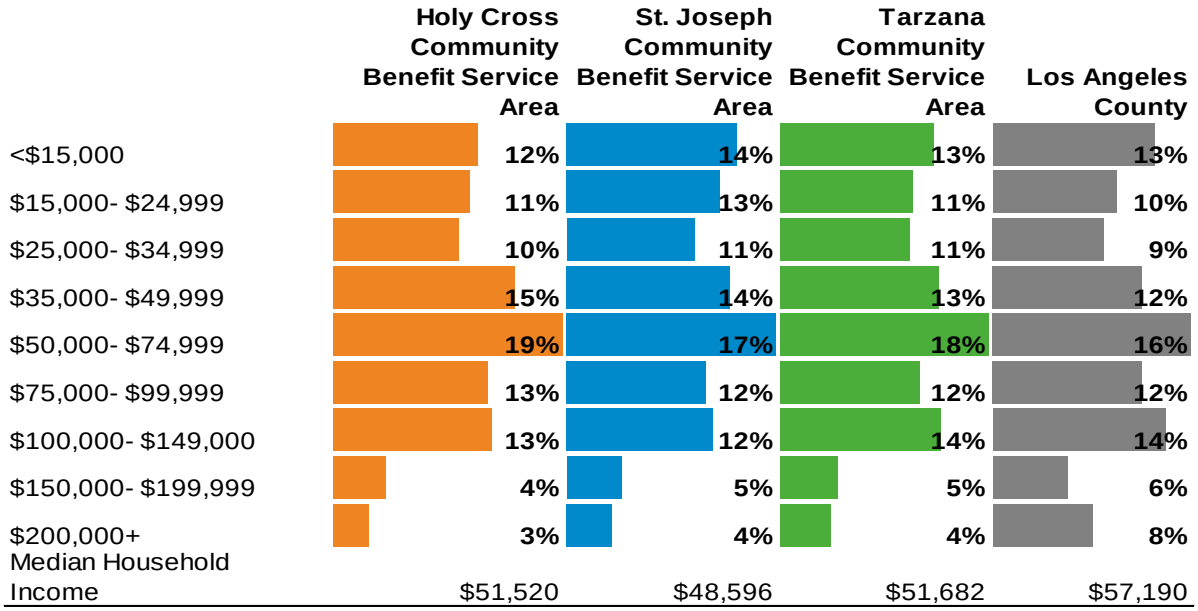
- 18.3 percent youth (0-14 years)
- 13.6 percent adolescent and young adults (15-24)
- 28.9 percent adults (25-44 years)
- 26.1 percent older adults (45-64 years)
- 13 percent seniors (65 years and older)

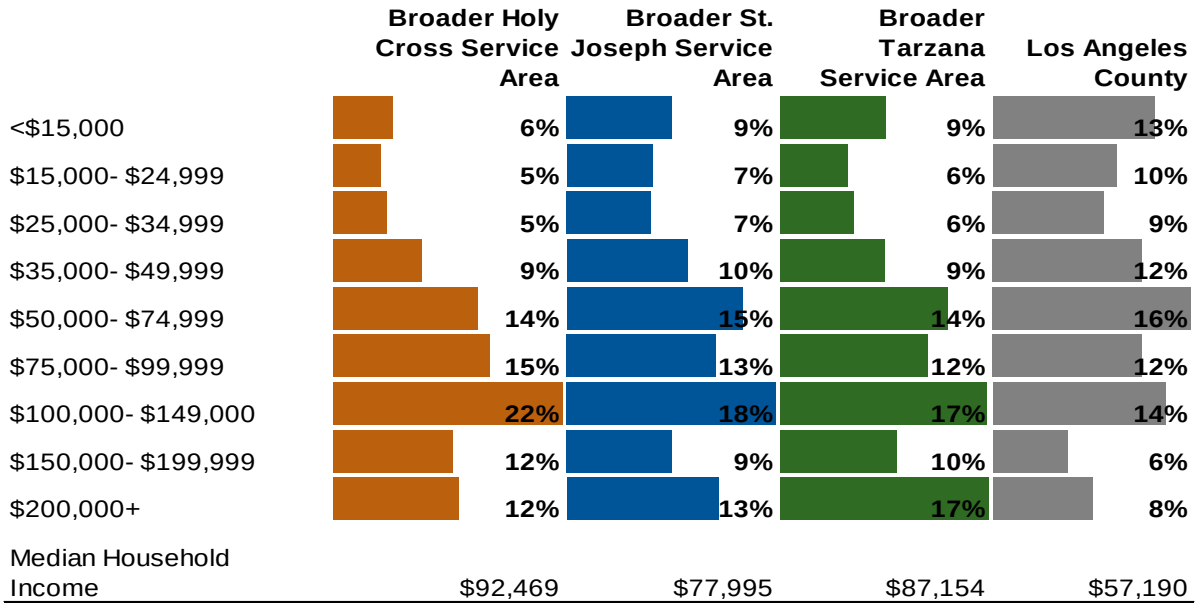
Ethnicity

Among Total Service Area residents in 2016, 60.4 percent were White, 12.1 percent Asian, 41 percent were Hispanic or Latino, 0.6 percent were Alaska Native or American Indian, 3.6 percent were African American or Black, 0.1 percent were Native Hawaiian or other Pacific Islander, and 5 percent were of two or more races.

Income levels and housing

In 2016, the median household income for the Total Service Area was $65,976. Comparatively, the median household income across the three Community Benefit Service Areas was $50,710 and $85,121 for the Broader Service Areas.





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

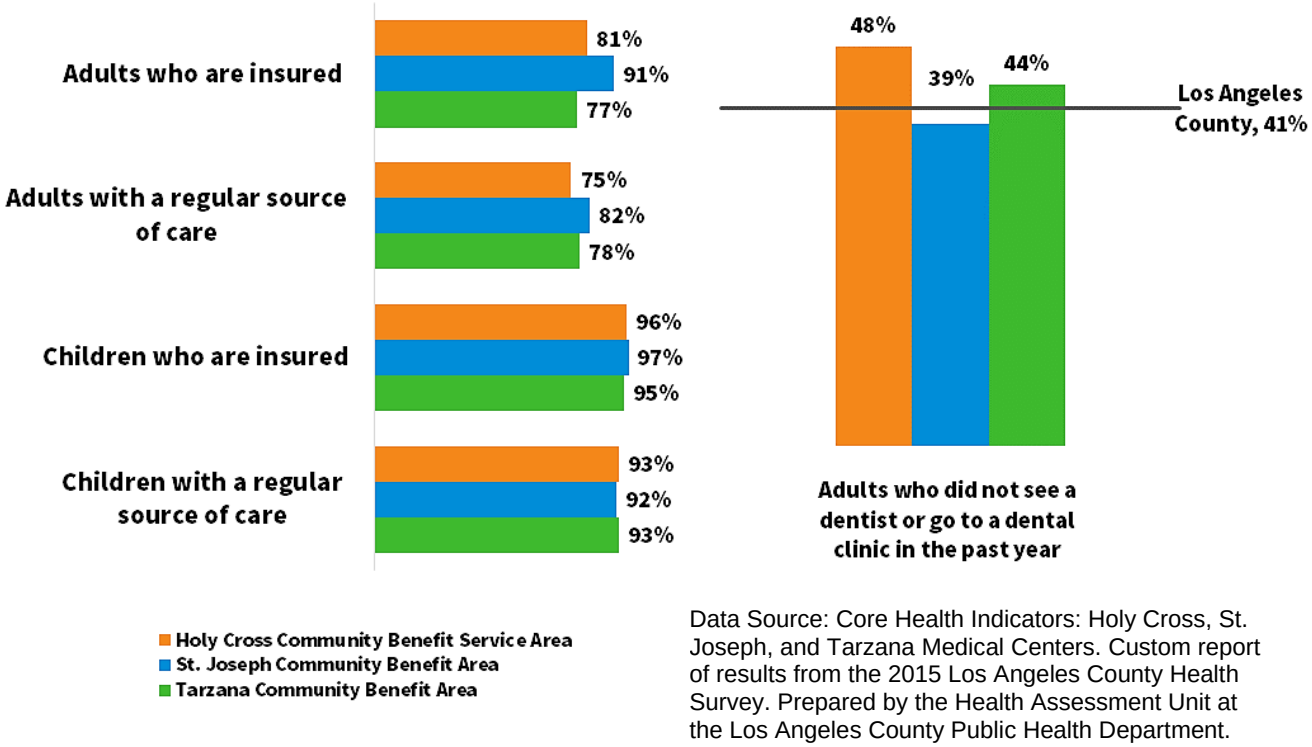
When looking at income by service area, one can see a near mirror image when comparing Community Benefit Service Areas to their respective Broader Service Areas. For example, 48 percent of households within the Tarzana Community Benefit Service Area earn an annual income of $49,999 or less, 18 percent earn $50,000 to $74,999 annually, and 35 percent earn $75,000 or greater. In comparison, in the Broader Tarzana Service area 30 percent of households earn an annual income of $49,000 or less, 14 percent earn $50,000 to $74,999 annually, and 56 percent of households earn $75,000 or greater. In comparison to estimates for

LA County, the Broader Service Areas have a higher percentage of high earning households. For example, 46 percent of households in the Broader Holy Cross Service Area earn $100,000 or more per year. In comparison, 28 percent of households throughout LA County have an annual household income of $100,000 or greater.

Health care and coverage

The share of adults age 18 to 64 years throughout the Total Service Area who are uninsured was 17 percent in 2014. The figure below shows the percentages of adults and children with insurance and access to a regular source of care. St. Joseph's Community Benefit Service Area had the highest percentage of insured adults and children, as well, as, adults with a regular source of care.

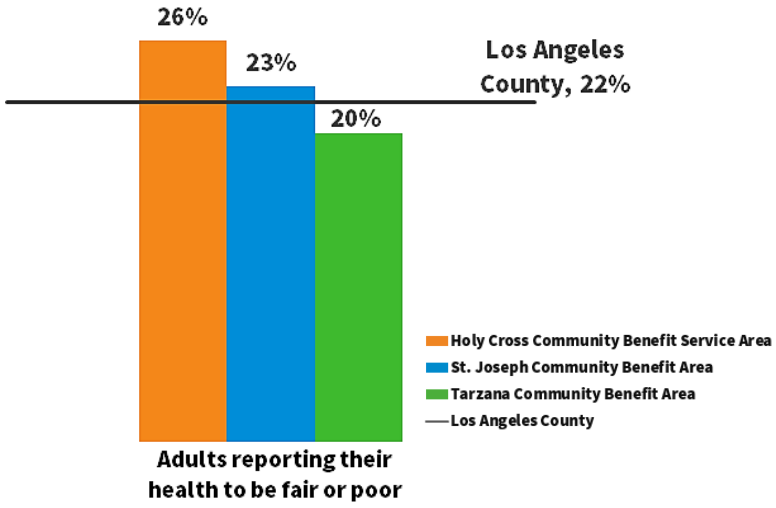
Lack of access to dental care in the Community Benefit Service Areas surpassed LA County estimates for both adults and children, except among adults living in St. Joseph's Community Benefit Service Area and children living in Holy Cross' Community Benefit Service Area. Among adults living in St. Joseph's Community Benefit Service Area, 39 percent of adults did not see a dentist in the past year. Comparatively 41 percent of adults throughout LA County did not receive dental care in the past year.



Data Source: Core Health Indicators: Holy Cross, St. Joseph, and Tarzana Medical Centers. Custom report of results from the 2015 Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

Health and well-being

In 2015, adults living in the Holy Cross Community Benefit Service Area reported the highest percentage of fair or poor health status, in comparison to the other two community benefit areas. In comparison, 13 percent of adults living in the Broader Holy Cross Service Area reported fair or poor health status.



Data Source: Core Health Indicators: Holy Cross, St. Joseph, and Tarzana Medical Centers. Custom report of results from the 2015 Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

Process, participants and health indicators

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

Assessment process

Every three years, Providence San Fernando Valley Region conducts a community health needs assessment (CHNA) for the communities served by Providence Holy Cross, St. Joseph, and Tarzana Medical Centers. This year is the first that the three hospitals have engaged in a joint community health needs assessment and represents a commitment to developing regional strategies, increased collaboration, and recognition of shared challenges and solutions among those we serve and partner with.

The CHNA is conducted to satisfy our annual community benefit obligations by meeting requirements that are outlined in section 501(r)(3) of the Federal IRS Code and to create partnerships that address identified needs. The goals of this assessment are to:

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

Beginning with the 2016 CHNA, the Hospitals agreed to conduct a Joint CHNA in accordance with §1.501(r)-3(b)(6)(v) of the Federal IRS code 26 CFR Parts 1, 53, and 602 ("Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return; Final Rule"). Accordingly, representatives of both medical centers agreed to participate on an Oversight Committee authorized by the Community Ministry Board. In collaboration with community representatives, the oversight group considered primary and secondary data collected and prioritized community needs as described hereinbelow.

Participants

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

Key Informant and Title	Organization	Community Representation
Kimberly Wyard, CEO	Northeast Valley Health Corporation	Northeast Valley Health Corporation (NEVHC) is one of the nation's largest community health centers. They are a nonprofit organization, focused on preventing and managing chronic health problems. Regardless of one's ability to pay, they provide medical care for children, the disabled, older adults, families, the homeless, children attending high risk schools, adults who are HIV positive and other vulnerable residents in service area.
Marine Dzhgalyan, CEO	All-Inclusive Community Health Center	A non-profit Community Health Center whose mission is to increase access to health-care and other social services for under-served populations in Burbank and surrounding communities, including but not limited to Los Angeles, Glendale, North Hollywood, Pasadena, Tujunga, Van Nuys, Sunland and San Fernando communities of greater Los Angeles County. All-Inclusive Community Health Center's (AICHC) quest is to promote increased access to health-care, social services and education, by creating linkages between community-based & faith-based organizations, businesses, educational & governmental institutions and health-care facilities.
Patricia Ochoa, Executive Director	Valley Care Community Consortium	Valley Care Community Consortium (VCCC) was founded in 1995 by key safety-net providers concerned about the lack of access and funding to services for low-income populations in Service Planning Area 2 (SPA2) of Los Angeles County. Understanding that the only way to improve the quality and access of health services, and end health disparities in the San Fernando and Santa Clarita Valleys was to work in partnership and collaboration, safety-net providers came together to form VCCC. Today, VCCC partners with over 200 agencies that include community health clinics, Los Angeles County health departments, local social service agencies, non-profit hospitals, universities and community residents.

Key Informant and Title	Organization	Community Representation
Marianne Haver Hill, President/CEO	Meet Each Need with Dignity (MEND)	In the early 1970's, MEND, Meet Each Need with Dignity, opened its doors in an effort to transform the lives of the neediest residents of the San Fernando Valley – poor children and their struggling families. Starting as a small group of volunteers working from a garage, MEND has grown primarily by word-of-mouth into one of the leanest operating non-profit organizations in existence. More than 94% of the support and donations received by MEND, now the largest poverty agency in the Valley, provides emergency food, clothing, medical, vision and dental care, job skills training and job placement assistance, English as a Second Language classes, youth activities, and a Christmas program. In 2015, we received over 37,000 client visits per month
Barbara Howell, CEO	Burbank Temporary Aid Center	BTAC is dedicated to providing the poor, working poor, and homeless of the local community with basic services they need to live with dignity, and to serve citizens of the city in times of emergency and disaster. As a conduit between the generous donors of the community, foundations, and government resources, BTAC works to provide clients with help such as food, utility assistance, transportation assistance, emergency shelter (off-site and short-term), medical assistance, referrals to other community resources, and holiday outreach.
Sandra Yanez, Regional Director	Catholic Charities, San Fernando Region	The programs of Catholic Charities focus on empowerment and seek to enact long-term, positive change in individuals, families and communities. As a nonprofit, public benefit corporation, the agency is built on the principles of dignity and inclusion, providing services irrespective of race, ethnicity, gender or religious belief. Programs address human suffering and larger social issues, such as poverty, hunger and nutrition, homelessness, immigration, health care, mental health and illiteracy.

Key Informant and Title	Organization	Community Representation
Roger Williams	Family Rescue Center	The Family Rescue Centers serves individuals and families in need in the West Valley by providing food, clothing, medical and vocational training assistance, as well as referrals as needed. Their ultimate goal is to sustain people in desperate circumstances, empowering them to achieve personal and financial independence.
Arlene Brown, MD, PhD	UCLA Geffen School of Medicine	The David Geffen School of Medicine at UCLA has in a little more than 60 years grown to become an internationally recognized leader in medical education, research, patient care and public service. It is a remarkable achievement for an institution that is among the youngest of the most elite medical schools in the country.
Matthew Horvath, Instructional Director	Los Angeles Unified School District, Local District Northwest	School district serving students in the Northwest San Fernando Valley Region.
Rosemary Veniegas, Senior Program Officer	California Community Foundation	The CCF's mission is to lead positive systemic change that strengthens Los Angeles communities. We envision a future where all Angelenos have the opportunity to contribute to the productivity, health and well-being of our region. And we believe that our common fate will be determined by how successfully we improve the quality of life for all of our residents.
Jenna Hauss, Director of the Senior Enrichment Center and the Care Management Department	ONEgeneration	ONEgeneration is committed to providing programs and services to seniors and their caregivers that help keep them safe and protected. We provide services that enable seniors to age with family, in community or independently. We promote physical health and mental well-being, provide socialization, nutrition and access to food and resources. This is all towards the goal of keeping seniors from the tipping point of decline and avoiding or delaying preventable hospitalizations and premature loss of independence.
Marcus Hong, Chief Administrative Officer	Hope of the Valley Rescue Mission	Hope of the Valley Rescue Mission's vision is to tangibly demonstrate God's love to the Hungry, Homeless and Hurting of the greater Los Angeles area by offering **h**ope, **h**ot meals, **h**ousing, **h**ealth services and **h**ealing to those in need.

Community Health Needs Assessment Oversight Committee

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

Name	Title	Organization	Sector
Frank Alvarez, MD, MPH	Area Health Officer, SPA 1 and 2	LA County Dept. of Public Health	Public Health
Rosa Bisellach, RN	Nurse Manager, ER	Providence Tarzana Medical Center	Hospital
Sr. Sheila Browne, RSM/ Fr. Mark Ciccone, SJ	Director, Mission Leadership/ Manager, Spiritual Care	Providence Saint Joseph Medical Center	Hospital
Marine Dzhgalyan	CEO	All-Inclusive Community Health Center	Federally Qualified Health Center
Victor Estrada/Elizabeth Diaz	Medical Clinic Manager/Medical Clinic Assistant Manager	Meet Each Need with Dignity (MEND)	Community Based Organization
Jenna Hauss	Director	ONEGeneration, Senior Enrichment Center and the Care Management Department	Seniors
Matthew Horvath, Ed.D.	Director, Instructional Services	Los Angeles Unified School District, Northwest Region	Academics
Donald Huey, MD	Specialist, Internal Medicine	Facey Medical Group	Medical Group
Natalie Komuro	Executive Director	Ascencia	Community Based Organization
Heidi Lennartz, FACHE, LCSW, CCM	Associate Administrator	Providence Holy Cross Medical Center	Hospital
Steven Loy, Ph.D	Professor of Physical Education, Department of Kinesiology	California State University, Northridge	Academics
Joan Maltese, Ph.D./Dana Kalek, Ed.D	President and CEO/ Director of Operations	Child Development Institute	Children
Jose Salazar, Dr. Ph., MPH	Director of Program Development	Tarzana Treatment Centers	Mental Health and Substance Abuse Clinic
Donovan Stewart, RN, MSN, MICN, CEN	Trauma Program Manager	Providence Holy Cross Medical Center	Hospital
Jeanne Sulka/Shawn T. Kiley	Director, Business Development/Director, Mission Leadership	Providence Tarzana Medical Center	Hospital

Name	Title	Organization	Sector
Olga Vigdorchik	Health Educator, SPA 1 and 2	LA County Dept. of Public Health	Public Health
Terry Walker	Manager, Business Development	Providence Saint Joseph Medical Center	Hospital
Brian Wren, LCSW	Manager, Clinical Social Work	Providence Saint Joseph Medical Center	Hospital
Sandra Yanez, MA,	Regional Director	Catholic Charities of Los Angeles, San Fernando Region	Faith-based

Outside Consultant: HC^2 Strategies, Inc.

Providence Health and Services contracted HC^2 Strategies, Inc. to conduct and document this community health needs assessment. HC^2 Strategies, Inc. is a consulting agency with expertise in health care systems, strategy and innovation, program evaluation, and community health needs assessments. Research and development of the final written product was led by HC^2's Healthcare Intelligence Director, Jessica L.A. Jackson, MA, MPH.

Data collection

CHNA Framework

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

Primary Data

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

Secondary Data

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

The custom report presented data for each hospital, grouped by zip code to further breakout and define areas of greater and lower need in the total service area and aide in greater comparisons. For each of the 65 core indicators, an estimate was obtained for the community benefit service area (areas of greater need), the Broader service area (remaining zip codes after application of the Community Need Index), and Los Angeles County. To better identify disparities, the Community Benefit Service Areas for all three hospitals are compared in the body of this document. The full tables with all 65 indicators for each hospital's community benefit service area, Broader service area, and comparison to Los Angeles County is provided in the appendix.

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

Data Limitations and Gaps

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

Identification of significant health needs

The criteria selected for determining significant health needs were chosen per the IRS 501(r) regulations for conducting community health needs assessments and developing

implementation plans. The Oversight Committee used these criteria in a prioritization matrix to determine the final list of prioritized needs by the Oversight Committee.

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

Health indicators and trends

Social and Economic Factors

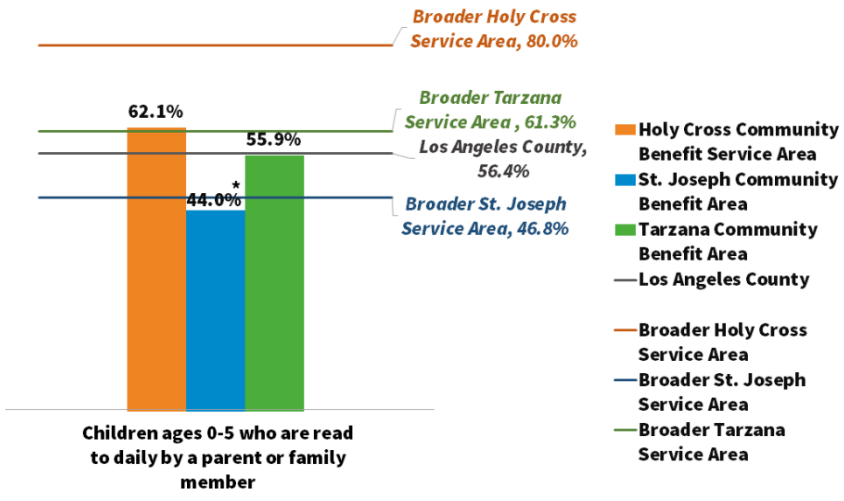
Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Our health is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

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

Education

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

The St. Joseph community benefit service area has the lowest percentage of children read to daily by a family member, in comparison to other service areas in the Providence San Fernando Valley Region



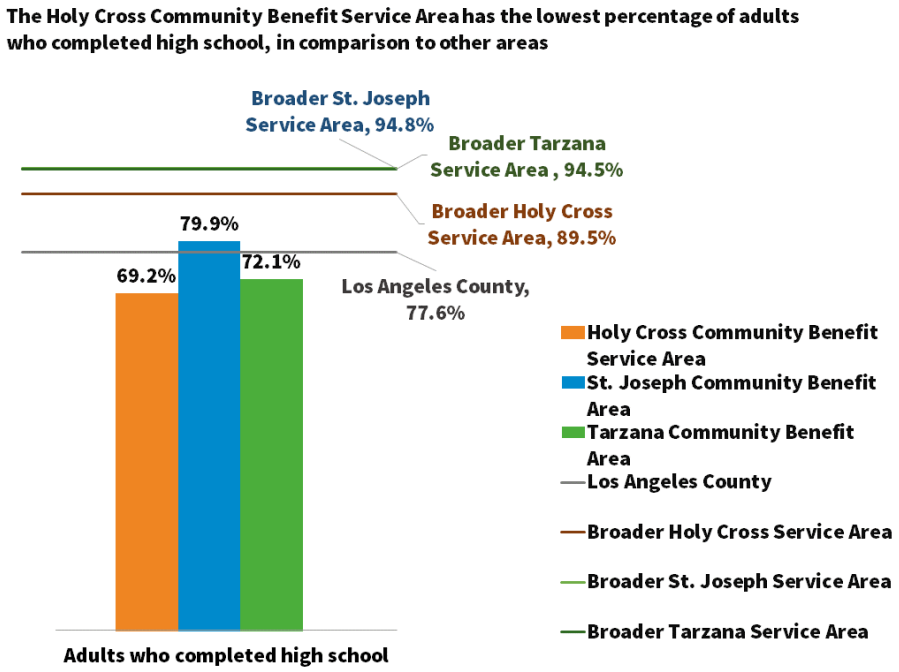
Note: * Statistically unstable estimate, should be interpreted with caution.
Data Source: Core Health Indicators: Holy Cross, St. Joseph, and Tarzana Medical Centers. Custom report of results from the 2015 Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

Beginning education early is particularly important, because the early years provide a window of opportunity to

shape a child's brain during the most rapid period of development. Study after study proves that smart investments made in the early years can lead to profoundly better outcomes for our children, families, and economy. In fact, the National Center for Education Statistics found that children who are read to more frequently at home recognized all of the letters of the alphabet compared to those who were read to less frequently. Children who were read to frequently were also more likely to count to 20 or higher, write their own names, and read or pretend to read than children who were not read to frequently.

In our region,the St. Joseph community benefit service area has the lowest percentage of chldren age 0-5 who are read to daily by a parent or family member (44 percent), followed by the Broader St. Joseph service area (46.8 percent). In comparison, the Broader Holy Cross service area has the highest percentage of children read to daily.

Graduation from high school is also associated with better health outcomes and lifetime earning potential. The Holy Cross Community Benefit Service Area has the lowest percentage of adults who completed high school, in comparison to other areas (69 percent). Both the Holy Cross and Tarzana Community Benefit Service Areas, have lower percentages of adults who completed high school in comparison to LA County. Comparatively, an average 93 percent of adults across the Broader Service Areas have completed high school.

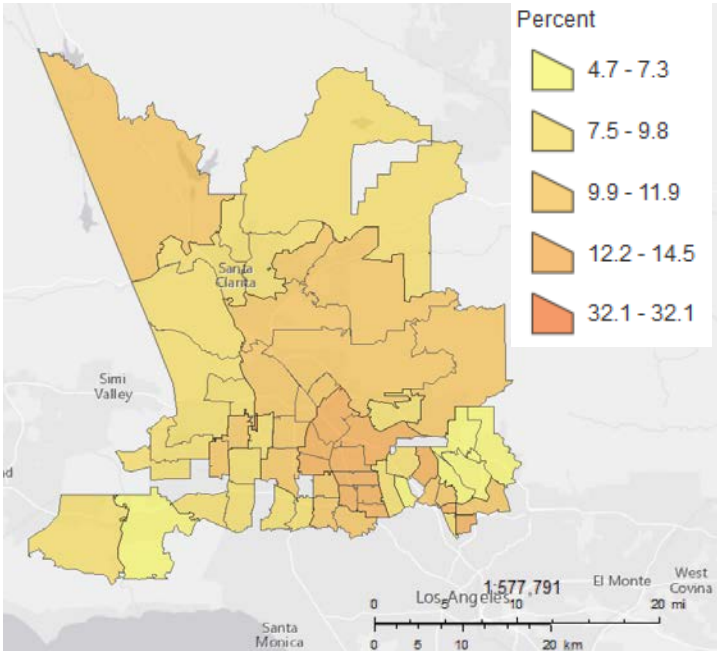


Data Source: Core Health Indicators: Holy Cross, St. Joseph, and Tarzana Medical Centers. Custom report of results from the 2015 Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

Employment

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

Unemployment rates



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

As of June 2016, the unemployment rate for LA County was 5.2 percent. This was slightly higher than the rate for the United States (5.1 percent) and slightly lower than the state (5.7 percent). Notably, unemployment estimates for LA County have steadily decreased in the past year from a high of 7.9 percent in January 2015, with the lowest rate (5.7 percent) occurring in December 2015.

Analysis at the census tract level, reveals deep pockets of unemployment throughout the Community Benefit Service Areas. For example, the unemployment rate is estimated to be as high as 32 percent in some areas.

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

local cost of living. As such, a working family's income would not be high enough to maintain a normal standard of living.

Analysis of median income demonstrates that having a job, is not sufficient to afford the cost of living and healthcare services. For example, the median income across the three Community Benefit Service Areas is $50,710 annually and $85,121 for the Broader Service Areas. Using the living wage calculator from MIT, it was found that a household with one adult and one child would need to earn $56,264 to maintain a normal standard of living. For a family with one adult and three children this figure skyrockets to $81,203.

	Holy Cross Community Benefit Service Area	St. Joseph Community Benefit Service Area	Tarzana Community Benefit Service Area
Total	202,454	171,286	182,324
White Collar	**46.4%**	**56.3%**	**53.5%**
Management/ Business/ Financial	**9.4%**	**11.5%**	**11.7%**
Professional	**14.1%**	**21.6%**	**18.2%**
Sales	**9.6%**	**10.0%**	**10.4%**
Administrative Support	**13.3%**	**13.3%**	**3.2%**
Services	**23.4%**	**22.1%**	**24.7%**
Blue Collar	**30.2%**	**21.5%**	**21.8%**
Farming/Forestry/Fishing	**1.0%**	**0.2%**	**0.4%**
Construction/Extraction	**9.0%**	**6.2%**	**7.3%**
Installation/ Maintenance/ Repair	**3.6%**	**2.7%**	**2.7%**
Production	**9.7%**	**6.0%**	**5.5%**
Transportation/ Material Moving	**7.0%**	**6.3%**	**5.9%**

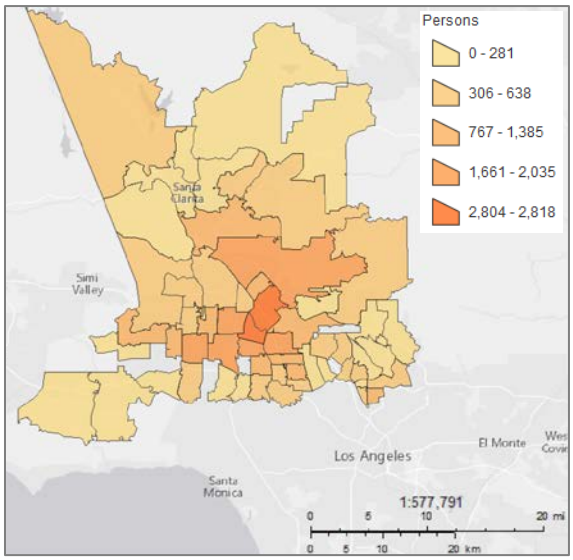
	Broader Holy Cross Service Area	Broader St. Joseph Service Area	Broader Tarzana Service Area
Total	189,380	207,346	137,686
White Collar	**71.7%**	**77.6%**	**78.1%**
Management/ Business/ Financial	**19.8%**	**20.4%**	**22.3%**
Professional	**26.0%**	**33.0%**	**30.8%**
Sales	**11.7%**	**11.3%**	**13.0%**
Administrative Support	**14.1%**	**12.9%**	**11.9%**
Services	**14.4%**	**12.3%**	**12.8%**
Blue Collar	**14.0%**	**10.1%**	**9.1%**
Farming/Forestry/Fishing	**0.2%**	**0.1%**	**0.1%**
Construction/Extraction	**3.7%**	**2.3%**	**2.7%**
Installation/ Maintenance/ Repair	**2.5%**	**1.8%**	**1.7%**
Production	**3.8%**	**2.8%**	**2.6%**
Transportation/ Material Moving	**4%**	**3.1%**	**2.1%**

Data Source: Esri, Inc. (2016). Custom reports created using Esri Community Analyst ® tool. Data from US Census Bureau's 2010-2014 American Community Survey 5-year estimates.

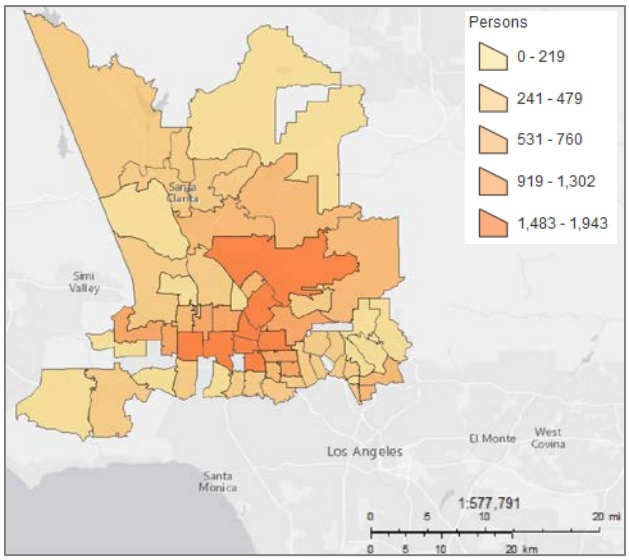
When looking at occupational trends across the service areas, one can see that there is a slightly higher number of people employed across the Community Benefit Service Areas in comparison to the Broader Service Areas (556,064 and 534,412, respectively). However, fewer people living in the Community Benefit Service Areas are employed in white collar (and generally higher paying) professions in comparison to the Broader Service Areas. Additionally, more people living across the Community Benefit Service Areas are employed in service and sales and blue collar-type occupations, in comparison to the Broader Service Areas.

The next two maps depict adults throughout the Total Service Area who are employed full-time, yet still living below the federal poverty level. By gender, adult males have higher rates of being employed but living below the federal poverty level (18 percent) than females (16 percent).

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



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



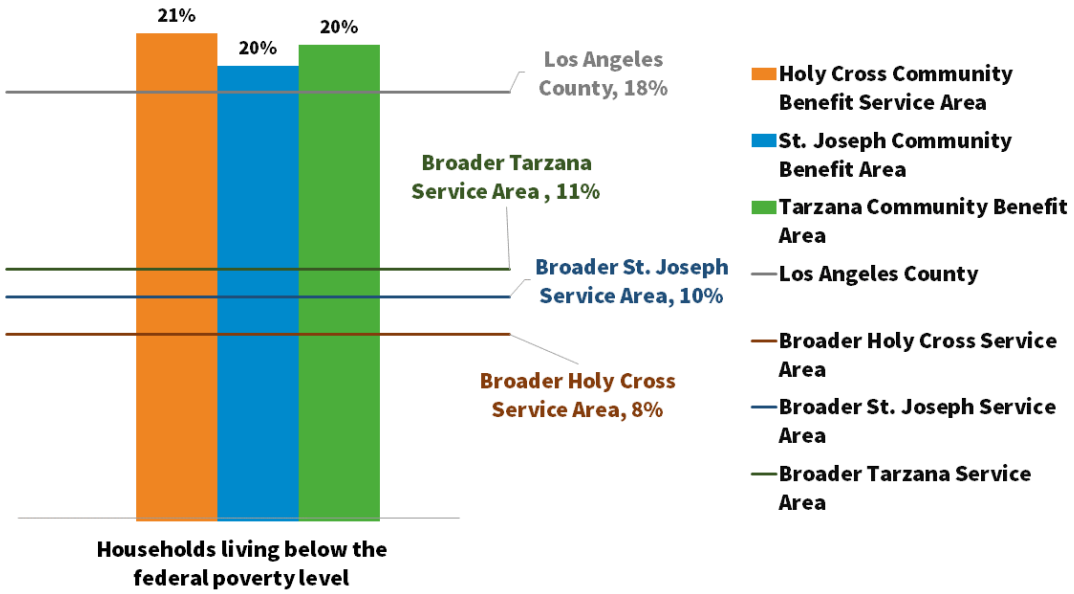
Data Source: US Census Bureau (2016). American Community Survey 5-year estimates, 2010-2014. Retrieved from https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

Poverty

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

The Holy Cross Community Benefit Service Area has the highest percentage of households living below the federal poverty level, in comparison to other areas, at 21 percent. The area with the smallest percentage of households living below the FPL is in the Broader Holy Cross Service Area at 8 percent.

The Holy Cross Community Benefit Service Area has the highest percentage of households living below the federal poverty level



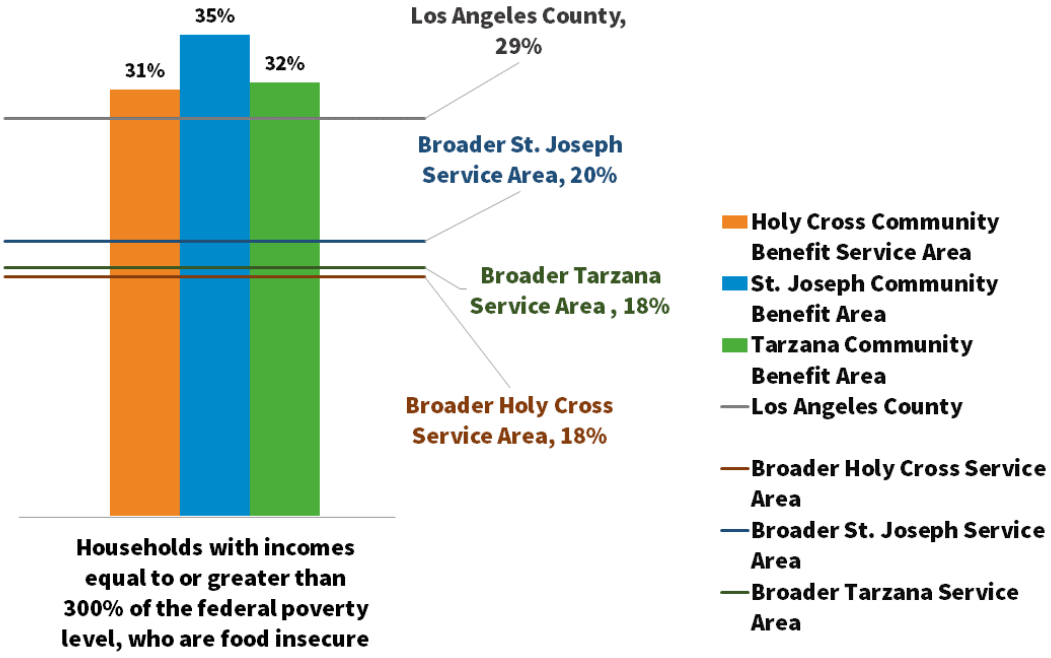
Data Source: Core Health Indicators: Holy Cross, St. Joseph, and Tarzana Medical Centers. Custom report of results from the 2015 Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

Food insecurity

Food security refers to access by all people, at all times, to enough food for an active, healthy life. Food insecurity is lack of consistent access to food resulting in reduced quality, variety, or desirability of diet or multiple indications of disrupted eating patterns and reduced food intake.

The St. Joseph Community Benefit Service Area has the highest percentages of households experiencing food insecurity, in comparison to other areas. Comparatively, the Broader Tarzana and Holy Cross Service Areas have the lowest percentage of households experiencing food insecurity.

The St. Joseph Community Benefit Service Area has the highest percentage of households experiencing food insecurity

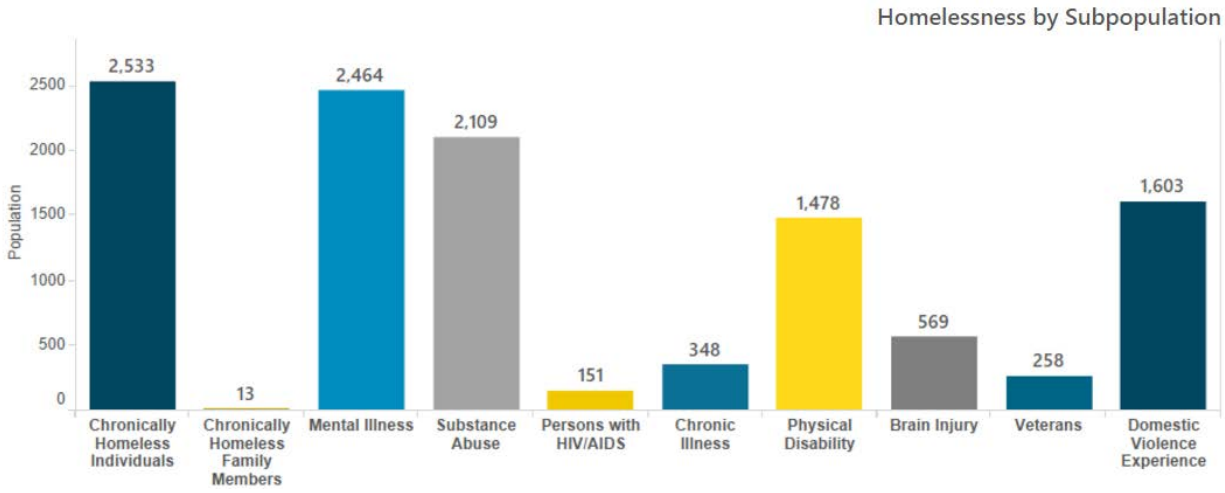


Data Source: Core Health Indicators: Holy Cross, St. Joseph, and Tarzana Medical Centers. Custom report of results from the 2015 Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

Homelessness

A lack of affordable housing and the limited scale of housing assistance programs have contributed to the current housing crisis and to homelessness. The lack of affordable housing leads to high rent burdens (rents which absorb a high proportion of income), overcrowding, and substandard housing. These phenomena, in turn, have not only forced many people to become homeless; they have put a large and growing number of people at risk of becoming homeless. SPA 2 (San Fernando Valley) has the third largest homeless population among the eight SPAs and a growing population. From 2015 to 2016, the homeless population increased by 36 percent. The 2016 Greater Los Angeles Homeless count estimated a total of 7,094 total

homeless persons on a night in 2016. 1,431 were sheltered (20%) and 5,663 (80%) were unsheltered.



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

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

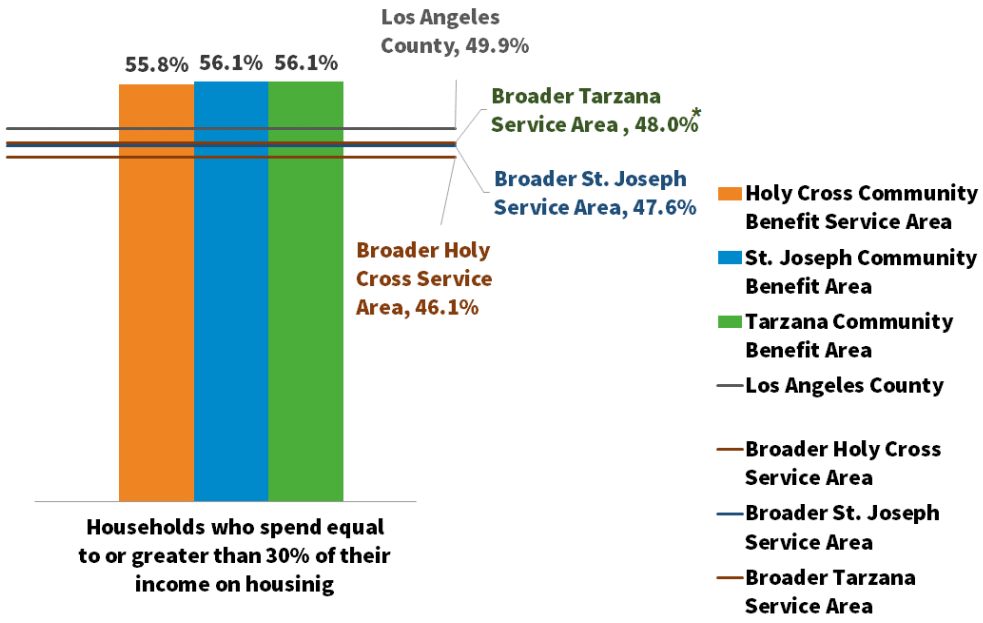
Housing affordability

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

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

Home prices in several traditionally working-class cities in Los Angeles County have risen dramatically in the past year. For example, the median price of homes sold during October 2016 in the San Fernando Valley hit $625,000, the highest monthly median price since August 2007. The median price has been above the $600,000 benchmark since April 2016 and twice — during October 2016 and August 2016— peaked at $625,000. That was 11.2 percent higher than October 2015. Until April 2016, the local median price had been below $600,000 every month since late 2007, hitting rock bottom at $339,000 in December 2011, which is when prices began to steadily climb. For comparison, the October 2016 median was 4.6 below the record high $655,000 median of June 2007.

A greater percentage of households in the Community Benefit Service Areas are experiencing housing cost burden in comparison to the Broader Service Areas



Note: * Statistically unstable estimate, should be interpreted with caution. Data Source: Core Health Indicators: Holy Cross, St. Joseph, and Tarzana Medical Centers. Custom report of results from the 2015 Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

A greater percentage of households living in the Community Benefit Service Areas are experiencing housing cost burden, in comparison to the Broader Service Areas. However, it should be noted that housing cost burden in the Broader Service Areas is nearly as high as the estimate for LA County.

Health system

Birth

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

	Holy Cross Community Benefit Service Area	St. Joseph Community Benefit Service Area	Tarzana Community Benefit Service Area	Broader Holy Cross Service Area	Broader St. Joseph Service Area	Broader Tarzana Service Area	Los Angeles County
Rate of births (per 1,000 females) to teens	71.4	40.8	48.6	26.2	7.1	15.1	53.4
Percent of low birth weight (<2,500 grams) births (per 100 live births)	7.4%	6.3%	7.2%	6.5%	6.8%	7.4%	6.9%
Infant death rate	6.0	3.9	5.0	3.3	4.0	7.0	4.4
Children (age 0-2) who were exclusively breastfed for at least 3 months	31.4%	37.9%	36.1%	51.0%	58.6%	46.2%	38.3%

Data Source: Core Health Indicators: Holy Cross, St. Joseph, and Tarzana Medical Centers. Custom report of results from the 2015 Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

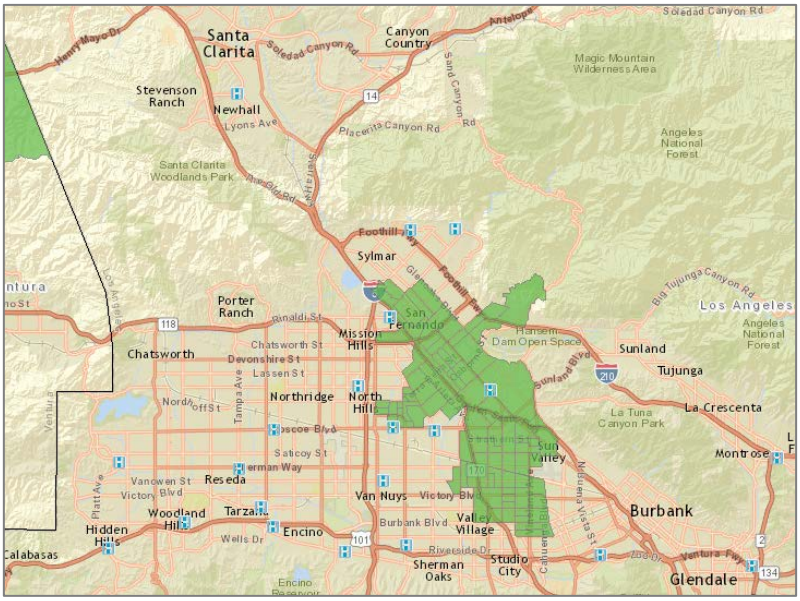
Low birth weight is indicative of the general health of newborns and often a key determinant of survival, health, and development. Understanding such data is critical as infants born at low birth weights are at a heightened risk of complications, including infections, neurological disorders, Sudden Infant Death Syndrome, breathing problems, learning disabilities, and even chronic diseases. The Healthy People 2020 goal is for 7.8 percent or less of infants to be born with weights below 2,500 grams. All areas of comparison, meet this goal; however, it must be noted that the Holy Cross Community Benefit Service Area, the Tarzana Community Benefit Service Area, and the Broader Tarzana Service Area fall only slightly below the HP2020 goal. Healthy People 2020 also strives for 95 percent of all infants to be breastfed exclusively for the first six months. All areas fell short of this goal within the first three months.

Finally, the infant mortality rate (IMR) is critical as it is indicative of the existence of broader issues pertaining to access to care and maternal child health. Such rates can further provide us metrics of community health outcomes and areas of needed services and interventions. The IMR for the Broader Holy Cross Service Area is the lowest at 3.3 per 1,000 live births. The highest rate can be found in the Broader Tarzana Service Area at 7.0 per 1,000 live births.

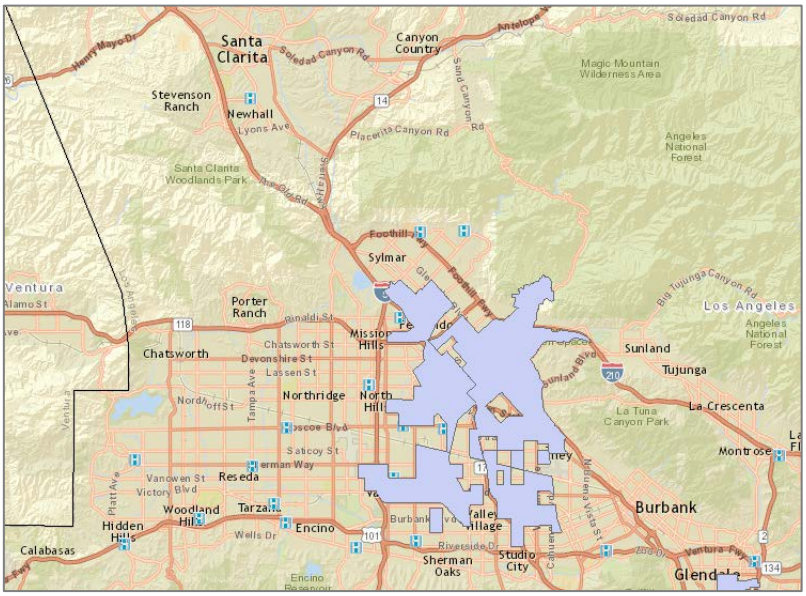
Health professional shortage areas

A health professional shortage area is a geographic area, population group, or health care facility that has been designated by the Federal government as having a shortage of health professionals. There are three categories of HPSAs: primary care (shortage of primary care clinicians), dental (shortage of oral health professionals), and mental health (shortage of mental health professionals). The areas around San Fernando, North Hills, and Sun Valley are most affected by a shortage of primary care health professionals. The areas around San Fernando, North Hills, Sun Valley, and parts of Glendale are defined as medically underserved populations or areas.

Primary care health professional shortage area



Medically underserved population/area



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

Leading causes of death

The leading causes of death in the United States are overwhelmingly the result of chronic and preventable diseases. Causes of death varied by the type of service area. For example, the Community Benefit Service Areas, generally had higher death rates for diabetes, corornary heart disease, stroke, and liver disease. However, there were some areas where the Broader Service Areas had higher mortality rates. For example, the Broader Holy Cross Service Area had the highest rates for colorectal cancer and lung specific cancer deaths, in comparison to the other service areas. The Broader Tarzana Service Area had the highest breast specific cancer deaths, in comparison to the other service areas.

	Holy Cross Community Benefit Service Area	St. Joseph Community Benefit Service Area	Tarzana Community Benefit Service Area	Broader Holy Cross Service Area	Broader St. Joseph Service Area	Broader Tarzana Service Area	Los Angeles County
Diabetes-specific death rate (per 100,000 population)	**26.8**	25.5	20.0	14.8	**12.7**	13.3	21.9
Coronary heart disease-specific death rate (per 100,000 population population)	131.3	132.3	**145.6**	114.5	**110.9**	116.1	116.7
Stroke-specific death rate (per 100,000 population)	28.5	**34.2**	33.4	30.5	28.6	**23.0**	32.8
Alzheimer's disease-specific death rate (per 100,000 population)	**24.8**	31.2	33.9	33.2	**36.8**	29.9	25.1
COPD specific mortality rate (per 100,000 population)	23.8	**23.1**	29.7	**33.1**	27.8	26.1	29.2
Lung-specific cancer death rate (per 100,000 population)	**22.7**	31.1	32.2	**33.1**	27.6	30.4	27.5
Breast cancer-specific death rate among females (per 100,000 females)	21.4	20.1	23.0	**19.0**	24.5	**28.9**	227.5
Colorectal cancer-specific death rate (per 100,000 population)	14.1	12.4	14.6	**17.6**	12.9	**12.1**	13.8
Liver disease-specific death rate (per 100,000 population)	**16.8**	14.8	10.3	12.2	8.3	**7.5**	218.1

Data Source: Core Health Indicators: Holy Cross, St. Joseph, and Tarzana Medical Centers. Custom report of results from the 2015 Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

Public Health and Prevention

Preventive practices

Access to primary care prevention care and screenings can help individuals treat and manage chronic diseases at early onset and prevent complications. Successfully managing risk factors for chronic diseases is important for preventing unnecessary hospitalizations. The next figure

shows rates for preventive screenings for women and influenza vaccination for adults and children. The Broader St. Joseph Service Area has the highest percentage of women who had a pap smear in the past three years, women who have had mammograms in the past two years, and adults vaccinated for influenza, in comparison to the other service areas. The St. Joseph Community Benefit Service Area had the lowest percentages for adults and children vaccinated against influenza.

	Holy Cross Community Benefit Service Area	St. Joseph Community Benefit Service Area	Tarzana Community Benefit Service Area	Broader Holy Cross Service Area	Broader St. Joseph Service Area	Broader Tarzana Service Area	Los Angeles County
Women ages 21-65 who had a Pap smear in the past three years	83.5%	90.0%	87.3%	89.3%	91.7%	86.9%	84.4%
Women (ages 50-74) who have had a mammogram in the past two years	76.8%	76.2%	80.2%	67.4%	87.7%	79.4%	77.3%
Adults vaccinated for influenza	34.8%	29.2%	41.8%	47.7%	52.7%	49.0%	40.1%
Children ages 6 months to 17 years vaccinated for influenza	47.1%	43.3%	61.4%	52.5%	60.5%	60.6%	55.2%

Data Source: Core Health Indicators: Holy Cross, St. Joseph, and Tarzana Medical Centers. Custom report of results from the 2015 Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

Alcohol, drug, and tobacco use

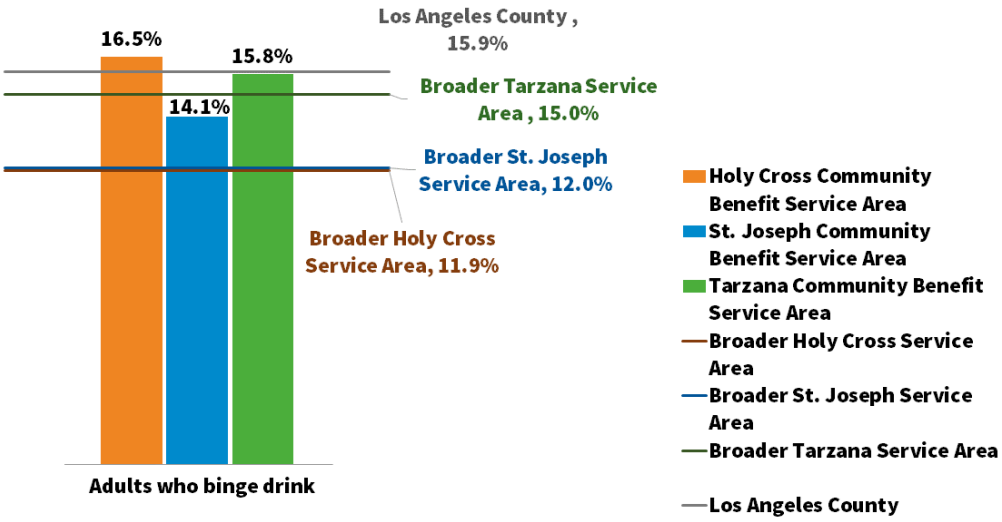
Alcohol and/or substance abuse has a major impact on individuals, families and communities. The effects of abuse are cumulative, contributing to costly social, physical, mental, and public health problems.

Binge drinking is the most common pattern of excessive alcohol use in the United States. The National Institute on Alcohol Abuse and Alcoholism defines binge drinking as a pattern of drinking that brings a person's blood alcohol concentration (BAC) to 0.08 percent or above. For men, this typically occurs with 5 or more drinks in about 2 hours; and for women, 4 or more drinks in about 2 hours.

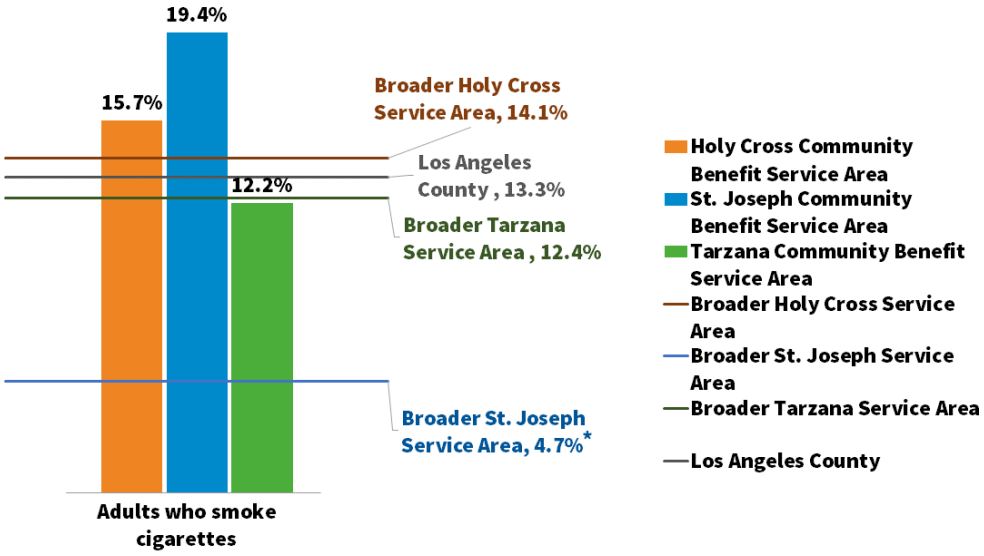
The Holy Cross Community Benefit Service Area has the highest percentage of adults who engaged in binge drinking, in the past 30 days, in comparison to the other service areas and LA County (16.5 percent). Comparatively the Broader Holy Cross Service Area had the lowest percent of adults who engaged in binge drinking in the last 30 days, at 11.9 percent.

Cigarette smoking is the leading preventable cause of death in the United States. Smoking causes diminished overall health and increases the risk of a number of health issues including, heart disease, cancer, and stroke. The St. Joseph Community Benefit Service Area has the highest percentage of adults who smoke cigarettes (19.4 percent), in comparison to the other service areas and LA County.

The Holy Cross Community Benefit Service Area has the highest percentage of adults who engaged in binge drinking, in the past 30 days



The St. Joseph Community Benefit Service Area has the highest percentage of adults who smoke cigarettes



Note: * Statistically unstable estimate, should be interpreted with caution. Data Source: Core Health Indicators: Holy Cross, St. Joseph, and Tarzana Medical Centers. Custom report of results from the 2015 Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

Preventing the start of alcohol, drug, and tobacco use among adolescents and teens is particularly important to prevent patterns of unhealthy behaviors that decrease overall well-being and development.

Grade 7	Los Angeles Unified	Las Virgenes Unified	Glendale Unified
Lifetime alcohol or drugs (excluding cold/cough medicines and prescription drugs)	20%	10%	9%
Current alcohol or drugs	11%	6%	4%
Current heavy drug users	3%	0%	1%
Current heavy alcohol user (binge drinker)	3%	2%	1%
Current alcohol or drug use on school property	6%	1%	2%

Grade 9	Los Angeles Unified	Las Virgenes Unified	Glendale Unified
Lifetime alcohol or drugs (excluding cold/cough medicines and prescription drugs)	41%	30%	28%
Current alcohol or drugs	24%	19%	15%
Current heavy drug users	10%	5%	4%
Current heavy alcohol user (binge drinker)	7%	5%	5%
Current alcohol or drug use on school property	10%	2%	6%

Grade 11	Los Angeles Unified	Glendale Unified
Lifetime alcohol or drugs (excluding cold/cough medicines and prescription drugs)	54%	48%
Current alcohol or drugs	30%	27%
Current heavy drug users	12%	9%
Current heavy alcohol user (binge drinker)	13%	12%
Current alcohol or drug use on school property	11%	9%

Data Sources: 1). Glendale Unified School District. California Healthy Kids Survey, 2013-14: Main Report. San Francisco: WestEd Health & Human Development Program for the California Department of Education.
2). Las Virgenes Unified School District. California Healthy Kids Survey, 2014-15: Main Report. San Francisco: WestEd Health & Human Development Program for the California Department of Education.
3). Los Angeles Unified School District. California Healthy Kids Survey, 2014-15: Main Report. San Francisco: WestEd Health & Human Development Program for the California Department of Education.

Per estimates from the California Healthy Youth Survey, alcohol and drug use increased with each grade level for the three school districts presented; suggesting earlier initiation to alcohol and drugs heavily influences lifelong use.

Injury

Injuries and violence affect everyone, regardless of age, race, or economic status. In the first half of life, more Americans die from violence and injuries — such as motor vehicle crashes, falls, or homicides — than from any other cause, including cancer, HIV, or the flu. The CDC estimates the total lifetime medical and work loss costs of injuries and violence in the United States was $671 billion in 2013. The costs associated with fatal injuries was $214 billion while nonfatal injuries accounted for over $457 billion.

When looking at the percent of adults who have ever experienced physical or sexual violence by an intimate partner by service area, one finds that the Broader St. Joseph Service Area has the highest percent in comparison to other service areas at 19 percent. The Broader Holy Cross Service Area and the St. Joseph Community Benefit Service Area had the next highest percentage at 18 percent.

Percent of adults who have ever experienced physical (hit, slapped, pushed, kicked, etc.) or sexual (unwanted sex) violence by an intimate partner	
Holy Cross CBSA	11%
St. Joseph CBSA	18%
Tarzana CBSA	13%
Broader Holy Cross SA	18%
Broader St. Joseph SA	19%
Broader Tarzana SA	9%
Los Angeles County	13%

Data Source: Core Health Indicators: Holy Cross, St. Joseph, and Tarzana Medical Centers. Custom report of results from the 2015 Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

Also, important to note is the issue of falls among older adults, particularly in our community where there is a large senior population. The Centers for Disease Control and Prevention estimate that over 800,000 patients a year are hospitalized because of a fall injury, most often because of a head injury or hip fracture, and each year at least 300,000 older people are hospitalized for hip fractures, the majority of which are caused by falling. The St. Joseph Total Service Area has the highest percentage of adults age 65 and older who have fallen in the past year in comparison to other areas (45.1 percent in the community benefit service area and 39.2 percent in the Broader St. Joseph service area).

Percent of adults ages 65+ years who have fallen in the past year	
Holy Cross CBSA	35%
St. Joseph CBSA	45%
Tarzana CBSA	31%
Broader Holy Cross SA	22%
Broader St. Joseph SA	39%
Broader Tarzana SA	20%
Los Angeles County	27%

Data Source: Core Health Indicators: Holy Cross, St. Joseph, and Tarzana Medical Centers. Custom report of results from the 2015 Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

Chronic disease

Chronic diseases and conditions—such as heart disease, stroke, cancer, type 2 diabetes, obesity, and arthritis—are among the most common, costly, and preventable of all health problems. The Centers for Disease Control and Prevention estimate that as of 2012, about half of all adults—117 million people—had one or more chronic health conditions and one of four adults had two or more chronic health conditions. Additionally, seven of the top 10 causes of

Percent of adults ever diagnosed with diabetes	
Holy Cross CBSA	9.6%
St. Joseph CBSA	8.3%
Tarzana CBSA	*8.4%
Broader Holy Cross SA	7.6%
Broader St. Joseph SA	5.9%
Broader Tarzana SA	9.7%
Los Angeles County	9.8%

Diabetes-related hospital admissions (per 10,000 population)	
Holy Cross CBSA	15.4
St. Joseph CBSA	16.5
Tarzana CBSA	14.3
Broader Holy Cross SA	9.0
Broader St. Joseph SA	7.3
Broader Tarzana SA	8.8
Los Angeles County	15.8

Percent of adults ever diagnosed with hypertension	
Holy Cross CBSA	26.3%
St. Joseph CBSA	19.0%
Tarzana CBSA	23.6%
Broader Holy Cross SA	25.8%
Broader St. Joseph SA	22.5%
Broader Tarzana SA	26.5%
Los Angeles County	23.5%

Hypertension-related hospital admissions (per 10,000 population)	
Holy Cross CBSA	6.1
St. Joseph CBSA	6.7
Tarzana CBSA	5.2
Broader Holy Cross SA	3.2
Broader St. Joseph SA	3.8
Broader Tarzana SA	3.1
Los Angeles County	5.5

Note: * Statistically unstable estimate, should be interpreted with caution. Data Source: Core Health Indicators: Holy Cross, St. Joseph, and Tarzana Medical Centers. Custom report of results from the 2015 Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

death in 2010 were chronic diseases. Two of these chronic diseases—heart disease and cancer—together accounted for nearly 48 percent of all deaths.

Of the service areas, the Holy Cross Community Benefit Service Area has the highest percentage of adults ever diagnosed with diabetes and the St. Joseph Community Benefit Service Area has the highest percentage of diabetes-related hospital admissions (per 10,000 population). The Broader St. Joseph Service Area has the lowest percentage of both adults diagnosed with diabetes and diabetes related hospital admissions.

When looking at indicators related to hypertension, one finds that the St. Joseph Community Benefit Service Area has the lowest percent of adults ever diagnosed with hypertension and the highest percent of hypertension-related hospital admissions (per 10,000 population); suggesting issues with underdiagnosis and access to primary care. In the Broader Tarzana Service Area

the opposite case is presented. This area had the highest percentage of adults ever diagnosed with hypertension and the lowest percentage of hypertension-related hospital admissions. This finding may suggest, that those who were diagnosed, were caught early and connected with the proper resources and education to promote self-care after diagnosis.

Sexually transmitted infections

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

	Holy Cross Community Benefit Service Area	St. Joseph Community Benefit Service Area	Tarzana Community Benefit Service Area	Broader Holy Cross Service Area	Broader St. Joseph Service Area	Broader Tarzana Service Area	Los Angeles County
Incidence of HIV (annual new cases per 100,000 population) among adolescents and adults (ages 13+ years)	13.1	**22.7**	19.0	7.0	12.2	**6.0**	20.7
Incidence of primary & secondary syphilis (annual new cases per 100,000)	13.1	**21.0**	12.1	**5.9**	11.7	6.3	14.3
Incidence of gonorrhea (annual new cases per 100,000 population)	117.0*	**168.0**	122.0	**52.1**	103.3	58.6	165.1
Incidence of chlamydia (annual new cases per 100,000 population)	**536.6**	476.3	417.8	**257.0**	309.4	285.3	532.1

Note: * Statistically unstable estimate, should be interpreted with caution. Data Source: Core Health Indicators: Holy Cross, St. Joseph, and Tarzana Medical Centers. Custom report of results from the 2015 Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

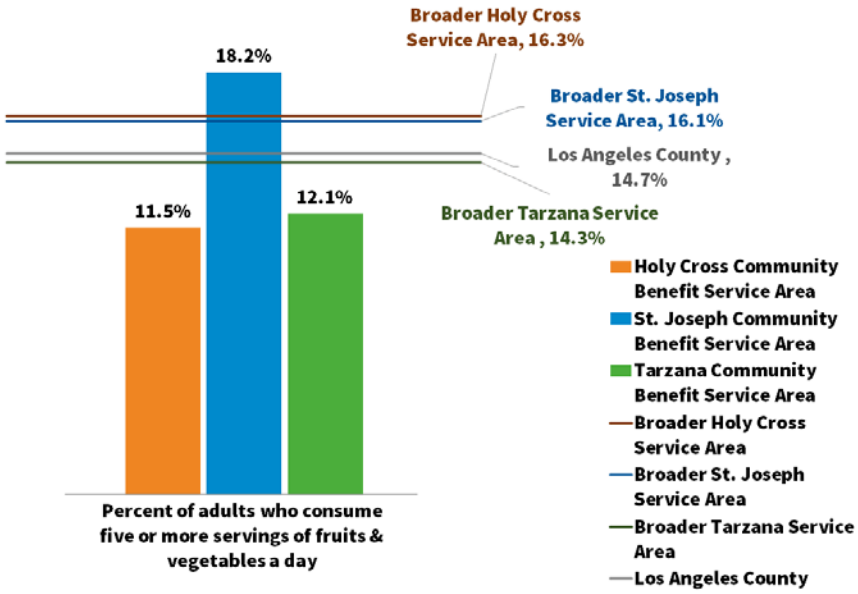
The St. Joseph Community Benefit Service Area has the highest rates for new cases of HIV, syphilis, and gonorrhea, in comparison to the other Service Areas. Comparatively, the Broader Holy Cross Service Area has the lowest rates for new cases of syphilis, gonorrhea, and chlamydia.

Physical activity and nutrition

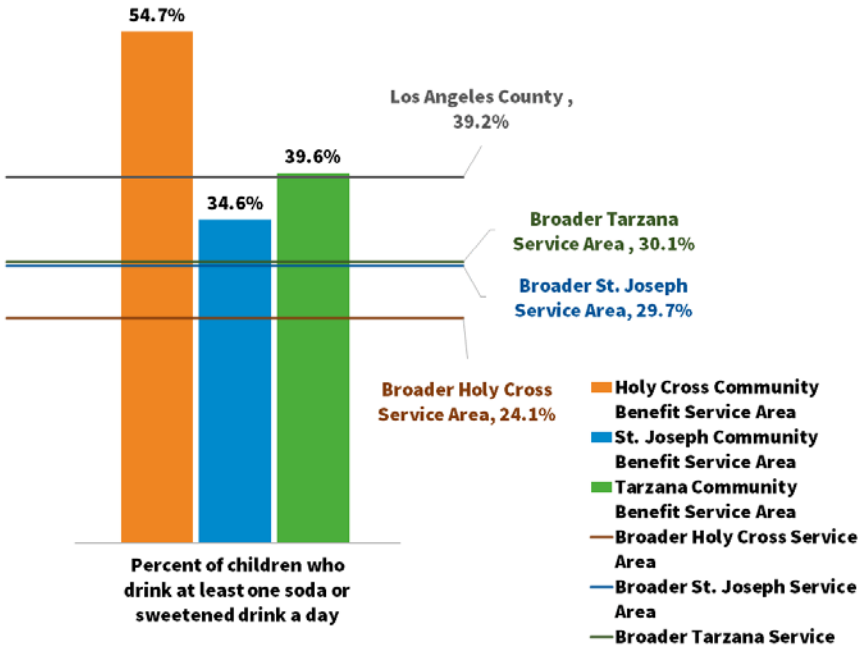
Making healthy food choices is important to losing or maintaining weight and fueling physical activity. When looking at fruit and vegetable consumption among adults and soda consumption among children, one sees a pattern where children's behavior is heavily shaped by their parent's. For example, the Holy Cross Community Benefit Service Area has the highest percentage of children who drink at least one soda per day (55 percent) and the lowest percentage of adults who consume recommeded daily servings of fruits and vegetables (11.5 percent). Similarly, the Broader Holy Cross Service Area has the next highest percentage of

adults meeting recommended dietary guidelines for fruits and vegetables (16 percent) and the lowest percent of children who drink at least one soda per day (24 percent) The figures on the next page detail the estimates for all six areas of comparison for fruit and vegetable consumption by adults and soda consumpation by children.

The St. Joseph Community Benefit Service Area has the highest percentage of adults who consume recommeded daily servings of fruits and vegetables



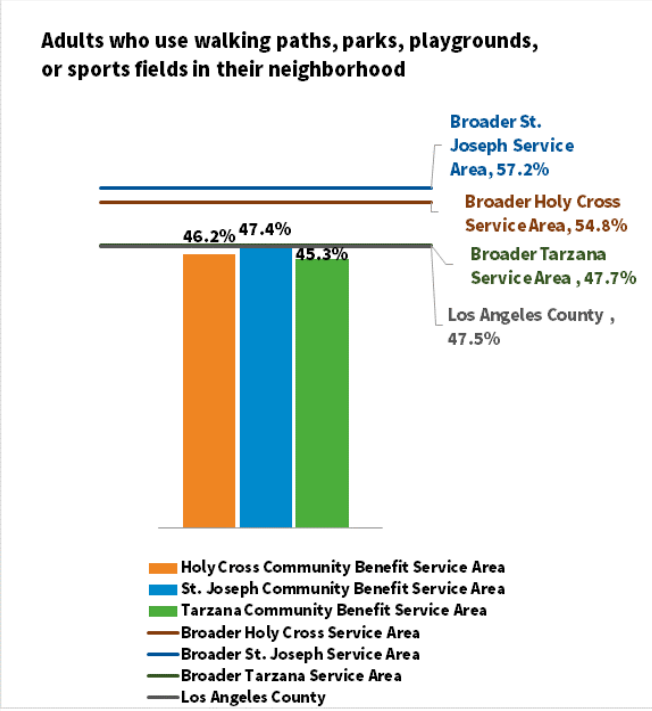
The Holy Cross Community Benefit Service Area has the highest percentage of children who drink at least one soda per day

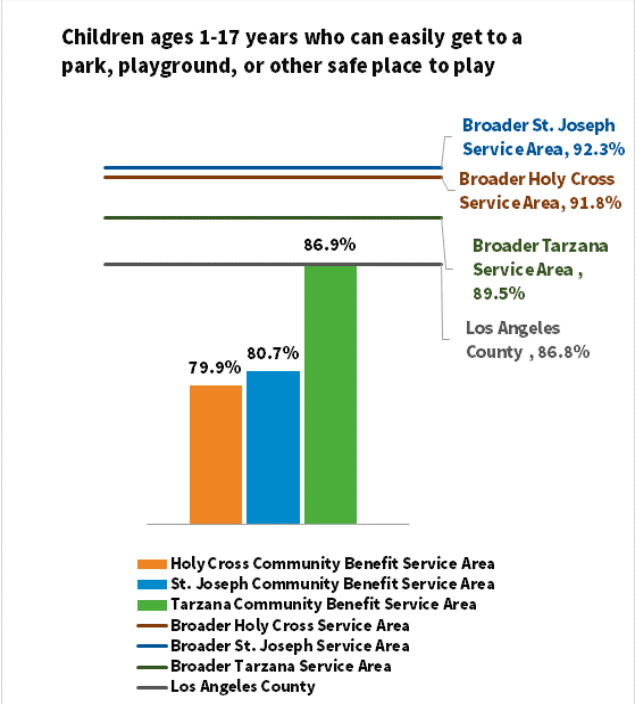


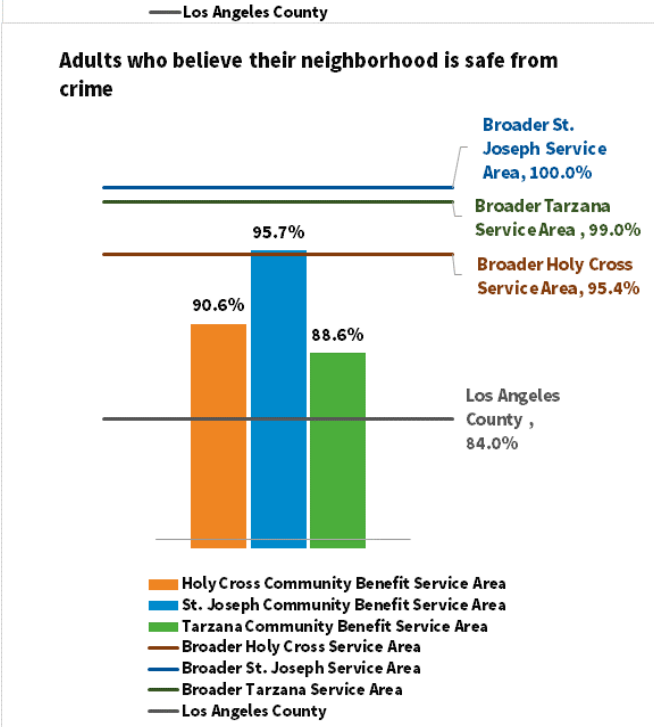
Data Source: Core Health Indicators: Holy Cross, St. Joseph, and Tarzana Medical Centers. Custom report of results from the 2015 Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

Physical environment

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







Data Source: Core Health Indicators: Holy Cross, St. Joseph, and Tarzana Medical Centers. Custom report of results from the 2015 Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

include air quality and exposure to toxic substances, as well as, factors such as the built environment and housing.

The lack of safe, green places to play can affect the health of a community through reduced opportunities to engage in physical activity. According to the latest results from the LA County Health Survey, adults and children in the Broader St. Joseph Service Area have more opportunities to use safe green spaces for physical activity, in comparison to the other service areas. For example, the Broader St. Joseph Service Area had the highest percent of adults and children that used/could easily get to a park or playground and adults who believe their neighborhood is safe from crime.

Other components of the built environment, such as access to quality grocery stores also affect health. When looking at the service areas, one finds that the Holy Cross Community Benefit Service Area has the lowest percent of children with excellent or good access to fresh fruits and vegetables in their community (64.9 percent). Comparatively, the Broader Tarzana Service Area has the highest percent of children with excellent or good access to fresh fruits at 96.7 percent. Without access to quality and affordable grocery stores, many families may experience food insecurity due to a reduction in reduced quality, variety, or desirability of diet.

Children with excellent or good access to fresh fruits and vegetables in their community	
Holy Cross CBSA	64.9%
St. Joseph CBSA	67.3%
Tarzana CBSA	75.7%
Broader Holy Cross SA	91.0%
Broader St. Joseph SA	91.5%
Broader Tarzana SA	96.7%
Los Angeles County	75.0%

Data Source: Core Health Indicators: Holy Cross, St. Joseph, and Tarzana Medical Centers. Custom report of results from the 2015 Los Angeles County Health Survey. Prepared by the Health Assessment Unit at the Los Angeles County Public Health Department.

Primary data

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

Overview

From July to September 2016, on behalf of Providence Health and Services, HC^2 Strategies, Inc. conducted multiple focus groups, key informant interviews, and an internet based survey for community partners. 70 people were surveyed to obtain input from the community in the form of 13 key informant interviews, five focus groups (37), and 20 people responded to the community based organization survey.

Focus Group Name	Number of Participants	Description	Location	Language
Mental Health Focus Group - August 24	10	Participants of coping skills and resilience workshop series	Meet Each Need with Dignity (MEND) 10641 San Fernando Rd, Pacoima, CA 91331	Spanish
Mental Health Focus Group - August 24	11	Participants of coping skills and resilience workshop series	Meet Each Need with Dignity (MEND) 10641 San Fernando Rd, Pacoima, CA 91331	Spanish
Welcome Baby - August 31	9	Mothers who have received services from Welcome Baby	1600 Indian Hills Rd. Mission Hills, CA 91345	Spanish/ English
Seniors - September 13	7	Participants in outreach program who receive counseling and social support at home and assistance with transportation to appointments and shopping	17400 Victory Blvd, Van Nuys, Ca 91406	English

Principals - September 20	3	Catholic school principals at partner schools that are currently receiving screening and counseling services	English

Objectives

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

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

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

Findings by Themes

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

Background and Service Area

The focus groups begin with introductions of the participants, which included city of residence and one point of pride in the community in which they reside. The majority of the participants in the focus group stated Pacoima (13), North Hills (6), and Reseda (6). Of the various responses offered regarding pride of the community, the availability of resources (9), sense of community (7), and convenience (proximity to shopping and gathering places) were the most frequently mentioned. Other frequently commented points of pride were church (4) and calmness (3).

One thing I like about my community is that the building where I live at, we have all lived there for many years and we know each other. I have seen how in the building, we all help each other and it is because we know each other. I have lived there since I was 15 years old and now I have my kids there. I think that knowing each other makes us feel good in our community.

I am proud that there are many resources for low income individuals and individuals who need special assistance. I have access to information and resources that is really helping me, and my family.

A community that strives for excellence that works together to provide every child with the best they can give them.

Additionally, the key informant interviews and surveys requested information about the participants' background and area of service. For the key informant interviews and surveys, San Fernando Valley was mentioned most often. Some also specified Los Angeles county (5) and SPA 2 (5). The majority of the key informant respondents were in health and health care (5). However, an equal number were representing social services (4) and community organizations (4), along with education (2).

The surveys provided information regarding the purpose of their organization in the community and the populations served by their organization. Health care services (4) was the most commonly provided service which included dental, prevention education, and primary care. Two organizations provided day programs for special needs people and residential services. Other services represented were employment service, economic development, social services, youth development.

Populations served by the respondents of the surveys included themes of ages, ethnicities, and socioeconomic classes. The majority of the respondents served children under 18 years of age (4), while some served all ages (3), and adults (2). One respondent mentioned service of ages 65 and older with mental and physical disabilities. Latinos (7) were the most common ethnic group being served, followed by all (5), and an even number of Caucasian, Black, and Asian. Most of the services were provided to populations with lower income (5) and some to lower to middle income populations (2).

Vision

The vision of a health community for both focus group and key informant respondents focused around awareness/information and provision/opportunities for all. The focus group responses leaned heavily on provision of services for all people (7), awareness and information about programs and services available (6), safe parks (5), and community centers (2). Others mentioned were cleanliness, transportation, healthy affordable foods, safety, respect, affordable health care, and education.

One of the things that I like to think a healthy community would do is to sort of to keep in touch with people that fall through the cracks, people that live alone, who don't get out very much, who are ill and I think that makes for a healthy community.

I had a very difficult time finding this place but once I found it, I realized that they offered many services. I think that more than often we lack publicity and accessibility…We just need more advertisement in places like the newspaper, wherever you find Latinos that is where we need advertisement so that everyone may have access to services and they are aware.

Access to health care (5), a supportive environment of health (4), and integrated preventive care (3) were the most mentioned visions of a healthy community among the key informant respondents. As in the focus groups, access to health information and awareness and opportunities for all people were commonly mentioned, along with a prioritization of health. Public policy, education, and collaboration among the community were also points to be considered.

People not only have access to good quality health care but also opportunities for physical exercise, buy healthy food, access to fresh produce that is affordable, safety so that there is not an excess crime and other factors that create crime, if people are fearful people are not going to walk, offers good educational opportunities, public transportation, decent jobs so that they can afford health care or have health care provide.

What we are realizing is that health care/health status is more influenced by what happens outside the 4 walls. Lifestyle/environments are far more significant to a person's life expectancy.

Top Issues

The commonly mentioned top health and social issues in the focus groups, interviews, and surveys are below. Following in the theme of provision of services for all, all three respondent groups provided some aspect of these issues.

- Access to health care
- Affordable housing
- Education
- Immigration
- Transportation
- Homelessness
- Crime
- Mental health
- Language barriers
- Access to healthy foods
- Resources and care for seniors
- Chronic Illness
- Income
- Safety

The responses from the focus groups most frequently mentioned access to healthy foods (9), access to health (6), education (5), behavioral health (4), awareness of services (3), unsafe environments (3), and drugs (3) as health and social issues in the community.

Knowledge of what is healthy. Not eating Hot Cheetos and Takis for breakfast and why we do that. What is the difference between organic and nonorganic and why we make healthy choices now for the long-range effect, long-term effect as opposed to "because an adult told me to".

People don't go the clinic because it's too costly, not enough time, can't take time off…

I understand that it's [marijuana] legal now and I understand that there are organizations where you can buy it legally but I think when there are children, sick people, or people who do not use drugs...in this case our children or kids, I am concerned for my children and other children.

Other responses included, chronic illness such as diabetes and obesity, stigma surrounding asking for help and counseling, improper dumping and cleanliness, lack of insurance, and vandalism.

Similar to some of the responses of the focus groups, the responses of the interviews focused on financial resources (13) and chronic illness (9). Housing (5), sufficient resources (5), wages (4), healthy environments and food (4), education (4), transportation (3), language barriers (3), immigration (3), health services (3), and health insurance (2) were also commonly mentioned health and social issues. In addition, dental care, information to the community, and cultural context were mentioned.

> *People don't have money. When we think about what the social component is a lot of the population consists of immigrant central and south America. Underserved community people who are essentially poor. Very limited educational attainment, lack of education and lack of financial resources are two of the biggest barriers we see in the community.*
>
> *The biggest health issue is the chronic illnesses that become, that are untreated, and undiagnosed for many years within the subcategory or subpopulation are arriving at the emergency room at a point where there needs to be an abdication.*
>
> *There's services such as providing food, or clothing, shelter any of those services. I think that there's a desperate need for services, like utility assistance and those kind of services. Rental assistance.*

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

Rank	Health or social issue	Responses
1	Mental health services (including substance abuse services)	13
2	Help navigating assistance programs	9
3	Economic opportunities and job growth	8
4	Access to health care	7
5	Health education and outreach	6
	Poverty	6
	Health insurance	6
	Dental care	6
	Access to healthy foods	6
	Early childhood education/daycare	6
	Other (Affordable Housing)	6

Societal Factors and Needs

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

mentioned factors in both the focus groups and key informant interviews. In the focus groups, youth services (3), safe housing (2), enjoyable activities for parents (2), and afternoon childcare (2) were mentioned the most. Some also provided comments on bed bugs, information on resources, need for community conversations, health aids, home based care, and massages. Health aids included someone other than a counselor and maybe another nurse who can assist the current school nurse with rashes, pink eye, fever, temperature, cut, infection, etc. Possibly someone once a week to support the nurse.

> *Well I would suggest that we need assistance with helping the youth. My concern is about helping the youth. It's not about us anymore, we have already lived out lives but the youth...we need to find help for them. I would like it if there was a center where the youth could be helped. I would like a program for the youth who have mothers who are forced to work long hours and to help them with their rent, food, and their children's schools.*
>
> *It would be better if these buildings were better controlled and monitored. What do you do in cases like that like the one of this lady where the manager is abusing the rights of the tenants and the safety of the unit; What are other alternative options where they can call to get resources in order to have order and control. Not just that, but also rights as an individual as a renter and the rights that our children have.*

Reponses from the interviews illuminated low income (4), immigration (4), mental health and behavioral health (3), and affordable housing (3) as societal factors that have influence on the issues in the community. Education (2), jobs (2), and generational differences (2) of culture and language were also mentioned as factors. Public policy, homelessness, lack of access to information, and fear of deportation or stigma are also reoccurring factors mentioned in this section.

> *We put ourselves in community that are in need purposefully to try to address those needs so indeed what we are seeing are some health issues. Certainly economic issues and particularly in the communities that we're in—immigration issues.*
>
> *I mean especially with the older adult population. A lot of them grew up with the mentality of, "I don't need to ask for help, it's wrong to ask for any kind of assistance and help, I can do things myself." And kind of, I'm too proud to be asking for assistance.*
>
> *Language barriers really, kinda is a really big problem here in the Valley, because we have a lot of people specifically in the Reseda area who speak Farsi, Armenian, Russian. And there's just this kind of lack of communication where we really can't have, you know, greater understanding of what their needs are because of that. That language barrier.*

In order to feel physically and emotionally fit in the community, respondents of the focus group need therapy (4), especially group therapy "*Groups that get together to socialize, to share, this helps you out emotionally"*, nutritional classes (2), and programs for older people (2) "*a place where they can go along with your rhythm for the older people."* Others agreed with this statement and added comments about a place and program catered to older people which focuses on their diet and nutrition and diabetic care.

Other needs mentioned included programs for children, health programs, workshops, church, community centers, clinics, and dental care.

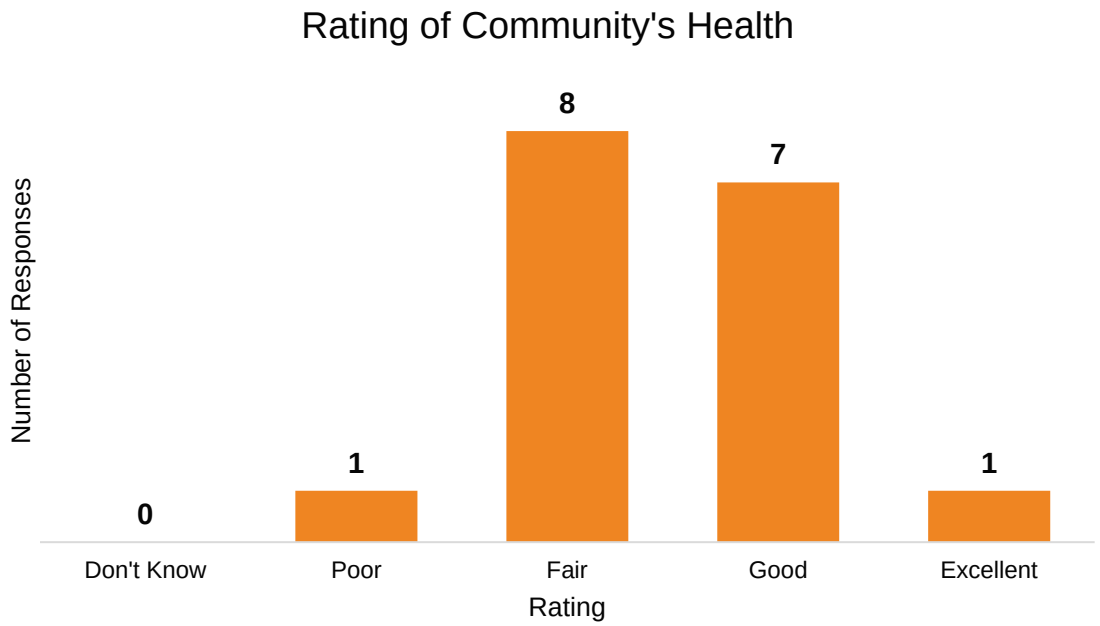
The aspects of a community which contribute to people's health in a positive way were provided by the survey responses. Accessible parks (7), resources for health care (5), community organizations (4), and safe learning environments (3) were among the most frequently mentioned positive aspects. Farmers' market, volunteerism, job training, libraries, food services, church, and affordable housing were also mentioned.

> *In the community they allow for the opportunity to engage in physical activities; be it walking or running along the park path, or doing organized sports on the soccer or baseball fields. There is also an esthetic aspect to our local parks that adds to the health of a community as well.*

The most frequently mentioned aspects of a community which contribute to people's health in a negative way were crime (5) including bullying, graffiti, speeding, and youth safety, lack of education or educational preparedness (2), lack of access to affordable health care (2), homelessness (2), and poverty (2). Others also provided lack of affordable childcare, lack of quality parks, lack of information, lack of or access to nutrition, transportation, poor mental health, severe heat, and lack of resources.

> *Crime can affect a community in a negative way. It can also divide us from our neighbors, making us feel that the best alternative is to operate in a protective silo. Those who deal with crime by banding together through neighborhood groups can turn the negative into a positive.*

The responses of the survey also included a rating of the health of the community. The results are in the figure below. The majority of the respondents felt the community's health was fair, followed by good. Only one respondent felt it was excellent and one rated poor.



Challenges

The challenges and barriers in addressing issues the community faces were included in the responses of the key informant interviews and focus groups. Information or awareness was the common theme. The interview respondents most frequently mentioned income (3), access to

health care (2) including prescriptions and issues for undocumented populations, information and understanding (2), and resource alignment (2) as the challenges in addressing community health issues. Other comments focused on urban versus rural disparities, access to mental health, insurance, chronic disease, homelessness, and retention in health and programs.

> *There's always lots of people who want to help. People will engage us, we engage people. But I think the problem is, is just the alignment of that. We are understaffed in terms of doing all of the multiple tasks that we all do. And I'm sure the hospitals and different organizations are as well. So, I think when we all want to help and do things, I think the part where we struggle of it is the alignment of it.*

> *Another thing that we tend not to think about a lot in Southern California is sort of rural versus urban opportunities. And I think in rural settings, we see for…across the board sometimes there's a racial/ethnic disparity, but there are these urban/rural disparities that result in poorer outcomes among Whites who are, may be low income or less educated.*

The focus group responses provided awareness of services and resources (6) and no childcare during the programs (5) as the barriers for reaching the needs in the community. In addition, technology, applications, incomplete care or services, money, and transportation were mentioned as other barriers.

> *Very often, parents not knowing what resources are there for them free, even for dental, maybe we need to do more marketing and maybe tell the parents in meetings.*

Effect

The focus groups and key informants were asked about the effect the unmet needs have on the community and populations which receive a disproportionate amount of pressure from the unmet needs. A few respondents felt that everyone feels the effect and there are no specific populations, while others provided children, low income, and Latinos as the most affected populations. The focus group respondents felt that unmet needs can affect everyone including children. Stress, frustration, tense environments, and poor nutrition of school children as effects societal factors and needs can have when unsatisfied.

> *Being stressed creates a tense environment and the kids are the ones that feel it and that is why they grow and they ignore our attention.*

The key informant responses focused on Latinos (6), low income (5), African Americans (4), and homeless (4) as the most affected populations. Undocumented populations, older adults, and Asian-Pacific Islanders were also commonly mentioned. Although only mentioned by one respondent each, these populations are also affected, Armenian, mental health, uninsured, and victims of intimate partner violence.

> *Those individuals that have, that come from underserved families, they don't really…there's a lot, there's a language barrier, there's transportation barriers they don't really know the resources available to them.*

Resources and Strategies

The existing resources and assets in the community to address the health and social issues

above and strategies needed in the community are provided by the respondents in this section. The respondents of the key informant interviews felt community organizations (7) such as LA Family Housing and Burbank Temporary Aid, and education (2) such as LA Unified were existing assets in the community. Uniquely mentioned were the political community, insurance enrollment services, and the church.

> *A number of organizations already working together. Neighborhood legal services a non-profit service, partner with them for legal issues that are impacting health. Landlord issues such as asthma, cockroaches, mold or something like that and in order to control the asthma you have to remove the environmental Issue and work with landlords and encourage to maintain safe/clean housing for people.*
>
> *Where the foundation has tried to support local community assets. We think of the various trusted networks which we can cooperate and advance in the political or community will.*

The focus group respondents felt classes and programs (3), awareness of the programs (2) and jobs (1) were needed. Classes included abuse treatment programs (6), nutrition (4), parenting (3), computers (2), English for Second Language learners (2), weekend and extended hours programs (2), counseling, and church activities. An interesting topic derived from the focus group responses was the idea of a mobile clinic which could provide vaccinations, dental care, CPR courses, and available in the morning while children are in school.

> *Sometimes it is the talks that we need so they take us from that error that we are in. They are simply talks but we know that when it is that, violence, then you need to look for help. We can't let the world close on us. Sometimes those places are close, and many live there but like a woman, you can move forward.*
>
> *Having maybe to do some things such as TB testing or mobile clinic to be checking and trying to at those time and bring homeless clients along and how they can receive affordable health care.*

Strategies for satisfying the needs of the community included providing information related to health care and resources (2) and improvements in transportation and Cal-Fresh, and help with daily activities for seniors. One respondent of the survey mentioned the need for continuity of care as a strategy for creating a healthy community.

> *The health care system remains somewhat disconnected from social support programs that can help to reduce re-admissions. In a more ideal health care system, hospitals would be more naturally and seamlessly connected to community-based non-profits that provide preventive/supportive health services including day-to-day social services. This would create an environment for a healthier community.*
>
> *The biggest challenge is what services are available, social services, financial services, health care services, medical services. If you could put together some information guide for most of the people, that would be a great service, then you could talk about improvement of those services.*

Partnerships

System-level partnerships which could help address the issues in the community were mainly focused on care coordination (9) among the respondents of the interviews. Technology (3) and

preventive care (2) were also commonly mentioned. Reoccurring points were collaborating around public policy advocacy, homelessness, and visible support in the community. Although few specific organizations were mentioned, the idea of coordinating care with various community entities was apparent.

> *It's about we stand together and we work together and we're integrated in the work we do. To me, just being visible, remaining a partner. Being an engaged partner. Somebody who's there and working on our campuses.*
>
> *It's just too difficult to have inconsistency [in providing services]. Because most of the individuals that come through here have inconsistencies in their lives already. Obviously with food or money or whatever the case may be. And we're just providing another inconsistent service which is their health care.*

Gaps in Health care

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

ACCESS TO PRIMARY AND SPECIALTY CARE	Children (0-17)	Adult (18-64)	Senior (65+)
1	Dental care that is affordable (6)	Acute mental health services (8)	Acute mental health services (7)
2	Acute mental health services (5)	Dental care that is affordable (6)	Dental care that is affordable (6)
3	Primary care medical services (5)	Specialty medical services (6)	Homecare, hospice, long-term care (6)

WELLNESS EDUCATION	Children (0-17)	Adult (18-64)	Senior (65+)
1	Self-care education programs after diagnosis (7)	Mental health education/coping skills (8)	Education about navigating the health care system (11)
2	Mental health education/coping skills (7)	Education about navigating health care system (7)	Mental health education/coping skills (9)
3	Education about navigating the health care system; nutrition skills education; physical activity/physical fitness; substance abuse prevention programs (4)	Physical activity/physical fitness; substance abuse prevention programs (6)	Self-care programs after diagnosis (8)

CONNECTING	Children (0-17)	Adult (18-64)	Senior (65+)

PEOPLE TO SERVICES			
1	Cultural and language barriers to obtaining health care (9)	Cultural and language barriers to obtaining health care (8)	Services that allow seniors to live at home (7)
2	Access to medical services outside of regular business hours (6)	Sliding scale or free services for low-income (6)	Cultural and language barriers to obtaining health care (6)
3	Affordable housing (5)	Affordable housing; Access to medical services outside of regular business hours (5)	Affordable housing (6)

One respondent provided this quote in the other option of this question.

> *The critical piece that most clinical/health organizations miss is preventive/supportive care. Mindset and funding streams are entrenched in reactive clinical/based care. That your survey doesn't list preventive health as something that's needed suggests it is not as much on your radar as it should be. Practical supportive health programs keep people healthy, save systems money, and make for a healthier community. In California, there is a lack of investment in community-based preventive health in general for seniors.*

Additional Comments

The respondents of the focus groups, key informant interviews, and surveys provided final comments. Although there were not many similarities among the responses, a theme of partnership and coordination was mentioned. The focus group respondents focused on police vigilance (3) in the communities, parenting classes (2), and counseling (2). Others suggested the need to promote current services, data/technology needs, home education, and funding as additional points of need.

> *More vigilance by the police because in one occasion, a family became intoxicated in the building I live at, and I felt anxious and annoyed. The dad would yell "my son is dying, my son is dying" and the ambulance wouldn't come. I felt that the hours were eternal. And the mom was just in bed, intoxicated. I felt that it was hours and that there was not help.*

Care coordination and partnerships (4), low income challenges (3) such as fresh food access and housing, and access (3) such as expansion of services, provider shortage, and social service assistance were the frequently mentioned additional comments in the interviews. Immigrants and violence and resource availability were also mentioned.

Well, in a perfect world it would be great if I had a staff that just specifically goes to hospitals and works with the case manage/discharge planning/case management department on linking them with services. You know, prior to being discharged. In a perfect world, home health agencies would have access and knowledge to referring people to community based organizations.

Access is a big issue, looking to increase bricks and mortar. Develop a way for social services that help us access but then have navigators, care coordinators, people that can help them plug them into resources.

The open-ended questions on the surveys gave the respondents the opportunities to leave additional comments. These included a connection of services (2) and affordable housing.

Umbrella organization that connects all services in the valley for easy referrals.

For senior services, invest more in community-based non-profits that can work with hospitals in a supportive way - create a working partnership between clinical/medical system and social services system. Ask CMS for grant funding towards a more seamless service system.

Identified priority health needs

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

Priority health issues and baseline data

On November 10, 2016, board members of the Oversight Committee met to debrief on the findings of the CHNA and prioritize the identified needs. The table below describes the top needs identified and the rationale for selections.

Priority Health Issue	Rationale/contributing factors
Access to healthcare and resources • Enrollment services • Health navigators • Culturally sensitive services • Affordable housing and homelessness*	• Issues with access to care, navigating the system, or other social resources were among the top barriers mentioned by key informants, focus group participants, and community based organizations. • Key informants consistently cited a need for more health education and outreach to ensure client access to and use of services. The need for health navigator type services in combination with medical care was also expressed. • Cultural and language barriers to obtaining health care was the top issue for children and adults and second top issue for seniors, selected by partners on the Community Based Organizations Survey. • Language barriers and services for undocumented populations was mentioned frequently by key informants. • Housing cost burden is about 56 percent across all three Community Benefit Service Areas. In comparison, about 50 percent of households across the Broader Service Areas spend 30 percent or more of their income on housing. • Safe and affordable housing was mentioned by both focus group participants and key informants as a major social issue in our community. • SPA 2 (San Fernando Valley) has the third largest homeless population, in comparison to the other SPAs. • The 2016 Greater Los Angeles Homeless count estimated a total of 7,094 total homeless persons on a night in 2016. 1,431 were sheltered (20%) and 5,663 (80%) were unsheltered. • From 2015 to 2016, SPA 2 experienced a 36% growth in the number of homeless.

Priority Health Issue	Rationale/contributing factors
Crime and community safety	• The most frequently mentioned aspects of a community which contribute to people's health in a negative way were crime including bullying, graffiti, speeding, and youth safety. • Key informants and focus group participants frequently mentioned unsafe environments, improper dumping and cleanliness, and access to safe and supportive spaces as drivers of health in our region. • 19.4 percent of adults living in the Broader St. Joseph service area, 18.4 percent of adults living in the St. Joseph Community Benefit service area, and 17.6 percent of adults living in the Broader Holy Cross service area have experienced some form of intimate partner violence. In comparison, 13.4 percent of adults throughout LA County reported experiencing intimate partner violence.
Low educational attainment and income • Early childhood education • Workforce development	• The need for education around financial literacy, resources, job training and quality child care/youth development programs was expressed by key informants, focus group members, and partners through the CBO survey. • Financial resources and chronic illness were the most frequently mentioned health and social issues by key informants. Housing, sufficient resources, and livable wages were also mentioned. • The need for quality child care and youth development programs was expressed by key informants, focus group members, and partners through the CBO survey. The focus group responses provided awareness of services and resources and no childcare during the programs as the barriers for reaching the needs in the community.
Mental health (including substance abuse treatment)	• Mental health was one of the most frequently mentioned health need by key informants, focus group participants, and community based organizations. All participants noted a need for more specialty (substance, trauma, coping skills) and integrated services for all age levels. • Binge drinking among adults was highest in Holy Cross's community benefit service area (16.5 percent), followed by Tarzana's community benefit service area (15.8 percent) and the Broader Tarzana service area (15 percent). In comparison, the percentage of adults throughout LA County reporting engaging in binge drinking is 15.9 percent. • 12.8 percent of adults living in the St. Joseph community benefit service area and 12.3 percent of adults living in the Broader Tarzana service area are at risk for major depression. In comparison, 11.8 percent of adults throughout LA County are at risk for major depression.

Priority Health Issue	Rationale/contributing factors
Poverty and food insecurity	• Poverty and the associated consequences were mentioned frequently by key informants. • An average 20 percent of households across the Community Benefit Service Areas and an average of 9.5 percent of households across the Broader Service Areas are living below the federal poverty level. In comparison, 18 percent of households throughout LA County are living below the federal poverty level. • All three Community Benefit Service Areas had rates for food insecurity above the County estimate and estimates for Broader Service Areas.
Prevention and management of chronic diseases • Diabetes • Obesity • Physical activity • Nutrition • Health education	• The need for health education on obesity, diabetes, and nutrition were mentioned by key informants as needs among clients. • Access to healthy foods and safe places to play were mentioned by both key informants and focus group participants as needs in the community. • The availability of green space is lowest in Tarzana's community benefit service area, in comparison to other areas in the region. For example, there are 0.57 acres of park areas per 1,000 people in Tarzana's community benefit service area. In comparison, the Broader Tarzana service area has 20.15 acres of park acres per 1,000 people.
Senior care and resources	• Generational differences in asking for assistance and accessing resources were noted as challenges by key informants, when helping seniors obtain health care. • In consideration of health and social needs of the community, focus group participants noted a need for better communication, awareness of resources and connection to those resources, access to transportation for handicapped and elderly people, food delivery for homebound, and access to a trainer for exercise and proper weight training as concerns for older adults. • The St. Joseph total service area has the highest percentage of adults age 65 and older who have fallen in the past year in comparison to other areas (45.1 percent in the community benefit service area and 39.2 percent in the Broader St. Joseph service area). In comparison, 27.1 percent of adults age 65 and older throughout LA County have fallen in the past year.

Note: *Members of the Oversight Committee suggested and adopted "affordable housing and homelessness" as part of an overall strategy to address "access to health care and resources".

Prioritization process and criteria

Following a review of the data, Board members asked clarifying questions prior to separating into two work groups for a deeper dive into the issues and potential priorities. The Committee was broken out into 3 groups with an even mix of Providence staff and Community representatives. Each group represented one of the three Providence Medical Centers in the San Fernando Valley (Holy Cross, St. Joseph and Tarzana). The individuals within each group included Providence staff from their respective hospital along with community representatives who work within that hospital's service area. Jim Tehan, Marie Mayen-Cho and Justin Joe facilitated a discussion of each health need against the criteria and the scores from the 3 groups were added.

Prioritization Matrix

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

Prioritized Needs 2016

Identified Need	Holy Cross Scaled Score	St. Joseph Scaled Score	Tarzana Scaled Score	Final Summed Scaled Score	Final Rank
Access to healthcare and resources • Enrollment services • Specialty services • Medical home • Homelessness and affordable housing**	15	15.625	15.5	46.125	1
Prevention and management of chronic diseases • Obesity • Diabetes • Physical activity • Nutrition • Health Education	14.75	15.625	14.75	45.125	2
Senior care and resources	13.75	13.25	15.5	42.5	3
Mental health services (including substance abuse)	12.75	13.75	13.75	40.25	4
Poverty and food insecurity	13	13	11.75	37.75	5
Low educational attainment and unemployment • Early childhood education • Workforce development	11.75	12	12.75	36.5	6
Crime and community safety	12.25	10.5	13	35.75	7
Affordable housing and homelessness	10.25	12	12.25	34.5	8

After tallying the results, there was discussion on the placement of Affordable Housing and Homelessness. Many Committee members felt that this should be among the top needs addressed by the hospitals. Thus, it was decided to include "Affordable Housing and Homelessness" as a health need that falls under "Access to health care and resources." There was a consensus from the Committee that this would solve their concerns. For more details on the prioritization process and results, please find the Board meeting minutes in the appendix.

Addressing identifed needs

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

Plan development

Providence will consider the prioritized health needs identified through this community health needs assessment and develop a strategy to address each need. Strategies will be documented in a community health improvement plan (CHIP). The CHIP will describe how Providence plans to address the health needs. If Providence does not intend to address a need, the CHIP will explain why[1].

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

The improvement plan will be approved by the Providence Community Ministry Board by May 15, 2017. When approved, the CHIP will be attached to this community health needs assessment report in Appendix V.

Providence prioritized needs

Providence prioritized needs
1. **Access to health care and resources**
2. **Prevention and management of chronic diseases**
3. **Senior care and resources**
4. **Mental health services**
5. **Poverty and food insecurity**

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

Evaluation of impact from 2014-2016 Community Health Improvement Plan

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

Based on a review of the primary and secondary data collected as part of the community needs assessment process, a group of community stakeholders (both within and outside the organization) were invited to review these needs to help the Medical Centers identify the key priority issues. The key needs/issues identified through the assessment and prioritization steps include the following (listed in priority order):

Providence Holy Cross Medical Center	Providence St. Joseph Medical Center	Providence Tarzana Medical Center
1. Expanded primary care capacity.	1. Affordable and expanded services for a growing senior population.	1. Affordable and accessible mental health services.
2. Obesity prevention programs, including more community based nutrition and physical activity programs.	2. Access to affordable primary and specialty care.	2. Diabetes and hypertension screening, management, and prevention programs.
3. Free, low-cost, and culturally/language appropriate health education programs.	3. Expanded primary care capacity.	3. Access to affordable primary and specialty care.
4. Diabetes, heart disease, and hypertension prevention and management programs.	4. Access to affordable mental health services.	4. Affordable and expanded services for a growing senior population.
5. Affordable and accessible mental health services.	5. Coordination of existing programs and services that are culturally and language appropriate.	5. Alcohol and drug abuse treatment and prevention programs.
	6. Heart disease, diabetes, hypertension, and cancer screening and prevention programs.	

The Medical Centers identified specific multi-year community benefit strategies to direct its resources and work with others in achieving unmet needs in the area. The following tables provide an update on progress made over the past year in meeting the measurable metrics targeted for 2015 and 2016.

Providence Holy Cross Medical Center

Priority Need #1-- Expanded primary care capacity and access to affordable health coverage

2015 Implementation Strategy	Measurable Metrics	Status Update
Operationalize the Providence Mobile Health Program	Hire and train the Nurse Practitioner	Nurse practitioner was hired, but the position is currently open.
	Confirm the Medical Director	Medical director confirmed
	Complete church/site agreements	Formal agreements signed for eight sites: 1) Valley Crossroads Seventh Day Adventist Church 2) St. Didacus Catholic Church 3) St. Elisabeth Catholic Church 4) St. Patrick's Catholic Church 5) Our Lady of the Valley Catholic Church 6) St. Mark's Episcopal Church 7) St. Catherine of Siena Catholic Church 8) Canoga Park Presbyterian Church
	Install Epic in the department and complete staff training	Epic installed and staff trained
	Develop promotional materials and begin recruiting patients by June 2015 with a target of 3,500 visits in the 12 months of operation	In addition to having an appointment line, brochures and flyers were made. 381 patient visits from April 2015 to December 2015.
Rollout the Health Insurance Navigation Project/BIEN (Benefits, Information, Educational Networking)	Develop and finalize curriculum for the classes	BIEN (Benefits, Information, Educational Networking) curriculum was developed. 25 staff and volunteers were trained (ten Providence staff and volunteers from a housing project in Pacoima and local churches).
	Conduct 7 sessions of the course series	Due to a lengthy review process, no workshops were conducted in 2015.
	Evaluate results to determine impact	

(Holy Cross Medical Center tables cont.)

2016 Implementation Strategy	Measurable Metrics	Status Update
Explore and implement options for wellness visits, immunizations, and screenings (mobile clinic)	Hire and train staff	We are reconsidering the need for a full-time nurse practitioner and considering a per diem nurse practitioner position. We are exploring with local clinics the feasibility of screening clinics, with referrals to clinics or Federally Qualified Health Centers (FQHCs) based on identified areas where access to primary care is limited. In the meantime, we have developed the concept of a wellness visit, in collaboration with the Cal State University Northridge (CSUN)-sponsored 3WINS program (formerly 100 Citizens). This wellness visit concept is likely due for expansion beyond the current sites.
	Expand to 4 new sites	Guadalupe Center (Catholic Charities) in Canoga Park Lanark Park in Canoga Park San Fernando Park in San Fernando
	Establish baseline wellness visit protocols	Benchmark met
Incorporate new health insurance enrollment unit into BIEN project (Benefits, Information, Educational Networking)	Expand to 10 new sites	We have expanded the BIEN program to 7 additional sites, including churches and schools, through September 2016. We are on target to meet our goal by the end of the year.
	Provide 1,000 individuals with enrollment assistance	115 individuals have been assisted with enrollment into Medi-Cal, including 100 first-time applications and 15 renewals (through September).
	Distribute Satisfaction Surveys	Satisfaction surveys will be distributed at the end of October 2016.

(Holy Cross Medical Center tables cont.)

Priority Need #2— Obesity prevention programs, including more community-based nutrition and physical activity programs

2015 Implementation Strategy	Measurable Metrics	Status Update
Complete the Nutrition Education and Obesity Prevention (NEOP) program at the churches per the requirements of the grant	Complete NEOP classes at the six churches	Providence arranged with another organization to conduct NEOP classes at ten churches: 1) Our Lady of Peace Catholic Church 2) Iglesia Poder De Dios 3) St. Didacus Catholic Church 4) Our Lady of Perpetual Help Church 5) Church of the Foothills 6) Guardian Angel Catholic Church 7) Canoga Park Presbyterian Church 8) Mired Christian Church 9) St. Mark's Episcopal Church 10) The Salvation Army of San Fernando Valley
	Conduct evaluation on the effectiveness of the NEOP project	There was no impact evaluation done in any of the churches as part of the program. However, with some of the nutrition classes, there were evaluations of the program and there was usually an 80% to 90% improvement with knowledge on nutrition by the end of the program.
	Implement policy component of the NEOP project	There were 109 classes, reaching 1,375 people. A garden was set up at St. Didacus Catholic Church. Healthy food and beverage policies were implemented this year at the Church of the Foothills and St. Didacus Catholic Church. A healthy food and beverage policy at Iglesia Poder De Dios is in the process of being done this year.

(Holy Cross Medical Center tables cont.)

2016 Implementation Strategy	Measurable Metrics	Status Update
Work in collaboration with Cal State University Northridge's (CSUN) 100 Citizens Program	Implement wellness visits for adults	We have established a partnership with CSUN, which developed the 100 Citizens program (now 3 WINS). We have established wellness screenings at San Fernando Park and Lanark Park in Canoga Park, which includes point-of-care testing for chronic conditions. We worked in collaboration with the Guadalupe Center in Canoga Park to bring a Summer Camp Program to their center, serving 22 children, ages 5 to 11. We hired a new P.E. Instructor and he conducted the fitness portion of the summer camp.
	Evaluate the impact of wellness visits by measuring A1C levels	We have measured the A1C level of 105 participants of the program (pre-A1C) and are currently in progress of performing the second set of A1C screenings (post-A1C); results should be available by the end of the year. The average pre-A1C for the 105 individuals is 6.17%.
	Identify high-risk adults with chronic conditions, develop physical activity plan, and link to new or existing programs designed to improve physical activity	We discuss physical activity goal-setting with those who enter the 3WINS program and we also have a conversation about readiness to change physical activity patterns and improve eating habits.
	Monitor and track physical activity levels of adults who participate in 100 Citizens or Providence-sponsored events or programs	We are in the process of performing a Fitness test for the 3 WINS participants. We established a baseline and will reassess after 3 months of participation in the program.

(Holy Cross Medical Center tables cont.)

Priority Need #3-- Free, low-cost and culturally/language appropriate health education programs

2015 Implementation Strategy	Measurable Metrics	Status Update
Review curriculum for health education classes offered in the community	Conduct review of the chronic disease classes provided in the community for uniformity and consistency between the outreach programs	A review was conducted.
	Update curriculum to include current information	The curriculum was revised and staff received training on the changes.
Expand the base of volunteers working in the community	Complete Latino Health Promoter training in partnership with CDI and the Guadalupe Center	Health Promoter training was not completed in 2015.
	Determine options for providing rewards / acknowledgements to volunteers who provide significant time to the outreach programs	Annual recognition receptions are scheduled. Volunteers receive certificates of appreciation.
2016 Implementation Strategy	**Measurable Metrics**	**Status Update**
Expand workshops (parenting, women's health, chronic disease management, and others)	Develop a baseline for attendance and the change in knowledge, attitude, and/or behavior by participants	New tracking systems have been developed for attendance, and pre- and post-tests are completed at each workshop.
	Expand to ten new sites	We have expanded our program to 15 new sites, including schools, churches, and housing projects.
Continue to expand volunteer base for the Health Promoter Program	Complete Health Promoter training	The eight-month health promoter training started in September, and it will continue into 2017. There is a total of 32 volunteers currently enrolled.
	Distribute Satisfaction Surveys	Surveys will be completed at the end of the training in 2017.

(Holy Cross Medical Center tables cont.)

Priority Need #4-- Diabetes, heart disease and hypertension prevention and management programs

2015 Implementation Strategy	Measurable Metrics	Status Update
Evaluate the effectiveness of existing and need for additional support groups	Implement ongoing educational component within the Wellness Support Groups	Additional information regarding hypertension and cholesterol has been integrated into four Wellness Support Groups started by Lorena Soria, RN, CDE. A total of 127 persons attended classes. The classes were on-going for persons with diabetes, hypertension, and/or high blood pressure.
	Add two English support groups in the community	No support groups were specifically developed to teach English to community members.
	Add a new support group focused on women's health issues	Two new women's health support groups were added, at Mary Immaculate Catholic Church and Pierce Park Community Center (housing project).
Conduct client surveys with the Faith Community Health Partnership, Latino Health Promoter, and School Nurse Outreach Programs	Develop survey questionnaires to assess which is the best method to provide follow-up communications and the best format to offer educational classes and support groups	Questionnaires developed in collaboration with UCLA research team.
	Distribute surveys to a sample of clients served by the program	Surveys distributed to people at the end of health fair events.
	Compile, review and summarize results	Analysis of results is pending.
2016 Implementation Strategy	**Measurable Metrics**	**Status Update**
Implement and evaluate Diabetes Self-Management Education (DSME) classes and support groups	Provide DSME classes for 5 cohorts (6 classes per cohort)	2 cohorts have been completed as of September. Classes are held in Our Lady of Peace Catholic Church and Santa Rosa Catholic Church.
	Develop a baseline for attendance	Of the two cohorts we have conducted, a total of 34 individuals have completed the 6-class series. The average attendance rate is 95.9%

(Holy Cross Medical Center tables cont.)

Priority Need #5-- Affordable and accessible mental health services

2015 Implementation Strategy	Measurable Metrics	Status Update
Develop the Behavioral Health Outreach Program in partnership with the three Providence Medical Centers	Determine staffing needs and hire staff	Funding was not secured for this program (Behavioral Health Outreach Program).
	Train staff using established curriculum	
	Establish partnership with professionals at the Medical Center to ensure client needs are met	
2016 Implementation Strategy	**Measurable Metrics**	**Status Update**
Continue partnership with Tarzana Treatment Center on the development and expansion of the Mental Health Project	Ensure that grant targets are being met and program components are implemented	The partnership with the Tarzana Treatment Center continues for the development and expansion of the Mental Health Project. Grant targets were met and funding was increased. Targets include: 1) Completing a minimum of 2,222 hours of outreach and education activities (We completed over 2,500 hours). 2) Refer 2-4 clients per month for follow-up to the Tarzana Treatment Center (We met our referral target of 25 clients per year).
	Reach grant target of 2,222 hours per year of outreach and education activities	We have completed 2,343 hours of outreach and education activities through the month of September. We will exceed our goal by the end of the year.

Providence St. Joseph Medical Center

Prioritized Need #1-- Affordable and expanded services for a growing senior population

2015 Implementation Strategy	Measurable Metrics	Status Update
Expand the base of volunteers working in the community --2015 & 2016	Complete the Senior Peer Counseling training to add at least ten new volunteer Peer Counselors to the program	Ten new volunteers were recruited and trained.
	Expand the relationship with the City of Burbank Retired Senior Volunteer Program to increase volunteer referrals to the Volunteers for Seniors Program	We collaborate with the Joslyn Center, a community center for seniors. As part of this partnership, the Center refers to clients to us for our senior counseling program and community residents who are interested in becoming volunteer Senior Peer Counselors.
	Recruit and train 10 new volunteer Peer counselors to the Senior Peer Counseling program	A total of 11 new volunteer peer counselors have been recruited. We will recruit a total of 13 by the end of the year. We have 63 total volunteers.
2016 Implementation Strategy	**Measurable Metrics**	**Status Update**
Evaluate the need for additional support groups in the community	Add a new support group under the Senior Peer Counseling Program focused on women's issues	Two new support groups were started at ONEgeneration Senior Enrichment Center in Reseda.

(St. Joseph Medical Center tables cont.)

Prioritized Need #2-- Access to affordable primary and specialty care

2015 Implementation Strategy	Measurable Metrics	Status Update
Expand the specialty referral network in the Providence Access to Care Program	Add two new specialists to the specialty care network serving Access to Care patients	Four new specialists have been added to the specialist network (Dermatology, Podiatry, Cardiology, and ENT).
2016 Implementation Strategy	**Measurable Metrics**	**Status Update**
Improve tracking and monitoring of service categories and expense	Link children and adults to a safety net medical home through immunization clinics or primary care clinic partnerships	Through our Access to Care program, 470 individuals, have scheduled visits at their new medical home (through September).
	Prepare monthly data reports that summarize unduplicated patients and utilization of specialty fund, including expenses	A new tracking system has been developed to summarize reports of unduplicated patients and utilization of specialty fund, including expenses. A total of 626 referrals were received through September; approximately 50% of the referrals were for specialty care consultations and the rest were for advanced diagnostics. On average, 90% of the referred patients for specialty care kept their scheduled appointment with a physician. A final report will be generated by the end of 2016.

(St. Joseph Medical Center tables cont.)

Prioritized Need #3-- Expanded primary care capacity

2015 Implementation Strategy	Measurable Metrics	Status Update
Operationalize the Providence Mobile Health Program	Hire and train the Nurse Practitioner	Nurse practitioner was hired, but the position is currently open.
	Confirm the Medical Director	Medical director confirmed
	Complete church/site agreements	Formal agreements signed for eight sites: 1) Valley Crossroads Seventh Day Adventist Church 2) St. Didacus Catholic Church 3) St. Elisabeth Catholic Church 4) St. Patrick's Catholic Church 5) Our Lady of the Valley Catholic Church 6) St. Mark's Episcopal Church 7) St. Catherine of Siena Catholic Church 8) Canoga Park Presbyterian Church
	Install Epic in the department and complete staff training	Epic installed and staff trained
	Develop promotional materials and begin recruiting patients by June 2015 with a target of 3,500 visits in the 12 months of operation.	In addition to having an appointment line, brochures and flyers were made. 381 patient visits from April 2015 to December 2015.

2016 Implementation Strategy	Measurable Metrics	Status Update
Explore and implement options for wellness visits, immunizations, and screenings (mobile clinic)	Hire and train staff	We are reconsidering the need for a full-time nurse practitioner and considering a per diem nurse practitioner position. We are exploring with local clinics the feasibility of screening clinics, with referrals to clinics or FQHCs based on identified areas where access to primary care is limited. In the meantime, we have developed the concept of a wellness visit, in collaboration with the CSUN-sponsored 3WINS program (formerly 100 Citizens). This wellness visit concept is likely due for expansion beyond the current sites.

(St. Joseph Medical Center tables cont.)

2016 Implementation Strategy	Measurable Metrics	Status Update
	Expand to 4 new sites	Guadalupe Center (Catholic Charities) in Canoga Park Lanark Park in Canoga Park San Fernando Park in San Fernando
	Establish baseline wellness visit protocols	Benchmark met

Prioritized Need #4-- Access to affordable mental health services

2015 Implementation Strategy	Measurable Metrics	Status Update
Develop the Behavioral Health Outreach Program in partnership with the three Providence Medical Centers	Determine staffing needs and hire staff	Funding was not secured for this program (Behavioral Health Outreach Program).
	Train staff using established curriculum	
	Establish partnership with professionals at the Medical Center to ensure client needs are met	
2016 Implementation Strategy	**Measurable Metrics**	**Status Update**
Continue partnership with the Tarzana Treatment Center on the development and expansion of the Mental Health Project --2016	Reach grant target of 2,222 hours per year of outreach and education activities	We have completed 2,343 hours of outreach and education activities through the month of September. We will exceed our goal by the end of the year.

Prioritized Need #5-- Coordination of existing programs and services that are culture/language appropriate

2015 Implementation Strategy	Measurable Metrics	Status Update
Rollout the Health Insurance Navigation Project/BIEN (Benefits, Information, Educational Networking)	Develop and finalize curriculum for the classes	BIEN (Benefits, Information, Educational Networking) curriculum was developed. 25 staff and volunteers were trained (ten Providence staff and volunteers from a housing project in Pacoima and local churches).
	Conduct 7 sessions of the course series	Due to a lengthy review process, no workshops were conducted in 2015.
	Evaluate results to determine impact	

(St. Joseph Medical Center tables cont.)

2015 Implementation Strategy	Measurable Metrics	Status Update
Conduct client surveys with the Faith Community Health Partnership, Latino Health Promoter, and School Nurse Outreach Programs	Develop survey questionnaires to assess which is the best method to provide follow-up communications and the best format to offer educational classes and support groups	Questionnaires developed in collaboration with UCLA research team.
	Distribute surveys to a sample of clients served by the program	Surveys distributed to people at the end of health fair events.
	Compile, review and summarize results	Analysis of results is pending.

2016 Implementation Strategy	Measurable Metrics	Status Update
Incorporate new health insurance enrollment unit into BIEN project (Benefits, Information, Educational Networking)	Expand to 10 new sites	We have expanded the BIEN program to 7 additional sites, including churches and schools, through September 2016. We are on target to meet our goal by the end of the year.
	Provide 1,000 individuals with enrollment assistance	115 individuals have been assisted with enrollment into Medi-Cal, including 100 first-time applications and 15 renewals (through September).
	Distribute Satisfaction Surveys	Satisfaction surveys will be distributed at the end of October.

Prioritized Need #6-- Heart disease, diabetes, hypertension, and cancer screening and prevention programs

2015 Implementation Strategy	Measurable Metrics	Status Update
Review curriculum for health education classes offered in the community	Conduct review of the chronic disease classes provided in the community for uniformity and consistency between the outreach programs	A review was conducted.
		The curriculum was revised and staff received training on the changes.

(St. Joseph Medical Center tables cont.)

2015 Implementation Strategy	Measurable Metrics	Status Update
Offer additional volunteer and staff resources to improve educational outreach to the community	Provide ongoing education of Latino Health Promoter staff and volunteers on chronic disease including hypertension, cancer and diabetes.	Provide monthly educational workshops for staff and volunteers. Each workshop is 3 hours long, usually with one presenter and one topic. Generally, workshops have between 20-30 participants, consisting of staff and volunteers. Conduct 2 annual seminars for staff to attend. Each seminar is an all-day event with at least 3 presenters and it may include 2-3 different topics. They generally have between 70-80 attendees, including approximately 10 staff, volunteers, and other community members.
	Expand Wellness Support Groups and classes with the assistance of the Certified Diabetes Educators in the Faith Community Health Partnership	Four additional support groups were started by Lorena Soria, RN, CDE, at: 1) St. Catherine of Siena Catholic Church in Reseda 2) St. Patrick's Catholic Church in North Hollywood 3) North Valley Caring Services in North Hills 4) Guardian Angel Catholic Church in Pacoima. We have 10-15 participants per support group. A total of 127 people attended classes. The classes were on-going for people with diabetes, hypertension, and/or high blood pressure.

(St. Joseph Medical Center tables cont.)

2016 Implementation Strategy	Measurable Metrics	Status Update
Work in collaboration with Cal State University Northridge's (CSUN) 100 Citizens Program	Implement wellness visits for adults	We have established a partnership with CSUN, which developed the 100 Citizens program (now 3 WINS). We have established wellness screenings at San Fernando Park and Lanark Park in Canoga Park, which includes point-of-care testing for chronic conditions. We worked in collaboration with the Guadalupe Center in Canoga Park to bring a Summer Camp Program to their center, serving 22 children, ages 5 to 11. We hired a new P.E. Instructor and he conducted the fitness portion of the summer camp.
	Evaluate the impact of wellness visits by measuring A1C levels	We have measured the A1C level of 105 participants of the program (pre-A1C) and are currently in progress of performing the second set of A1C screenings (post-A1C); results should be available by the end of the year. The average pre-A1C for the 105 individuals is 6.17%.
	Identify high-risk adults with chronic conditions, develop physical activity plan, and link to new or existing programs designed to improve physical activity	We discuss physical activity goal-setting with those who enter the 3WINS program and we also have a conversation about readiness to change physical activity patterns and improve eating habits.
	Monitor and track physical activity levels of adults who participate in 100 Citizens or Providence-sponsored events or programs	We are in the process of performing a Fitness test for the 3 WINS participants. We established a baseline and will reassess after 3 months of participation in the program.

Providence Tarzana Medical Center

Priority Need #1-- Affordable and accessible mental health services

2015 Implementation Strategy	Measurable Metrics	Status Update
Develop the Behavioral Health Outreach Program in partnership with the three Providence Medical Centers	Determine staffing needs and hire staff	Funding was not secured for this program (Behavioral Health Outreach Program).
	Train staff using established curriculum	
	Establish partnership with professionals at the Medical Center to ensure client needs are met	
2016 Implementation Strategy	**Measurable Metrics**	**Status Update**
Continue partnership with the Tarzana Treatment Center on the development and expansion of the Mental Health Project --2016	Ensure that grant targets are being met and program components are implemented	The partnership with the Tarzana Treatment Center continues for the development and expansion of the Mental Health Project. Grant targets were met and funding was increased. Targets include: 1) Completing a minimum of 2,222 hours of outreach and education activities (We completed over 2,500 hours). 2) Refer 2-4 clients per month for follow-up to the Tarzana Treatment Center (We met our referral target of 25 clients per year).
	Reach grant target of 2,222 hours per year of outreach and education activities	We have completed 2,343 hours of outreach and education activities through the month of September. We will exceed our goal by the end of the year.

(Tarzana Medical Center tables cont.)

Prioritized Need #2-- Diabetes and hypertension screening, management and prevention programs

2015 Implementation Strategy	Measurable Metrics	Status Update
Review curriculum for health education classes offered in the community	Conduct review of the chronic disease classes provided in the community for uniformity and consistency between the outreach programs	A review was conducted.
	Update curriculum to include current information on preventing and managing chronic illnesses	The curriculum was revised and staff received training on the changes.
Offer additional volunteer and staff resources to improve educational outreach to the community	Provide ongoing education of Latino Health Promoter staff and volunteers on chronic disease including hypertension, cancer and diabetes.	Provide monthly educational workshops for staff and volunteers. Each workshop is 3 hours long, usually with one presenter and one topic. Generally, workshops have between 20-30 participants, consisting of staff and volunteers. Conduct 2 annual seminars for staff to attend. Each seminar is an all-day event with at least 3 presenters and it may include 2-3 different topics. They generally have between 70-80 attendees, including approximately 10 staff, volunteers, and other community members.
	Improve Wellness Support Groups and classes with the assistance of the Certified Diabetes Educators in the Faith Community Health Partnership	Lorena Soria, RN, CDE, conducted screenings and Diabetes Self-Management Education (DSME) at Mary Immaculate Catholic Church in Pacoima and Santa Rosa Catholic Church in San Fernando.

(Tarzana Medical Center tables cont.)

2015 Implementation Strategy	Measurable Metrics	Status Update
	Add two additional Wellness Support Groups and Wellness Education Classes in the community	Four additional support groups were started by Lorena Soria, RN, CDE, at: 1) St. Catherine of Siena Catholic Church in Reseda 2) St. Patrick's Catholic Church in North Hollywood 3) North Valley Caring Services in North Hills 4) Guardian Angel Catholic Church in Pacoima. We have 10-15 participants per support group. A total of 127 people attended classes. The classes were on-going for people with diabetes, hypertension, and/or high blood pressure.

2016 Implementation Strategy	Measurable Metrics	Status Update
Work in collaboration with Cal State University Northridge's (CSUN) 100 Citizens Program	Implement wellness visits for adults	We have established a partnership with CSUN, which developed the 100 Citizens program (now 3 WINS). We have established wellness screenings at San Fernando Park and Lanark Park in Canoga Park, which includes point-of-care testing for chronic conditions. We worked in collaboration with the Guadalupe Center in Canoga Park to bring a Summer Camp Program to their center, serving 22 children, ages 5 to 11. We hired a new P.E. Instructor and he conducted the fitness portion of the summer camp.
	Evaluate the impact of wellness visits by measuring A1C levels	We have measured the A1C level of 105 participants of the program (pre-A1C) and are currently in progress of performing the second set of A1C screenings (post-A1C); results should be available by the end of the year. The average pre-A1C for the 105 individuals is 6.17%.
	Identify high-risk adults with chronic conditions, develop physical activity plan, and link to new or existing programs designed to improve physical activity	We discuss physical activity goal-setting with those who enter the 3WINS program and we also have a conversation about readiness to change physical activity patterns and improve eating habits.

2016 Implementation Strategy	Measurable Metrics	Status Update
	Monitor and track physical activity levels of adults who participate in 100 Citizens or Providence-sponsored events or programs	We are in the process of performing a Fitness test for the 3 WINS participants. We established a baseline and will reassess after 3 months of participation in the program.
Implement and evaluate Diabetes Self-Management Education (DSME) classes and support groups	Provide DSME classes for 5 cohorts (6 classes per cohort)	2 cohorts have been completed as of September. Classes are held in Our Lady of Peace Catholic Church and Santa Rosa Catholic Church.
	Develop a baseline for attendance	Of the two cohorts we have conducted, a total of 34 individuals have completed the 6-class series. The average attendance rate is 95.9%

Prioritized Need #3-- Access to affordable primary and specialty care

2015 Implementation Strategy	Measurable Metrics	Status Update
Operationalize the Providence Mobile Health Program --2015	Hire and train the Nurse Practitioner	Nurse practitioner was hired, but the position is currently open.
	Confirm the Medical Director	Medical director confirmed
	Complete church/site agreements	Formal agreements signed for eight sites: 1) Valley Crossroads Seventh Day Adventist Church 2) St. Didacus Catholic Church 3) St. Elisabeth Catholic Church 4) St. Patrick's Catholic Church 5) Our Lady of the Valley Catholic Church 6) St. Mark's Episcopal Church 7) St. Catherine of Siena Catholic Church 8) Canoga Park Presbyterian Church
	Install Epic in the department and complete staff training	Epic installed and staff trained
	Develop promotional materials and begin recruiting patients by June 2015 with a target of 3,500 visits in the 12 months of operation.	In addition to having an appointment line, brochures and flyers were made. 381 patient visits from April 2015 to December 2015.

(Tarzana Medical Center tables cont.)

2016 Implementation Strategy	Measurable Metrics	Status Update
Explore and implement options for wellness visits, immunizations, and screenings (mobile clinic)	Hire and train staff	We are reconsidering the need for a full-time nurse practitioner and considering a per diem nurse practitioner position. We are exploring with local clinics the feasibility of screening clinics, with referrals to clinics or FQHCs based on identified areas where access to primary care is limited. In the meantime, we have developed the concept of a wellness visit, in collaboration with the CSUN-sponsored 3WINS program (formerly 100 Citizens). This wellness visit concept is likely due for expansion beyond the current sites.
	Expand to 4 new sites	Guadalupe Center (Catholic Charities) in Canoga Park Lanark Park in Canoga Park San Fernando Park in San Fernando
	Establish baseline wellness visit protocols	Benchmark met

Prioritized Need #4-- Affordable and expanded services for a growing senior population

2015 Implementation Strategy	Measurable Metrics	Status Update
Expand the base of volunteers working in the community --2015	Complete the Senior Peer Counseling training to add at least ten new volunteer Peer Counselors to the program	Ten new volunteers were recruited and trained.
	Continue to expand the relationship with the ONE Multigenerational Center regarding services for seniors	Two new support groups were started at ONEgeneration Senior Enrichment Center in Reseda.
Evaluate the need for additional support groups in the community --2015	Develop an additional support group for seniors in the PTMC service area	New support groups are conducted at ONEgeneration Senior Enrichment Center in Reseda.
2016 Implementation Strategy	**Measurable Metrics**	**Status Update**
Expand the base of volunteers working in the community --2016	Recruit and train 10 new volunteer Peer counselors to the Senior Peer Counseling program	A total of 11 new volunteer peer counselors have been recruited. We will recruit a total of 13 by the end of the year. We have 63 total volunteers.

 (Tarzana Medical Center tables cont.)

Prioritized Need #5-- Alcohol and drug abuse treatment and prevention programs

2015 Implementation Strategy	Measurable Metrics	Status Update
Develop partnership with UCLA around alcohol and drug abuse prevention outreach programs	Complete and submit grant proposal with UCLA on alcohol and chemical dependency outreach	Proposal was submitted to NIH. Not funded. Resubmitted in 2016.
Latino Health Promoter Program to conduct education in the community focused on alcohol and chemical dependency issues	Offer eight educational sessions in the community by Latino Health Promoter staff on alcohol and chemical dependency prevention and treatment	Was not offered (lack of funding).

2016 CHNA approval

This community health needs assessment was adopted on December 15, 2016 by the Valley Service Area Community Ministry Board. The final report was made widely available on December 31, 2016.

Vic Georgino
Chair, Valley Service Area Community Ministry Board

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

Dale Surowitz
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Appendices

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

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

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

Organization Type	Organization	Description	Address	City	Zip
Child development	New Horizons	New Horizons is a non-profit organization dedicated to helping individuals with special needs reach their potential and fulfill their dreams. Founded in 1954 by eight parents whose children had special needs, the agency has evolved to provide services and support each year to more than 1,000 individuals (age 18 and older) and social/recreational services to nearly 3,000 individuals from throughout the greater San Fernando and Santa Clarita Valleys of Los Angeles.	15725 Parthenia St.	North Hills	91343
Domestic Violence	Domestic Violence Center of Santa Clarita Valley	The DVC of SCV provides emergency shelter and an outreach center to victims of domestic violence. We work to break the cycle of abuse with crisis intervention, counseling, and support groups.	23780 Newhall Ave	Newhall	91321

Organization Type	Organization	Description	Address	City	Zip
Domestic Violence	Glendale YWCA Domestic Violence Project - Glendale, CA	YWCA Glendale strives to address domestic violence by providing emergency shelter, support services, legal assistance, therapeutic services, education and outreach.	75 E Lexington	Glendale	91206
Domestic Violence	Haven Hills	Haven Hills provides safety, shelter, and support to all victims of domestic violence while working to break the cycle of abuse. We save lives, inspire change, and transform victims to empowered survivors.	If you need immediate help, please call 911 or the Crisis Line at 818. 887.6589. If you are looking for a DV support group, please call 818.887.7481 for more information.		
Education	Los Angeles Unified School District, Local District Northwest	School district serving students in the Northwest San Fernando Valley Region.	6621 Balboa Blvd	Van Nuys	91406
Education	Sepulveda Middle School	School	15330 Plummer St	North Hills	91343
Education	Guardian Angel Catholic School	School	10919 Norris Ave	Pacoima	91331
Education	Mary Immaculate Catholic School	School	10390 Remick Ave	Pacoima	91331
Education	Our Lady of the Holy Rosary School	School	7802 Vineland Ave	Sun Valley	91352
Education	St. Didacus Parish School	School	14325 Astoria St	Sylmar	91342

Organization Type	Organization	Description	Address	City	Zip
Education	St. Ferdinand Catholic School	School	1012 Coronel St	San Fernando	91340
Education	St. Jane Frances de Chantel School	School	12930 Hamlin St	North Hollywood	91606
Education	St. Patrick Catholic School	School	10626 Erwin St	North Hollywood	91606
Education	Santa Rosa/Bishop Alemany Catholic School	School	1316 Griffith St	San Fernando	91340
Education	St. Elisabeth School	School	6635 Tobias Ave	Van Nuys	91405
Education	St. Catherine of Siena	School	18125 Sherman Way	Reseda	91335
Education	Our Lady of the Valley School	School	22041 Gault St	Canoga Park	91303
Education	Our Lady of Lourdes School	School	7324 Apperson St	Tujunga	91042
Education	Our Lady of Peace Elementary School	School	9022 Langdon Ave	North Hills	91343
Education	St. Joseph the Worker School	School	19812 Cantlay St	Winnetka	91306

Organization Type	Organization	Description	Address	City	Zip
Health care	All Inclusive Health Center	A non-profit Community Health Center whose mission is to increase access to health-care and other social services for under-served populations in Burbank and surrounding communities, including but not limited to Los Angeles, Glendale, North Hollywood, Pasadena, Tujunga, Van Nuys, Sunland and San Fernando communities of greater Los Angeles County. All-Inclusive Community Health Center's (AICHC) quest is to promote increased access to health-care, social services and education, by creating linkages between community-based & faith-based organizations, businesses, educational & governmental institutions and health-care facilities.	1311 N San Fernando Blvd	Burbank	91504

Organization Type	Organization	Description	Address	City	Zip
Health care	Northeast Valley Health Corporation	Northeast Valley Health Corporation (NEVHC) is one of the nation's largest community health centers. They are a nonprofit organization, focused on preventing and managing chronic health problems. Regardless of one's ability to pay, they provide medical care for children, the disabled, older adults, families, the homeless, children attending high risk schools, adults who are HIV positive and other vulnerable residents in service area.	1. 1600 San Fernando Road 2. 7107 Remmet Avenue 3. 12756 Van Nuys Boulevard 4. 18533 Soledad Canyon Road 5. 7223 N. Fair Avenue 6. 23763 Valencia Boulevard 7. 7138 Van Nuys Boulevard	1. San Fernando 2. Canoga Park 3. Pacoima 4. Santa Clarita 5. Sun Valley 6. Valencia 7. Van Nuys	1. 91340 2. 91303 3. 91331 4. 91351 5. 91352 6. 91355 7. 91405
Health care	FPA Women's Health	FPA Women's Health provides primary care and family planning services for women throughout the San Fernando Valley region.	1. 372 Arden Ave #200 2. 10200 Sepulveda Blvd #200	1. Glendale 2. Mission HIlls	1. 91203 2. 91345

Organization Type	Organization	Description	Address	City	Zip
Health care	Valley Care Community Consortium	Valley Care Community Consortium (VCCC) was founded in 1995 by key safety-net providers concerned about the lack of access and funding to services for low-income populations in Service Planning Area 2 (SPA2) of Los Angeles County. Understanding that the only way to improve the quality and access of health services, and end health disparities in the San Fernando and Santa Clarita Valleys was to work in partnership and collaboration, safety-net providers came together to form VCCC. Today, VCCC partners with over 200 agencies that include community health clinics, Los Angeles County health departments, local social service agencies, non-profit hospitals, universities and community residents.	7515 Van Nuys Blvd	Van Nuys	91405
Health care	Children's Burn Foundation	The Children's Burn Foundation is a 501(c)3 nonprofit organization dedicated to providing support services for child burn survivors, ages 0-18 and their families.	5000 Van Nuys Boulevard, Suite 210	Sherman Oaks	91403

Organization Type	Organization	Description	Address	City	Zip
Health care	HealthCare Partners	Since 1992, HealthCare Partners has been committed to developing innovative models of healthcare delivery that improve our patients' quality of life while containing healthcare costs. In LA's San Fernando Valley, you'll find more than 150 primary care physicians to choose from. Some practice out of offices that say "HealthCare Partners" on the building, and many other have their own private practices and affiliate with HealthCare Partners. For a complete list of primary care physicians in your area, enter your city or ZIP code into the doctor search on home page (http://www.healthcarepartners.com/). For more information, please call toll-free 888.715.4922.			
Health care	Hearing Aid Specialists, Inc.	With more than 50 years experience serving the San Fernando Valley and surrounding communities, Hearing Aid Specialists, Inc.(HAS) is the most qualified hearing health care provider to assist you with your hearing needs.	9153 Reseda Boulevard	Northridge	91324

Organization Type	Organization	Description	Address	City	Zip
Health care	Mission City Community Network	Mission City Community Network, Inc. (MCCN), a non profit community health clinic has been providing medical, dental and mental health services to the community for over 20 years. Mission City Community Network serves the low-income and uninsured populations in the San Fernando Valley primarily in the surrounding communities of North Hills, Van Nuys, Panorama City, Pacoima, Mission Hills, and Reseda. MCCN also provide service to patients throughout the San Fernando Valley and in Hollywood.	1. 15210 Parthenia St. 2. 8363 Reseda Blvd., Suite 11 3. 10200 Sepulveda Blvd., # 300A 4. 8771 Van Nuys Blvd. 5. Pacoima Middle School; 9919 Laurel Canyon Blvd	1. North Hills 2. Northridge 3. Mission Hills 4. Panorama 5. Pacoima	1. 91343 2. 91324 3. 91345 4. 91402 5. 91331
Health care	Professional Mammography Imaging	Professional Mammography Imaging is on Site Mobile Mammography screening as a Breast Image Center of Outstanding quality by providing services for low-income patients. Our knowledgeable doctors and technicians in cancer detection services will provide high quality care to our patients with our new technology that will detect breast cancer at earlier stages.	18429 Sherman Way	Reseda	91335

Organization Type	Organization	Description	Address	City	Zip
Health care	Samuel Dixon Family Health Centers, Inc.	With three primary health centers - the Val Verde Health Center, Canyon Country Health Center, and the Newhall Health Center; the Samuel Dixon Family Health Centers provide immunizations and vaccines, physicals, screening and diagnostic tests, well baby care, preventative programs, family planning, women's health services, prenatal services, treatment of illness and injury, and more. They also have two outreach locations at the College of the Canyons and the California Institute of the Arts.	1. 30257 San Martinez Road 2. 27225 Camp Plenty Rd, Ste 3. 23772 Newhall Avenue	1. Val Verde 2. Canyon Country 3. Newhall	1. 91384 2. 91351 3. 91321
Health care	Valley Community Healthcare	Established in 1970, Valley Community Healthcare, a private non-profit agency, serves over 30,000 men, women, and children annually. Our North Hollywood Health Center and North Hills Wellness Center provide an easily accessible medical home for the lower-income and uninsured residents of the San Fernando Valley.	1. North Hollywood Center; 6801 Coldwater Canyon Ave. 2. North Hills Center; 9119 Haskell Avenue 3. Kennedy High School; 11254 Gothic Avenue	1. North Hollywood 2. North Hills 3. Granada Hills	1. 91605 2. 91343 3. 91344
Health care	Kids' Community Dental Clinic	The Kids' Community Dental Clinic in Burbank, CA is dedicated to improving children's oral health through quality dental care and preventive education for low-income families in Southern California.	400 W. Elmwood Avenue	Burbank	91506

Organization Type	Organization	Description	Address	City	Zip
Homelessness	United States Mission Canoga Park Transitional Housing - Canoga Park, CA	Their purpose is to provide residents with a long term clean and sober home with quality meals and a self-help work program that provides each person with the opportunity of turning their lives around.	7522 Independence Ave.	Canoga Park	91303
Homelessness	Family Promise of the Verdugos	Family Promise of the Verdugos is a non-profit organization providing assistance to homeless children and their family. Working in partnership with local faith-based congregations and other community resources; Family Promise provides food, shelter, counseling support and job readiness training resulting in self-reliance and a more stable future for situationally-homeless families	P.O. Box 1307	Burbank	91507
Homelessness	Hope of the Valley Rescue Mission	Hope of the Valley Rescue Mission's vision is to tangibly demonstrate God's love to the Hungry, Homeless and Hurting of the greater Los Angeles area by offering **h**ope, **h**ot meals, **h**ousing, **h**ealth services and **h**ealing to those in need.	11134 Sepulveda Blvd	Mission Hills	91345
Homelessness	LA Family Housing	LA Family Housing (LAFH) helps people transition out of homelessness and poverty by providing a continuum of housing enriched with supportive services. Since 1983, LAFH has become one of the largest comprehensive real estate developers and homeless service providers in Los Angeles and a regional leader providing solutions to end homelessness.	7843 Lankershim Boulevard	North Hollywood	91605

Organization Type	Organization	Description	Address	City	Zip
Homelessness	The Nancy Painter Home for Mothers with Children	The Nancy Painter Home for Mothers with Children is a community-based grass roots transitional housing program devoted to single mothers and their children who are homeless or in danger of becoming homeless.	4804 Laurel Cyn. Blvd. #308	Valley Village	91607
Homelessness	Salvation Army Glendale Chester Village For Homeless Families	The Salvation Army offers many programs that offer refuge to struggling men, women, children and families from overnight and emergency shelters for those finding themselves homeless for the first time to transitional living centers that help rebuild lives. The Salvation Army also offers meal assistance, bill pay assistance, and employment assistance at this location.	320 W. Windsor Rd	Glendale	91204
Homelessness	Ascencia	Ascencia's mission is to end homelessness in the greater Glendale area, one person, one family at a time. We envision a community where people in need can find safe affordable housing and access resources to become self-sufficient.	1851 Tyburn Street	Glendale	91204

Organization Type	Organization	Description	Address	City	Zip
Homelessness	Bridge to Home	Bridge to Home provides support services – including an emergency winter shelter, case management, housing navigation, and medical and dental clinics – that help individuals and families in the Santa Clarita Valley transition out of homelessness. Bridge to Home is funded through contracts with the Los Angeles Homeless Services Authority, subcontracts with Los Angeles Family Housing, private and public grants, and extensive in-kind donations and participation from the local community.	23031 Drayton St.	Santa Clarita	91355
Homelessness	Family Promise of Santa Clarita Valley	Family Promise of Santa Clarita Valley brings shelter, meals, and support services to families without homes, helping them to get back on their feet.	18565 Soledad Canyon Road #133	Canyon Country	91351
Homelessness	A Better Living Permanent Housing and Supportive Services	A Better Living Permanent Housing and Supportive Services (ABLPHSS) mission is to assist and elevate the San Fernando Valley's homeless population by providing nurturing, comprehensive and balanced housing/ supportive services. The aim is to successfully transition each individual in need into permanent housing of their own, and become self-reliant contributors to the communities in which they live.	9733 Columbus Avenue	North Hills	91343

Organization Type	Organization	Description	Address	City	Zip
Homelessness	San Fernando Valley Rescue Mission	The Family Shelter provides a fresh start to families who are experiencing homelessness by offering up to 10 months of shelter in a comfortable, home-like setting. The shelter includes community gathering spaces, a large dining room, a commercial kitchen, a computer lab and individual rooms for families. For families with infants, we provide cribs and changing tables.	8756 Canby Ave.	Northridge	91325
Hospital	Northridge Hospital	Northridge Hospital Medical Center, a 409-bed not-for-profit hospital, has earned the Gold Seal of Approval from The Joint Commission. We are ranked as one of America's 100 Best Hospitals in the United States by Healthgrades—a national healthcare ratings organization.	18300 Roscoe Blvd.	Northridge	91328
Hospital	USC Verdugo Hills Hospital	USC Verdugo Hills Hospital, part of Keck Medicine of USC, has been serving the needs of patients in the cities of Glendale and La Cañada Flintridge, as well as the surrounding Foothill communities of Southern California for more than 40 years. Their mission is to provide personalized, high-quality healthcare relevant to our patient community.	1812 Verdugo Blvd	Glendale	91208

Organization Type	Organization	Description	Address	City	Zip
Hospital	Southern California Hospital at Van Nuys	Located in the heart of the San Fernando Valley, Southern California Hospital at Van Nuys is a 57-bed psychiatric hospital that provides acute inpatient and outpatient psychiatric services on a voluntary basis. The facility, which became part of the Southern California Hospital group in 2013, has been a psychiatric hospital for more than 20 years.	14433 Emelita St.	Van Nuys	91401
Hospital	West Hills Hospital & Medical Center	West Hills Hospital & Medical Center offers compassionate and responsive care for the improvement of human life. Serving the West Valley for more than 50 years, West Hills Hospital brings "quality care, close to home."	7300 Medical Center Dr	West Hills	91307
Hospital	Children's Hospital Los Angeles Encino Outpatient Center	Children’s Hospital Los Angeles – Encino offers Board-certified and Board-eligible pediatric specialists in numerous areas.	5363 Balboa Blvd.	Encino	91316
Hospital	San Fernando Post Acute Hospital	San Fernando Post Acute Hospital is a 204 bed skilled nursing facility, contracted by the State of California, to provide sub-acute services to a 59 bed dedicated unit within our facility. This dual classification allows us to meet the individual needs of a more diverse population.	12260 Foothill Blvd.	Sylmar	91342

Organization Type	Organization	Description	Address	City	Zip
Hospital	Kaiser Permanente Panorama City Medical Center	The medical center campus includes the 218-bed hospital and five medical office buildings. Approximately 260 physicians and 2,100 employees provide high quality, primary and specialty care to about 265,000 members.	13651 Willard St.	Panorama City	91402
Hospital	Encino Hospital Medical Center	Not-for-Profit Encino Hospital Medical Center, part of the Prime Healthcare Services Foundation, is a 150-bed state of the art hospital located in the Encino, California. Its multi-disciplinary staff consists of 330 physicians and 520 professional support staff.	16237 Ventura Blvd	Encino	91436
Hospital	Sherman Oaks Hospital	Sherman Oaks Hospital (SOH) is a 153-bed nonprofit Prime Healthcare community hospital centrally located in Sherman Oaks, California. Serving the medical needs of the San Fernando Valley, SOH endeavors to provide comprehensive, quality healthcare in a convenient, compassionate and cost effective manner.	4911 Van Nuys Blvd #102	Sherman Oaks	91403
Hospital	Mission Community Hospital	Mission Community provides a full range of medical, surgical and mental health care, including 24-hour emergency services.	14850 Roscoe Blvd	Panorama City	91402
Hospital	Valley Presbyterian Hospital	Valley Presbyterian Hospital is a 350-bed hospital that serves thousands of families each year, with access to a wide range of medical expertise and leading-edge technology across all elements of care.	15107 Vanowen St	Van Nuys	91405

Organization Type	Organization	Description	Address	City	Zip
Hospital	Pacifica Hospital of the Valley	Pacifica Hospital of the Valley, a 231 bed acute care facility, has been a major provider of healthcare to adults and children in the San Fernando Valley for over three decades. The hospital offers a full range of inpatient and outpatient services, including 24-hour Emergency Care, Surgery, Behavioral Health Services and Maternity. Comprehensive ancillary support includes ultrasound, MRI and Nuclear Medicine.	9449 San Fernando Rd	Sun Valley	91352
Hospital	Glendale Adventist Medical Center	Glendale Adventist Medical Center (GAMC) is a 515-bed hospital built on the Seventh-day Adventist faith and mission to improve the health of communities and to share God's love by promoting healing and wellness for the whole person.	1509 Wilson Terrace	Glendale	91206

Organization Type	Organization	Description	Address	City	Zip
Legal aid	Neighborhood Legal Services of Los Angeles County	Each year NLSLA provides free assistance to more than 100,000 individuals and families through innovative projects that expand access to justice and address the most critical needs of Los Angeles' poverty communities. Founded in 1965 as part of the nation's War on Poverty, NLSLA is now one of the largest and most prominent public interest law offices in California. NLSLA attorneys, based in offices, courthouses and clinics throughout Los Angeles County, specialize in areas of the law that disproportionately impact the poor, including housing, public benefits and healthcare.	1. 1102 East Chevy Chase Drive 2. 13327 Van Nuys Blvd	1. Glendale 2. Pacoima	1. 91205 2. 91331
Legal aid	The Center For Conflict Resolution at Loyola Law School	The Center For Conflict Resolution (The CCR) provides mediation, conciliation and facilitation services, and conflict resolution training to the communities throughout Los Angeles County (particularly those adjacent to the Law School), and to students, faculty and staff at Loyola.	800 S. Figueroa St. Suite 1140	Los Angeles	90017

Organization Type	Organization	Description	Address	City	Zip
Legal aid	Neighborhood Legal Services	Neighborhood Legal Services is a steadfast advocate for individuals, families and communities throughout Los Angeles County. Through a combination of individual representation, high impact litigation and public policy advocacy, NLSLA combats the immediate and long-lasting effects of poverty and expands access to health, opportunity, and justice in Los Angeles' diverse neighborhoods.	1. 1102 East Chevy Chase Drive 2. 13327 Van Nuys Blvd.	1. Glendale 2. Pacoima	1. 91205 2. 91331
Mental Health	Child and Family Guidance Center	The Center provides services to low income families with children that have significant emotional problems requiring comprehensive mental health interventions. Families served, often come to the Center feeling alone, and overwhelmed with the day-to-day challenges of raising a special needs child.	9650 Zelzah Avenue	Northridge	91325
Mental Health	Tarzana Treatment Centers	Tarzana Treatment Centers, Inc. is a full-service behavioral healthcare organization that provides high quality, cost-effective substance abuse and mental health treatment to adults and youth.	1. 8330 Reseda Boulevard 2. 7101 Baird Avenue 3. 18646 Oxnard Street 4. 18700 Oxnard Street	1. Northridge 2. Reseda 3. Tarzana 4. Tarzana	1. 91324 2. 91335 3. 91356 4. 91356

Organization Type	Organization	Description	Address	City	Zip
Mental Health	San Fernando Valley Community Mental Health Center, Inc.	The San Fernando Valley Community Mental Health Center, Inc. founded in 1970, is a private, non-profit agency dedicated to improving the mental health of individuals and families within the community. Primary emphasis is placed on providing culturally sensitive and linguistically relevant services to infants, toddlers, children, adolescents and transitional age youth with serious emotional disorders, and services for adults and older adults with severe and persistent mental illness.	16360 Roscoe Blvd	Van Nuys	91406
Mental Health	Valley Family Center	Valley Family Center provides individual, couple and family therapy, coordinated services for victims, children, and perpetrators of domestic violence and parenting education. The Learning Center provides tutoring and academic support for at-risk youth.	302 S Brand Blvd	San Fernando	91340
Mental Health	Valley Care Community Consortium	Valley Care Community Consortium leads a collaboration of public and private community partners to advocate, plan, assess needs and facilitate development of effective programs and policies to improve the health of the residents in the San Fernando and Santa Clarita Valleys	7515 Van Nuys Blvd., 5th Floor	Van Nuys	91405

Organization Type	Organization	Description	Address	City	Zip
Mental Health	Hillview Mental Health Center, Inc.	The mission of Hillview Mental Health Center, Inc. is to assist in empowering individuals and families affected by mental illness to assess their needs, strengths and goals, and work collaboratively with mental health professionals and other staff to plan services that are person-centered, culturally competent and effective in promoting recovery and the ability to live as fully participating members of the community.	12450 Van Nuys Blvd., Suite 200	Pacoima	91331
Mental Health	Family Service Agency of Burbank	Family Service Agency of Burbank is a 501(C)3 non-profit social service agency dedicated to providing quality mental health care for all and eliminating domestic violence, suicide, and all other forms of interpersonal violence, as well as preventing homelessness and serving our respected veterans and their families.	2721 W Burbank Blvd,	Burbank	91505
Public health center	Glendale Health Center	Clinical services offered at Public Health Centers include immunizations, and screening and treatment of tuberculosis and sexually transmitted diseases.	501 N. Glendale Avenue	Glendale	91206
Public health center	North Hollywood Health Center	Clinical services offered at Public Health Centers include immunizations, and screening and treatment of tuberculosis and sexually transmitted diseases.	5300 Tujunga Ave	North Hollywood	91601

Organization Type	Organization	Description	Address	City	Zip
Public health center	Pacoima Health Center	Clinical services offered at Public Health Centers include immunizations, and screening and treatment of tuberculosis and sexually transmitted diseases.	13300 Van Nuys Blvd	Pacoima	91331
Seniors	Community Integration Services	(CIS) is a non-profit organization in Granada Hills serving the San Fernando Valley community since 2006. Our identity is Multi-cultural, Intergenerational and Ability-Diverse. We serve high need seniors with aging challenges, seniors of various cultures, adults of all ages with developmental disabilities and our participants' caregivers.	10100 Balboa Blvd.	Granada Hills	91344
Seniors	ONEgeneration	ONEgeneration is committed to providing programs and services to seniors and their caregivers that help keep them safe and protected. We provide services that enable seniors to age with family, in community or independently. We promote physical health and mental well-being, provide socialization, nutrition and access to food and resources. This is all towards the goal of keeping seniors from the tipping point of decline and avoiding or delaying preventable hospitalizations and premature loss of independence.	17400 Victory Blvd	Van Nuys	91406

Organization Type	Organization	Description	Address	City	Zip
Social service	Therapeutic Living Centers for the Blind	The mission of Therapeutic Living Centers for the Blind is to provide for the lifetime needs of individuals with multiple-disabilities and blindness. TLC believes in the value of each individual and promotes the philosophy that each participant can be assisted to achieve his or her full potential.	7915 Lindley Avenue	Reseda	91335
Social services	Valley Interfaith Council	Valley Interfaith Council (VIC) provides nutritionally balanced meals to mature adults, families, and individuals throughout the San Fernando Valley through various nutrition programs.	1. 11300 Glenoaks Blvd. 2. 8956 Vanalden Ave. 3. 5056 Van Nuys Blvd 4. 6514 Sylmar Ave	1. Pacoima 2. Northridge 3. Sherman Oaks 4. Van Nuys	1. 91331 2. 91324 3. 91403 4. 91401
Social services	Meet Each Need with Dignity (MEND)	In the early 1970's, MEND – Meet Each Need with Dignity opened its doors in an effort to transform the lives of the neediest residents of the San Fernando Valley – poor children and their struggling families. More than 94% of the support and donations received by MEND, now the largest poverty agency in the Valley, provides emergency food, clothing, medical, vision and dental care, job skills training and job placement assistance, English as a Second Language classes, youth activities, and a Christmas program.	10641 San Fernando Rd	Pacoima	91331

Organization Type	Organization	Description	Address	City	Zip
Social services	Burbank Temporary Aid Center	BTAC is dedicated to providing the poor, working poor, and homeless of the local community with basic services they need to live with dignity, and to serve citizens of the city in times of emergency and disaster. As a conduit between the generous donors of the community, foundations, and government resources, BTAC works to provide clients with help such as food, utility assistance, transportation assistance, emergency shelter (off-site and short-term), medical assistance, referrals to other community resources, and holiday outreach.	1304 W Burbank Blvd	Burbank	91506
Social services	LSS Community Care	LSS Community Care Center in Canoga Park focuses mainly on homeless and at-risk individuals and families. Programs are developed to provide families with the resources, education and long term plans needed to help them find their way out of poverty to become contributing members of the community. They offer a full range of short-term assistance such as food and clothing, but also offer urban garden classes and garden boxes, computer training, counseling and case management which provide referrals and individual guidance to assist an individual or family to reach a place of self-confidence and dignity.	21430 Strathern Street	Canoga Park	91304

Organization Type	Organization	Description	Address	City	Zip
Social services	Catholic Charities, San Fernando Region	The programs of Catholic Charities focus on empowerment and seek to enact long-term, positive change in individuals, families and communities. As a nonprofit, public benefit corporation, the agency is built on the principles of dignity and inclusion, providing services irrespective of race, ethnicity, gender or religious belief. Programs address human suffering and larger social issues, such as poverty, hunger and nutrition, homelessness, immigration, health care, mental health and illiteracy.	21600 Hart Street	Canoga Park	91303
Social services	Family Rescue Center	The Family Rescue Centers serves individuals and families in need in the West Valley by providing food, clothing, medical and vocational training assistance, as well as referrals as needed. Their ultimate goal is to sustain people in desperate circumstances, empowering them to achieve personal and financial independence.	22103 Vanowen St	Canoga Park	91303

Organization Type	Organization	Description	Address	City	Zip
Social Services	New Economics for Women, FamilySource Center	New Economics for Women (NEW) is a non-profit community development corporation. For 30 years, NEW has been dedicated to the economic security of women, especially immigrant women, in low-wealth communities. Their programs and investments focus on creating culturally relevant whole family financial education, affordable housing, and community engagement as the primary tools needed to overcome economic insecurity.	1. 21400 Saticoy St., 2nd Floor 2. 6931 Van Nuys Blvd., Suite 201	1. Canoga Park 2. Van Nuys	1. 91304 2. 91406
Youth development	Boys & Girls Club of Burbank and Greater East Valley	The Boys & Girls Club of Burbank and Greater East Valley supports and nurtures potential in more than 1500 youth ages 6-18 every day. Through professional, dedicated and trained staff, the boys and girls at our Main Club and at 17 local sites are encouraged to fully participate in a variety of enrichment programs all designed to help young people experience a positive sense of self and build strong character in a safe, nurturing and affordable environment. No child is ever turned away for an inability to pay.	2244 N. Buena Vista St	Burbank	91504

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Appendix II—LA County Health Survey Core Health Indicators

Comparison by community benefit service area and broader service area

		Holy Cross Community Benefit Service Area	St. Joseph Community Benefit Service Area	Tarzana Community Benefit Service Area	Los Angeles County
	Physical & Social Determinants				
1	Percent of adults who completed high school[1]	69.2%	79.9%	72.1%	77.6%
2	Percent of adults who are employed[1]	63.6%	60.1%	65.3%	56.6%
3	Percent of population with household incomes <100% Federal Poverty Level (FPL)	20.9%	19.5%	20.4%	18.4%
4	Percent of households (owner/renter-occupied) who spend ≥30% of their income on housing.	55.8%	56.1%	56.1%	49.9%
5	Housing instability (Percent of adults who reported being homeless or not having their own place to live or sleep in the past 5 years)[1]	6.5% *	6.6% *	3.1% *	4.8%
6	Percent of households with incomes <300% who are food insecure[1]	31.3%	35.3%	31.8%	29.2%
7	Percent of children with excellent or good access to fresh fruits and vegetables in their community[1]	64.9%	67.3%	75.7%	75.0%
8	Percent of adults who believe their neighborhood is safe from crime[1]	90.6%	95.7%	88.6%	84.0%
9	Percent of children ages 1-17 years who can easily get to a park, playground, or other safe place to play[1]	79.9%	80.7%	86.9%	86.8%
10	Percent of adults who use walking paths, parks, playgrounds, or sports fields in their neighborhood[1]	46.2%	47.4%	45.3%	47.5%
11	Amount of green space (park acres) per 1,000 population[2]	3.70	1.84	0.57	8.06
12	Percent of children ages 0-5 years who are read to daily by a parent or family members[1]	62.1% *	44.0%	55.9%	56.4%
	Health Status				
13	Percent of adults reporting their health to be fair or poor[1]	25.5%	22.9%	19.9%	21.5%
14	Average number of days in past month adults reported regular daily activities were limited due to poor physical/mental health[1]	2.6	2.8	1.8	2.3
15	Percent of children ages 0-17 years who have special health care needs[1]	12.2% *	13.3% *	11.5% *	14.5%
	Access to Care				
16	Percent of children ages 0-17 years who are insured[1]	95.9%	96.7%	94.7%	96.6%
17	Percent of adults ages 18-64 years who are insured[1]	81.0%	91.2%	76.7%	88.3%
18	Percent of children ages 0-17 years with a regular source of health care[1]	93.3%	91.7%	93.2%	94.3%
19	Percent of adults 18-64 years with a regular source of health care[1]	74.8%	82.0%	77.6%	77.7%
20	Percent of adults who did not see a dentist or go to a dental clinic in the past year[1]	48.1%	38.8%	43.5%	40.7%
21	Percent of children ages 3-17 years who did not obtain dental care (including check-ups) in the past year because they could not afford it[1]	* 9.9%	19.1% *	14.0% *	11.5%

		Holy Cross Community Benefit Service Area	St. Joseph Community Benefit Service Area	Tarzana Community Benefit Service Area	Los Angeles County
	Preventive Services				
22	Percent of all live births where mother received prenatal care during 1st trimester	85.2%	85.1%	89.7%	83.1%
23	Percent of women ages 21 - 65 years who had a Pap smear within the past 3 years[1]	83.5%	90.0%	87.3%	84.4%
24	Percent of women ages 50- 74 years who had a mammogram within the past 2 years[1]	76.8%	76.2%	80.2%	77.3%
25	Percent of children ages 6 months - 17 years vaccinated for influenza[1]	47.1%	43.3%	61.4%	55.2%
26	Percent of adults vaccinated for influenza[1]	34.8%	29.2%	41.8%	40.1%
	Health Behaviors				
27	Percent of adults who binge drink (men who had 5 or more alcoholic drinks, women 4 or more, on at least one occasion in the past 30 days)[1]	16.5%	14.1%	15.8%	15.9%
28	Percent of adults who consume five or more servings of fruits & vegetables a day[1]	11.5%	18.2%	12.1%	14.7%
29	Percent of children who drink at least one soda or sweetened drink a day[1]	54.7%	34.6%	39.6%	39.2%
30	Percent of children ages 0-2 years who were exclusively breastfed for at least 3 months[3]	31.4%	37.9%	36.1%	38.3%
31	Percent of adults who smoke cigarettes[1]	15.7%	19.4%	12.2%	13.3%
32	Percent of adults who obtain recommended amount of aerobic exercise (≥150 minutes/wk of moderate exercise, or ≥75 minutes/wk of vigorous exercise) and muscle-strengthening (at least 2 days/wk) each week[1]	38.0%	39.7%	29.3%	34.1%
33	Percent of children ages 6-17 years who obtain recommended amount of aerobic exercise (≥60 minutes, daily) and muscle-strengthening (at least 2 days/wk) each week[1]	20.2% *	17.9% *	9.5%	17.7%
	Health Outcomes				
	Obesity				
34	Percent of children in grades 5,7&9 who are obese (BMI above the 95th percentile)	Data Not Available	Data Not Available	Data Not Available	Data Not Available
35	Percent of adults who are obese (BMI≥30.0)[1]	25.4%	17.0%	21.9%	23.5%
	Diabetes				
36	Percent of adults ever diagnosed with diabetes[1]	9.6%	8.3% *	8.4%	9.8%
37	Diabetes-related hospital admissions (per 10,000 population)[4]	15.4	16.5	14.3	15.8
38	Diabetes-specific death rate (per 100,000 population)[5]	26.8	25.5	20.0	21.9
	Cardiovascular Disease				
39	Hypertension-related hospital admissions (per 10,000 population)[4]	6.1	6.7	5.2	5.5
40	Percent of adults ever diagnosed with hypertension[1]	26.3%	19.0%	23.6%	23.5%
41	Coronary heart disease-specific death rate (per 100,000 population population)[5]	131.3	132.3	145.6	116.7
42	Stroke-specific death rate (per 100,000 population)[5]	28.5	34.2	33.4	32.8

		Holy Cross Community Benefit Service Area	St. Joseph Community Benefit Service Area	Tarzana Community Benefit Service Area	Los Angeles County
	Health Outcomes				
	Reproductive Health				
43	Rate of births (per 1,000 females) to teens ages 15-19[6]	71.4	40.8	48.6	53.4
44	Percent of low birth weight (<2,500 grams) births (per 100 live births)[6]	7.4%	6.3%	7.2%	6.9%
45	Infant death rate (per 1,000 live births)[7]	6.0	3.9	5.0	4.4
	Injury				
46	Premature death rate due to suicide in total Years of Potential Life Lost (YPLL) per 100,000 population[8]	211.9	339.3	225.5	208.4
47	Premature death rate due to homicide in total Years of Potential Life Lost (YPLL) per 100,000 population[8]	125.1	125.8	104.4	235.2
48	Premature death rate due to motor vehicle crashes in total Years of Potential Life Lost (YPLL) per 100,000 population[8]	259.0	259.8	270.8	227.5
49	Percent of adults who have ever experienced physical (hit, slapped, pushed, kicked, etc.) or sexual (unwanted sex) violence by an intimate partner[1]	10.6%	18.4%	13.3%	13.4%
50	Percent of adults ages 65+ years who have fallen in the past year[1]	34.5%	45.1%	30.5%	27.1%
	Drug Overdose				
51	Rate (per 10,000 population) of adult opioid use-related hospitalizations[4]	0.3	0.5	0.3	0.5
52	Premature death rate due to drug overdose in total Years of Potential Life Lost (YPLL) per 100,000 population[8]	196.8	208.0	243.6	218.1
	Mental Health				
53	Percent of adults at risk for major depression[1]	12.4%	12.8%	10.8%	11.8%
54	Alzheimer's disease-specific death rate (per 100,000 population)[5]	24.8	31.2	33.9	25.1

		Holy Cross Community Benefit Service Area	St. Joseph Community Benefit Service Area	Tarzana Community Benefit Service Area	Los Angeles County
	STD and HIV Disease				
55	Incidence of HIV (annual new cases per 100,000 population) among adolescents and adults (ages 13+ years)[9]	13.1	22.7	19.0	20.7
56	Incidence of primary & secondary syphilis (annual new cases per 100,000)[10]	13.1	21.0	12.1	14.3
57	Incidence of gonorrhea (annual new cases per 100,000 population)[10]	* 117.0	168.0	122.0	165.1
58	Incidence of chlamydia (annual new cases per 100,000 population)[10]	536.6	476.3	417.8	532.1
	Respiratory Disease				
59	Percent of children ages 0-17 years with current asthma (ever diagnosed with asthma and reported still have asthma and/or had an asthma attack in the past year)[1]	5.6% *	8.6% *	4.7%	7.4%
60	Pediatric asthma-related hospital admissions per 10,000 child population[4]	11.4	9.2	11.9	11.9
61	COPD specific mortality rate (per 100,000 population)[5]	23.8	23.1	29.7	29.2
	Cancer				
62	Lung-specific cancer death rate (per 100,000 population)[5]	22.7	31.1	32.2	27.5
63	Breast cancer-specific death rate among females (per 100,000 females)[5]	21.4	20.1	23.0	227.5
64	Colorectal cancer-specific death rate (per 100,000 population)[5]	14.1	12.4	14.6	13.8
	Liver Disease				
65	Liver disease-specific death rate (per 100,000 population)[5]	16.8	14.8	10.3	218.1

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

Data Sources

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

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

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

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

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

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

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

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

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

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

			Broader Holy Cross Service Area		Broader St. Joseph Service Area		Broader Tarzana Service Area	Los Angeles County
	Physical & Social Determinants							
1	Percent of adults who completed high school[1]		**89.5%**		**94.8%**		**94.5%**	**77.6%**
2	Percent of adults who are employed[1]		**66.9%**		**59.0%**		**59.7%**	**56.6%**
3	Percent of population with household incomes <100% Federal Poverty Level (FPL)		**8.0%**		**9.6%**		**10.8%**	**18.4%**
4	Percent of households (owner/renter-occupied) who spend ≥30% of their income on housing.		**46.1%**		**47.6%**	*	**48.0%**	**49.9%**
5	Housing instability (Percent of adults who reported being homeless or not having their own place to live or sleep in the past 5 years)[1]		**-**		**-**		**-**	**4.8%**
6	Percent of households with incomes <300% who are food insecure[1]		**17.6%**		**20.2%**		**18.2%**	**29.2%**
7	Percent of children with excellent or good access to fresh fruits and vegetables in their community[1]		**91.0%**		**91.5%**		**96.7%**	**75.0%**
8	Percent of adults who believe their neighborhood is safe from crime[1]		**95.4%**		**100.0%**		**99.0%**	**84.0%**
9	Percent of children ages 1-17 years who can easily get to a park, playground, or other safe place to play[1]		**91.8%**		**92.3%**		**89.5%**	**86.8%**
10	Percent of adults who use walking paths, parks, playgrounds, or sports fields in their neighborhood[1]		**54.8%**		**57.2%**		**47.7%**	**47.5%**
11	Amount of green space (park acres) per 1,000 population[2]		**41.27**		**7.69**		**20.15**	**8.06**
12	Percent of children ages 0-5 years who are read to daily by a parent or family members[1]		**80.0%**		**46.8%**		**61.3%**	**56.4%**
	Health Status							
13	Percent of adults reporting their health to be fair or poor[1]		**12.6%**		**12.5%**		**13.5%**	**21.5%**
14	Average number of days in past month adults reported regular daily activities were limited due to poor physical/mental health[1]		**2.4**		**2.5**		**3.2**	**2.3**
15	Percent of children ages 0-17 years who have special health care needs[1]		**21.2%**		**22.6%**	*	**15.0%**	**14.5%**
	Access to Care							
16	Percent of children ages 0-17 years who are insured[1]		**98.6%**		**99.9%**		**100.0%**	**96.6%**
17	Percent of adults ages 18-64 years who are insured[1]		**92.1%**		**96.0%**		**94.1%**	**88.3%**
18	Percent of children ages 0-17 years with a regular source of health care[1]		**96.7%**		**96.2%**		**98.1%**	**94.3%**
19	Percent of adults 18-64 years with a regular source of health care[1]		**80.8%**		**85.1%**		**79.5%**	**77.7%**
20	Percent of adults who did not see a dentist or go to a dental clinic in the past year[1]		**31.6%**		**22.3%**		**24.2%**	**40.7%**
21	Percent of children ages 3-17 years who did not obtain dental care (including check-ups) in the past year because they could not afford it[1]	*	**7.7%**	*	**10.9%**	*	**6.5%**	**11.5%**

		Broader Holy Cross Service Area	Broader St. Joseph Service Area	Broader Tarzana Service Area	Los Angeles County
	Preventive Services				
22	Percent of all live births where mother received prenatal care during 1st trimester	**88.0%**	**86.6%**	**91.4%**	**83.1%**
23	Percent of women ages 21 - 65 years who had a Pap smear within the past 3 years[1]	**89.3%**	**91.7%**	**86.9%**	**84.4%**
24	Percent of women ages 50- 74 years who had a mammogram within the past 2 years[1]	**67.4%**	**87.7%**	**79.4%**	**77.3%**
25	Percent of children ages 6 months - 17 years vaccinated for influenza[1]	**52.5%**	**60.5%**	**60.6%**	**55.2%**
26	Percent of adults vaccinated for influenza[1]	**47.7%**	**52.7%**	**49.0%**	**40.1%**
	Health Behaviors				
27	Percent of adults who binge drink (men who had 5 or more alcoholic drinks, women 4 or more, on at least one occasion in the past 30 days)[1]	**11.9%**	**12.0%**	**15.0%**	**15.9%**
28	Percent of adults who consume five or more servings of fruits & vegetables a day[1]	**16.3%**	**16.1%**	**14.3%**	**14.7%**
29	Percent of children who drink at least one soda or sweetened drink a day[1]	**24.1%**	**29.7%**	**30.1%**	**39.2%**
30	Percent of children ages 0-2 years who were exclusively breastfed for at least 3 months[3]	**51.0%**	**58.6%**	**46.2%**	**38.3%**
31	Percent of adults who smoke cigarettes[1]	**14.1%**	*** 4.7%**	**12.4%**	**13.3%**
32	Percent of adults who obtain recommended amount of aerobic exercise (≥150 minutes/wk of moderate exercise, or ≥75 minutes/wk of vigorous exercise) and muscle-strengthening (at least 2 days/wk) each week[1]	**38.6%**	**33.4%**	**37.6%**	**34.1%**
33	Percent of children ages 6-17 years who obtain recommended amount of aerobic exercise (≥60 minutes, daily) and muscle-strengthening (at least 2 days/wk) each week[1]	**15.0%**	**22.6%**	**19.3%**	**17.7%**
	Health Outcomes				
	Obesity				
34	Percent of children in grades 5,7&9 who are obese (BMI above the 95th percentile)	**Data Not Available**	**Data Not Available**	**Data Not Available**	**Data Not Available**
35	Percent of adults who are obese (BMI≥30.0)[1]	**22.8%**	**13.0%**	**16.7%**	**23.5%**
	Diabetes				
36	Percent of adults ever diagnosed with diabetes[1]	**7.6%**	**5.9%**	**9.7%**	**9.8%**
37	Diabetes-related hospital admissions (per 10,000 population)[4]	**9.0**	**7.3**	**8.8**	**15.8**
38	Diabetes-specific death rate (per 100,000 population)[5]	**14.8**	**12.7**	**13.3**	**21.9**
	Cardiovascular Disease				
39	Hypertension-related hospital admissions (per 10,000 population)[4]	**3.2**	**3.8**	**3.1**	**5.5**
40	Percent of adults ever diagnosed with hypertension[1]	**25.8%**	**22.5%**	**26.5%**	**23.5%**
41	Coronary heart disease-specific death rate (per 100,000 population)[5]	**114.5**	**110.9**	**116.1**	**116.7**
42	Stroke-specific death rate (per 100,000 population)[5]	**30.5**	**28.6**	**23.0**	**32.8**

		Broader Holy Cross Service Area	Broader St. Joseph Service Area	Broader Tarzana Service Area	Los Angeles County
	Reproductive Health				
43	Rate of births (per 1,000 females) to teens ages 15-19[6]	26.2	7.1	15.1	53.4
44	Percent of low birth weight (,2,500 grams) births (per 100 live births)[6]	6.5%	6.8%	7.4%	6.9%
45	Infant death rate (per 1,000 live births)[7]	3.3	4.0	7.0	4.4
	Injury				
46	Premature death rate due to suicide in total Years of Potential Life Lost (YPLL) per 100,000 population[8]	180.9	221.8	188.1	208.4
47	Premature death rate due to homicide in total Years of Potential Life Lost (YPLL) per 100,000 population[8]	47.8	N/A	N/A	235.2
48	Premature death rate due to motor vehicle crashes in total Years of Potential Life Lost (YPLL) per 100,000 population[8]	196.1	197.5	247.5	227.5
49	Percent of adults who have ever experienced physical (hit, slapped, pushed, kicked, etc.) or sexual (unwanted sex) violence by an intimate partner[1]	17.6%	19.4%	9.4%	13.4%
50	Percent of adults ages 65+ years who have fallen in the past year[1]	21.6%	39.2%	20.4%	27.1%
	Drug Overdose				
51	Rate (per 10,000 population) of adult opioid use-related hospitalizations[4]	0.9	0.9	0.9	0.5
52	Premature death rate due to drug overdose in total Years of Potential Life Lost (YPLL) per 100,000 population[8]	262.6	223.5	295.7	218.1
	Mental Health				
53	Percent of adults at risk for major depression[1]	6.7%	8.4%	12.3%	11.8%
54	Alzheimer's disease-specific death rate (per 100,000 population)[5]	33.2	36.8	29.9	25.1
	STD and HIV Disease				
55	Incidence of HIV (annual new cases per 100,000 population) among adolescents and adults (ages 13+ years)[9]	7.0	12.2	6.0	20.7
56	Incidence of primary & secondary syphilis (annual new cases per 100,000)[10]	5.9	11.7	6.3	14.3
57	Incidence of gonorrhea (annual new cases per 100,000 population)[10]	52.1	103.3	58.6	165.1
58	Incidence of chlamydia (annual new cases per 100,000 population)[10]	257.0	309.4	285.3	532.1

		Broader Holy Cross Service Area	Broader St. Joseph Service Area	Broader Tarzana Service Area	Los Angeles County
	Respiratory Disease				
59	Percent of children ages 0-17 years with current asthma (ever diagnosed with asthma and reported still have asthma and/or had an asthma attack in the past year)[1]	**10.6%**	**8.0%**	**-**	**7.4%**
60	Pediatric asthma-related hospital admissions per 10,000 child population[4]	**6.6**	**4.7**	**5.3**	**11.9**
61	COPD specific mortality rate (per 100,000 population)[5]	**33.1**	**27.8**	**26.1**	**29.2**
	Cancer				
62	Lung-specific cancer death rate (per 100,000 population)[5]	**33.1**	**27.6**	**30.4**	**27.5**
63	Breast cancer-specific death rate among females (per 100,000 females)[5]	**19.0**	**24.5**	**28.9**	**227.5**
64	Colorectal cancer-specific death rate (per 100,000 population)[5]	**17.6**	**12.9**	**12.1**	**13.8**
	Liver Disease				
65	Liver disease-specific death rate (per 100,000 population)[5]	**12.2**	**8.3**	**7.5**	**218.1**

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

Data Sources

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

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

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

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

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

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

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

Appendix III—Community Need Index Scores

This section provides the zip codes and associated community need index score for each of the six subareas within the Providence San Fernando Valley Community.

Holy Cross Community Benefit Service Area		
Zip Code	**CNI Score**	**City**
91342	4	Sylmar
91321	4.2	Newhall
91340	4.2	San Fernando
91343	4.4	North Hills
91331	4.6	Pacoima
91352	4.6	Sun Valley
91402	4.6	Panorama City

Broader Holy Cross Service Area		
Zip Code	**CNI Score**	**City**
91390	1.8	Santa Clarita
91350	2.2	Santa Clarita
91326	2.4	Porter Ranch
91354	2.4	Valencia
91381	2.4	Stevenson Ranch
91384	2.6	Castaic
91355	2.8	Valencia
91311	3	Chatsworth
91344	3	Granada Hills
91351	3.2	Canyon Country
91387	3.4	Canyon Country
91345	3.6	Mission Hills

St. Joseph Community Benefit Service Area		
Zip Code	**CNI Score**	**City**
91201	3.8	Glendale
91203	3.8	Glendale
91042	4	Tujunga
90039	4	Los Angeles
91601	4.2	North Hollywood
91205	4.4	Glendale
91502	4.4	Burbank
91204	4.6	Glendale
91352	4.6	Sun Valley
91605	4.6	North Hollywood
91606	4.6	North Hollywood

Broader St. Joseph Service Area		
Zip Code	**CNI Score**	**City**
91011	1.6	La Canada Flintridge
91214	2.6	La Crescenta
91602	2.6	North Hollywood
91604	2.6	Studio City
91207	2.8	Glendale
91208	2.8	Glendale
91423	3	Sherman Oaks
91505	3	Burbank
91020	3.2	Montrose
91403	3.2	Sherman Oaks
91506	3.2	Burbank
91202	3.4	Glendale
91501	3.4	Burbank
91504	3.4	Burbank
91607	3.4	Valley Village
91206	3.6	Glendale
91040	3.8	Sunland

Tarzana Community Benefit Service Area		
Zip Code	**CNI Score**	**City**
91304	4	Canoga Park
91335	4	Reseda
91306	4.2	Winnetka
91303	4.4	Canoga Park
91406	4.4	Van Nuys
91411	4.4	Van Nuys
91401	4.6	Van Nuys
91405	4.6	Van Nuys

Broader Tarzana Service Area		
Zip Code	**CNI Score**	**City**
91307	1.8	West Hills
91436	1.8	Encino
91301	2.2	Agoura Hills
91302	2.2	Calabasas
91364	2.6	Woodland Hills
91367	2.8	Woodland Hills
91356	3.2	Tarzana
91316	3.4	Encino
91325	3.6	Northridge
91330	3.6	Northridge
91324	3.8	Northridge

Appendix IV – Qualitative Data Collection Tools

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

MEND Focus Group Questions

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

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

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

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

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

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

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

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

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

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

Preguntas

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

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

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

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

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

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

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

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

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

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

Insurance Assistance (End-User) Focus Group

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

2. What is your vision of a healthy community?

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

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

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

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

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

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

Preguntas

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

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

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

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

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

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

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

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

School Principals Focus Group Questions

1. Let's start by introducing ourselves. Please tell us very briefly your first name, the town/city you live in, and one thing that you are proud of about your community.
2. What is your vision of a healthy community?
3. From your perspective, what are the biggest health and social issues in your community? Why?
    a. Any populations disproportionately affected?
4. What are the barriers to accessing resources in your community? What resources are missing?
5. What unique social and health needs do your students have? Their parents and families?
6. What services are you not currently receiving that you would like to receive? Any services requested by parents?
7. What improvements could we make to how we deliver services and health education classes? Any additional topics you would like to see addressed in future classes?
8. Thank you for the information you've shared with me on issues in your community and potential solutions. Is there anything else you would like to add that we haven't discussed?

ONEgeneration, Senior Focus Group Questions

9. Let's start by introducing ourselves. Please tell us very briefly your first name, the town/city you live in, and one thing that you are proud of about your community.
10. What is your vision of a healthy community?
11. From your perspective, what are the biggest health and social issues in your community? Why?
    a. Any populations disproportionately affected?

12. What are the barriers to accessing resources in your community? What resources are missing?
13. What type of support or services would better allow you to live independently and stay healthy?
14. What services are you currently receiving? What could we do to improve them?
15. Are there any activities that you or someone you know struggle with on a day to day basis?
16. Have you received referrals through this program for other health care related or other needs? Did you follow-up on them (and probe for outcome)?
17. Thank you for the information you've shared with me on issues in your community and potential solutions. Is there anything else you would like to add that we haven't discussed?

Welcome Baby (Early Childhood Education) Focus Group

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

2. What is your vision of a healthy community?

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

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

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

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

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

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

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

Preguntas

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

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

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

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

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

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

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

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

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

Invitation to Community Based Organizations to Participate in Survey

PROVIDENCE
Health & Services
Providence Holy Cross Medical Center
Providence Saint Joseph Medical Center
Providence Tarzana Medical Center

Dear Community Partner,

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

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

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

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

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

Sincerely,

Jim Tehan
Regional Director, Community Partnerships
6801 Coldwater Canyon
North Hollywood, CA 91605
James.Tehan@providence.org
310.303.5086 (direct)
310.257.3599 (fax)

Providence Holy Cross, St. Joseph, and Tarzana Medical Centers
2016 Community Health Needs Assessment Survey

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

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

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

   ☐ Excellent
   ☐ Good
   ☐ Fair
   ☐ Poor
   ☐ Don't Know

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

   ☐ Access to health care
   ☐ Health education and outreach
   ☐ Help navigating assistance programs
   ☐ Poverty
   ☐ Education
   ☐ Homelessness
   ☐ Food insecurity
   ☐ Affordable housing
   ☐ Health insurance
   ☐ Dental care
   ☐ Mental health services (including substance abuse services)
   ☐ Pediatric care

☐ Geriatric care

☐ Access to healthy foods

☐ Early childhood education/daycare

☐ Economic opportunities and job growth

☐ Other _____

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

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

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

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

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

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

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

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

Please complete and return by email or mail to:

James Tehan
Providence Community Health Department
6801 Coldwater Canyon
North Hollywood, CA 91605
James.tehan@providence.org

2016 Community Health Needs Assessment
Key Informant Interview

Name:
Date:
Organization:
Title:

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

2. What geographic area do you primarily serve?

3. What is your vision of a healthy community?

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

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

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

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

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

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

Appendix V—Glossary of Terms

Benchmark

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

Community asset

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

Federal poverty level

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

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

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

Focus group

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

Food insecurity

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

Housing cost burden

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

Health indicator

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

Health professional shortage area

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

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

Healthy People 2020

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

Inadequate prenatal care

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

Infant mortality rate

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

Live or crude birth rate

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

Low birth weight

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

Medically underserved area

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

The IMU involves four variables - ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. The value of each of these variables for the service area is converted to a weighted value, per established criteria. The four values are summed to obtain the area's IMU score.

Medically underserved population

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

Primary data

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

Secondary data

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

Stakeholder

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

Teen birth rate

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

Appendix VI—Minutes from Oversight Committee Meeting

Providence Holy Cross Medical Center
Providence Saint Joseph Medical Center
Providence Tarzana Medical Center

Minutes from 2016 Community Health Needs Assessment Oversight Committee
November 10, 2016
11:30-1:30

Meeting Leaders: Carrie Leonard, Dora Barilla, Jim Tehan
Meeting Organizers: Justin Joe, Laura Acosta, Joshua Mendez, Marie Mayen-Cho, Evelyn Enriquez Abraham Gossai

Meeting Participants:

Frank Alvarez, MD, MPH
Elizabeth Diaz
Marine Dzhgalyan
Jenna Hauss
Matthew Horvath, Ed.D (Excused)
Natalie Komuro
Steven Loy, Ph.D
Dana Kalek, Ed.D
Jose Salazar, Dr. Ph., MPH
Olga Vigdorchik
Sandra Yanez, MA
Rosa Bisellach, RN
Sr. Sheila Browne, RSM
Donald Huey, MD
Heidi Lennartz, FACHE, LCSW, CCM
Donovan Stewart, RN, MSN, MICN, CEN
Shawn T. Kiley
Terry Walker
Brian Wren, LCSW

1. Welcome and Reflection [Video] – Carrie Leonard

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

2. Purpose – Dora Barilla

    a. Dora introduced her new position as Executive Leader of Community Investment with Providence Health and Services. She then explained how not-for-profits were required to conduct Community Health Needs Assessments (CHNA). The CHNA process includes data collection and analysis to identify health needs in the service area of the three Providence medical centers in the San Fernando Valley region. The purpose of this Committee is to then prioritize which health needs will be recommended to the governing Community Ministry Board. After the priority health needs are approved, an implementation plan is developed to address those needs. Once the CHNA and implementation strategies are approved, they are disseminated to the larger community.
    b. Dora went over the different types of data that were collected as part of this CHNA. Secondary data consisted of publicly available state and nationally

recognized data sources, including US Census Bureau and Centers for Disease Control. We also received geographically customized data from the Los Angeles County Department of Public Health on 65 core indicators. There were also three sources for primary data. First, we conducted key informant interviews of leaders in community organizations that serve low-income and other vulnerable populations. Next, we used an online survey to gain a better understanding of the communities we serve and the health needs present. Lastly, we conducted end-user focus groups of our community benefit programs.

3. CHNA Findings – Dora Barilla

    a. Dora listed the top priority health issues that were found in the CHNA
        (i) Access to healthcare and resources
            1. Enrollment services
            2. Health navigators
            3. Culturally sensitive services
        (ii) Affordable housing and homelessness
        (iii) Crime and community safety
        (iv) Low educational attainment and unemployment
            1. Early childhood education
            2. Workforce development
        (v) Mental health services (including substance abuse)
        (vi) Poverty and food insecurity
        (vii) Prevention and management of chronic diseases
            1. Obesity
            2. Diabetes
            3. Physical activity
            4. Nutrition
            5. Health education
        (viii) Senior care and resources

    Dora emphasized the importance of looking at social determinants and their social and economic impact. She also explained the importance of collaboration and partnerships, reiterating that hospitals cannot do everything alone.

    b. For each of the aforementioned health issues, Dora presented data that highlighted disparities between the Community Benefit Service Area (CBSA) and the Broader Service Area (BSA). Data for all of LA County was often included as a baseline. Some of the data presented include:
        (i) Service Planning Area 2 (San Fernando Valley) has the third largest homeless population in comparison to the other SPAs. From 2015 to 2016, the homeless population in SPA 2 increased by 36 percent, to 7,094 people, according to the Los Angeles Homeless Services Authority.
        (ii) For all three medical centers, the percent of households living below the federal poverty level in the CBSA were not only above the County level, but also twice as high as the percentages seen in the BSA.

4. Criteria for Prioritization – Dora Barilla, Jim Tehan

    a. Dora presented the criteria that the group will consider for prioritization. Criteria include:
        (i) Attorney General requirements
        (ii) Input from community
        (iii) Mission alignment and resources of hospital

(iv) Severity and magnitude
(v) Addresses disparities of subgroups
(vi) Existing resources and programs
(vii) Opportunity for partnership

Jim expanded on the Attorney General Requirements and explained which programs each medical center is being asked to continue.

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

The Committee was broken out into 3 groups with an even mix of Providence staff and Community representatives. Each group represented one of the three Providence Medical Centers in the San Fernando Valley (Holy Cross, St. Joseph and Tarzana). The individuals within each group included Providence staff from their respective hospital along with community representatives who work within that hospital's service area. Jim Tehan, Marie Mayen-Cho and Justin Joe facilitated a discussion of each health need against the criteria and the scores from the 3 groups were added.

Below are the results of the prioritization:

Table 1: Prioritized Health Needs 2016

Identified Need	Holy Cross Scaled Score	St. Joseph Scaled Score	Tarzana Scaled Score	Final Summed Scaled Score	Final Rank
Access to healthcare and resources • Enrollment services • Specialty services • Medical home • Homelessness and affordable housing**	**15**	**15.625**	**15.5**	**46.125**	**1**
Prevention and management of chronic diseases • Obesity • Diabetes • Physical activity • Nutrition • Health Education	**14.75**	**15.625**	**14.75**	**45.125**	**2**

Senior care and resources	13.75	13.25	15.5	42.5	3
Mental health services (including substance abuse)	12.75	13.75	13.75	40.25	4
Poverty and food insecurity	13	13	11.75	37.75	5
Low educational attainment and unemployment • Early childhood education • Workforce development	11.75	12	12.75	36.5	6
Crime and community safety	12.25	10.5	13	35.75	7
Affordable housing and homelessness	10.25	12	12.25	34.5	8

**After tallying the results, there was discussion on the placement of Affordable Housing and Homelessness. Many Committee members felt that this should be among the top needs addressed by the hospitals. As a result, it was decided to include "Affordable Housing and Homelessness" as a health need that falls under "Access to health care and resources." There was a general consensus from the Committee that this would solve their concerns.

5. Results and Next Steps – Dora Barilla

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

Dora explained that the next step is to present this subcommittee's recommendations to the Community Ministry Board on December 15th. An implementation strategy would then be developed to address the priority needs.

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

PROVIDENCE
Health & Services

Providence Holy Cross Medical Center
Providence Saint Joseph Medical Center
Providence Tarzana Medical Center

Community Health Improvement Plan: 2017-19

Providence Holy Cross Medical Center—
Mission Hills, California

Providence Saint Joseph Medical Center—
Burbank, California

Providence Tarzana Medical Center—
Tarzana, California

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Community Health Improvement Plan 2017-19

Executive Summary

2017 – 2019 Community Health Improvement Plan

Providence Holy Cross Medical Center
Providence Saint Joseph Medical Center
Providence Tarzana Medical Center

Creating healthier communities, together

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

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

Responding to community need, together

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

Access to Care: Issues with access to care, navigating the health system, or other social resources were among the top barriers mentioned by key informants, focus group participants, and community based organizations.
Prevention of Chronic Disease: The need for health education on obesity, diabetes, and nutrition were mentioned by key informants as needs among clients.
Senior Care: Generational differences in asking for assistance and accessing resources were noted as challenges by key informants, when helping seniors obtain health care.
Mental health: Mental health was one of the most frequently mentioned health needs by key informants, focus group participants, and community based organizations. All participants noted a need for more specialty (substance, trauma, coping skills) and integrated services for all age levels.
Poverty/Food Insecurity: An average 20 percent of households across the Community Benefit Service Areas and an average of 9.5 percent of households across the Broader Service Areas are living below the federal poverty level. In comparison, 18 percent of households throughout LA County are living below the federal poverty level.

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

Priority health needs

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

1. Access to Healthcare and Community Resources
2. Prevention and Management of Chronic Diseases
3. Senior care and resources
4. Mental Health Services (including substance abuse)
5. Poverty and Food Insecurity

Action Plans

1) Improve Access to Health Care Services

Our goal is to improve access to quality health care services for vulnerable populations. We will do this by collaborating with community partners to provide services that increase enrollment in and utilization of health insurance, increase the number of people with access to primary care, and increase the number of children who receive their recommended immunizations. Complete details are on pages 16-17 of the full report.

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

Our goal is to reduce the prevalence of diabetes and obesity. We will do this by partnering with organizations to increase physical activity, promote healthy nutrition, and educate individuals with diabetes or at-risk of developing diabetes on how to manage the disease. Complete details are on pages 18-19 of the full report.

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

Our goal is to improve access to the mental health continuum of care in the San Fernando Valley. We will do this by improving integration of mental health in primary care settings, teaching community classes and workshops that build resilience in and reduce the stigma of mental illness, and coordinate access to community mental health resources for patients discharged from our ministries. Complete details are on pages 20-21 of the full report.

4) Align Community Benefit programs with San Fernando valley Medical Centers

Our goal is to improve the alignment of Community Health programs to each of the Providence Medical Centers in the San Fernando Valley. We will do this by raising the visibility of Community

Health programs within each Medical Center by offering opportunities for caregivers to volunteer in local communities, communicating internally about the progress we are making in high-need communities within each Medical Center's Service Area and developing pilot programs for vulnerable patients being discharged from medical centers or pilot programs that address specific populations prioritized by the 2016 CHNA. Complete details are on pages 22-23 of the full report.

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

Introduction

Creating healthier communities, together

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

Serving the San Fernando Valley Community

During 2016, the Providence San Fernando Valley Medical Centers provided $138,530,697 in community benefit in response to unmet needs and to improve the health and well-being of those we serve in the South Bay. This includes $15.4 million in Charity Care, $16.5 million in Community Benefit Services, and $106.5 million in Medi-Cal Shortfall. For 2016, the California region provided $250,960,992 in community benefit. The following entities are sponsored by the San Fernando Valley Medical Centers and include:

- Three Providence hospitals:
  - Providence Holy Cross Medical Center
  - Providence Saint Joseph Medical Center
  - Providence Tarzana Medical Center
- One home health provider:
  - Providence Home Care
- One Long-term care, assisted living and adult day center:
  - Providence St. Elizabeth Care Center
- One hospice for adults
  - Providence TrinityCare Hospice
- One hospice for children
  - Providence TrinityKids Care

About us

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

Mission

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

Vision

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

Values

Respect, Compassion, Justice, Excellence, Stewardship

Purpose of this Plan

In 2016, Providence San Fernando Valley Medical Centers conducted a Joint Community Health Needs Assessment. This community health improvement plan is designed to address key health needs identified in that assessment. The top 5 prioritized needs were chosen by the Board Committee on Community Benefit (BCCB) authorized by the Community Ministry Board for Providence Holy Cross, Providence Saint Joseph and Providence Tarzana Medical Centers. The BCCB prioritized needs based on primary and secondary data on community health, while taking into account identifiable gaps in available care and services. In the course of our collaborative work, we determined that emphasis on these needs would have the greatest impact on the community's overall health with significant opportunities for collaboration. These are:

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

Our overall goal for this plan

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

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

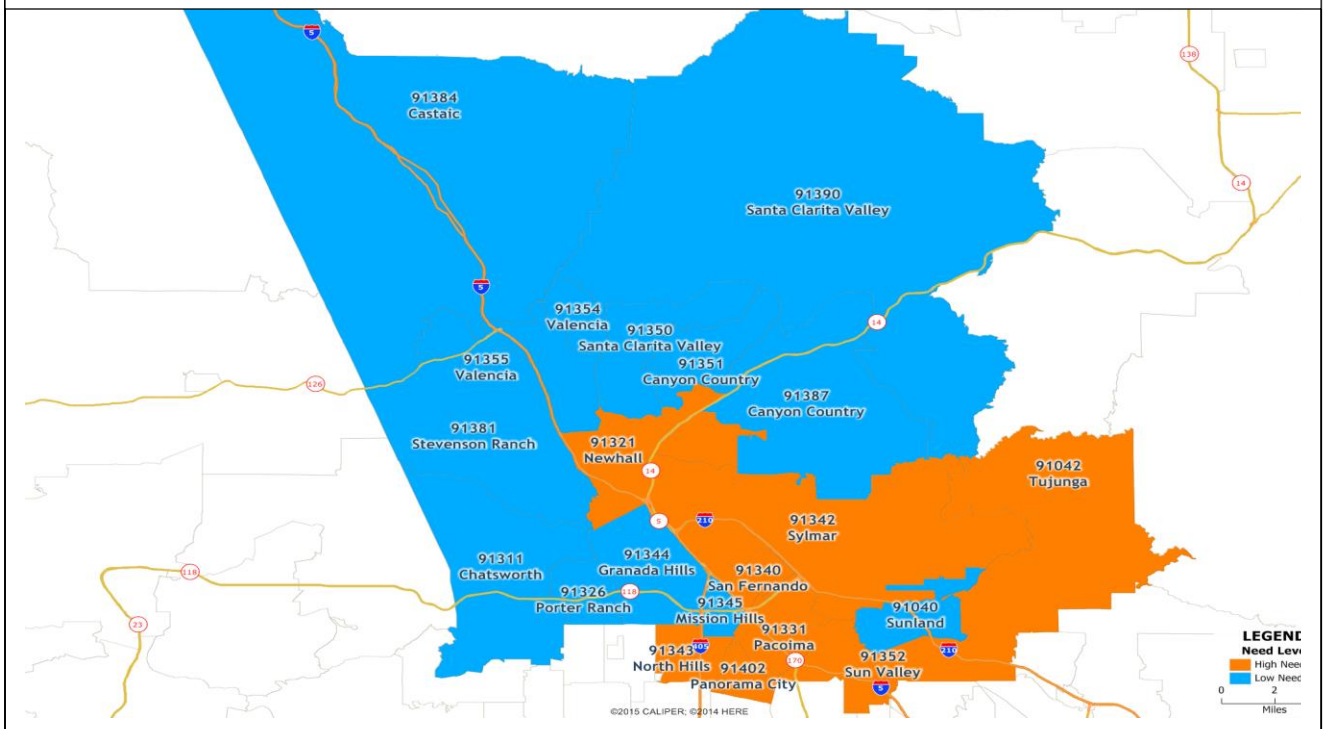
Community Profile

The service area of Providence Holy Cross, Saint Joseph and Tarzana Medical Centers encompasses the San Fernando/Santa Clarita Valley Region of Southern California. The San Fernando Valley is a dynamic and diverse area with a population that spans the socioeconomic spectrum. Neighborhoods include the more resource rich and affluent areas such as Porter Ranch, Calabasas, and Studio City and other areas experiencing various barriers, including but not limited to, the neighborhoods and surrounding areas of San Fernando, Pacoima, North Hills, Canoga Park, Reseda, North Hills, North Hollywood and Sun Valley.

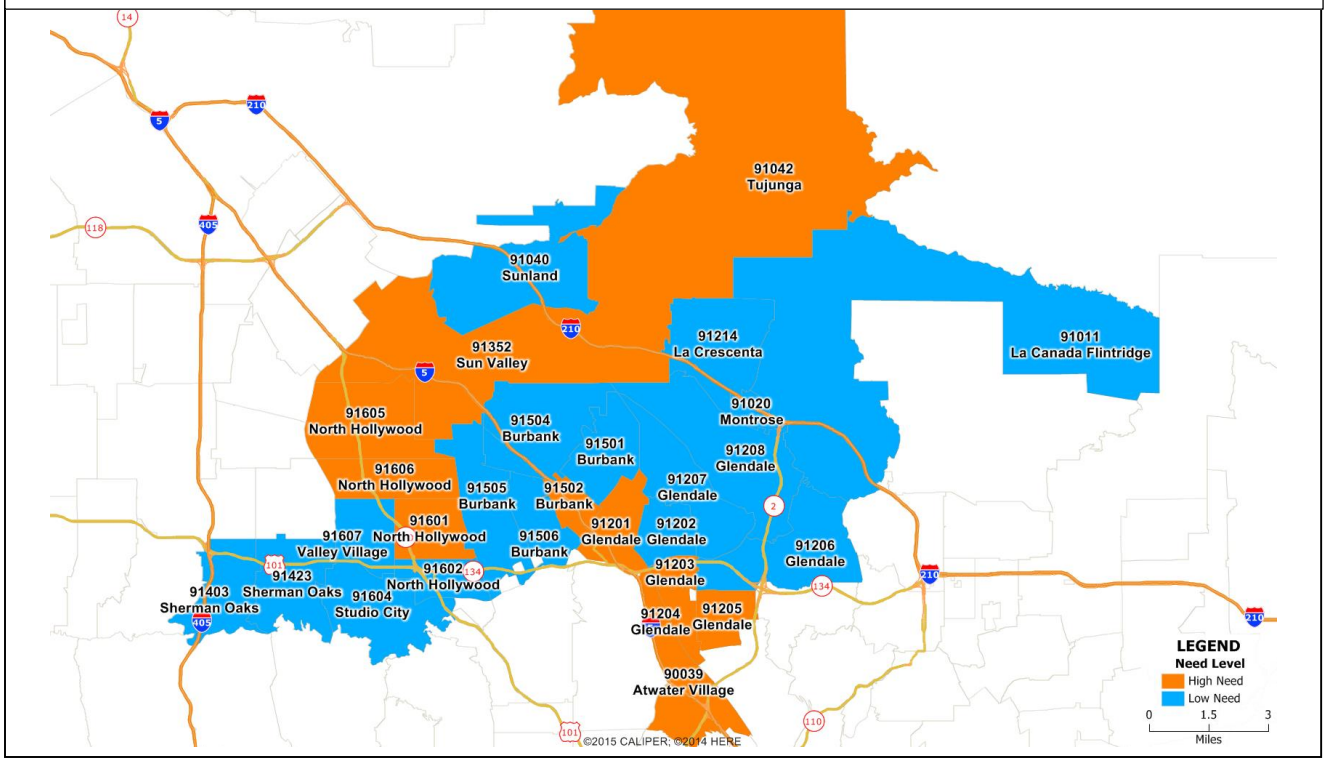
The Total Service Area for the Providence San Fernando Valley Community is divided into six distinct areas using the Community Need Index (CNI) mapping tool from Dignity Health and Truven Health Analytics. There are three community benefit areas, one for each hospital and three Broader Service Areas, one for each hospital. Secondary data was collected in this manner to highlight the disparities within each medical center's service area between the high need communities and more resource-rich communities.

The Community Benefit Service Area was defined using the CNI mapping tool. All communities with a score of 4 or greater on the scale were included. Communities identified as having higher need using the scale experience greater barriers to health care including income, cultural, educational, health insurance, and housing barriers. The Broader South Bay Service Area are the communities in blue within the Total Service Area of each of the three Medical Centers remaining after application of the CNI. These areas are more resource-rich with a population on the higher end of the socioeconomic spectrum.

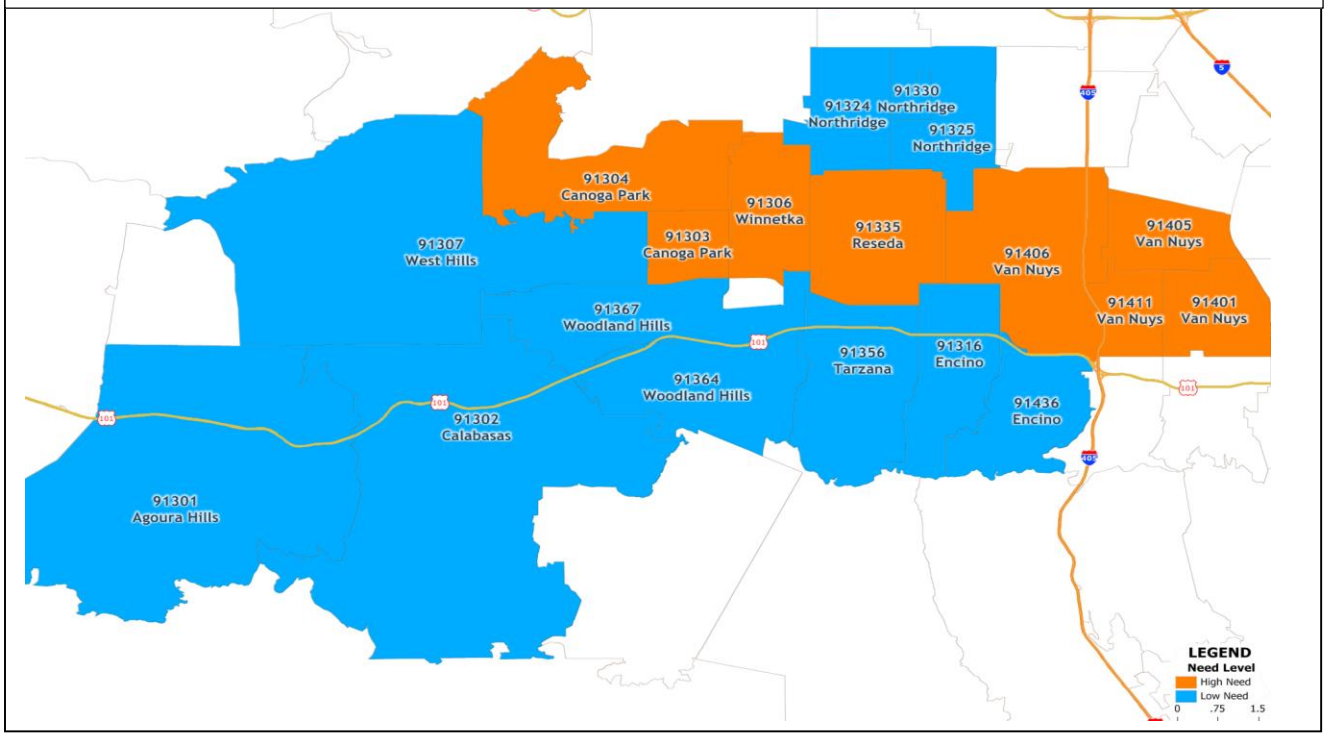
Providence Holy Cross Medical Center Service Area



Providence Saint Joseph Medical Center Service Area



Providence Tarzana Medical Center Service Area



Population and Age Demographics

According to the latest US Census Bureau estimates, the total population for the Total Service Area is 2,220,756, with an average annual growth rate of about 0.7% percent in 2016. Age demographics are 78 percent of the population are age 18 or older, and the median age is 37.2, compared to a U.S. median age of 38. In 2016 the population comprised:

- 18.3 percent youth (0-14 years)
- 13.6 percent adolescent and young adults (15-24)
- 28.9 percent adults (25-44 years)
- 26.1 percent older adults (45-64 years)
- 13 percent seniors (65 years and older)

Ethnicity

Among Total Service Area residents in 2016, 60.4 percent were White, 12.1 percent Asian, 41 percent were Hispanic or Latino, 0.6 percent were Alaska Native or American Indian, 3.6 percent were African American or Black, 0.1 percent were Native Hawaiian or other Pacific Islander, and 5 percent were of two or more races.

Income Levels and Housing

In 2016, the median household income for the Total Service Area was $65,976. Comparatively, the median household income across the three Community Benefit Service Areas was $50,710 and $85,121 for the Broader Service Areas.

When looking at income by service area, one can see a near mirror image when comparing Community Benefit Service Areas to their respective Broader Service Areas. For example, 48 percent of households within the Tarzana Community Benefit Service Area earn an annual income of $49,999 or less, 18 percent earn $50,000 to $74,999 annually, and 35 percent earn $75,000 or greater. In comparison, in the Broader Tarzana Service area 30 percent of households earn an annual income of $49,000 or less, 14 percent earn $50,000 to $74,999 annually, and 56 percent of households earn $75,000 or greater. In comparison to estimates for LA County, the Broader Service Areas have a higher percentage of high earning households. For example, 46 percent of households in the Broader Holy Cross Service Area earn $100,000 or more per year. In comparison, 28 percent of households throughout LA County have an annual household income of $100,000 or greater.

Health Care and Coverage

In 2016, the percent of individuals who were uninsured was 5.75 percent. Lack of access to dental care in the Community Benefit Service Areas surpassed LA County estimates for both adults and children, except among adults living in St. Joseph's Community Benefit Service Area and children living in Holy Cross' Community Benefit Service Area. Among adults living in St. Joseph's Community Benefit Service Area, 39 percent of adults did not see a dentist in the past year. Comparatively 41 percent of adults throughout LA County did not receive dental care in the past year.

Health and Wellbeing

In 2015, adults living in the Holy Cross Community Benefit Service Area reported the highest percentage of fair or poor health status, in comparison to the other two community benefit areas. In contrast, 13 percent of adults living in the Broader Holy Cross Service Area reported fair or poor health status.

Summary of Providence Prioritized Needs and Associated Action Plans

Assessment process

Every three years, Providence San Fernando Valley Region conducts a community health needs assessment (CHNA) for the communities served by Providence Holy Cross, Providence St. Joseph, and Providence Tarzana Medical Centers. 2016 is the first that the three hospitals have engaged in a joint community health needs assessment and represents a commitment to developing regional strategies, increased collaboration, and recognition of shared challenges and solutions among those we serve and partner with. The passage of California Senate Bill (SB) 697 in 1994 initiated a requirement that non-profit Hospitals in California conduct a triennial CHNA. Additionally, the CHNA is conducted to satisfy our annual community benefit obligations by meeting requirements that are outlined in section 501(r)(3) of the Federal IRS Code and to create partnerships that address identified needs. The goals of the assessment are to:

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

Beginning with the 2016 CHNA, the Hospitals agreed to conduct a Joint CHNA in accordance with §1.501(r)-3(b)(6)(v) of the Federal IRS code 26 CFR Parts 1, 53, and 602 ("Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return; Final Rule"). Accordingly, nine representatives across all three Providence medical centers agreed to participate on the Board Committee on Community Benefit (BCCB) authorized by the Providence Valley Service Area Community Ministry Board. In collaboration with nine community representatives, the oversight group considered primary and secondary data collected and prioritized community needs as described below.

Outside Consultant: HC2 Strategies, Inc.

Providence Health and Services contracted HC2 Strategies, Inc. to conduct and document this community health needs assessment. HC2 Strategies, Inc. is a healthcare consulting firm with expertise in health care systems, strategy and innovation, community health needs assessments, and program evaluation. Research and development of the final written product was led by HC2's Healthcare Intelligence Director, Jessica L.A. Jackson, MA, MPH.

Data collection

Primary Data

Providence Holy Cross, Providence St. Joseph, and Providence Tarzana Medical Centers conducted key informant interviews, focus groups, and an online survey with community based organizations to gather more insightful data and aid in describing the community. Key informants were selected based on their

expertise in working with low-income, medically underserved, minority, or otherwise vulnerable populations. Focus groups focused on end-user experiences and needs. The online survey was targeted to community based safety net organizations and focused on service needs among clients.

Secondary Data

In 2016, regional staff from Providence Health and Services Southern California provided leadership that resulted in the formation of a coalition of hospitals across Los Angeles County. This group—the LA County Community Health Assessment and Action Partnership ("LA Partnership")—worked to devise standard core indicators for community health to be used in community health needs assessments, implementation plans, and program planning. The efforts of the coalition resulted in an enhanced custom report furnished by the Epidemiology Unit at the Los Angeles Public Health Department.

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

Identification of significant health needs

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

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

Identified Community Health Needs in 2016	
Priority Health Issue	**Rationale/contributing factors**
Access to healthcare and resources • Enrollment services • Health navigators • Culturally sensitive services • Affordable housing and homelessness*	• Issues with access to care, navigating the health system, or other social resources were among the top barriers mentioned by key informants, focus group participants, and community based organizations. • Key informants consistently cited a need for more health education and outreach to ensure client access to and use of services. The need for health navigator type services in combination with medical care was also expressed. • Cultural and language barriers to obtaining

	health care was the top issue for children and adults and second top issue for seniors, selected by partners on the Community Based Organizations Survey. • Language barriers and services for undocumented populations was mentioned frequently by key informants. • Housing cost burden is about 56 percent across all three Community Benefit Service Areas. In comparison, about 50 percent of households across the Broader Service Areas spend 30 percent or more of their income on housing. • Safe and affordable housing was mentioned by both focus group participants and key informants as a major social issue in our community. • SPA 2 (San Fernando Valley) has the third largest homeless population, in comparison to the other SPAs. • The 2016 Greater Los Angeles Homeless count estimated a total of 7,094 total homeless persons on a night in 2016. 1,431 were sheltered (20%) and 5,663 (80%) were unsheltered. • From 2015 to 2016, SPA 2 experienced a 36% growth in the number of homeless.
Crime and community safety	• The most frequently mentioned aspects of a community which contribute to people's health in a negative way were crime including bullying, graffiti, speeding, and youth safety. • Key informants and focus group participants frequently mentioned unsafe environments, improper dumping and cleanliness, and access to safe and supportive spaces as drivers of health in our region. • 19.4 percent of adults living in the Broader St. Joseph service area, 18.4 percent of adults living in the St. Joseph Community Benefit service area, and 17.6 percent of adults living in the Broader Holy Cross service area have experienced some form of intimate partner violence. In comparison, 13.4 percent of adults throughout LA County reported experiencing intimate partner violence.

Low educational attainment and income • Early childhood education • Workforce development	• The need for education around financial literacy, resources, job training and quality child care/youth development programs was expressed by key informants, focus group members, and partners through the CBO survey. • Financial resources and chronic illness were the most frequently mentioned health and social issues by key informants. Housing, sufficient resources, and livable wages were also mentioned. • The need for quality child care and youth development programs was expressed by key informants, focus group members, and partners through the CBO survey. The focus group responses provided awareness of services and resources and no childcare during the programs as the barriers for reaching the needs in the community.
Mental health (including substance abuse treatment)	• Mental health was one of the most frequently mentioned health needs by key informants, focus group participants, and community based organizations. All participants noted a need for more specialty (substance, trauma, coping skills) and integrated services for all age levels. • Binge drinking among adults was highest in Holy Cross's community benefit service area (16.5 percent), followed by Tarzana's community benefit service area (15.8 percent) and the Broader Tarzana service area (15 percent). In comparison, the percentage of adults throughout LA County reporting engaging in binge drinking is 15.9 percent. • 12.8 percent of adults living in the St. Joseph community benefit service area and 12.3 percent of adults living in the Broader Tarzana service area are at risk for major depression. In comparison, 11.8 percent of adults throughout LA County are at risk for major depression.
Poverty and food insecurity	• Poverty and the associated consequences were mentioned frequently by key informants. • An average 20 percent of households across

	the Community Benefit Service Areas and an average of 9.5 percent of households across the Broader Service Areas are living below the federal poverty level. In comparison, 18 percent of households throughout LA County are living below the federal poverty level. • All three Community Benefit Service Areas had rates for food insecurity above the County estimate and estimates for Broader Service Areas.
Prevention and management of chronic diseases • Diabetes • Obesity • Physical activity • Nutrition • Health education	• The need for health education on obesity, diabetes, and nutrition were mentioned by key informants as needs among clients. • Access to healthy foods and safe places to play were mentioned by both key informants and focus group participants as needs in the community. • The availability of green space is lowest in Tarzana's community benefit service area, in comparison to other areas in the region. For example, there are 0.57 acres of park areas per 1,000 people in Tarzana's community benefit service area. In comparison, the Broader Tarzana service area has 20.15 acres of park acres per 1,000 people.
Senior care and resources	• Generational differences in asking for assistance and accessing resources were noted as challenges by key informants, when helping seniors obtain health care. • In consideration of health and social needs of the community, focus group participants noted a need for better communication, awareness of resources and connection to those resources, access to transportation for handicapped and elderly people, food delivery for homebound, and access to a trainer for exercise and proper weight training as concerns for older adults. • The St. Joseph total service area has the highest percentage of adults age 65 and older who have fallen in the past year in comparison to other areas (45.1 percent in the community benefit service area and 39.2 percent in the Broader St. Joseph service area). In comparison, 27.1 percent of adults age 65 and older throughout LA County have fallen in the past year.

Prioritization of Community Health Needs

On November 10, 2016, BCCB members, authorized by the Valley Service Area Community Ministry Board, met to debrief on the findings of the CHNA and prioritize the identified needs. Committee members were provided the scores for three criteria: input from the community (primary data), severity and magnitude (secondary data), and programs required by the Attorney General as part of the Combination Agreement between Providence Health and Services and St. Joseph Health. Committee members were broken into three separate groups (one group representing each of the three Providence Medical Centers) and asked to rank the remaining four criteria based on their expertise, using a scale of 1 (criterion not met) to 4 (criterion well met). Three facilitators helped participants reach a ranking for each of the identified priority issues. The rankings for each group were scored and the scores were tallied for each priority health need. The final ranked list:

(1) Access to healthcare and resources
(2) Prevention and management of chronic diseases
(3) Senior care and resources
(4) Mental health services (including substance abuse)
(5) Poverty and food insecurity
(6) Low educational attainment and unemployment
(7) Crime and community safety

Strategy 1: Improve Access to Healthcare Services

Community need addressed: Access to Healthcare and Resources

Goal: Improve access to primary health care services and immunizations for vulnerable populations

Objectives

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

Action plan

Health Insurance

Tactics

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

Primary Care

Tactics

- Increase the number of clinics/FQHC's who participate in the Access to Care program and improve access to specialists who provide consults for clinic/FQHC patients
- Emergency Room Promotoras: link uninsured emergency department patients with a local community clinic to serve as their medical home for future primary care visits
- Facilitate follow-up appointments to a medical home for health fair participants who receive out-of-range POCT test results

Immunizations

Tactics

- Start-up immunization clinic, establish schedules of participating schools and document immunizations provided
- Promote HPV and meningococcal immunizations with local pediatricians and family practice physicians to encourage parents to have their children receive the cancer prevention vaccinations

Partners in collaboration

MEND – Meet Each Need With Dignity, Pacoima

San Fernando Community Health Center

All-Inclusive Community Health Center, Burbank

Northeast Valley Health Corporation, Van Nuys

Family Health Clinic, Sylmar

Vista Community Health Center, Sylmar

Center for Family Health and Education, Panorama City

Los Angeles Unified School District, Northwest District

Catholic School Network (15 schools)

OneGeneration

Child Development Institute

Measurement

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

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

Community needs addressed:

- Prevention and Management of Chronic Diseases
- Senior Care and Resources
- Poverty and Food Insecurity

Goal: To reduce the prevalence of diabetes and obesity

Objectives:

- Increase physical activity for children by partnering with elementary schools and community-based youth services providers.
- Initiate physical activity for adults by partnering with clinics, churches and CBO's
- Increase access to healthier foods, nutrition events & start follow-up classes
- Increase scope of services and partners to strengthen Senior outreach program
- Implement a diabetes prevention program for an at-risk adult population

Action plan

Increase Physical Activity

Tactics

- Initiate Creating Opportunities for Physical Activity (COPA) in schools, churches and/or community centers
- Conduct Wellness visits as part of the Faith Community Health Partnership and CSUN/3 Wins programs

Increase Access to Healthier Foods

Tactics

- Host "Fit Food Fairs," which teach local residents how to cook healthy foods
- Pilot Groceryships—a non-profit nutrition education and support group program
- Increase CalFresh enrollment through application assistance in community settings
- Work with local farmers markets to accept CalFresh as a form of payment

Strengthen Senior Outreach Program

Tactics

- Partner with San Fernando Valley senior services agencies to improve continuum of services, including seeking funding to fill identified gaps
- Improve documentation on sources of referrals to program, scope of referrals, and confirmation of partner services provided
- Plan, design and implement a physical activity program for seniors

Diabetes Self-Management Education

Tactics

- Adopt an evidence-based curriculum for Pre-diabetic adults
- Work with hospital or community partners to strengthen the infrastructure of classes for adults through the Latino Health Promoter program

Partners in collaboration

California State University, Northridge, Department of Kinesiology, 3WINS Program

Los Angeles Unified School District, Northwest District

Catholic School Network (15 schools)

Los Angeles County Department of Health Services, including Public Health and Mental Health

OneGeneration

Faith Community Health Partnership (25 churches)

Measurement

- # of sites providing COPA
- # of COPA participants, attendance rate, BMI and other metrics TBD
- # of households enrolled in CalFresh
- # of Groceryships cohorts, # of participants who complete course, attendance rate and course completion rate
- # of Fit Food Fairs hosted
- # of Diabetes Prevention cohorts

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

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

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

Objectives:

- Improve access to mental health services in school and community settings
- Build resilience in children, teens, families and seniors
- Reduce the stigma of mental illness
- Reduce symptoms of depression and anxiety

Action plan

Improve access

Tactics

- Coordinate linkage of participants in Health Promoter classes to mental health providers

Prevention

Tactics

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

Treatment

Tactics

- Implement mental health first aid training in partnership with the National Council for Behavioral Health
- Explore the feasibility of a Wellness and Activity Center

Partners in collaboration

Child and Family Guidance Center, Northridge

Tarzana Treatment Centers

Center for Individual and Family Counseling, North Hollywood

National Council for Behavioral Health

Los Angeles County Department of Mental Health, Reseda

Strength United, Van Nuys and Reseda

Measurement

- # of community residents trained on mental health first aid
- # of adults who participate in Health Promoter classes and request assistance in finding a mental health safety net clinic
- # of adults who complete a coping skills curriculum
- # of youth who complete ACES curriculum
- # of referrals to community-based mental health providers

Strategy 4: Align Community Benefit programs with San Fernando Valley Medical Centers

Community needs addressed:

- Access to Healthcare and Resources
- Prevention and Management of Chronic Diseases
- Senior Care and Resources
- Mental Health (including substance abuse treatment

Goal: Align Community Health priorities and activities with each San Fernando Valley Medical Center

Action plan

Providence Holy Cross Medical Center

Tactics

- Develop a network of private sub-specialty physician who provide consults to patients referred by Providence Holy Cross Medical Center to local clinics
- Develop a pilot program that addresses mental health/resiliency skills for middle school students.

Providence Saint Joseph Medical Center

Tactics

- Strengthen the network of private sub-specialty physician consults for patients referred by ER to community clinics
- Support "Live Well" program operations and expand to high need communities in Saint Joseph Medical Center Service Area

Providence Tarzana Medical Center

Tactics

- Develop a pilot program for seniors at risk for social isolation at time of hospital discharge
- Implement peer coach training related to physical education for elementary classroom teachers and/or community based youth organizations.

Measurement

- # of volunteer specialty physicians, by Medical Center, participating in Access to Care
- # of patients referred by clinic partners for specialty consult
- # of seniors participating in pilot program
- # of volunteer hours from caregivers and community residents in pilot program
- # of peer coach training sessions provided by COPA
- # of COPA participants, attendance rate, BMI and other metrics TBD

Identified Health Needs Not Addressed in Plan

As part of the CHNA process, the Valley Service Area Community Ministry Board (CMB) approved the formation of the Board Committee on Community Benefit (BCCB), a group of nine Providence employees across both medical centers and nine external representatives from Public Health, local schools, community based organizations, an FQHC and a local grant-making agency, After considering all of the assembled data, this group of 18, along with the Mission Committee Chair, prioritized the identified health needs using specific criteria described in the CHNA.

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

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

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

- Low educational attainment and income
- Crime and community safety

It was the consensus of the BCCB members that **Affordable housing and homelessness** should be addressed in the context of **Access to healthcare and resources**.

2017-19 Plan approval

This Community Health Improvement Plan was adopted on April 20, 2017 by the Valley Service Area Community Ministry Board.

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

4-20-2017
Date

Kerry Carmody
Interim Chief Executive, Providence St. Joseph Medical Center

4-20-17
Date

Dale Surowitz
Chief Executive, Providence Tarzana Medical Center

4/20/17
Date

Sarah Karzel
Chair, Valley Service Area Community Ministry Board

4/20/17
Date

Jim Tehan
Regional Director, Community Benefit and Partnerships
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4/20/17
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