Providence

2025 COMMUNITY HEALTH NEEDS ASSESSMENT

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

California

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Understanding and Responding to Community Needs

The Community Health Needs Assessment (CHNA) is an opportunity for Providence Little Company of Mary Medical Center San Pedro (PLCMMC-SP) and Providence Little Company of Mary Medical Center Torrance (PLCMMC-T) to engage the community every three years with the goal of better understanding community strengths and needs. At Providence, this process informs our partnerships, programs, and investments. Improving the health of our communities is fundamental to our Mission and deeply rooted in our heritage and purpose.

This report is a joint CHNA and reflects the hospitals' collaborative efforts to identify the significant health-related needs in the community and the community strengths. The hospitals participating in this joint CHNA share a service area and community served. The 2025 CHNA was approved by the Mission Community Health Committee of the Board of Directors on September 9, 2025, and made publicly available by the end of the 2025 fiscal year.

Gathering Community Health Data and Community Input

Through a mixed-methods approach, using quantitative and qualitative data, we collected information from the following sources: American Community Survey, Behavioral Risk Factor Surveillance System, Environmental Justice Index, local public health data, Providence electronic medical records data, and the Los Angeles Homeless Services Authority (LAHSA) Homeless Count. To actively engage the community, we conducted six listening sessions with fifty-two participants who have chronic conditions, are from diverse communities, have low income, and are medically underserved. We also conducted thirty-eight community stakeholder interviews with representatives from organizations that serve these populations, specifically seeking to gain a deeper understanding of community strengths and opportunities. Some central findings include the following:

- South Bay residents living in areas of highest need experience higher rates of depression than Los Angeles County and California. There is a shortage of providers and services; and stigma and fear around seeking care often keeps people away from services.
- South Bay residents living in areas of highest need are less likely to have health insurance than those living in Los Angeles County or California. Additionally, the community experiences challenges in accessing primary and specialty services, especially services that are culturally responsive and language appropriate. This impacts residents' ability to manage chronic disease. South Bay's Service Area has higher rates of asthma, diabetes, heart disease, obesity, and COPD than Los Angeles County and California.
- Mixed status families and those with immigration concerns are experiencing greater barriers to accessing care.

Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance community stakeholder interviews were planned and implemented in collaboration with Torrance Memorial Medical Center, a local area hospital with an overlapping service area.

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

Identifying Top Health Priorities

After a presentation of key data findings by Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance leadership, the Mission Community Health Committee participated in a robust discussion on how consistent the data aligned with what they knew about the community. The committee then prioritized significant health needs using an assessment scorecard based on the following criteria:

- Listening session input
- Community stakeholder survey prioritization score
- Service area health indicator data, compared to county, state, or national benchmarks
- Opportunity to impact: current Providence Community Benefit programs
- Opportunity to impact: external partnerships
- Alignment with Providence health system strategies

The committee took a vote on the top three needs for Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance to prioritize over the next three years. Below are the resulting health needs priorities, based on the CHNA Advisory Committee's process, ranked in order of priority.

ACCESS TO CARE

Local community stakeholders identified specific barriers to accessing care in the service area include high costs, difficulties navigating the health care system, appointment delays, language barriers, insufficient health education, lack of culturally responsive services, and transportation challenges.

Access to care goes beyond health insurance coverage, however, people without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. In addition, obtaining coverage for lower income households will become more challenging as new policy changes will impact eligibility for Medi-Cal, and premium and co-pay costs for Covered California.

BEHAVIORAL HEALTH (MENTAL HEALTH & SUBSTANCE USE/MISUSE)

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

Mental health programs include the prevention, screening, assessment, and treatment of mental disorders and behavioral conditions.

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

Community stakeholders frequently expressed the need for more access to services such as therapists and other mental health professionals, as well as drug prevention and mental health awareness classes.

CHRONIC DISEASE

Chronic diseases are persistent health conditions—such as heart disease, diabetes, cancer, and respiratory illnesses—that typically last for one year or more and often require ongoing medical care or limit activities of daily living. These diseases represent a significant burden on individuals, families, and the broader community by increasing healthcare costs, reducing productivity, and diminishing quality of life. The South Bay Service Area had a higher percentage of people with heart disease, diabetes, and respiratory illness compared to the entire county and state.

In many cases, chronic conditions are closely linked to upstream factors like unhealthy diets, physical inactivity, tobacco use, and limited access to preventative care. Poor nutrition and sedentary lifestyles, for example, can contribute to the development and progression of these illnesses. The South Bay Service Area had higher percentages of obesity prevalence and people reporting physical inactivity compared to Los Angeles County and California.

Addressing chronic disease requires a comprehensive approach that not only supports those living with these conditions but also focuses on prevention through promoting healthy behaviors and improving community environments. Community stakeholders expressed a desire for more exercise programs, walking groups, and health education on nutrition, fitness, and preventive care for all ages. They also mentioned air pollution and poor air quality as local environmental factors impacting rates of chronic disease.

Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs in collaboration with community partners considering resources and community strengths and capacity. The 2026-2028 CHIP will be approved and made publicly available no later than May 15, 2026.

RESULTS FROM THE 2022 CHNA AND 2023-2025 CHIP

Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices. In addition, we invited written comments on the 2022 CHNA and 2023-2025 CHIP, made widely available to the public through posting on our website and distribution to community partners. No written comments were received on the most recent CHNA and CHIP. The 2022 CHNA and 2023-2025 CHIP priorities were the following: Homelessness and Housing Instability, Behavioral Health (Mental Health and Substance Use/Misuse), and Access to Health Care and Preventive Care

A few of the key outcomes from the previous CHIP are listed below:

- 2,457 health insurance applications assisted per year
- 3,648 childhood vaccines administered per year
- 1,616 follow up primary care referrals and appointments made per year for uninsured and underinsured patients in the emergency department
- 113 unhoused patients in the emergency department connected to shelter/housing per year
- Trained 311 participants in Mental Health First Aid, annually
- Averaged 81 patients annually who received mental health therapy services at Vasek Polak Health Clinic

WHO WE ARE

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

Providence Little Company of Mary Medical Center Torrance (PLCMMC-T) and Providence Little Company of Mary Medical Center San Pedro (PLCMMC-SP) serve the South Bay with comprehensive, high-quality care. Located just miles apart, the two acute care hospitals share a common service area and a commitment to clinical excellence.

The Sisters of Little Company of Mary chose their name to honor the small group of women who stood with Mary at the foot of the cross as Jesus lay dying. From the beginning, the Sisters demonstrated an enduring commitment to the poor and vulnerable through outreach to underserved communities and care for the sick and dying.

In 1982, Little Company of Mary Hospital adopted a social accountability budget to strengthen its mission. When the organization expanded to include San Pedro Hospital, that commitment continued. By the 1990s, the Sisters recognized that declining numbers across the American Province threatened their ability to sustain core mission work. After a period of discernment, they entered a joint sponsorship agreement with Providence in 1998. Today, the two medical centers share a governing board and leadership team for the South Bay and operate as part of Providence.

Providence Little Company of Mary Medical Center Torrance, a 327-bed hospital, has cared for the community since 1960. It offers minimally invasive surgery with the advanced da Vinci® 5 robotic system. Its cardiovascular center of excellence features advanced cardiac catheterization and angiography equipment, making coronary angioplasty and open-heart surgery available around the clock. The hospital also houses a state-of-the-art maternity unit, including the county's first single-family level III neonatal intensive care unit to enhance parent-child bonding for even the most fragile infants.

Providence Little Company of Mary Medical Center San Pedro, a 231-bed hospital, has been a trusted health care provider since 1925. It delivers specialized services such as behavioral health, advanced rehabilitation therapy, and comprehensive recovery programs. Its Sub Acute Care Center ranks among California's largest, and the Center for Optimal Aging provides complete care for older adults.

Both hospitals partner with leading organizations to expand access to specialized care:

- Pacific Neuroscience Institute for complex neurosurgical and neuro-spine cases
- Keck Medicine of USC for academic-based cardiovascular procedures
- City of Hope for state-of-the-art cancer care at the Advanced Care Center

These collaborations bring world-class expertise close to home for South Bay residents.

In addition to advanced services and technology, both medical centers have earned national recognition. Providence Little Company of Mary Medical Center Torrance has been named a World's Best Hospital by Newsweek seven years in a row and recognized by U.S. News & World Report as one of California's best hospitals. Providence Little Company of Mary Medical Center San Pedro ranks nationally in rehabilitation, according to U.S. News & World Report.

For more information on the resources invested to improve the health and quality of life for the communities we serve, please refer to our Annual Report to our Communities: https://www.providence.org/about/annual-report.

Joint CHNA

This is a "joint CHNA report," within the meaning of Treas. Reg. § 1.501(r)-3(b)(6)(v), by and for Providence including Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance. This report reflects the hospitals' collaborative efforts to identify the significant health-related needs in the community as well as the community strengths. The hospitals participating in this joint CHNA share a service area and community served. This CHNA engaged with and sought input from that community.

Collaborating Community Partners

Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance community stakeholder interviews were planned and implemented with Torrance Memorial Medical Center, a local area hospital with an overlapping service area. Community health leadership from all hospitals developed a list of stakeholders, invited stakeholder participation, and agreed upon a stakeholder interview protocol for qualitative data collection.

Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance is grateful for the contributions of community members and community stakeholders who gave their time and expertise in sharing insights about community strengths and unmet needs to guide community health improvement strategies and commitments.

Contractor

Forward Community Health Consulting (Forward CHC) conducted the CHNA stakeholder interviews and compiled the final CHNA report. Forward CHC is an independent consulting firm that works with hospitals and community-based nonprofit organizations. Cindy Levey, MPH, Forward CHC Principal, has over 25 years of experience conducting CHNAs and working with hospitals and health systems on developing, implementing, and evaluating Community Benefit programs. Sevanne Sarkis, JD, MHA, Med, Forward CHC Data Specialist, provided interview services. www.ForwardCHC.com.

Equity Practices in the CHNA

At Providence, we are committed to addressing the underlying and root causes of health disparities and inequities in the communities we serve. We work to address not only the clinical factors that determine a person's length and quality of life, but also the social and economic dimensions, physical environment, and other factors that play a role in determining health outcomes. Addressing these factors includes leveraging community strengths and utilizing evidence-based, leading practices.

The CHNA is an important process for better understanding health disparities and social inequities, including how racism and discrimination have detrimental effects on community health and wellbeing. Through literature and our community partners, we recognize that long-standing systemic inequities exist and that they can lead to health disparities. To ensure we are taking a holistic approach to understanding the health of the communities we serve, we define health broadly including social, cultural, and environmental factors that affect wellbeing, and engage community members from diverse backgrounds in the CHNA process. We routinely evaluate health disparities in the communities we serve and use qualitative and quantitative data to inform how we enhance access to high-quality, evidence-based care.

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

Approach

Share equity practices in the CHNA

Highlight community strengths

Use people first and non-stigmatizing language

Community Engagement

Use multiple methods to engage with community members

Implement equitable practices for community participation

Share findings back with communities

Quantitative Data

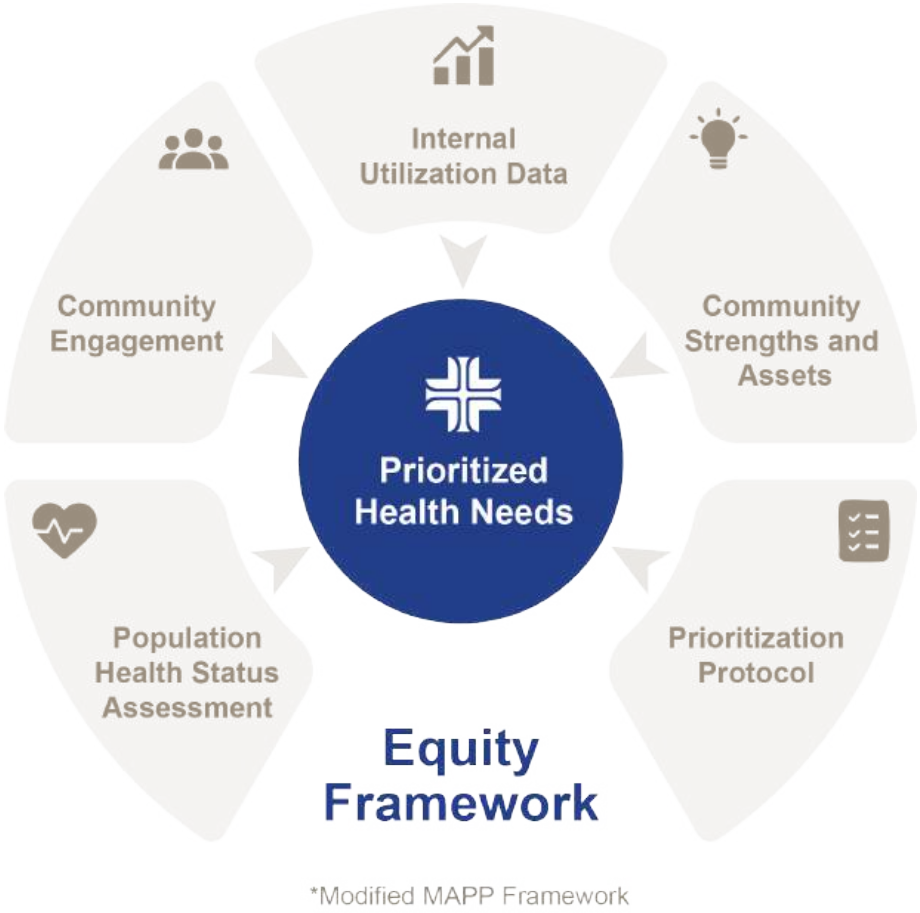
Report data at the local level to avoid masking

Disaggregate data when responsible

Acknowledge inherent bias in data and screening tools

CHNA Framework

The equity framework is foundational to our overall CHNA framework, a modified version of the Mobilizing for Action through Planning and Partnerships 2.0 (MAPP 2.0) developed by the National Association of County and City Health Officials (NACCHO). The modified MAPP framework takes a mixed methods approach to prioritize health needs, considering population health data, community input, internal utilization data, community strengths and assets, and a prioritization protocol.



*Modified MAPP Framework

Data Sources

In gathering information on the communities served by the hospital, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. In addition, we recognize that there are often geographic areas where the conditions for supporting health are poorer than nearby areas. Whenever possible and reliable, data are reported at census tract level. These smaller geographic areas allow us to better understand the neighborhood level needs of our communities and better address inequities within and across communities. We reviewed data from the following sources:

Primary Data Sources	Secondary Data Sources
• Community stakeholder interviews • Community listening sessions • Internal hospital utilization data	• American Community Survey from the U.S. Census Bureau • Behavioral Risk Factor Surveillance System (BRFSS) • CDC Places • Environmental Justice Index • Electronic medical records data • Social Determinants of Health screening data • Los Angeles Homeless Services Authority (LAHSA) Homeless Count

Data Limitations and Information Gaps

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

- Not all desired data were readily available, so sometimes we had to rely on tangential or proxy measures or not have any data at all.
- While most indicators are relatively consistent from year to year, other indicators are changing quickly and the most recent data available are not a good reflection of the current state.
- Reporting data at the county level can mask inequities within communities. This can also be true when reporting data by race, which can mask what is happening within racial and ethnic subgroups. Therefore, when appropriate and available, we disaggregated the data by geography and race.
- Data that are gathered through interviews and surveys may be biased depending on who is willing to respond to the questions and whether they are representative of the population as a whole.
- The accuracy of data gathered through interviews and surveys depends on how consistently the questions are interpreted across all respondents.

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

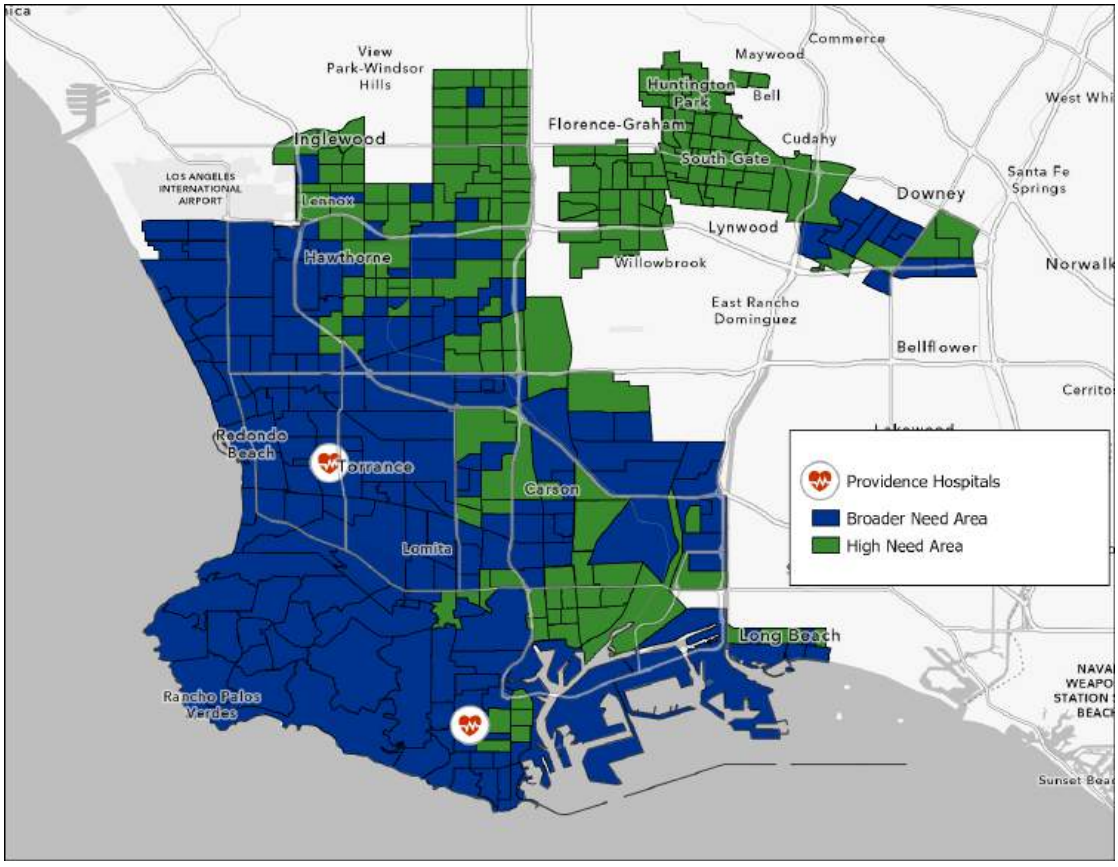
Written comments were solicited on the 2022 CHNA and 2023-2025 CHIP reports, which were made widely available to the public via posting on the internet in December 2022 (CHNA) and May 2023 (CHIP), as well as through various channels with our community-based organization partners. No comments to the 2022 CHNA and 2023-2025 CHIP reports were received.

CHNA Service Area

In defining its community for purposes of this report, we modified the service area from most recent Community Health Needs Assessment conducted by the two Providence Little Company of Mary hospitals in the South Bay region of Los Angeles County in 2022. We considered the location of the hospital and the surrounding communities, the ZIP Codes of our patients on entry into the hospital for services, and incorporated additional neighborhoods to the north and the east within South Los Angeles. These new census tracts were added considering newly developing partnerships with community-based organizations and their surrounding neighborhoods.

Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance share a common geographic service area because of their close proximity to each other in a part of LA County colloquially known as the “South Bay.” Therefore, the service area is referred to as the “South Bay Service Area” throughout the report.

Figure 1: South Bay Service Area Map



Environmental Justice Index

Providence uses the Center for Disease Control's (CDC) Environmental Justice Index (EJI) to identify communities of higher need within our service areas. Census tracts that score higher than the median EJI score are classified as "high need" and are depicted in green. All other census tracts are labeled "broader need" and are shown in blue. The median 2024 EJI score for census tracts in the South Bay Service Area is 0.797. *Source: Environmental Justice Index | Place and Health - Geospatial Research, Analysis, and Services Program (GRASP) | ATSDR*

Community Demographics

The tables and graphs below provide demographic and socioeconomic information about the total service area and how the high need area compares to the broader service area. In addition, data is provided for the entirety of LA County when available for comparison purposes. The Providence-developed data hub maps many of the indicators at the census tract level, which can be accessed via hyperlink here:

2025 South Bay CHNA Datahub

Total Population

Table 1: Total Population the South Bay Service Area

Geographic Designation	Population
High Need	755,824
Broader Need	741,888
Total Service Area	1,497,712
Los Angeles County	9,848,406

Table 1 Source: U.S Census Bureau, 2019 – 2023 American Community Survey 5-Year Estimates, Tables B01001, B02001 and B03003

Population by Age Groups by Geography

The South Bay service area (23.0%) has a higher percentage of population aged 18 and under compared to Los Angeles County (20.9%). The South Bay's High Need Service Area (11.7%) has a lower percentage of people aged 65 and over than Los Angeles County (14.7%).

Figure 2: Population Age by Geography

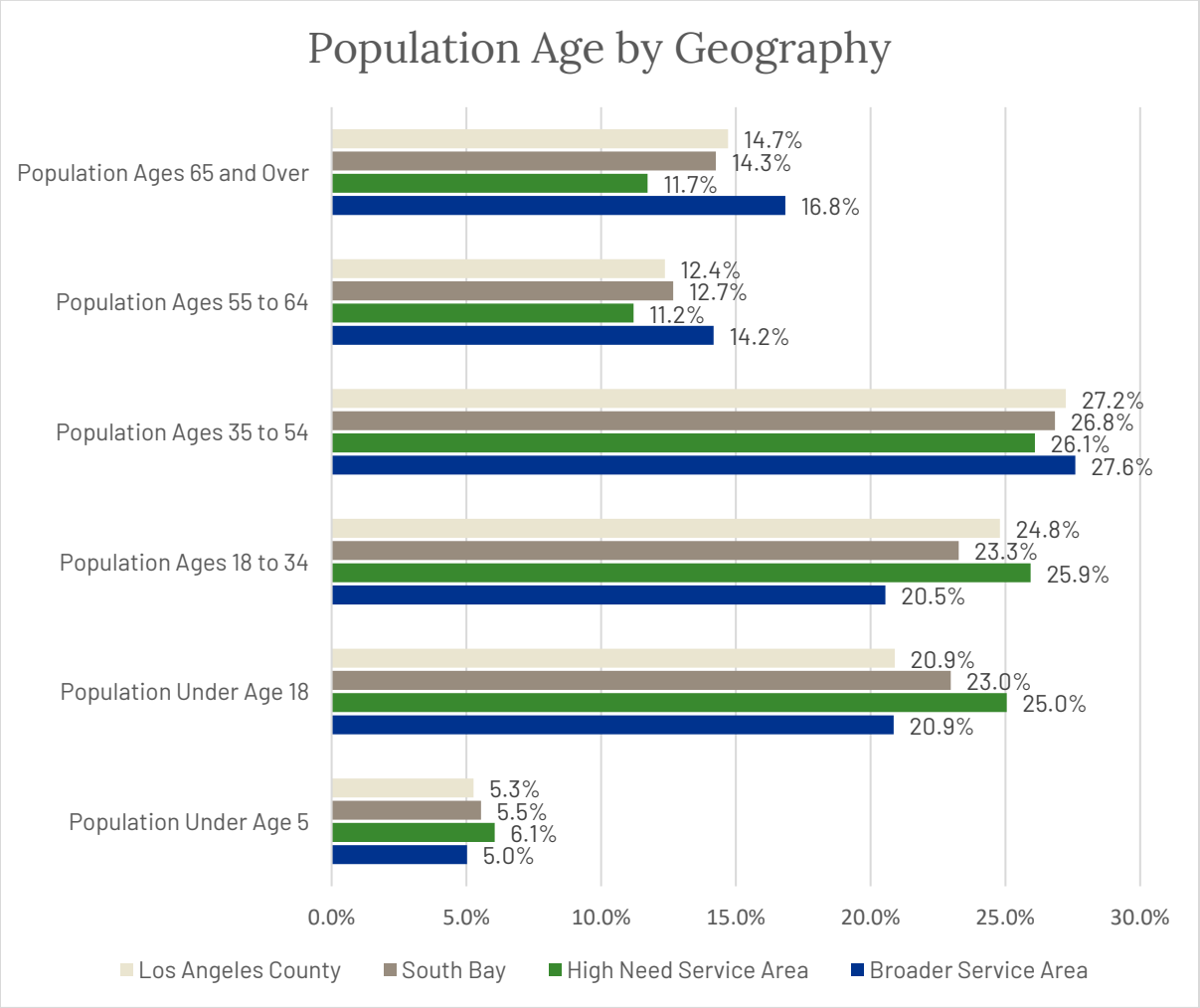


Figure 2 Source: U.S Census Bureau, 2019 – 2023 American Community Survey 5-Year Estimates, Tables B01001, B02001 and B03003

Population by Race by Geography

The South Bay's High Need (21.1%) and Total Service Areas (31.0%), have lower percentages of White population than Los Angeles County (35.4%). The percentage of Black or African American population is higher in the South Bay's High Need (17.2%), Broader (8.2%) and Total Service Areas (12.8%) than in Los Angeles County (7.8%).

Figure 3: Population Race by Geography

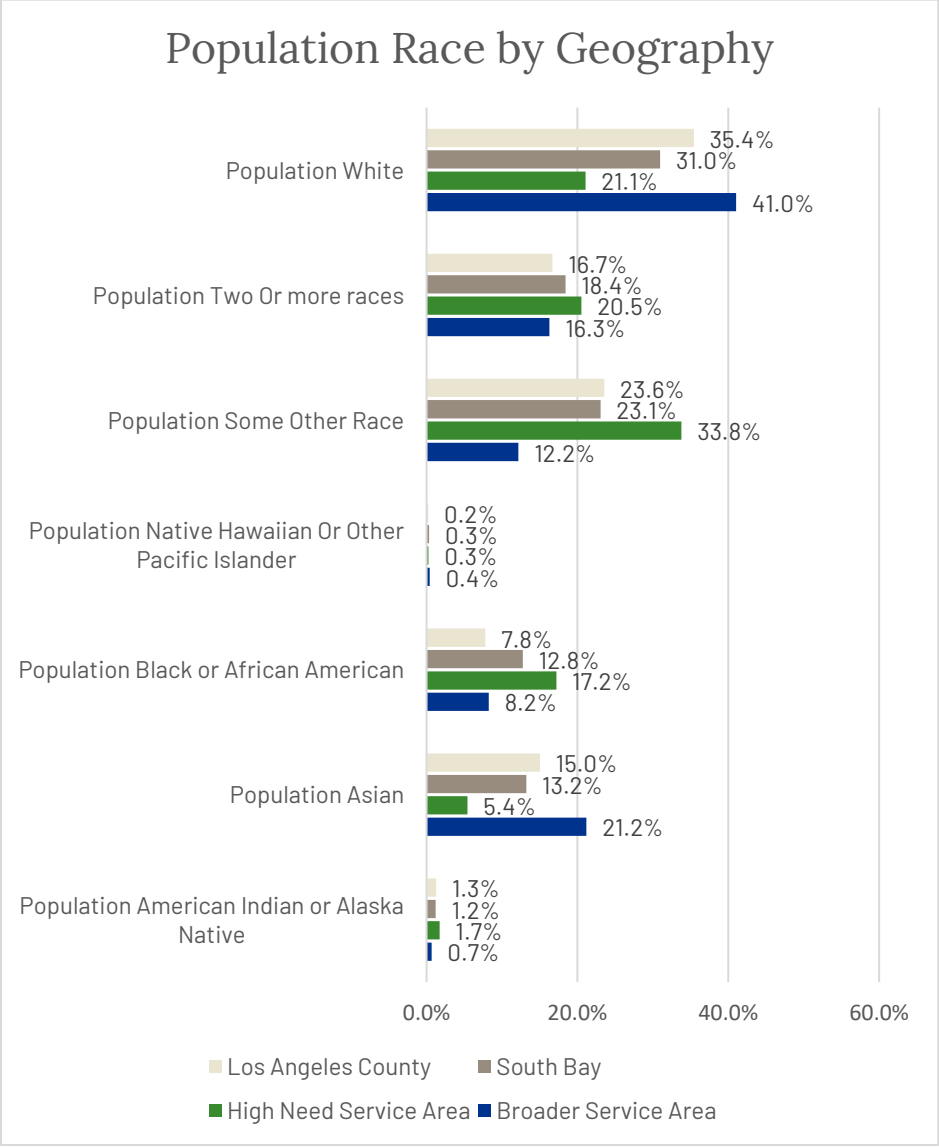


Figure 3 Source: U.S Census Bureau, 2019 – 2023 American Community Survey 5-Year Estimates, Tables B01001, B02001 and B03003

Population by Ethnicity by Geography

The Hispanic population is highest by percentage in the High Need Service area, with 70.9% of that population identifying as Hispanic compared to 32.3% in the broader service area and 51.8% in South Bay Total Service Area.

Figure 4: Population Ethnicity by Geography

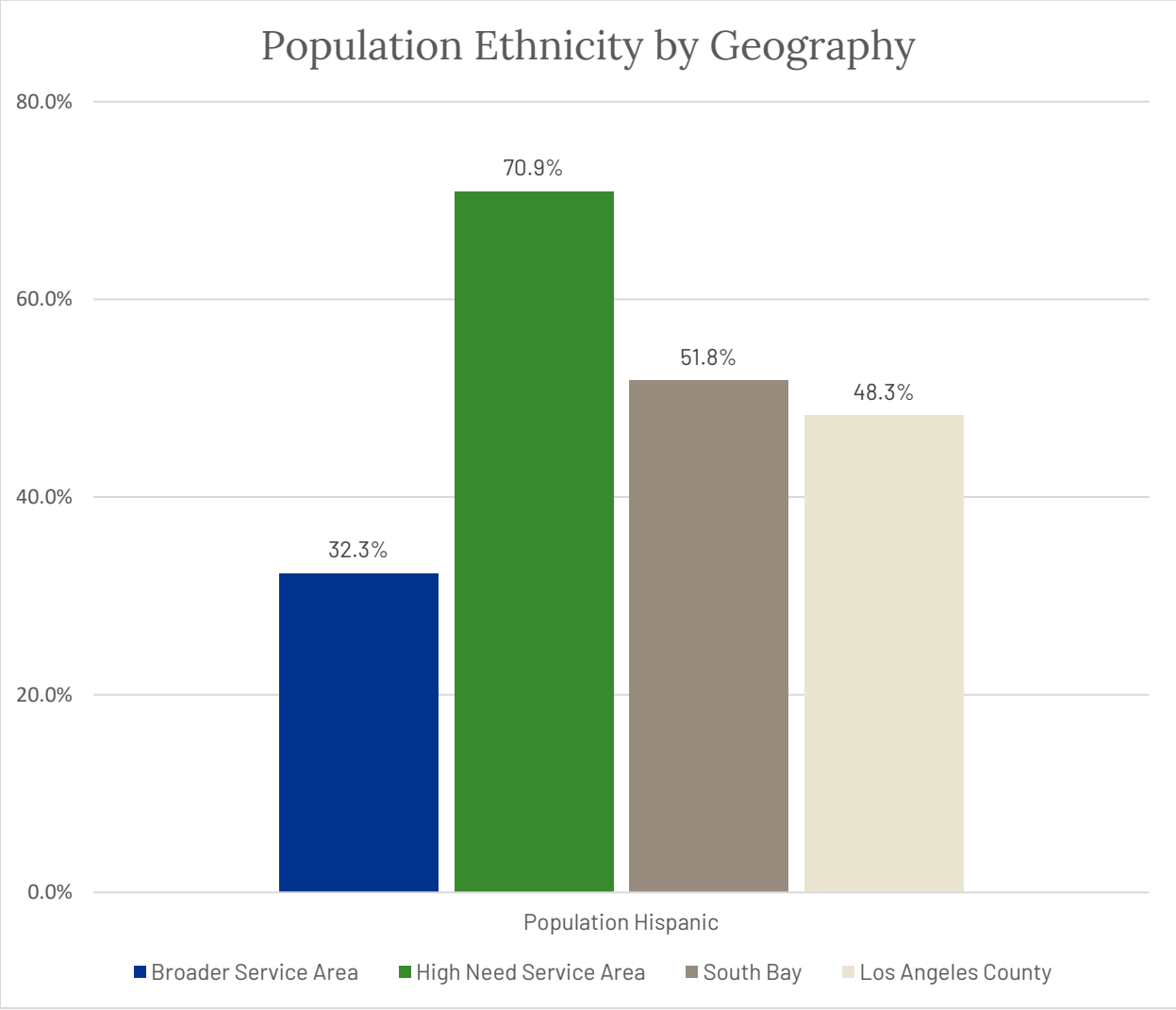


Figure 4 Source: U.S Census Bureau, 2019 – 2023 American Community Survey 5-Year Estimates, Tables B01001, B02001 and B03003

Median Income

Household median incomes include the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one person, average household income is usually less than average family income.

The median household income in the High Need Service Area is about $24,000 lower than Los Angeles County and about $33,000 lower than California.

Table 2: Median Household Income

Geographic Designation	Median Income
High Need	$63,437
Broader Need	$122,545
Total Service Area	$93,073
LA County	$87,760
CA	$96,334

Table 2 Source: 2023 American Community Survey, 5-Year Estimates

Population Below 200% of the Federal Poverty Level (FPL)

According to the U.S. Census Bureau, the total number of people below the poverty level is the sum of people in families and the number of unrelated individuals with incomes in the last 12 months below the poverty threshold. Specified poverty levels are adjusted thresholds that are obtained by multiplying the official thresholds by a specific factor. For reference, in 2022, 200% Federal Poverty Level was equivalent to an annual household income of $55,500 or less for a family of four in the contiguous United States. (More info here).

The percentage of population below 200% the federal poverty level in the High Need and Total Service Area is higher than Los Angeles County and California. Within the total service area, there is a 26.5 percentage point gap between the High Need and Broader Need Areas indicating significant economic inequities.

Table 3: Federal Poverty Level

Geographic Designation	Percent Below 200% FPL
High Need	45.6%
Broader Need	19.1%
Total Service Area	32.3%
LA County	31.1%
CA	27.5%

Table 3 Source: 2023 American Community Survey, 5-Year Estimates

Supplemental Nutrition Assistance Program (SNAP)

According to Healthy People 2030: Households receiving SNAP is used as a proxy measure to identify households that may be experiencing food insecurity. High unemployment rates among low-income populations make it more difficult to meet basic household food needs. In addition, children with unemployed parents have higher rates of food insecurity than children with employed parents. Racial and ethnic disparities exist related to food insecurity.

The percentage of households in the Total Service Area (15.6%) and High Need Area (23.7%) are higher than Los Angeles County (13.0%) and California (11.4%), indicating potentially more food insecurity in the service area.

Table 4: Households Receiving Supplemental Nutrition Assistance Program (SNAP)

Geographic Designation	Percent SNAP
High Need	23.7%
Broader Need	7.6%
Total Service Area	15.6%
LA County	13.0%
CA	11.4%

Table 4 Source: 2023 American Community Survey, 5-Year Estimates

Limited English Households

According to Healthy People 2030: Limited English is a barrier to knowledge access, proper medication use, and utilization of preventive services. Individuals with limited literacy face difficulties with medication instructions, communicating with health care providers, and attaining health information—all of which may adversely affect their health. Research has also shown a correlation between limited literacy skills and chronic conditions, including diabetes and cancer.

The percentage of limited English-speaking households in the High Need area is about six percentage points higher than Los Angeles County and almost ten percentage points higher than California. These households are overrepresented in the High Need area.

Table 5: Limited English Households

Geographic Designation	Percent Limited English
High Need	18.0%
Broader Need	7.7%
Total Service Area	12.8%
LA County	12.1%
CA	8.3%

Table 5 Source: 2023 American Community Survey, 5-Year Estimates

Health Professional Shortage Area

The Federal Health Resources and Services Administration designates a Health Professional Shortage Area (HPSA) as an area with a shortage of primary medical care, dental care, or mental health providers. This information can be used to understand access issues, guide state and local health care planning, determine placement of providers, and influence allocation of limited health care resources.

The two hospitals (Little Company of Mary Torrance and Little Company of Mary San Pedro) are not located in an HPSA, but both are located just outside of the boundaries of Primary Care HPSAs, and Little Company of Mary Torrance is located just outside the boundary of a Mental Health HPSA.

The following 13 Primary Care HPSAs are partially or entirely located within the boundaries of the hospitals' service area:

- Two Medicaid-Eligible-Population HPSAs: Torrance East Central and Carson
- Six Low-Income-Population HPSAs: Inglewood West, South Central Southwest, Florence South, Gardena West, Long Beach Port, and Lynwood North Central
- Two Geographic HPSAs: Inglewood East, Athens/Gardena Northeast
- Three High-Needs Geographic HPSAs: South Central Northwest, South Central Northeast, and Long Beach West Central

The following 10 Mental Health HPSAs are partially or entirely located within the boundaries of the hospitals' service area:

- Two Low-Income-Population HPSAs: Harbor Gateway South/Lomita and Hawthorne/Inglewood East
- One Geographic HPSA: Athens/Gardena Northeast

- Seven High-Needs Geographic HPSAs: Long Beach West Central, South Central Southwest, South Central Northwest, South Central Northeast, Firestone/Florence South, Watts/Willowbrook, and Bell Southwest

The following three Dental Care HPSAs are partially or entirely located within the boundaries of the hospitals' service area:

- One Medicaid-Eligible-Population HPSA: Firestone/Florence South/Watts)
- Two Low-Income-Population HPSAs: South Central Northeast and Long Beach Central

See Appendix 1 for additional quantitative data.

Health Indicators from South Bay CHNA Data Hub

Please refer to the 2025 South Bay CHNA Datahub to review each of the following health indicators mapped at the census tract level. The hub provides data on each indicator in the South Bay Service Area's High Need, Broader Need and Total Service Areas, and in Los Angeles County and California, as well as information about the importance of each indicator. The following are a featured selection of some of the indicators available in the data hub.

Health Insurance, Percent Uninsured

According to Healthy People 2030: Inadequate health insurance coverage is one of the largest barriers to health care access. Vulnerable populations are at risk for insufficient health insurance coverage. People with lower incomes are often uninsured and communities of color account for over half of the uninsured population. The percentage of population uninsured in the South Bay High Need Service Area is substantially higher (13.1%) than the Broader Need, Total Service Area, Los Angeles County and California.

Table 6: Health Insurance

Geographic Designation	Percent without Insurance
High Need	13.1%
Broader Need	5.9%
Total Service Area	9.5%
LA County	8.7%
CA	6.9%

Source Table 6: 2023 American Community Survey, 5-Year Estimates

Chronic Diseases

Asthma: According to the Center for Disease Control, "Compared to persons without asthma, persons with asthma are more likely to report depression, be unemployed, spend more days sick in bed, and have limitations or inability to conduct normal work." The percentage of people with asthma in the Total Service Area is slightly higher than both Los Angeles County and California.

Diabetes: According to the Center for Disease Control, "Multiple long-term complications of diabetes can be prevented by managing blood glucose, blood lipids, and blood pressure regularly, eating healthy foods, being physically active, and screening and early treatment for eye, foot, and kidney abnormalities." The percentage of people with diabetes in the Total Service Area is higher than Los Angeles County and California.

Coronary Heart Disease (CHD): According to the Center for Disease Control, "Approximately 20.5 million adults aged ≥20 years have CHD (about 7.1%) (NHANES 2017–2020) with men (8.7%) more commonly affected than women (5.8%). CHD is the largest category of heart disease mortality with 371,506 people killed in 2022. Timely, effective treatment for heart attacks can reduce the risk for long-term disability and death." The percentage of people with coronary heart disease in the Total Service Area is roughly similar to Los Angeles County and California.

Chronic Obstructive Pulmonary Disease (COPD): According to the Center for Disease Control, "Major risk factors include tobacco smoking, occupational and environmental exposures, respiratory infections, and genetics. Although there is no cure for COPD, it can be treated and managed to slow declining lung function, improve exercise tolerance, and prevent and treat exacerbations." The percentage of people with COPD in the Total Service Area is higher than Los Angeles County and California.

Obesity: According to the Center for Disease Control, "Many adults in the United States have obesity. Adults with obesity have higher risks for stroke, many types of cancer, premature death, and mental illness such as clinical depression and anxiety. Obesity-related stigma and discrimination can also lead to health problems. Evidence suggests that intensive behavioral interventions that use more than one strategy — like group sessions and changes in both diet and physical activity — are an effective way to address obesity." The percentage of people considered obese with a body mass index ≥30 km/m^2 in the Total Service Areas is higher than Los Angeles County and similar to California.

Table 7: Chronic Diseases

Chronic Disease	Total South Bay Service Area	LA County	California
Asthma	9.8%	9.1%	8.7%
Diabetes	13.4%	12.3%	11.5%
Coronary Heart Disease	5.6%	5.4%	5.3%
COPD	5.4%	4.8%	4.7%
Obesity	28.3%	26.2%	28.1%

Source Table 7: PLACES. Center for Disease Control and Prevention, Indicator uses crude prevalence for year 2022 estimates

Physical Inactivity

According to the Centers for Disease Control, “Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults and older adults, physical activity can lower the risk of early death, coronary heart disease, stroke, high blood pressure, type 2 diabetes, breast and colon cancer, falls, and depression. The second edition of the Physical Activity Guidelines for Americans states that adults should move more and sit less throughout the day. Adults who sit less and do any amount of moderate-to-vigorous physical activity gain some health benefits.”

The South Bay Service High Need and Total Services Areas show higher percentages of people reporting physical inactivity than Los Angeles County and California

Table 8: Physical Inactivity

Geographic Designation	Physical Inactivity Prevalence Estimates
High Need	32.6%
Broader Need	20.3%
Total Service Area	26.4%
LA County	23.1%
CA	21.9%

Source Table 8: PLACES. Center for Disease Control and Prevention, Indicator uses crude prevalence for year 2022 estimates

Mental Health

According to the Center for Disease Control, “Depression causes severe symptoms that affect how you feel, think, and handle daily activities, such as sleeping, eating, or working. In 2022, an estimated 54 million U.S. adults (21%) reported they had been told by a doctor they had a depressive disorder, including depression, major depression, dysthymia, or minor depression in their lifetime.”

The High Need and Total Service Area show higher percentages of people with depression than Los Angeles County and California.

Table 9: Depression Prevalence

Geographic Designation	Depression Prevalence Estimates
High Need	22.5%
Broader Need	19.5%
Total Service Area	21.0%
LA County	20.2%
CA	18.1%

Source Table 9: PLACES. Center for Disease Control and Prevention, Indicator uses crude prevalence for year 2022 estimates

Frequent Mental Health Distress (FMD): According to the Center for Disease Control, FMD is used to identify individuals with more severe or persistent mental health problems in the previous month. "Many chronic diseases can impact general health status, including mental distress. Practicing healthy behaviors (e.g., not smoking, eating healthy, being active, and limiting drinking) can reduce the likelihood of getting a chronic disease and improve the odds of staying well, feeling good, and living longer."

The South Bay High Need and Total Service Areas show the highest percentage of individuals reporting frequent mental health distress compared to Los Angeles County and California.

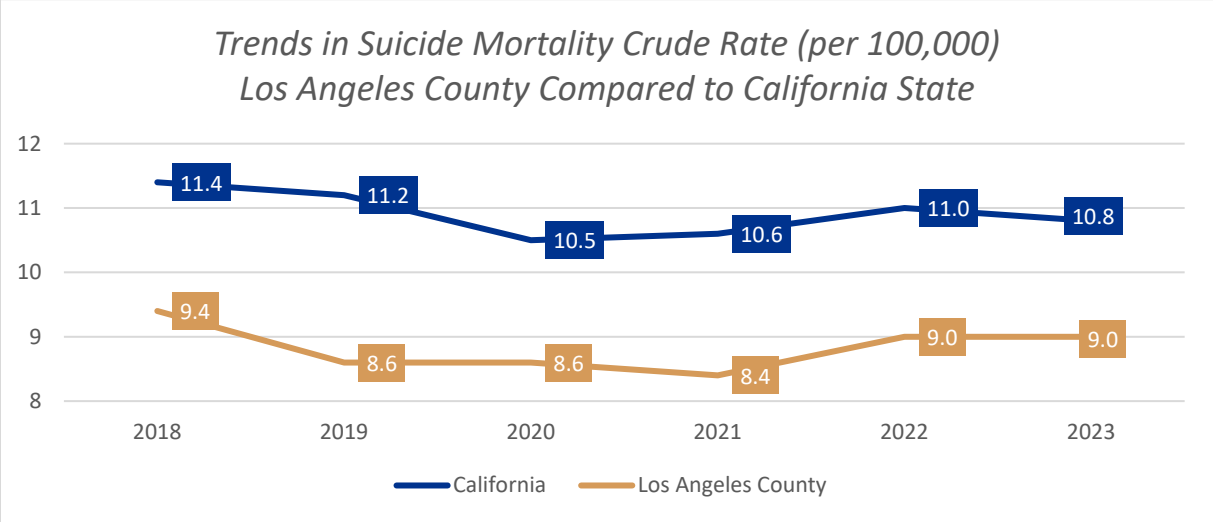
Table 10: Frequent Mental Health Distress Prevalence

Geographic Designation	FMD Prevalence Estimates
High Need	20.6%
Broader Need	14.7%
Total Service Area	17.6%
LA County	16.0%
CA	14.3%

Source Table 10: PLACES. Center for Disease Control and Prevention, Indicator uses crude prevalence for year 2022 estimates

Suicide Deaths: Suicide mortality data is shown here for all of Los Angeles County and California. Los Angeles County follows the trajectory of California rates from 2018-2023 but are lower overall than the state.

Figure 5: Trends in Suicide Mortality (Crude rate per 100,000, 2018-2023) – Los Angeles County and California



Source Figure 5: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2023 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

Substance Use

Binge Drinking: According to the Center for Disease Control, "Excessive drinking —which includes binge drinking —is associated with many health problems including unintentional injuries, violence, sexually transmitted diseases, poor pregnancy outcomes, fetal alcohol spectrum disorders, and chronic diseases (e.g., high blood pressure, cancer). Evidence-based alcohol policies, such as those recommended in the Community Guide, can be effective in preventing excessive alcohol use, including binge drinking. violence, suicide, chronic conditions, sexually transmitted diseases, unintended pregnancy, and fetal alcohol disorders."

The South Bay High Need and Total Service Areas show slightly lower percentages of binge drinking than Los Angeles County and California.

Table 11: Binge Drinking Prevalence

Geographic Designation	Binge Drinking Prevalence Estimates
High Need	16.9%
Broader Need	17.5%
Total Service Area	17.2%
LA County	17.6%
CA	17.5%

Source Table 11: PLACES. Center for Disease Control and Prevention, Indicator uses crude prevalence for year 2022 estimates

Housing and People Experiencing Homelessness

Households Experiencing Severe Housing Cost Burden

Households experiencing severe housing cost burden are spending 50% or more of their income on housing costs. According to County Health Rankings and Roadmaps: “When the majority of a paycheck goes toward the rent or mortgage, it makes it hard to afford doctor visits, healthy foods, utility bills, and reliable transportation to work or school. This can, in turn, lead to increased stress levels and emotional strain."

A greater percentage of households in the South Bay High Need and Total Service Areas experience severe housing cost burden than in California, with the highest percentage of severe housing cost burden in the High Need Service Area.

Table 12: Households Experiencing Server Housing Cost Burden

Geographic Designation	Percent Severe Housing Cost Burden
High Need	27.8%
Broader Need	17.2%
Total Service Area	22.5%
LA County	23.4%
CA	19.4%

Source Table 12: 2023 American Community Survey, 5-Year Estimates

Persons Experiencing Homelessness: Service Planning Area (SPA) 8 (South Bay)

Since 2005, the Los Angeles Homeless Services Authority (LAHSA) has conducted the annual Greater Los Angeles Homeless Point-in-Time (PIT) Count to determine how many individuals and families are homeless on a given day.

For the 2025 PIT Count, SPA 8 had an estimated 5,465 individuals who were experiencing homelessness, a decrease of 15.6% from 2023. 82.1% of those experiencing homelessness in SPA 8 were individual adults, 16.6% were members of families experiencing homelessness, and three individuals (0.05%) were unaccompanied minors. People experiencing sheltered homelessness are defined as those sleeping in either emergency shelters, transitional housing, or safe havens, while unsheltered individuals include anyone sleeping on the street or in a dwelling not meant for human habitation, including those living in cars, RVs, tents, and temporary structures (e.g., cardboard). The percentage of people experiencing homelessness in SPA 8 who were unsheltered decreased by 19.4 percentage points from 2023 to 2025, with individuals experiencing homelessness in SPA 8 going from much less likely to be sheltered than the county average, in 2023, to slightly more likely to be sheltered in 2025.

Table 13: Persons Experiencing Homelessness SPA 8

Persons Experiencing Homelessness (PEH)	SPA 8		Los Angeles County Continuum of Care *	
	2023	2025	2023	2025
Total persons experiencing homelessness	6,476	5,465	71,320	67,918
Sheltered	17.1%	36.5%	26.7%	34.6%
Unsheltered	82.9%	63.5%	73.3%	65.4%

*Source Table 13: Los Angeles Homeless Service Authority, 2023 and 2025 Greater Los Angeles Homeless Count. *These data represent the homeless counts from the Los Angeles County Continuum of Care, which does not include Glendale, Long Beach, and Pasadena homeless counts.*

Persons Experiencing Homelessness: Service Planning Area (SPA) 6 (South Los Angeles)

For the 2025 PIT Count, SPA 6 had an estimated 13,598 individuals who were experiencing homelessness, an increase of 4.6% from 2023. 75.2% of those experiencing homelessness in SPA 6 were individual adults, 21.3% were members of families experiencing homelessness, and eight individuals (0.06%) were unaccompanied minors. People experiencing sheltered homelessness are defined as those sleeping in either emergency shelters, transitional housing, or safe havens, while unsheltered individuals include anyone sleeping on the street or in a dwelling not meant for human habitation, including those living in cars, RVs, tents, and temporary structures (e.g., cardboard). The percentage of persons experiencing homelessness

in SPA 6 who were unsheltered decreased by 4.9 percentage points from 2023 to 2025, and individuals experiencing homelessness in SPA 6 were more likely to be sheltered than the county average.

Table 14: Persons Experiencing Homelessness SPA 6

Persons Experiencing Homelessness (PEH)	SPA 6		Los Angeles County Continuum of Care *	
	2023	2025	2023	2025
Total persons experiencing homelessness	12,995	13,598	71,320	67,918
Sheltered	35.1%	40.0%	26.7%	34.6%
Unsheltered	64.9%	60.0%	73.3%	65.4%

*Source Table 14: Los Angeles Homeless Service Authority, 2023 and 2025 Greater Los Angeles Homeless Count. *These data represent the homeless counts from the Los Angeles County Continuum of Care, which does not include Glendale, Long Beach, and Pasadena homeless counts.*
https://www.lahsa.org/news?article=1043-2023-greater-los-angeles-homeless-count-data *and* https://www.lahsa.org/news?article=1043-2025-greater-los-angeles-homeless-count-data

See Appendix 1 to review more data on PEH in SPA 8 and SPA 6 Los Angeles County.

Leading Causes of Death

Mortality information, based on death certificates for U.S. residents, is collected by state registries and provided to the National Vital Statistics System. Each death certificate contains a single underlying cause of death, and demographic data. For more information, refer to National Vital Statistics System - Mortality Data. The leading causes of death are shown below for all of Los Angeles County.

Table 15: Leading Causes of Death Ranked by Los Angeles County Compared to California

	Cause of Death	Los Angeles County (Crude Rate Per 100,000)	California (Crude Rate Per 100,000)
1st	Diseases of heart	173.6	164.4
2nd	Malignant neoplasms	146.7	152.6
3rd	COVID-19	52.5	41.7
4th	Alzheimer disease	46.3	43.5
5th	Cerebrovascular diseases	39.5	45
6th	Accidents (unintentional injuries)	38.2	47.1
7th	Diabetes mellitus	33.4	27.7
8th	Chronic lower respiratory diseases	28.3	31.9
9th	Influenza and pneumonia	19.4	14.4
10th	Essential hypertension and hypertensive renal disease	17.8	15.7
11th	Chronic liver disease and cirrhosis	16.5	15.8
12th	Nephritis, nephrotic syndrome, and nephrosis	15.3	11.4
13th	Parkinson disease	9.2	10.2
14th	Intentional self-harm (suicide)	8.8	10.9
15th	Assault (homicide)	6.8	5.4

Source Table 15: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2023 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

See Appendix 1 to review a summary of Los Angeles County death data by race.

Social Determinants of Health (SDOH) Screening Data

Providence implemented SDOH screenings for all admitted adult inpatients. Data from SDOH screenings January 1-December 31, 2024, at Providence Little Company of Mary San Pedro and Providence Little Company of Mary Torrance showed the following:

- 17.8% (San Pedro) and 5.9% (Torrance) of patients screened positive for at least one SDOH need.
- At Providence Little Company of Mary Medical Centers San Pedro and Torrance, housing was reported as a need substantially more than any other need, followed by food, utilities, and transportation.

Hospital Utilization Data

In addition to public health surveillance data, our hospitals provide timely information regarding access to care and disease burden across the service area. Avoidable Emergency Department (AED) use is reported as a percentage of all Emergency Department visits over a given period, which are identified based on an algorithm developed by Providence's Population Health Care Management team based on NYU and Medi-Cal definitions.

AED use serves as a proxy for inadequate access to, or engagement in, primary care. We review and stratify utilization data by a several factors including self-reported race and ethnicity, patient origin ZIP Code, age, and sex. This detail helps us identify disparities to improve outreach and partnerships. In 2024, our data showed the following insights for Little Company of Mary San Pedro and Providence Little Company of Mary Medical Center Torrance:

- 31.7% of all ED visits were considered potentially avoidable across both medical centers in 2024, a slight decrease from 2023.
- The top diagnosis groupings for avoidable ED visits were the following: bronchitis and other upper respiratory diseases, urinary tract infections, and skin infections.
- Patients with the following demographics had higher percentages of avoidable ED visits than the patient population overall (i.e., looking at what percentage of ED cases for each population were considered potentially avoidable):

  <u>Providence Little Company of Mary Medical Center San Pedro:</u>

  - Patients under 18 years of age (37.7%) and patients ages 18-39 (35.2%) had higher percentages of avoidable ED cases than patients overall at Providence Little Company of Mary Medical Center San Pedro (34.3%)
  - Patients with Medicaid coverage (37.0%) and those who are self-pay (38.5%)
  - Patients who live in the ZIP codes 90731 (34.9%), 90744 (35.0%), 90745 (34.7%) and 90710 (34.9%)

- 4.4% of all ED visits were primarily for behavioral health needs in 2024. Patients with the following demographics had higher percentages of behavioral health related ED visits compared to the patient population overall (i.e., looking at what percentage of ED cases for each population were related to behavioral health):
  - Patients ages 18-39 years (6.1%) and patients ages 40-64 years (5.2%)
  - Patients with Medicaid coverage (4.5%) and those who are self-pay (8.6%)
  - The top five diagnosis groupings for behavioral health related ED visits were the following: substance use disorders, anxiety and personality disorders, mood disorders (episodic), psychosis and poisonings

Providence Little Company of Mary Medical Center Torrance:

- Patients under 18 years of age (32.6%) had higher percentages of avoidable ED cases than patients overall at Providence Little Company of Mary Medical Center Torrance (29.7%)
- Patients with Medicaid coverage (33.7%) and those who are self-pay (32.1%)
- Patients who live in the ZIP codes 90250 (32.1%), 90260 (30.5%), 90503 (30.4%) and 90304 (31.4%)

- 3.7% of all ED visits were primarily for behavioral health needs in 2024. Patients with the following demographics had higher percentages of behavioral health related ED visits compared to the patient population overall (i.e., looking at what percentage of ED cases for each population were related to behavioral health):
  - Patients ages 18-39 years (5.5%) and ages 40-64 (4.4%)
  - Patients with Medicaid coverage (4.4%) and those who are self-pay (8.5%)
  - The top five diagnosis groupings for behavioral health related ED visits were the following: substance use disorders, anxiety and personality disorders, mood disorders (episodic), psychosis and poisonings

Source: Providence Epic, 2024

Summary of Community Input

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, representatives from Providence Little Company of Mary Medical Center San Pedro and Providence Little Company of Mary Medical Center Torrance worked in partnership with Torrance Memorial Medical Center to conduct 38 interviews with community stakeholder organizations and leaders, including input from the department of public health. In addition, PLCMMC-SP and PLCMMC-T conducted six listening sessions with a total of fifty-two community members and hospital leaders.

During these interviews and listening sessions, community members and nonprofit and government community stakeholders discussed the issues and opportunities of the people, neighborhoods, and cities of the service area.

FINDINGS FROM COMMUNITY STAKEHOLDER INTERVIEWS

Community stakeholders have broad interests in the community, as well as specific experience and expertise with health and wellbeing in Los Angeles County, and the South Bay in particular. Stakeholders included, but were not limited to, local governmental health and public health leaders and leaders of nonprofits serving medically underserved, BIPOC (Black, Indigenous, and People of Color) and low-income populations. Community stakeholder interviews were conducted between October 2024 and July 2025.

Community stakeholders, especially those who provide programs and services to populations with vulnerabilities, were forthcoming with their views and experiences with healthcare access, mental health, housing, food insecurity, chronic disease and other health needs and health-related social needs. See themes and quotes from community stakeholder interviews below.

Access to Care

- Navigating health insurance and Medi-Cal is difficult, especially when there are language barriers.
- Co-pays and transportation challenges keep people from seeing the doctor.
- Culturally responsive care/multilingual care is lacking.
- Immigrant populations fear coming in for care.

Quotes from stakeholders:

“It seems there is less availability of providers and there are longer wait times to get services. In some cases, you are waiting one or two months.”

“There's a large population of people who don't seek out services because they either believe that will put them in jeopardy with their immigration status, or they don't think that it's affordable. There's a big fear of family separation, even among native born.”

“Traditionally in communities of color there has been a distrust of the healthcare system.”

Behavioral Health

- More mental health providers and substance use treatment providers are needed, especially culturally responsive mental health providers.
- There is still a stigma when it comes to accessing mental health care.
- There is a rise in anxiety and anxiety-related behaviors.
- Narcotics and other forms of drugs are easily accessible, multiple community stakeholders have responded by increasing access to Narcan.
- There is increased usage of vaping and marijuana

Quotes from stakeholders:

"Some people are turning towards substances, especially young people, to be able to manage the big emotions that they're experiencing."

"There are no substance use providers for Medi-Cal in Service Planning Area 8. There are limited Medi-Cal resources for substance abuse for kids and adolescents."

"There are not enough practitioners. Salaries are increasing at an unsustainable level and patient need is high. We are seeing a lack of workforce."

"If I had to rank mental health right now, with 10 being the highest, I would put mental health as a 10, for all ages. There are limited resources out there. There is a lot of depression in our families, some suicide ideation because a lot of people are being laid off."

Chronic Disease

- Access to medication is inequitable.
- Access to nutritious food is a barrier to health.
- There are substantial gaps in specialty care and barriers to care, including many specialists who do not accept Medi-Cal, there are long wait times for appointments, and patients often must travel for specialty care.
- Costs and perceived costs of accessing care to manage chronic diseases are too high.
- Air quality from the ports and refineries is poor and impacts communities and rates of chronic disease.

Quotes from stakeholders:

"Patients often are asked to travel long distances to see a specialist and wait times are quite long, three to six months to see a specialist."

"In the South Bay, with a lot of the refineries and the ports, we have a lot of kids who have asthma, and they are triggered by the air quality."

"We are seeing obesity spike again. We're noticing that a lot of the families are very stressed and are not always making the healthiest choices. We're also seeing a lot less physical activity, too much tech time, too much screen time."

Food Insecurity

- More families are food insecure and need for support is growing.
- Wilmington in particular lacks access to fresh, healthy, and affordable foods.
- Transportation is a barrier to food access.
- The prohibitive cost and lack of accessibility to healthy foods, as well as the time it takes to make healthy meals, contribute to obesity and people being overweight.

Quotes from stakeholders:

"We have the CalFresh program, however, CalFresh is under-resourced in terms of staffing, and the intake forms take time and sometimes people just give up."

"We don't have a lot of fresh food options here in Wilmington. We have one Farmers' Market, and a handful of markets, but not a lot of access to fresh foods. People are eating more processed foods and fast foods."

"A lot of our clients are food insecure and are asking for a food pantry in the area. In that part of town (Wilmington), there is nothing

Housing and Homelessness

- More affordable housing is needed. Current housing availability is insufficient.
- People are forced to make spending trade-offs – paying for housing often outweighs paying for medical care or medications.
- Older adults are especially at risk of losing their housing.

Quotes from stakeholders:

"There aren't enough affordable, available beds and places for transitional housing."

"The price of housing is forcing people to decide - it's either a roof or dealing with health issues."

"There are older adults who have lived in their homes for many decades, and the value of the apartments or homes have escalated significantly. What we're seeing is more people are being evicted or pushed out of their homes because they are older adults. They're being targeted."

Safety

- Gun violence and domestic violence are significant concerns in the community.
- Older adults, families, and kids don't feel safe outside for physical activity, leading to too much screen time.
- People experiencing homelessness experience more violent crimes perpetrated against them.

Quotes from stakeholders:

"Gun violence is a significant concern across all communities. It comes back to mental health concerns and financial concerns."

"Economic insecurity, mental health, substance abuse, all those things can impact safety and violence."

"The biggest violent issue that we see is domestic violence."

Workforce Development

- Workforce training has not been effective enough at meaningfully raising incomes and connecting to industries
- Paying for basic needs – housing and food – is becoming unattainable for many
- An education gap leads to a health literacy gap and economic insecurity
- Port automation is leading to joblessness.

Quotes from stakeholders:

"Minimum wage has increased, but it still doesn't allow you to afford housing."
"That dream and opportunity for becoming a longshoreman is pretty much dead because of the automation."

"Even after training, it is still difficult to get an entry level position. It would be helpful if employers were more flexible with needed experience and providing more opportunities to gain experience in those entry level jobs. Also, organizations need to help incoming employees understand what career ladders look like within their organization."

See Appendix 2 for a list of community stakeholders interviewed.

Community Stakeholder Interviewee Survey

The partner hospitals in the South Bay developed a preliminary list of identified community health needs for community stakeholder interviewees to be surveyed about:

- Access to Care
- Chronic Diseases
- Economic Security and Workforce Development
- Environmental Health
- Food Insecurity
- Housing and Homelessness
- Mental Health
- Overweight and Obesity
- Preventive Services
- Safety and Violence
- Substance Use and Misuse

Survey input from the community stakeholder interviewees revealed the following:

- The perceived severity of a health or community issue as it affects the health and lives of those in the community -
    - Scored in the following order: Economic insecurity and workforce development, Mental health and Housing insecurity and homelessness.

- Improving or worsening of an issue in the community -
  - Scored in the following order: Housing insecurity and homelessness, food insecurity and mental health having worsened the most over time.
- Availability of resources to address the need -
  - Scored in the following order: Mental health, Housing insecurity and homelessness, and food insecurity were ranked as having the most insufficient/absent resources in the community.
- The level of importance the hospital should place on addressing the issue -
  - The top five health needs that were prioritized by community stakeholders were Mental health, Substance use, Access to care, Preventive services and Housing and homelessness.

See Appendix 2 to review survey data.

FINDINGS FROM LISTENING SESSIONS

To better understand the unique perspectives, opinions, experiences, and knowledge of community members and hospital leaders, Providence conducted six listening sessions with fifty-two participants. Listening sessions were completed in June and July 2025.

Listening session participants were asked to discuss community health-related needs. The following themes emerged most frequently:

- **Behavioral Health Challenges & Access:** There is a strong need for more behavioral health services, including therapists and mental health professionals, as well as drug prevention and mental health awareness classes. Emotional support for all ages is a recurring theme.
- **Access to Health Care Services:** Barriers include prohibitive costs, appointment delays, and the need for more health education, post-acute transitional care, language support, and mobile health clinics. Participants emphasized the importance of providers listening empathetically and communicating clearly.
- **Community Resources & Outreach:** While resources exist, there is a significant need for better communication and outreach. Suggestions include more direct engagement (e.g., door-to-door outreach, regular community meetings) and addressing barriers faced by older adults and people with disabilities.
- **Community Engagement, Advocacy & Reform:** More involvement and representation are needed, especially to address issues like immigration-related fears. Safe, centralized gathering spaces and volunteer opportunities can foster unity and support.
- **Safety:** Concerns include the need for improved traffic signs, street lighting, sidewalk repairs, and addressing homelessness and encampments. Safety in schools and apartments was also highlighted, with calls for more police presence and rule enforcement.

- **Physical Health & Recreation:** There is a desire for more exercise programs, walking groups, and health education on nutrition, fitness, and preventive care for all ages.

See Appendix 2 for methodology, participant details, and in-depth findings on the Listening Sessions.

Review of Primary and Secondary Data

After a careful review of the qualitative and quantitative data, we developed a preliminary list of identified community health needs. These needs were identified by interview participants through a weighted ranking process and by community members through discussion and theming of the data. Additionally, needs were identified after reviewing the quantitative data.

The Mission Community Health Committee met on September 9, 2025, and reviewed the quantitative and qualitative data collected for each of the following community health-related needs (listed in alphabetical order below):

- Access to Care
- Behavioral Health (Mental Health & Substance Use)
- Chronic Disease
- Food Insecurity
- Housing Insecurity and Homelessness
- Safety
- Social Isolation
- Workforce Development

Identification and Prioritization of Significant Health Needs

After a presentation of the key findings from the data on the eight identified significant needs by Providence Little Company of Mary Community Health department leadership, committee members participated in a robust discussion on the various identified needs and how consistent the data aligned with what they knew about the community. For prioritization of the identified needs the Committee was encouraged to take into consideration the following criteria when making their choices, and were provided with an initial assessment scorecard by Providence Little Company Community Health based on those criteria:

- Listening Session Input
- Key Stakeholder Survey Prioritization Score
- Service Area Rates Worse Than County, State, or National Benchmarks
- Opportunity to Impact: Current Providence Community Benefit Programs
- Opportunity to Impact: External Partnerships
- Alignment with Providence System Strategies

The committee took a vote on the top three needs for PLCMMC-SP and PLCMMC-T to prioritize over the next three years. Based on those voting results the identified needs ranked in the following order of priority.

1. Access to Care
2. Behavioral Health (Mental Health & Substance Use)
3. Chronic Disease
4. Workforce Development
5. Food Insecurity
6. Social Isolation
7. Safety
8. Housing Insecurity and Homelessness

2025 Priority Needs

The list below summarizes the significant health needs identified through the 2025 Community Health Needs Assessment process, ranked in order of priority:

ACCESS TO CARE

Local community stakeholders identified specific barriers to accessing care in the service area include high costs, difficulties navigating the health care system, appointment delays, language barriers, insufficient health education, lack of culturally responsive services, and transportation challenges.

Access to care goes beyond health insurance coverage, however, people without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. In addition, obtaining coverage for lower income households will become more challenging as new policy changes will impact eligibility for Medi-Cal, and premium and co-pay costs for Covered California.

BEHAVIORAL HEALTH (MENTAL HEALTH & SUBSTANCE USE/MISUSE)

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

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

Community stakeholders frequently expressed the need for more access to services such as therapists and other mental health professionals, as well as drug prevention and mental health awareness classes.

CHRONIC DISEASE

Chronic diseases are persistent health conditions—such as heart disease, diabetes, cancer, and respiratory illnesses—that typically last for one year or more and often require ongoing medical care or limit activities of daily living. These diseases represent a significant burden on individuals, families, and the broader community by increasing healthcare costs, reducing productivity, and diminishing quality of life. The South Bay Service Area had a higher percentage of people with heart disease, diabetes, and respiratory illness compared to the entire county and state.

In many cases, chronic conditions are closely linked to upstream factors like unhealthy diets, physical inactivity, tobacco use, and limited access to preventative care. Poor nutrition and sedentary lifestyles, for example, can contribute to the development and progression of these illnesses. The South Bay Service Area had higher percentages of obesity prevalence and people reporting physical inactivity compared to Los Angeles County and California.

Addressing chronic disease requires a comprehensive approach that not only supports those living with these conditions but also focuses on prevention through promoting healthy behaviors and improving community environments. Community stakeholders expressed a desire for more exercise programs, walking groups, and health education on nutrition, fitness, and preventive care for all ages. They also mentioned air pollution and poor air quality as local environmental factors impacting rates of chronic disease.

Providence Little Company of Mary San Pedro and Providence Little Company of Mary Torrance will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs in collaboration with community partners considering resources and community strengths and capacity. The 2026-2028 CHIP will be approved and made publicly available no later than May 15, 2026.

Potential Resources Available to Address Significant Health Needs

Understanding the potential resources to address significant health needs is fundamental to determining current state capacity and gaps. The organized health care delivery systems include the Department of Public Health, Centinela Hospital Medical Center, Del Amo Hospital, Kaiser Foundation Hospital - Downey, Kaiser Foundation Hospital - South Bay, Kindred Hospital South Bay, LAC Harbor UCLA Medical Center, LAC Rancho Los Amigos National Rehabilitation Center, Martin Luther King Jr. Community Hospital, Memorial Hospital of Gardena, Torrance Memorial Medical Center, and the U.S. Army Hospital. In addition, there are numerous social service non-profit agencies, faith-based organizations, and private and public-school systems that contribute resources to address these identified needs.

See Appendix 3 for a full list of resources potentially available to address the significant health needs.

SECTION VI: EVALUATION OF 2023-2025 CHIP

The 2022 CHNA and 2023-2025 CHIP priorities were the following: Homelessness and Housing Instability, Behavioral Health, Access to Health Care and Preventive Care. This report evaluates the impact of the previous Community Health Improvement Plan (CHIP). PLCMMC-SP and PLCMMC-T responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices.

Table16. Outcomes from 2023-2025 CHIP

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Access to Health Care and Preventive Care	Community Health Insurance Program	CHWs provide community-based outreach and enrollment assistance for affordable health insurance options including Medi-Cal and Covered California health plans	2,457 health insurance applications assisted per year
Access to Health Care and Preventive Care	Partners for Healthy Kids	A mobile clinic offering childhood immunizations at elementary and middle schools; COVID-19 and flu immunizations for adults; and health insurance enrollment information and navigation assistance	3,648 childhood vaccines administered per year
Access to Health Care and Preventive Care	Emergency Department Community Health Workers	CHWs who assist uninsured patients in the emergency department with affordable health care options, applications for enrollment in eligible health insurance programs and coordination of follow-up visits at a clinic in their community	1,616 follow up primary care referrals and appointments made per year for uninsured and underinsured patients in the emergency department

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Homelessness and Housing Insecurity	CHW Homeless Care Navigators	CHWs placed within our emergency department to specifically care for patients experiencing homelessness. They function as liaisons between homeless service providers and our Medical Centers to reduce avoidable emergency department visits and link patients with permanent and interim housing.	113 unhoused patients in the emergency department connected to shelter/housing per year
Behavioral Health (Mental Health and Substance Use/Misuse)	Mental Health First Aid	The skills-based course teaches participants how to identify, understand and respond to signs and symptoms of mental health and substance use challenges	Annually trained 311 participants in Mental Health First Aid
Behavioral Health (Mental Health and Substance Use/Misuse)	Integrated Therapy Services within Vasek Polak Health Clinic	A partnership with Richstone Family Services to integrate mental health screenings and free short-term therapy services for patients at Providence's Vasek Polak Health Clinic – an outpatient clinic for uninsured and low-income populations	Averaged 81 patients annually who received mental health therapy services at Vasek Polak Health Clinic

Addressing Identified Needs

The Community Health Improvement Plan developed for South Bay Service Area will consider the prioritized health needs identified in this CHNA and develop strategies to address needs considering resources, community capacity, and core competencies. Those strategies will be documented in the CHIP, describing how Little Company of Mary San Pedro and Little Company of Mary Torrance plans to address the health needs. If the hospital does not intend to address a need or plans to have limited response to the identified need, the CHIP will explain why. The CHIP will not only describe the actions Little Company of Mary San Pedro and Little Company of Mary Torrance intend to take, but also the anticipated impact of these actions and the resources the hospital plans to commit to address the health need.

Because partnership is important when addressing health needs, the CHIP will describe any planned collaboration between Little Company of Mary San Pedro and Little Company of Mary Torrance and community-based organizations in addressing the health need. The CHIP will be approved and made publicly available no later than May 15, 2026.

2025 CHNA GOVERNANCE APPROVAL

This Community Health Needs Assessment was adopted by the Mission Community Health Committee of the Community Ministry Board[1] of the hospital on September 9, 2025. The final report was made widely available by December 28, 2025.

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Michael Ricks
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12/2/2025

Michael Ricks — Date
Chief Executive, LA-Coastal Service Area
Providence Saint John's Health Center
Providence Little Company of Mary Medical Centers

Signed by:
Dean W. Nelson
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12/4/2025

Dean Nelson — Date
Mission Community Health Committee Chair
Providence Little Company of Mary Community Ministry Board

Signed by:
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12/4/2025

Michael Robinson — Date
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Contact CHI@providence.org to provide feedback about this CHNA or to request a free printed copy.

[1] **See Appendix 4: Mission Community Health Committee**

Appendix 1: Quantitative Data

POPULATION LEVEL DATA

South Bay Service Area Demographics

Demographic Category	Los Angeles County	Total South Bay Service Area	Broader Service Area	High Need Service Area
Population by Age				
Total Population	1,497,712	741,888	755,824	9,848,406
Population Under Age 5	5.5% (83,004)	5.0% (37,261)	6.1% (45,743)	5.3% (518,797)
Population Under Age 18	23.0% (344,039)	20.9% (154,727)	25.0% (189,312)	20.9% (2,057,536)
Population Ages 18 to 34	23.3% (348,450)	20.5% (152,436)	25.9% (196,014)	24.8% (2,441,889)
Population Ages 35 to 54	26.8% (401,923)	27.6% (204,701)	26.1% (197,222)	27.2% (2,682,862)
Population Ages 55 to 64	12.7% (189,811)	14.2% (105,144)	11.2% (84,667)	12.4% (1,217,548)
Population Ages 65 and Over	14.3% (213,489)	16.8% (124,880)	11.7% (88,609)	14.7% (1,448,571)
Population by Sex				
Female	50.6% (758,152)	50.5% (374,745)	50.7% (383,407)	50.5% (4,969,120)
Male	49.4% (739,560)	49.5% (367,143)	49.3% (372,417)	49.5% (4,879,286)
Population by Race				
American Indian and Alaska Native	1.2% (18,098)	0.7% (4,952)	1.7% (13,146)	1.3% (125,310)
Asian Population	13.2% (198,095)	21.2% (157,107)	5.4% (40,988)	15.0% (1,480,146)
Black or African American Population	12.8% (191,185)	8.2% (61,112)	17.2% (130,073)	7.8% (769,139)
Native Hawaiian and Other Pacific Islander Population	0.3% (5,075)	0.4% (3,160)	0.3% (1,915)	0.2% (21,691)
Other Race Population	23.1% (345,599)	12.2% (90,280)	33.8% (255,319)	23.6% (2,320,096)
Two or more Races Population	18.4% (275,899)	16.3% (120,753)	20.5% (155,146)	16.7% (1,642,818)
White Population	31.0% (463,761)	41.0% (304,524)	21.1% (159,237)	35.4% (3,489,206)
Population by Ethnicity				
Hispanic Population	51.8% (775,688)	32.3% (239,491)	70.9% (536,197)	48.3% (4,753,369)

Source: U.S Census Bureau, 2019 – 2023 American Community Survey 5-Year Estimates, Tables B01001, B02001 and B03003

Leading Causes of Death Ranked by Race in Los Angeles County, Per 100,000 Population

Rank	Los Angeles County	American Indian or Alaska Native	Asian	Black or African American	More than one race	Native Hawaiian or Other Pacific Islander	White
1st	**Diseases of heart** 173.6	**Diseases of heart** 42.1	**Malignant neoplasms** 145.8	**Diseases of heart** 277.4	**Diseases of heart** 46.2	**Diseases of heart** 161.2	**Diseases of heart** 176.8
2nd	**Malignant neoplasms** 146.7	**Malignant neoplasms** 30.0	**Diseases of heart** 139.1	**Malignant neoplasms** 196.7	**Malignant neoplasms** 40.6	**Malignant neoplasms** 121.0	**Malignant neoplasms** 148.0
3rd	**COVID-19** 52.5	**Accidents** 13.8	**COVID-19** 46.6	**Accidents** 66.2	**Accidents** 25.6	**COVID-19** 63.5	**COVID-19** 56.2
4th	**Alzheimer disease** 46.3	**COVID-19** 12.9	**Cerebro-vascular diseases** 42.4	**Cerebro-vascular diseases** 60.4	**COVID-19** 11.1	**Diabetes mellitus** 53.0	**Alzheimer disease** 50.4
5th	**Cerebro-vascular diseases** 39.5	**Diabetes mellitus** 10.4	**Alzheimer disease** 36.8	**Diabetes mellitus** 57.4	**Cerebro-vascular diseases** 10.1	**Accidents** 32.9	**Accidents** 40.3

Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2023 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

Point in Time (PIT) 2025 Los Angeles County Homeless Count

Population Experiencing Homelessness SPA 8, 2023-2025 Comparison*

	SPA 8		Los Angeles County Continuum of Care *	
	2023	**2025**	**2023**	**2025**
Total experiencing homelessness	6,476	5,465	71,320	67,918
Sheltered	17.1%	36.5%	26.7%	34.6%
Unsheltered	82.9%	63.5%	73.3%	65.4%
Individual adults, aged 25+	86.9%	82.1%	81.3%	80.1%
Individual youth, aged 18-24	0.9%	1.2%	3.9%	3.3%
Unaccompanied minors (<18)	0.20%	0.05%	0.13%	0.08%
Families/family members	12.0%	16.6%	14.7%	16.5%

Source: Los Angeles Homeless Service Authority, 2023 and 2025 Greater Los Angeles Homeless Count.
**These data represent the homeless counts from the Los Angeles County Continuum of Care, which does not include Glendale, Long Beach, and Pasadena homeless counts.*

Among persons experiencing homelessness in 2025 in SPA 8, 33.3% were experiencing chronic homelessness, a large decrease from 2023 (46.7%). Between 2023 and 2025, homelessness decreased locally for people with a developmental disability, are living with HIV/AIDS, have a substance use disorder, and/or have a serious mental illness (people can be members of numerous sub-groups), but rose slightly for all other subpopulations.

People Experiencing Homelessness Subpopulations*

	SPA 8		Los Angeles County Continuum of Care *		
	2023	2025	2023	2025	
Individuals experiencing chronic homelessness	46.7%		33.3%	42.7%	38.1%
Family members experiencing chronic homelessness	2.1%		2.5%	2.2%	2.6%
Developmental disability	7.8%		6.3%	8.9%	8.3%
Domestic violence (DV) experience	36.1%		36.5%	34.5%	37.8%
Homelessness due to fleeing DV / intimate partner violence (IPV)	7.8%		8.3%	8.0%	8.9%
Persons with HIV/AIDS	2.0%		1.4%	2.1%	1.8%
Physical disability	19.2%		21.8%	17.2%	21.4%
Serious mental illness	20.8%		20.5%	22.4%	23.5%
Substance use disorder	26.7%		21.0%	27.1%	22.0%
Veterans	7.5%		NR	5.4%	NR

*Source: Los Angeles Homeless Service Authority, 2023 and 2025 Greater Los Angeles Homeless Count. NR = Not reported. *These data represent homeless counts from the Los Angeles County Continuum of Care, which does not include Glendale, Long Beach, and Pasadena homeless counts. https://www.lahsa.org/news?article=1043-2023-greater-los-angeles-homeless-count-data and* https://www.lahsa.org/news?article=1043-2025-greater-los-angeles-homeless-count-data

Population Experiencing Homelessness SPA 6, 2023-2025 Comparison*

	SPA 6		Los Angeles County Continuum of Care *	
	2023	2025	2023	2025
Total experiencing homelessness	12,995	13,598	71,320	67,918
Sheltered	35.1%	40.0%	26.7%	34.6%
Unsheltered	64.9%	60.0%	73.3%	65.4%
Individual adults, aged 25+	76.8%	75.2%	81.3%	80.1%
Individual youth, aged 18-24	1.8%	3.4%	3.9%	3.3%
Unaccompanied minors (<18)	0.08%	0.06%	0.13%	0.08%
Families/family members	21.4%	21.3%	14.7%	16.5%

*Source: Los Angeles Homeless Service Authority, 2023 and 2025 Greater Los Angeles Homeless Count. *These data represent the homeless counts from the Los Angeles County Continuum of Care, which does not include Glendale, Long Beach, and Pasadena homeless counts.*

Among persons experiencing homelessness in 2025 in SPA 6, 29% were experiencing chronic homelessness, a decrease from 2023 (39.7%). Between 2023 and 2025, homelessness decreased locally for people with a developmental disability, are living with HIV/AIDS, have a serious mental illness and/or those who have a substance use disorder (people can be members of numerous sub-groups), but rose for those with a history of domestic violence experience, those who were experiencing homelessness due to fleeing domestic violence, and/or those with a physical disability.

	SPA 6		Los Angeles County Continuum of Care *	
	2023	**2025**	**2023**	**2025**
Individuals experiencing chronic homelessness	39.7%	29.0%	42.7%	38.1%
Family members experiencing chronic homelessness	3.3%	3.3%	2.2%	2.6%
Developmental disability	11.9%	6.3%	8.9%	8.3%
Domestic violence (DV) experience	30.3%	34.8%	34.5%	37.8%
Homelessness due to fleeing DV / intimate partner violence (IPV)	7.3%	8.3%	8.0%	8.9%
Persons with HIV/AIDS	2.7%	0.8%	2.1%	1.8%
Physical disability	16.7%	17.2%	17.2%	21.4%
Serious mental illness	24.5%	16.3%	22.4%	23.5%
Substance use disorder	24.1%	15.6%	27.1%	22.0%
Veterans	3.8%	NR	5.4%	NR

Source: Los Angeles Homeless Service Authority, 2023 and 2025 Greater Los Angeles Homeless *Count. NR = Not reported. *These data represent homeless counts from the Los Angeles County Continuum of Care, which does not include Glendale, Long Beach, and Pasadena homeless counts. https://www.lahsa.org/news?article=1043-2023-greater-los-angeles-homeless-count-data and* https://www.lahsa.org/news?article=1043-2025-greater-los-angeles-homeless-count-data

Appendix 2: Community Input

METHODOLOGY: COMMUNITY STAKHOLDER INTERVIEWS

Little Company of Mary San Pedro and Little Company of Mary Torrance completed thirty-eight community stakeholder interviews in collaboration with Torrance Memorial Medical Center. The interviews took place between October 2024 and July 2025.

The goal was to engage representatives from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives. The hospital included the Regional Health Officer of Service Planning Area 8 from the Los Angeles County Department of Public Health as a stakeholder to ensure the input from a state, local, tribal, or regional governmental public health department.

Stakeholders were invited by email to participate in the phone interview and provided flexibility in scheduling. Stakeholders were also invited to participate in an online survey on significant health needs identified by the collaborative of hospitals.

At the start of each interview, the purpose and context of the assessment was explained, the stakeholders were assured their responses would remain confidential, and consent to proceed was obtained. The interviews were structured to obtain greater depth and richness of information on significant health needs. First, interview participants were asked to describe, from their professional perspective, some of the major health or social needs impacting the community. During the interviews, participants were asked to share their perspectives on issues, challenges, and barriers relative to the identified significant health needs, along with identifying resources to address these health needs, such as services, programs, and/or community efforts. Interviews were conducted via Zoom and recorded using the Fireflies note taking app.

Community Stakeholders Participants

Organization	Name	Title	Sector
Los Angeles County Department of Public Health	Alicia H. Chang, MD, MS	Regional Health Officer	Public Health
South Bay Cities Council of Governments	Ronson Chu	Senior Project Manager for Homeless and Senior Services	Government
City of Torrance	Heather Cousin, MLIS	City Librarian	Government
Goodwill Industries	Ben Espitia	Vice President Workforce Development	Social Services
Volunteer Center South Bay/ Harbor/ Long Beach	Josh Gezahegn, Ed. D	President and Chief Executive Officer	Youth/Mental Health
Connected to Lead	Jen Harris	Founder & Executive Director	Youth
Harbor Interfaith Services	Tahia Hayslet	Executive Director	Homeless Services
City of Torrance	Viet Hoang	Deputy City Manager	Government/Homeless Services

Organization	Name	Title	Sector
Boys and Girls Clubs of the Los Angeles Harbor	Bryan Jebo	Chief Operating Officer	Youth
Lawndale Elementary School District	Julie Kane, Ed. D	Director of Special Projects	Education
Harbor Community Health Centers	Tamra King	Chief Executive Officer	Healthcare
Watts Healthcare Foundation	Olusheyi Lawoyin, Ph.D., MBA, MPH	Chief Operations Officer	Healthcare
Unite LA	Ilia Lopez, JD	Associate Director, Inclusion and Community Partnerships	Workforce Development
Rainbow Services	Laura Lull	Chief Executive Officer	Homelessness
Torrance-South Bay YMCA	Steve MacAller	District Vice President	Social Services
Los Angeles Police Department	Captain Brent Mcguyre	Captain, Harbor Division	Government
Friendship Foundation	Rabbi Yossi Mintz	Founder and Executive Director	Disabilities
Torrance Unified School District	Sara Myers + Nancy Gutierrez, Ed. D	Director, Communications + Coordinator, Parent Community Engagement; Homeless Foster Liaison	Education
LA Care	Candace Nafissi, MPA	Manager, Community Resource Center	Healthcare
Community's Child	Tara Nierenhausen	Executive Director	Social Services
El Camino College	Ann O'Brien	Executive Director, Marketing and Communications	Education
California State University Dominguez Hills	Thomas A. Parham, Ph.D., MA + Mi-Sook Kim, Ph.D. +Tiffany Herbert, Ph.D.	President + Dean, College of Health, Human Services, and Nursing + Associate Vice President, Health and Well-Being	Education
Venice Family Clinic/South Bay Family Healthcare	Mitesh Popat, MD, MPH	Chief Executive Officer	Healthcare
Adobe Communities	Mariana Ruelas, MSW + Jacqueline Miranda	Resident Services Supervisor + Resident Services Coordinator Lead	Housing
San Pedro Mental Health Center	Maria Salas, MPA	Case Manager	Mental Health
Open Paths Counseling Center	Sierra Smith	Executive Director	Mental Health
NAMI South Bay Chapter	Paul Stansbury, MBA, Ed.D., MA	President	Mental Health

Organization	Name	Title	Sector
WISE & Healthy Aging	Rachel Tate, MSW	Vice President, Ombudsman Services	Older Adults
EXP	Mary Tran	Chief Executive Officer	Workforce Development
Unihealth	Jennifer Vanore, Ph.D.	President and Chief Operating Officer	Philanthropy
California Community Foundation	Rosemary Veniegas, Ph.D.	Director of Health Programs	Philanthropy
Forensic Nurse Specialists, Inc.	Malinda Wheeler, RN, MH, FNP	President	Domestic Violence
Richstone Family Center	Veronica Williams, LMFT	Therapist and Community Outreach Coordinator	Mental Health
South Bay Children's Health Center	Angela Wilson, LMFT	Director Mental Health	Healthcare

COMMUNITY STAKEHOLDER INTERVIEWEE SURVEY RESULTS

When asked about the level of importance the hospital should place on addressing the health issue, community stakeholders scored the health needs according to the table below, on 4-point scale. The top five health needs that were prioritized by community stakeholders were Mental health, Substance use, Access to care, Preventive services and Housing and homelessness.

Significant Needs	Priority Ranking (Total Possible Score of 4)
Mental health	3.93
Substance use	3.79
Access to care	3.72
Preventive services	3.67
Housing and homelessness	3.34
Chronic disease	3.34
Food insecurity	3.21
Overweight and obesity	3.07
Safety and violence	3.04
Economic insecurity and workforce development	2.93

Source: Providence South Bay 2025 CHNA Community Stakeholder Survey

When asked about the perceived severity of a health or community issue as it affects the health and lives of those in the community; when asked whether a health need was improving or worsening over time; and when asked about resources in the community for a specific health or health-related social need, community stakeholder interviewees responded with the following survey results.

Significant Health Needs	Severe Impact on the Community	Worsened Over Time	Insufficient or Absent Resources
Access to Care	60%	27%	70%
Chronic Disease	50%	18%	47%
Economic Insecurity and Workforce Development	80%	52%	70%
Environmental Conditions	40%	20%	53%
Food Insecurity	63%	77%	77%
Housing Insecurity and People Experiencing Homelessness	80%	83%	87%
Mental Health	83%	73%	97%
Overweight/Obesity	33%	24%	41%
Preventive Practices	47%	17%	50%
Safety and Violence	37%	23%	47%
Substance Use/Misuse	50%	53%	72%

METHODOLOGY: LISTENING SESSIONS

Facilitation

For the listening sessions, participants were asked an icebreaker and three questions:

- Community members' definitions of health and well-being
- The community needs
- The community strengths

Training

The facilitation guides provided instructions on how to conduct a listening session, including basic language on framing the purpose of the sessions. Facilitators participated in trainings on how to successfully facilitate a listening session and were provided question guides.

Data Collection

At least two note takers documented the listening session conversations.

Analysis

For the listening sessions, analysis was conducted by Providence using Atlas.ti, a qualitative data analysis software. The two sets of notes were merged and the data were coded into themes, which allows the grouping of similar ideas across the interviews, while preserving the individual voice.

The analyst used a standard list of codes, or common topics that are mentioned multiple times. These codes represent themes from the dataset and help organize the notes into smaller pieces of information that can be rearranged to tell a story. The analyst developed a definition for each code which explained what information would be included in that code. The analyst coded three domains relating to the topics of the questions: 1) vision, 2) needs, and 3) strengths.

The analyst then coded the information line by line. All information was coded, and new codes were created as necessary. All quotations, or other discrete information from the notes, were coded with a domain and a theme. Codes were then refined to better represent the information. Codes with only one or two quotations were coded as "other," and similar codes were groups together into the same category. The analyst reviewed the code definitions and revised as necessary to best represent the information included in the code.

The analyst determined the frequency each code was applied to the dataset, highlighting which codes were mentioned most frequently. Codes for unmet health-related needs were cross-referenced with the domains to better understand the populations most affected by a certain unmet health-related need. The analyst documented patterns from the dataset related to the frequency of codes and codes that were typically used together.

Limitations

We acknowledge there are limitations to the data collection and analysis process, which may include, but are not limited to, selection bias, variation in style between facilitators and notetakers, barriers to participation, and subjective bias from the analyst.

Listening Session Participants

The hospital completed six listening sessions that included a total of fifty-two participants. The sessions took place between June 2025 and July 2025.

Population	Community Partner	Location	Date	Language
Black/African American, Faith-Based Leaders	First AME Church of Los Angeles/Lincoln Memorial Church/The Sentinel	FAME Church	6/9/2025	English
Latino, San Pedro Subsidized Housing Residents	One San Pedro	One San Pedro	6/23/2025	Spanish
Latino, Wilmington Residents	Providence Wilmington Wellness and Activity Center	Virtual	6/26/2025	Spanish
Latino Lawndale/Hawthorne Residents	Lawndale Elementary School District; St. Joseph Church Health Committee	Providence Lawndale Wellness & Activity Center	6/30/2025	Spanish
Hospital Leadership	Providence Little Company of Mary	Virtual	7/9/2025	English
Hospital Leadership	Providence Little Company of Mary	Virtual	7/21/25	English

FINDINGS FROM LISTENING SESSIONS

Vision for a Healthy Community

Community members shared their vision for a healthy community:

- **Connection and care for one another:** In every listening session, community members spoke about the importance of having an engaged, connected community, where there is unity, belonging, and caring for one another. Healthy communities have community spaces where people come together, including multigenerational spaces where all ages are present. People feel a sense of belonging and no one is isolated, particularly older adults. There are events and connection opportunities through school groups, teams, volunteering, and other social gatherings, like parades. In healthy communities, people help one another, particularly their neighbors. They greet one another and treat each other with respect.

  "It's about a neighbor helping out a neighbor."—Hospital Leadership

- **Safety**: In healthy communities, people feel physically and emotionally safe. They feel safe walking in the community and enjoying public spaces like parks, free from violence and encampments. They also feel safe to practice their faith and to gather with their community. They feel emotionally safe to speak up and express themselves.

  "Practice faith safely without having to worry about having a church bombed."—Community Faith Leader

- **Physical health and recreation**: People are active and engaged in caring for their physical health and can be seen enjoying recreation opportunities. In healthy communities, kids are outdoors playing and not overweight, the parks are full, and people are out walking and running. There are recreation classes available, like exercise groups, youth sports leagues, and nutrition classes. People take an active role in their health, and it is easy to access resources that promote healthy habits, like through health fairs and prevention programs.

- **Behavioral health—including mental and spiritual health:** Behavioral health, including mental and spiritual health, is necessary for healthy communities. In healthy communities, there is a focus on holistic well-being and behavioral health services to address substance use disorders and mental health conditions are accessible. People can practice their faith safely, manage their stress, and be free from substances.

  "You cannot have a healthy body without a healthy mind."—Hospital Leadership

  "Without mental health, you do not have well-being."—Community Faith Leader

- **Clean environment with green spaces:** Healthy communities are clean and appear well-kept, with green spaces and trees. In clean, well-kept communities there are no encampments, graffiti, poorly maintained sidewalks, or contamination. The air is healthy and free of pollution.

- **Access to health care services:** Everyone has access to health care services and health insurance in a healthy community, including primary care providers, pediatricians, and specialists. Preventive health services are available, and people have the tools and resources to be involved in their own health, including access to health education classes and support groups.

- **Basic needs are met for housing, food, and education:** People can meet their basic needs and access adequate housing, healthy food, and educational opportunities. In healthy communities, everyone has access to housing and there are no homeless encampments. People have access to affordable and healthy foods to meet their nutritional needs and there are good quality schools for all children.

Unmet Health-Related Needs

Community members were asked to discuss community health-related needs. Needs that were talked about in detail in a majority of the sessions were prioritized as high priority, while those

that were talked about in fewer than half of the sessions were identified as medium priority. The following themes emerged:

High priority unmet health-related needs

- **Behavioral health challenges and access (mental health and substance use/misuse)**: Most listening sessions discussed the importance of addressing behavioral health needs in the community, including providing more emotional support to individuals. There is a strong need for more behavioral health services for all ages, including more therapists and mental health professionals. There is also a need for more drug prevention and mental health awareness classes.

- **Access to health care services:** Addressing access to health care challenges is critical to meeting other community needs. Community members shared the following needs:
    - Health education classes: More education is needed to help people be actively engaged in their own health and well-being, including medication management.
    - Post-acute transitional care: Appropriate transitional care is needed to provide follow-up services after receiving acute hospital care.
    - Language support: Additional language support is needed to ensure patients and families understand treatment plans and guidance.
    - Mobile health clinics: Care that meets residents where they are is needed.

  The high cost of care and delays in getting appointments prevent people from accessing needed care. Community members shared providers need to listen more closely to patients and use clear, empathetic language.

  "For a community to thrive, we should all be able to see a doctor without worrying how it's going to be paid for."—Community Faith Leader

  "If you cannot function mentally and physically, nothing else matters. In my opinion, health care should be free. Period."—Community Faith Leader

- **Community resources and outreach:** Community members shared that while there are resources available in the community, there is a strong need for more communication and outreach to the community to ensure people know how to access those resources. They suggested more intentional outreach to engage with all populations by providing information in churches, medical offices, and community events. They also recommended going door-to-door to talk to people, moving beyond simply handing out flyers or posting on social media. Hosting regular meetings or convenings where people can learn more about what is available and hear what people need would also be beneficial.

Many resources are currently siloed and not working together, making it more difficult for people to access resources. Certain populations, including older adults and people with disabilities, may experience more barriers to accessing resources.

"We do have resources, but people do not participate."—Wilmington Resident

"We should help each other by sharing information and resources because we don't read the flyers."—Lawndale Resident

- **Community engagement, advocacy, and reform**: Community members shared that more community involvement and representation is needed to foster unity and work to address needs collaboratively. Community representation, including youth, is needed to work with government representatives to advocate for reform, particularly related to immigration. A persistent theme is that many people are afraid to leave their home because of immigration raids, affecting people's mental health.

"Do not let fear get us down, since you are not alone, we are not alone."—Wilmington Resident

To promote community involvement and engagement, participants shared there needs to be a centralized hub where community members feel safe gathering. These gatherings are important for promoting more cultural unity, respect for one another, and support for people who are isolated. Volunteer opportunities can also help people engage in their communities.

"A place for the community to meet. Social media and COVID drove us inside."—Hospital Leadership

"Bridging the gap between all different cultures so we can all feel a part of it. Making sure everybody in the community feels welcomed."—Community Faith Leader

"Debemos unirnos… y apoyar unos a otros." ("We must unite… and support each another.")—Lawndale Resident

- **Safety:** Community members discussed a variety of safety concerns in the community. To make walking in the community safer, community members noted needing more traffic signs, better street lighting, and repaired and even sidewalks. Additionally, homelessness and encampments create safety concerns for people and can prevent people from utilizing parks or walking in their neighborhoods. Community members were also concerned about safety in schools and apartment buildings, noting a need for more police patrolling and enforcement of rules.

"Seguridad en la escuela y la calle." ("Safety in the schools and streets.")—Lawndale Resident

- **Physical health and recreation:** To address chronic conditions and promote physical health, community members would like to see more exercise programs and walking

groups, for both adults and young people. More health education programs are also needed to educate people on nutrition, fitness, and preventive care.

Medium priority unmet health-related needs

- **Affordable housing and homelessness**: Participants were concerned about homelessness in their community, stating that all people should be safely housed. They noted that homelessness affects their feeling of safety in the community and can prevent people from utilizing parks or walking in their neighborhoods. They would like to see more affordable housing and homelessness services available, including supportive housing with wraparound services, job skills training, and provision of food and clothing. There is also a need for more accountability from housing agencies to ensure funding is used to move people into housing.

  "[People experiencing homelessness] deserve housing."—Community Faith Leader

  "Provide solutions for the unhoused, like job skills… [and] wraparound services."—Community Faith Leader

  "People say they're helping people [get into housing], but they're not. There is no accountability."—Community Faith Leader

- **Economic security, including jobs and education:** Community members discussed the importance of ensuring families have economic security to meet their basic needs. More job training and skill development is needed, as well as classes for financial education and literacy. Additionally, all people should have access to high-quality education, which is foundational for economic security. Education needs to include trade classes and support young people in developing vocational skills in high school. Low expectations and inequities in funding and the quality of education students receive can contribute to young people leaving school early without necessary skills.
  For younger students, more early childhood development programs and support for students in elementary school that are falling behind their peers is important. Community members shared that there are inequities in funding for public versus private schools and not all students have the same access to high-quality educational programs.

  "We need job trainings and skill development."—Community Faith Leader

  "Learn a trade and you'll never be broke."—Community Faith Leader

  "When you look at our community, say 'Black males, they can't do anything. Can't do math or reading.' What reason do they have to go to school?"—Community Faith Leader

"We have third graders that can't write, spell, or even read."—Community Faith Leader

- **Food security**: The cost of food is high, and healthy food can be hard for people to access, particularly in neighborhoods that lack nearby grocery stores with healthy foods. Community members would like to see more local grocery stores, community gardens, and farmers' markets with vendors from within the community. More nutrition programs to teach families how to prepare healthy meals on a budget are also needed considering the high cost of fresh foods.

"Right now, eggs are as high as $15 a dozen."—San Pedro Resident

"Vegetales orgánicos están caros." ("Organic vegetables are expensive.")—San Pedro Resident

- **Clean and well-maintained environment**: Participants would like to see more efforts to keep their community clean, including adding more trees, maintaining roads and sidewalks, adding trash cans, and removing graffiti.

Appendix 3: Community Resources Available to Address Significant Health Needs

Little Company of Mary San Pedro and Little Company of Mary Torrance cannot address all of the significant community health needs by working alone. Improving community health requires collaboration across community key informants and with community engagement. Below outlines a list of community resources potentially available to address community needs.

Community Resources Available to Address Significant Health Needs

Significant Health Needs	Community Resources
Access to care	211, Benevolence Health Centers, Harbor Community Health Centers, Harbor Interfaith Services, Healthcare in Action, Los Angeles Department of Public Health, Northeast Community Clinics, Public Health Alliance of Southern California, Torrance Health Center, Venice Family Clinic/South Bay Family Healthcare, Wilmington Community Clinic, Wilmington Community Resource Center, Wilmington Wellness and Activity Center
Chronic diseases	America Diabetes Association, American Heart Association, Behavioral Health Services Inc: El Puerto Health Center, Benevolence Health Centers, Harbor Community Health Centers, Long Beach Alliance for Children with Asthma (LBACA), Northeast Community Clinics, Torrance Health Center, Venice Family Clinic/South Bay Family Healthcare, Wilmington Community Clinic, Wilmington Community Resource Center, Wilmington Wellness and Activity Center, WISE & Healthy Aging
Economic security and workforce development	1736 Family Crisis Center, allcove Beach Cities, America's Job Center of California (AJCC), Black Math Collective, Boys and Girls Club, Community's Child, Easter Seals, EXP, Friendship Foundation, Goodwill Industries, Harbor Gateway Worksource Center, Harbor YouthSource Center, ICANN, San Pedro Recovery Alliance, South Bay Workforce Investment Board
Environmental health	American Lung Association, Asthma Coalition of Los Angeles, Breathe California, California Coastal Commission, Coalition for Clean Air, Feed and Be Fed, South Bay Environmental Services Center
Food insecurity	Boys and Girls Club, CalFresh, Catholic Charities, Community's Child, Curt's Kitchen, El Camino Community College, Feed and Be Fed, Food Forward, Harbor Interfaith Services, LA Regional Food Bank, New Challenge Ministries, Rotary Club, Salvation Army, San Pedro Recovery Alliance, South Bay Mommies and Daddies, Toberman Neighborhood Center, Volunteer Center South Bay/ Harbor/ Long Beach, WIC, Wilmington Community Resource Center, Wilmington Wellness and Activity Center, YMCA

Significant Health Needs	Community Resources
Housing and homelessness	CIRCLE: Urban Alchemy, Community's Child, Harbor Community Health Centers, Family Promise, Functional Zero Project, Harbor Connects, Harbor Interfaith Services, Healthcare in Action, Long Beach Multi Service Center, Los Angeles Domestic Violence & Homeless Services Coalition, Safe Place for Youth, Salvation Army, Sanctuary of Hope, South Bay Cities Council of Governments, South Bay Cities Homelessness Services Task Force, South Bay Coalition to End Homelessness, St. Margaret's Center, Venice Family Clinic/South Bay Family Healthcare
Mental health	allcove Beach Cities, Behavioral Health Services Inc: El Puerto Health Center, Benevolence Health Centers, California Youth Crisis Line, Care Solace, Community's Child, Connected to Lead, Exodus, Harbor Community Health Centers, Harbor Interfaith Services, Hazel Health, Healthcare in Action, NAMI South Bay Chapter, National Suicide Prevention Lifeline, Open Paths Counseling Center, Richstone Family Center, SALT 8: the Service Area Leadership Team for Service Area 8, San Pedro Mental Health Center, San Pedro Recovery Alliance, South Bay Center for Counseling (SBCC), South Bay Children's Health Center, South Bay Community Coalition Against Hate, South Bay Families Connected, South Bay Youth Project, Substance Abuse and Mental Health Services Administration (SAMHSA), The Jimmy Miller Foundation The Teen Line, Toberman Neighborhood Center, Torrance Health Center, Trevor Lifeline, Venice Family Clinic/South Bay Family Healthcare, Volunteer Center South Bay/ Harbor/ Long Beach, Wilmington Community Clinic
Overweight and obesity	Benevolence Health Centers, Boys and Girls Club, Feed and Be Fed, Harbor Community Health Centers, South Bay Mommies and Daddies, Torrance Health Center, Venice Family Clinic/South Bay Family Healthcare, Wilmington Community Clinic, Wilmington Community Resource Center, Wilmington Wellness and Activity Center, YMCA
Preventive services	allcove Beach Cities, Behavioral Health Services Inc: El Puerto Health Center, Benevolence Health Centers, CIRCLE: Urban Alchemy, Friendship Foundation, Harbor Community Health Centers, Los Angeles Department of Public Health, Northeast Community Clinics, Public Health Alliance of Southern California, The Arming Minorities Against Addiction & Disease (AMAAD) Institute, Torrance Health Center, Venice Family Clinic/South Bay Family Healthcare, Wilmington Community Clinic, Wilmington Community Resource Center, Wilmington Wellness and Activity Center, WISE & Healthy Aging
Safety and violence	1736 Family Crisis Center, CIRCLE: Urban Alchemy, Community Legal Aid, Community's Child, Doors of Hope Shelter, Family Promise of the South Bay, Harbor Interfaith Services, Human Trafficking Hotline, Los Angeles Domestic Violence & Homeless Services Coalition, National Domestic Violence Hotline, Rainbow Services, Rape, Abuse & Incest National Network (RAINN), Survivor Justice Center, Toberman Neighborhood Center, WISE & Healthy Aging, YWCA

Significant Health Needs	Community Resources
Substance use and Misuse	Aim High Sober Living, allcove Beach Cities, Asian American Drug Abuse Program (AADAP), Beacon House Association of San Pedro, Behavioral Health Services Inc: El Puerto Health Center, Care Solace, Community's Child, Exodus Recovery, Gardena Drug and Alcohol Abuse Prevention Task Force (GDAAP), Harbor Community Health Centers, Healthcare in Action, House of Hope, KickIt California, San Pedro Recovery Alliance, SHAWL House, South Bay Families Connected, Substance Abuse and Mental Health Services Administration (SAMHSA), Substance Abuse Services Hotline (SASH), The Arming Minorities Against Addiction & Disease (AMAAD) Institute, Torrance Health Center, Twin Town Treatment Centers, Venice Family Clinic/South Bay Family Healthcare, Wilmington Community Clinic

Appendix 4: Providence Little Company of Mary Medical Centers San Pedro and Torrance Mission Community Health Committee

Mission Community Health Committee Members, 2025

Name	Title	Organization
Albert Paredes	Director, Student Support services	Lawndale Elementary School District
Amber Sheikh	Community Member	
Chris Caras	Community Member	PLCM Foundation Board Member
Jeff Parker	Community Member	
Jim Hartman	Community Member	
Rabbi Zalman Gordon	Community Member	
Suzi Gulcher	Community Member	
Veronica Williams	Marriage and Family Therapist, Richstone	Richstone Family Services
Bishop Dean Nelson	Mission Community Health Committee Chair	PLCM Community Ministry Board
Richard Afable	PLCM Board Chair	PLCM Community Ministry Board
Tom Connaghan	PLCM Board Member	PLCM Community Ministry Board
Candice Washilewski	Chief Nursing Officer, PLCMMC-T	Providence Caregiver
Peter Kang	Chief Mission Officer, PLCMMC-SP & PLCMMC-T	Providence Caregiver
Justin Joe	Director, Community Health	Providence Caregiver
Lori Nolan	Philanthropy Officer, PLCM Foundation	Providence Caregiver
Michael Ricks	Chief Executive, Coastal Service Area	Providence Caregiver
Nate Mabry	Chief Administrative Officer, PLCMMC-SP & PLCMMC-T	Providence Caregiver
Michael Robinson	Chief Community Health Officer	Providence Caregiver