Saint John's Health Center
Providence

2025 COMMUNITY HEALTH NEEDS ASSESSMENT

Providence Saint John's Health Center

Santa Monica, CA

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

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EXECUTIVE SUMMARY

Understanding and Responding to Community Needs

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

The 2025 CHNA was approved by the Board of Directors on November 19, 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 (6) listening sessions with 74 participants who have chronic conditions, are from diverse communities, have low-incomes, and are medically underserved. We also conducted 44 community stakeholder interviews with representatives from organizations that serve these populations, specifically seeking to gain deeper understanding of community strengths and opportunities. Some central findings include the following:

- The percentage of people experiencing depression and mental health distress in the service area is higher 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.
- Housing is unaffordable for many in the service area. Even with higher median household incomes in the service area, the cost-burden of housing is notably high. The community is concerned about the region's recent wildfires and their impact on housing. (The quantitative data in this CHNA does not yet show the impact of the Los Angeles region's devastating wildfires of January 2025.)
- While health insurance rates are relatively high compared to Los Angeles County and California, underserved populations experience significant challenges in accessing primary and specialty services, especially services that are culturally responsive and linguistically appropriate.
- Older adults, and families impacted by immigration status are at-risk for poor health outcomes.

Providence Saint John's Health Center's community stakeholder interviews were planned and implemented in collaboration with local area hospitals with overlapping service areas. The partnership is referred to as the Westside Hospital Collaborative and includes Providence Saint John's Health Center, Ronald Reagan UCLA Medical Center, UCLA Santa Monica Medical

Center, Resnick Neuropsychiatric Hospital at UCLA, Cedars-Sinai Medical Center and Cedars-Sinai Marina Hospital.

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 Saint John's Health Center leadership, Saint John's CHNA Advisory 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 Saint John's 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 Saint John's Health Center 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.

BEHAVIORAL HEALTH (MENTAL HEALTH & SUBSTANCE USE)

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. Specific mental health needs in the Westside include availability of affordable services and reducing the stigma of having a mental health condition. Additionally, in the wake of the recent Palisades Fire, mental health for community members has been significantly affected with many individuals experiencing increased stress, anxiety, and trauma.

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/misuse includes the use of illegal drugs and the inappropriate use of legal substances, such as alcohol, prescription drugs and tobacco.

HOUSING INSECURITY AND PEOPLE EXPERIENCING HOMELESSNESS

Housing insecurity encompasses several challenges such as having trouble paying rent, overcrowding, moving frequently, staying with relatives, or spending the bulk of household

income on housing. Households are considered "severely cost burdened" if spending more than 50% of household income on housing. The damage caused by Palisades Fire will limit the supply of affordable housing on the Westside. The damage caused by the Palisades Fire is expected to further constrain the already limited supply of housing on the Westside, increasing challenges for individuals and families seeking stable accommodations.

People experiencing homelessness lack a fixed, regular, and adequate nighttime residence; an individual or family who will imminently lose their primary nighttime residence; and any individual or family who is fleeing, or is attempting to flee, domestic violence, has no other residence, and lacks the resources or support networks to obtain other permanent housing. Health and housing instability are inextricably linked. Health problems can cause a person to experience homelessness and being unhoused can exacerbate existing health issues.

ACCESS TO CARE

While the Saint John's service area has lower percentages of people without health insurance compared to the rest of LA County, access to care goes beyond health insurance coverage. Additional barriers identified specifically by community stakeholders in the Westside include limited appointment availability for primary and specialty care (especially for patients with Medi-Cal coverage), long travel distances or lack of transportation, culturally appropriate care, and care coordination.

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.

Providence Saint John's Health Center 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 Saint John's Health Center 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:

- Average of 342 unduplicated patients served per year by Community Health Worker (CHW) Homeless Navigators.

- 556 annual patients provided with outpatient therapy services through the PSJHC Child and Family Development Center to children, teens, young adults and adults with developmental disabilities.

- Annual grantmaking was by Providence Saint John's Health Center and Providence Saint John's Health Center to local non-profit organizations addressing homelessness and housing insecurity, behavioral health, and access to care.

INTRODUCTION

Who We Are

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

Our Vision Health for a Better World.

Our Values Compassion — Dignity — Justice — Excellence — Integrity

Providence Saint John's Health Center has served Westside Los Angeles for more than 80 years. The nationally renowned, 266-bed hospital delivers advanced diagnostic technology and specialty care with a strong focus on heart and vascular care, oncology, orthopedics and women's health. Saint John's earned a 4-star rating from the Centers for Medicare and Medicaid Services and ranks among the top 10 hospitals in Los Angeles and Orange Counties and the top 19 in California in U.S. News & World Report's "Best Hospitals" list.

Our clinical institutes drive high-quality care for the community. Saint John's is home to the Saint John's Cancer Institute and Pacific Neuroscience Institute, both recognized for groundbreaking research and treatment. Additional institutes specialize in digestive health, orthopedics and spine, women's health and wellness, heart and vascular care and behavioral health.

These institutes combine advanced medical expertise with personalized, compassionate care tailored to each patient. Physicians and care teams use innovative technology and minimally invasive treatments to deliver effective therapies, improve outcomes and speed recovery. Through a strong commitment to research, Saint John's offers access to clinical trials and the latest medical advancements.

Founded by the Sisters of Charity of Leavenworth and sponsored by Providence Health & Services since 2014, Saint John's upholds the Catholic health care tradition of delivering leading-edge medicine with compassion and personalized care. As a nonprofit, Saint John's invests in community benefit programs, prioritizing the poor and vulnerable.

Through the commitment of physicians, nurses, staff, volunteers and community partners, Saint John's continues to advances its legacy of breakthrough medicine in an environment of inspired healing.

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.

COLLABORATING PARTNERS AND CONTRACTOR

Collaborating Community Partners

Providence Saint John's Health Center's community stakeholder interviews were planned and implemented in collaboration with local area hospitals with overlapping service areas. The partnership is referred to as the Westside Hospital Collaborative and includes Providence Saint John's Health Center, Ronald Reagan UCLA Medical Center, UCLA Santa Monica Medical Center, Resnick Neuropsychiatric Hospital at UCLA, Cedars-Sinai Medical Center and Cedars-Sinai Marina Hospital. 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 Saint John's Health Center 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 Providence Saint John's Health Center's 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 Framework

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

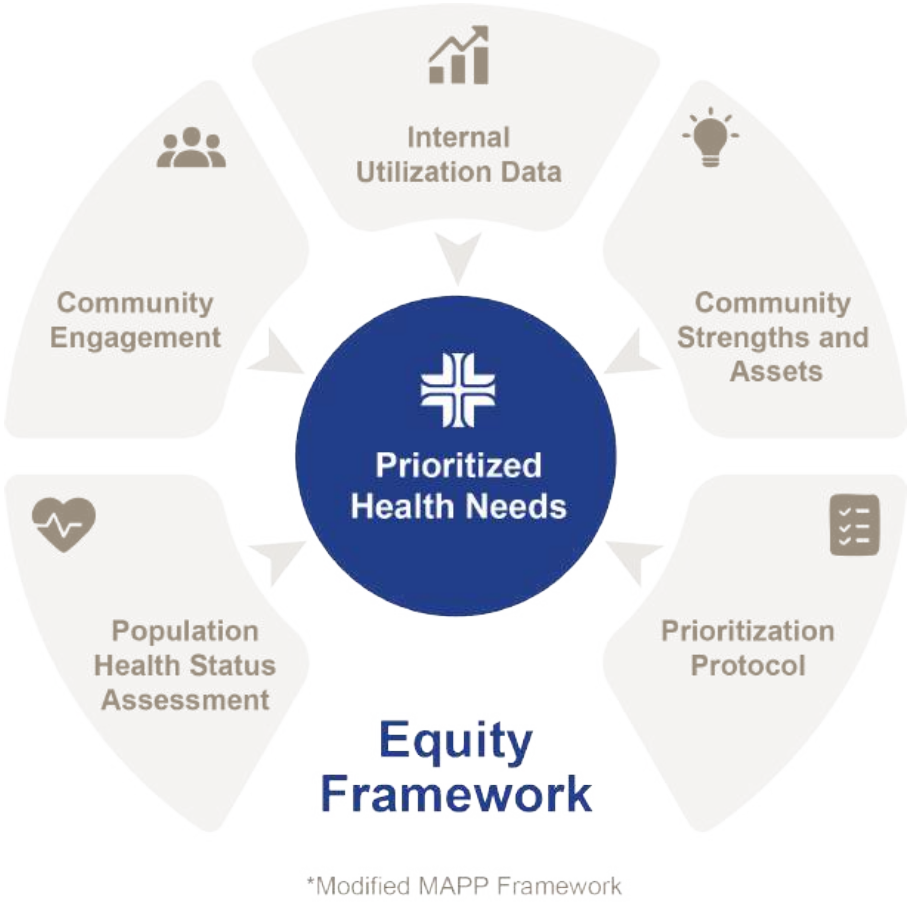
Report data at the local level to avoid masking

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.



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 the 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

- Stakeholder interviews
- Community listening sessions
- Internal hospital utilization data, including social determinant of health screenings

Secondary Data Sources

- American Community Survey from the U.S. Census Bureau
- Behavioral Risk Factor Surveillance System (BRFSS)
- CDC Places
- Environmental Justice Index
- 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.

SECTION II: DESCRIPTION OF COMMUNITY

CHNA Service Area

Based on the availability of data, geographic access to the facility, and other hospitals in neighboring counties, Los Angeles County's Department of Public Health Service Planning Area (SPA) 5 colloquially known as the "Westside" serves as the boundary for the majority of the 2025 CHNA service area. SPA 5 closely matches where a majority of Providence Saint John's Health Center patients reside; and utilizing the SPA definition aligned data collection to boundaries used by the L.A. County Department of Public Health and other government agencies. Along with census tracts within SPA 5, this year we have included additional census tracts in the 90290 ZIP Code based upon volume of Saint John's patients who reside there, and additional census tracts in the east in consideration of potential developing partnerships within the West Angeles neighborhoods.

Figure 1: Providence Saint John's Health Center 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 in the service area 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 Saint John's service area is 0.384. *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 Saint Johns's Health Center CHNA Datahub

Total Population

Table 1: Total Population Providence Saint John's Health Center Service Area

Geographic Designation	Population
High Need	358,745
Broader Need	343,046
Total Service Area	701,791
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

Providence Saint John's Health Center service area (15.8%) has a lower percentage of population aged 18 and under compared to Los Angeles County (20.9%). Providence Saint John's Health Center service area has a higher percentage of the population aged 65 and over (17.1%) than Los Angeles County.

Figure 2: Population Age by Geography

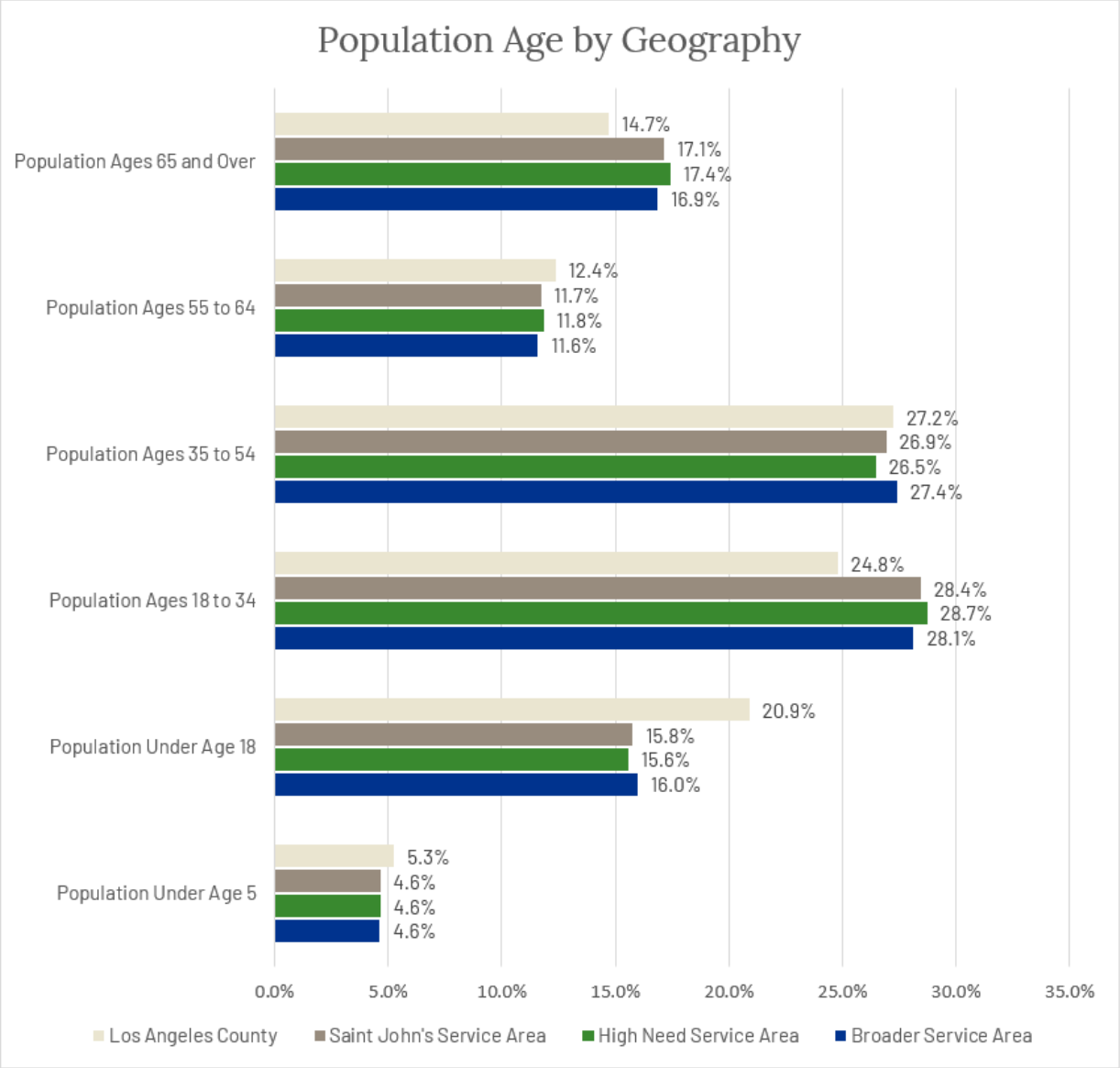


Figure 2 Source: U.S Census Bureau, 2019 – 2023 American Community Survey 5-Year Estimates, Tables B01001, B02001 and B03003

Population by Race by Geography

Providence Saint John's Health Center High Need, Broader Need and Total Service Areas have higher percentages of White population (50.4%, 66.7% and 58.4%, respectively), than Los Angeles County (35.4%). The percentage of Black or African American population is higher in Providence Saint John's Health Center High Need Service Area compared to the Broader Need and Total Service Area, as well as Los Angeles County.

Figure 3: Population Race by Geography

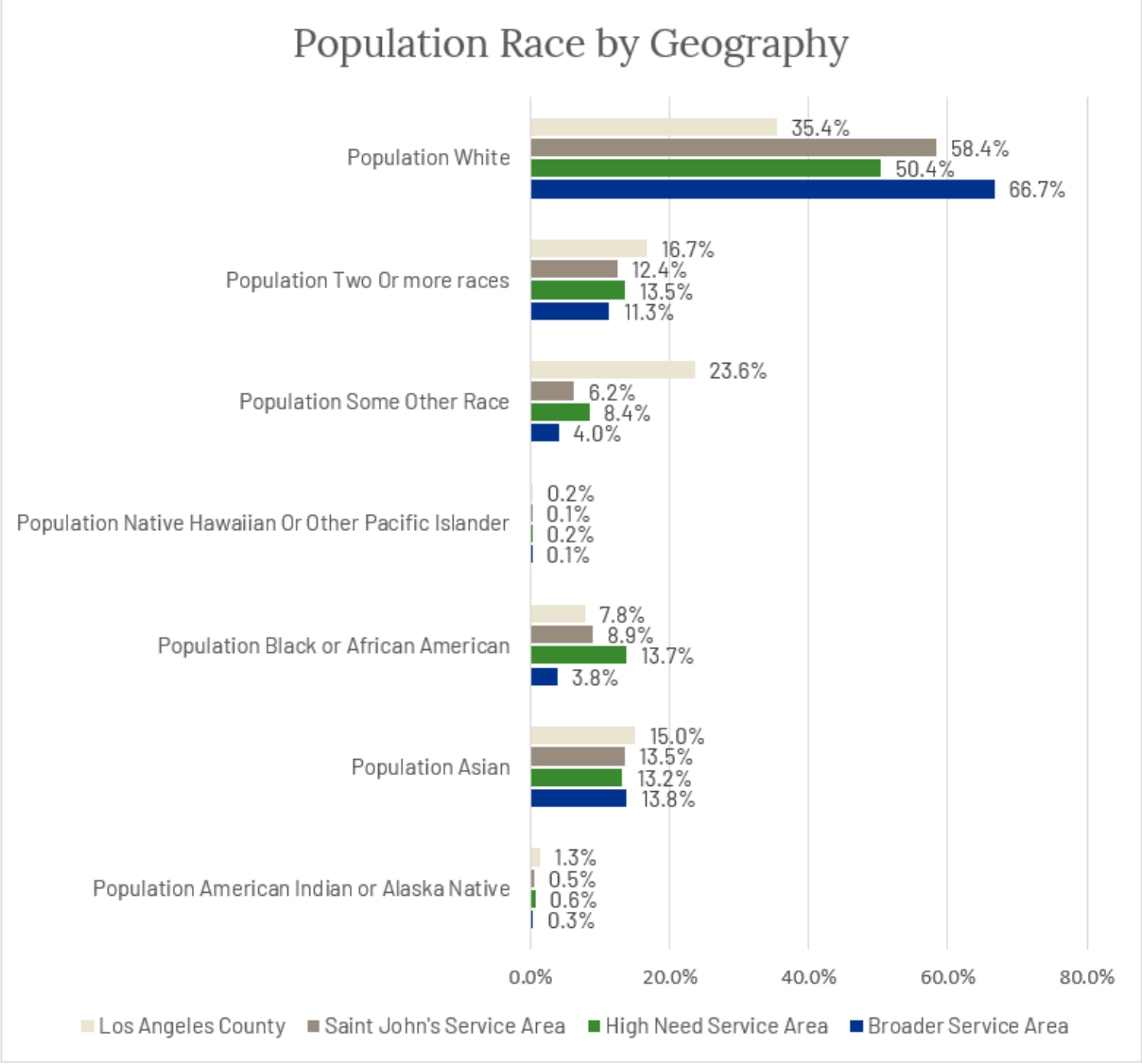


Figure 3 Source: U.S Census Bureau, 2019 – 2023 American Community Survey 5-Year Estimates, Tables B01001, B02001 and B03003

Population by Ethnicity by Geography

The Hispanic population is highest by percentage in the Providence Saint John's Health Center's High Need Service Area (21.0%), compared to 12.4% in the Broader Service Area and 16.8% in Providence Saint John's Health Center's Total Service Area.

Figure 4: Population Ethnicity by Geography

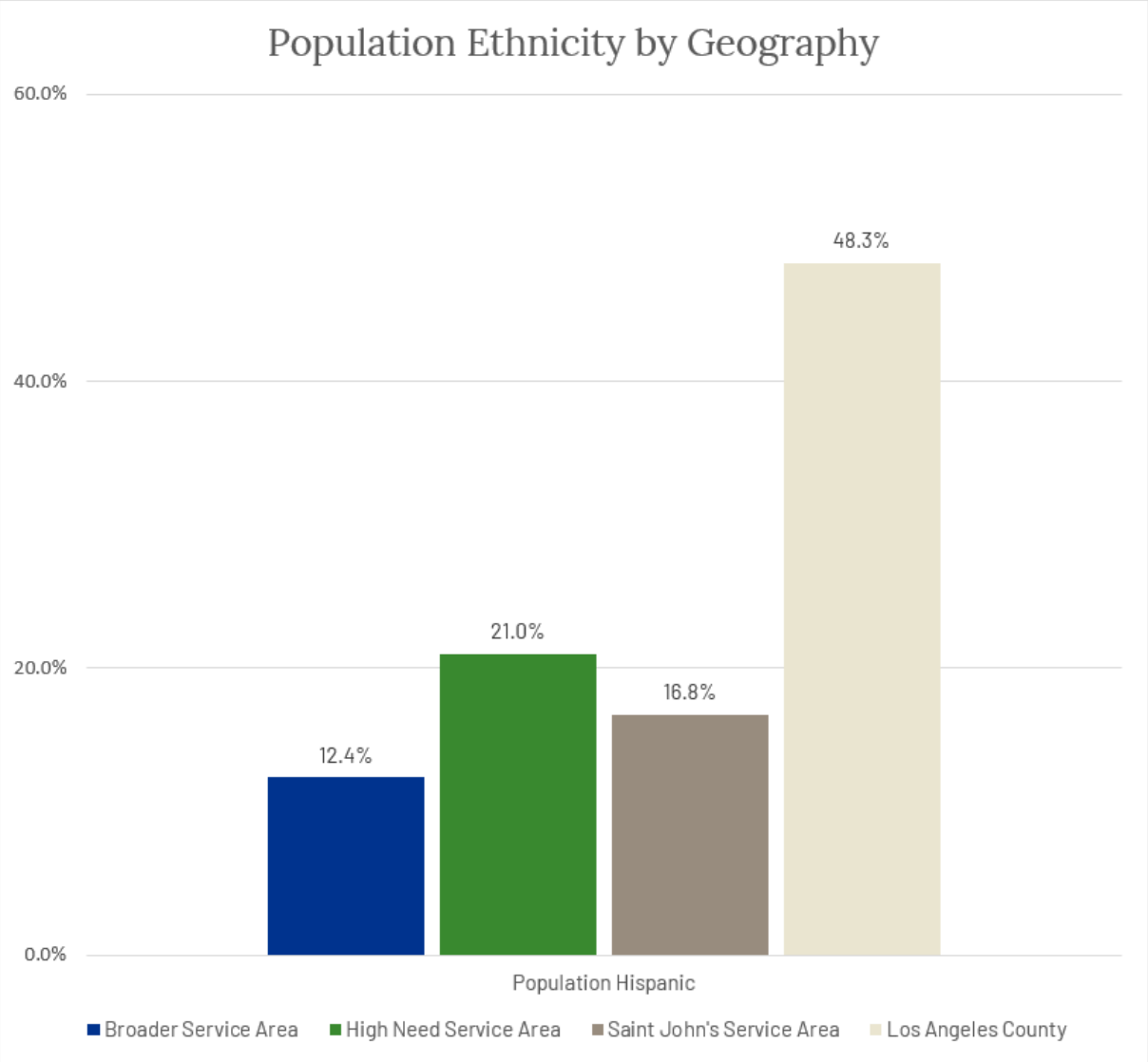


Figure 4 Source: U.S Census Bureau, 2019 – 2023 American Community Survey 5-Year Estimates, Tables B01001, B02001 and B03003

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.

Median incomes in the service area are higher than those in Los Angeles County and California. The median income of the High Need area is around $44,000 lower than the median income in the Broader Need Area.

Table 2: Median Household Income

Geographic Designation	Median Income
High Need	$104,228
Broader Need	$148,522
Total Service Area	$126,488
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 specific factors. 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 and $69,380 in the state of Alaska. (More info here)

The percent of population below 200% the federal poverty level in the High Need, Broader Need and Total Service Areas is lower than Los Angeles County and California. Within the service area, there is an 11.2 percentage point gap between the High Need and Broader Need Areas.

Table 3: Federal Poverty Level

Geographic Designation	Percent Below 200% FPL
High Need	26.7%
Broader Need	15.5%
Total Service Area	21.1%
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.

Lower percentages of households in the Providence Saint John's Health Center's High Need, Broader Need and Total Service Areas receive SNAP benefits than in Los Angeles County and in California. The percentage of households receiving SNAP is substantially higher in the High Need Service Area compared to the Broader Need Service Area.

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

Geographic Designation	Percent SNAP
High Need	8.2%
Broader Need	3.6%
Total Service Area	5.9%
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.

There are lower percentages of limited English-speaking households in Providence Saint John's Health Center's High Need, Broader Need and Total Service Areas than in Los Angeles County and in California. A higher percentage of limited English-speaking households are in the High Need Service Area compared to the Broader Need and Total Service Areas.

Table 5: Limited English Households

Geographic Designation	Percent Limited English
High Need	5.7%
Broader Need	3.4%
Total Service Area	4.5%
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 hospital is not located in an HPSA, but there are portions of two Primary Care HPSAs within the southern and southeastern boundary of the Providence Saint John's Health Center Service Area: A Low-Income HPSA, "Inglewood West" and a High Needs Geographic HPSA, "South Central Northwest" in the View Park/Windsor Hills area.

There are nine census tracts within the View Park/Windsor Hills area that are designated as a High Needs Geographic HPSA for Mental Health.

There are no Dental Care HPSAs within the service area boundaries.

The Facility HPSAs located in the service area, for Primary Care, Dental Care, and Mental Health, are: Complete Care Community Health Center Inc., Prime Wellness Community Health Center, The Achievable Foundation, Venice Family Clinic, and Westside Family Health Center (all three).

See Appendix 1 for additional quantitative data.

SECTION III: HEALTH-RELATED INDICATORS

Health Indicators from Saint John's CHNA Data Hub

Please refer to the **2025 Saint John's CHNA Data Hub** to review each of the following health indicators mapped at the census tract level. The hub provides data on each indicator in Providence Saint John's Health Center'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 people of color account for over half of the uninsured population.

The High Need, Broader Need and Total Service Area all show lower percentages of people without health insurance than Los Angeles County and California.

Table 6: Health Insurance

Geographic Designation	Percent without Insurance
High Need	5.1%
Broader Need	2.7%
Total Service Area	3.9%
LA County	8.7%
CA	6.9%

Source Table 7: 2023 American Community Survey, 5-Year Estimates

Chronic Diseases

Asthma: According to the U.S. Centers for Disease Control and Prevention, "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 Providence Saint John's Health Center's Service Area is higher than both Los Angeles County and California.

Diabetes: According to the U.S. Centers for Disease Control and Prevention, "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 Providence Saint John's Health Center's Total Service Area is lower than in Los Angeles County and California.

Heart Disease: According to the U.S. Centers for Disease Control and Prevention, "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 Saint John's Health's Center's Total Service Area is lower than in Los Angeles County and California.

Chronic Obstructive Pulmonary Disease (COPD): According to the U.S. Centers for Disease Control and Prevention, "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 Saint John's Health's Center's Total Service Area is slightly lower than in Los Angeles County and California.

Obesity: According to the U.S. Centers for Disease Control and Prevention, "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 is substantially lower in Providence Saint John's Health Center's Total Service Area than Los Angeles County and California.

Table 7: Chronic Diseases

Chronic Disease	Saint John's Total Service Area	LA County	California
Asthma	9.3%	9.1%	8.7%
Diabetes	8.9%	12.3%	11.5%
Heart Disease	4.8%	5.4%	5.3%
COPD	4.3%	4.8%	4.7%
Obesity	22.9%	26.2%	28.1%

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

Physical Inactivity

According to the U.S. Centers for Disease Control and Prevention, "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. Some physical activity is better than none. Adults who sit less and do any amount of moderate-to-vigorous physical activity gain some health benefits."

Providence Saint John's Health Center's Total Service Areas, as well as both the High Need and Broader Need service areas, all have substantially lower percentages of people reporting physical inactivity compared to Los Angeles County and California.

Table 8: Physical Inactivity

Geographic Designation	Physical Inactivity Prevalence Estimates
High Need	18.9%
Broader Need	13.9%
Total Service Area	16.4%
LA County	23.1%
CA	21.9%

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

Mental Health

Depression: According to the U.S. Centers for Disease Control and Prevention, "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, Broader Need and Total Service Area all show higher percentages of people with depression than Los Angeles County and California.

Table 9: Depression Prevalence

Geographic Designation	Depression Prevalence Estimates
High Need	21.8%
Broader Need	21.6%
Total Service Area	21.7%
LA County	20.2%
CA	18.1%

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

Frequent Mental Health Distress (FMD): According to the U.S. Centers for Disease Control and Prevention, 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 High Need Service Area shows the highest percentage of individuals reporting frequent mental health distress compared to the Broader Need and Total Service Areas, as well as Los Angeles County and California.

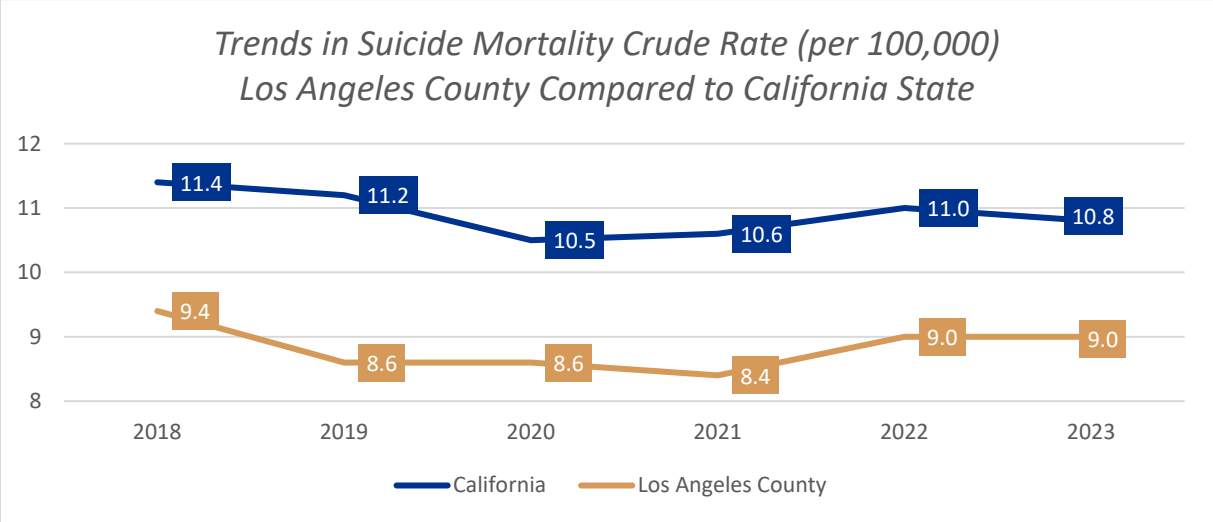
Table 10: Frequent Mental Health Distress Prevalence

Geographic Designation	Mental Health Distress Prevalence Estimates
High Need	16.3%
Broader Need	14.2%
Total Service Area	15.3%
LA County	16.0%
CA	14.3%

Source Table 11: 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 rates generally follow 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 U.S. Centers for Disease Control and Prevention, "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."

Providence Saint John's Health Center's High Need, Broader, and Total Service Areas show higher percentages of binge drinking than Los Angeles County and California.

Table 11: Binge Drinking Prevalence

Geographic Designation	Binge Drinking Prevalence Estimates
High Need	18.9%
Broader Need	20.2%
Total Service Area	19.6%
LA County	17.6%
CA	17.5%

Source Table 12: 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 Providence Saint John's Health Center High Need, Broader Need and Total Service Areas experience severe housing cost burden than in California, with the highest severe cost burden experiences in the High Need Service Area. The Total Service Area has a higher percentage of households severely burdened by housing costs compared to LA County.

Table 12: Households Experiencing Severe Housing Cost Burden

Geographic Designation	Percent Severe Housing Cost Burden
High Need	27.0%
Broader Need	23.4%
Total Service Area	25.2%
LA County	23.4%
CA	19.4%

Source Table 13: 2023 American Community Survey, 5-Year Estimates

Persons Experiencing Homelessness: Service Planning Area (SPA) 5

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 5 had an estimated 5,040 individuals who experienced homelessness, a decrease of 24.4% from 2023. Sheltered homeless 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 5 who were unsheltered increased by 1.8 percentage points from 2023 to 2025, and a greater percentage of people experiencing homelessness in SPA 5 were living unsheltered compared to Los Angeles County.

Table 13: Persons Experiencing Homelessness

Persons Experiencing Homelessness (PEH)	SPA 5		Los Angeles County Continuum of Care *	
	2023	2025	2023	2025
Total persons experiencing homelessness	6,669	5,040	71,320	67,918
Sheltered	21.5%	19.7%	26.7%	34.6%
Unsheltered	78.5%	80.3%	73.3%	65.4%

*Source Table 14: Los Angeles Homeless Service Authority, 2023 and 2025 Greater Los Angeles Homeless Count (SPA 5 data as of 7/10/2025). *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.*

See Appendix 1 to review more data on PEH in SPA 5 and Los Angeles County.

Leading Causes of Death

Mortality information is collected by state registries and provided to the National Vital Statistics System, based on death certificates for U.S. residents. Each death certificate contains a single underlying cause of death. 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 14: Leading Causes of Death Ranked, 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 6: 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 Jan 1-Dec 31, 2024, at Providence Saint John's Health Center showed the following:

- 4.5% of patients screened positive for at least one SDOH need.
- Housing instability was the most frequent SDOH need reported, followed by transportation needs, food insecurity, and utility difficulties.

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 Providence Saint John's Health Center:

- 29.0% of all ED visits were considered potentially avoidable in 2024, a slight decrease from 2023.
- The top three diagnosis groupings for avoidable ED visits were the following: urinary tract infections, skin infections and substance use disorders.
- 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):
  - Patients under 18 years of age (29.4%), patients ages 18-39 years (30.6%) and patients ages 40-64 years (31.0%)
  - Patients with Medicaid coverage (36.5%) and those who are self-pay (31.7%)
  - Patients who live in the ZIP codes 90404 (36.9%), 90025 (30.0%) and 90403 (29.5%)
- 6.6% 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 (11.1%) and patients ages 40-64 years (8.1%)
  - Patients with Medicaid coverage (12.2%) and those who are self-pay (15.1%)

- Patients who live in the ZIP code 90404 (14.7%)

➢ 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

SECTION IV: COMMUNITY INPUT

Summary of Community Input

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, representatives from Providence Saint John's Health Center worked in partnership with Ronald Reagan UCLA Medical Center, UCLA Santa Monica Medical Center, Resnick Neuropsychiatric Hospital at UCLA, Cedars-Sinai Medical Center and Cedars-Sinai Marina Hospital to conduct 44 interviews with community stakeholder organization leaders. Providence Saint John's Health Center also facilitated six listening sessions with various groups of community members, including Santa Monica residents in English and Spanish, Older Adults in the Westside, Faith Leaders in South Los Angeles, and non-profit organizational representatives from the Westside Coalition.

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 in the service area. Full details on the methodology and participants are available in Appendix 2.

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 on the west side of Los Angeles 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 November 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

- Transportation, language, financial constraints, shortage of providers willing to accept Medi-Cal and distrust of the healthcare system are key barriers to accessing care.
- Women of Color, immigrant families, individuals experiencing homelessness, individuals identifying as LGBTQIA+, and older adults are populations most impacted by access to care.

Quotes from stakeholders:

"There's still a significant need for basic primary care services."
"Barriers include transportation, language and education on available services."
"Even though immigrant families are entitled to healthcare, they don't often trust or believe that it is true, or they think that there's going to be a bill on the backend."

Chronic Disease

- Upstream social determinants of health, including food, housing and transportation, are impacting disparities in chronic disease.
- There is limited specialty care access in the Westside for patients with Medi-Cal, leading to wait times and the need to travel long distances across LA for care.

Quotes from stakeholders:
"Being able to access good, healthy, nutritional foods is important."
"Specialists are not accepting patients that have Medi-Cal coverage."
"We know that some of our most vulnerable immigrant communities are going to be less likely to seek preventative care or any type of care and will end up in our ERs with chronic conditions."

Environmental Health

- Concerns with pollution and air quality, especially in the aftermath from the Palisades and Eaton fires.

Quotes from stakeholders:

"Depending on where you live, you might have very high exposures. This is a community with high exposure to toxic substances."
"Especially with the fires, kids are asking to stay inside, even when the air has gotten better. We've seen an increased need for inhalers and flare-ups of asthma."

Food Insecurity

- Food insecurity is increasing with more people seeking services.
- Food costs are rising, especially in Santa Monica and the Westside.
- College students and aging populations on fixed incomes are often unable to afford food.

Quotes from stakeholders:

"The grocery stores are expensive. People frequently travel outside of Santa Monica to get their groceries which can add stress."
"We have the largest food pantry on the west side of Los Angeles. The lines continue to increase. We see aging populations on fixed incomes having challenges. We're seeing lines increase, particularly among families who have lost business due to the wildfires."
"It used to be that we saw very low-income people coming to us. Now we are seeing a range of people across different income brackets. Even people who are middle income making a good wage are coming for food assistance to help offset their housing costs. We are seeing families, professionals, college graduates."

Housing and People Experiencing Homelessness

- More affordable housing is needed. Current housing availability is insufficient.
- Even for those that are housed, they might be on the edge of homelessness.

- Older adults, people identifying as LGBTQIA+ and college students are populations especially at risk of losing their housing.
- The impact of January wildfires puts additional pressure on housing across the county.
- The cost of housing is affecting everybody's ability to afford everything else they need, whether it's healthcare, food, or childcare.

Quotes from stakeholders:

"LGBTQ young people are disproportionately affected by housing insecurity and homelessness. We also know that a lot of LGBTQ seniors were in careers or in situations where they were not prepared for retirement."
"We have about 20% of our students who are unhoused in some capacity."
"Seniors are among the highest population who are losing their homes for the first time because of their fixed incomes which are not keeping up with the cost of living and medical costs."

Mental Health

- There is a need for more culturally responsive mental health and inpatient services
- Anxiety and fear about finances, wildfires and immigration are impacting communities.
- It's difficult for people to access services in-person, especially if they are experiencing homelessness.
- There is still a stigma when it comes to accessing mental health care.

Quotes from stakeholders:
"There are not enough providers available for direct mental health services."
"With so many people impacted by the recent events in January with the wildfires, and the large number of folks that may not have documentation status as an immigrant, that stokes a lot of fear and concern about their ability to access services that they need and that exacerbates mental health."

Substance Use and Misuse

- More treatment options are needed in the community, with an additional focus on the lack of treatment options for youth.
- Fentanyl usage is rising and of great concern.
- Substance use is seen frequently in the homeless population.

Quote from stakeholder:
"Our school district started stocking naloxone, the antidote to opioid overdose at every school. Since 2022, we've had to administer it about 50 times."

Workforce Development

- There is a shortage of providers and workforce training in the health sector. Primary care, specialty care, and mental health access are impacted. People of color are underrepresented in health professions, which impacts accessibility.

- Jobs available are mostly for the lower wage sector; people have two to three jobs to pay for housing, without much money left over.

Quotes from stakeholders:

"There continues to be underrepresentation of Blacks and Latinos and Asian Pacific Islanders practicing health professions. That impacts access, care coordination and compliance."
"People cannot live close to where they work because of housing costs. We have the most challenges recruiting on the Westside."
"It is difficult to find employers willing to train and provide the necessary work experience."

Community Stakeholder Interviewee Survey

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

- Access to Care
- Birth Indicators
- Chronic Disease
- Community Safety (Including intimate partner violence)
- Economic Insecurity and Workforce Development
- Environmental Health
- Food Insecurity
- Housing Insecurity and Homelessness
- Mental Health
- Overweight and Obesity
- Preventive Practices
- 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 –
  - **Housing Insecurity and People Experiencing Homelessness**, **Access to Care** and **Mental Health** were ranked as having the most severe impact on the community.
- Improving or worsening of an issue in the community.
  - **Housing Insecurity and People Experiencing Homelessness** was ranked by far as having worsened the most over time.
- Availability of resources to address the need.
  - **Housing Insecurity and People Experiencing Homelessness**, **Mental health**, **Substance Use and Misuse** and **Economic Insecurity and Workforce**

Development 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 **Housing and People Experiencing Homelessness**, **Access to Care**, **Mental Health**, **Substance Use and Misuse** and **Chronic Disease**.

See Appendix 2 for survey data.

FINDINGS FROM LISTENING SESSIONS

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, Providence conducted six listening sessions with 74 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:

- Behavioral health challenges: Mental health access barriers include cost, stigma, and systemic issues. Desired services include meditation, therapy, support groups, family counseling, and community-building activities. Vulnerable groups are older adults, homeless individuals, low-income residents, parents, and undocumented people. The Palisades Fire exacerbated trauma and mental health needs.
- Affordable housing and homelessness: There is a strong need for more shelters, transitional housing, supportive services, and policy changes to increase truly affordable housing. Barriers include stigma and fear, especially post-Palisades Fire. Populations most impacted are people experiencing long-term homelessness, people with disabilities, and older adults.
- Access to health and social services: Community members seek more preventative education, specialist availability, mobile clinics, and expanded community programs. Barriers include distance, stigma, systemic inefficiencies, cost, and immigration-related fears, affecting youth, people experiencing homelessness, and older adults disproportionately.
- Safe and clean environment: Safety concerns include drug-free areas, better lighting, and security. Cleanliness and environmental care are priorities, alongside improved infrastructure for walkability and emergency preparedness. Beautification and public engagement foster community pride and investment.
- Community involvement and engagement: Increased awareness and motivation are needed to boost participation in family-inclusive, cultural, artistic, and social events to improve connectedness and reduce social isolation. Transportation improvements are requested. Latino/a community, parents, youth, and people with disabilities face particular engagement challenges.

- Economic security, education, and job training: Needs include literacy and trade skill programs, technology access, job training for youth and retirees, financial education, and better resource navigation. Economic insecurity worsened after the Palisades Fire, especially for immigrant communities and people with undocumented status.
- Aging adult well-being: Support for older adults includes assistance with daily routines, social inclusion, therapy, mobile grooming, access to outdoor spaces, and animal companionship programs. Funding for senior mental health therapy is limited.
- Community advocacy: Participants emphasized cultural unity through exchanges and arts, better representation in local governance, non-partisan advocacy for housing and health programs, and respectful storytelling to raise awareness and correct misconceptions about community needs.

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

SECTION V: SIGNIFICANT HEALTH NEEDS

Review of Primary and Secondary Data

After 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 Saint John's CHNA Advisory Committee met on September 19, 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
- Environmental Health
- Food Insecurity
- Housing Insecurity and Homelessness
- 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 Saint John's Community Health 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 Saint John's 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 Saint John's Community Benefit Programs
- Opportunity to Impact: External Partnerships
- Alignment with Providence System Strategies

The committee voted on the top three needs for Providence Saint John's Health Center to prioritize over the next three years. Based on those voting results the identified needs ranked in the following order of priority.

1. Behavioral Health (Mental Health & Substance Use)
2. Housing Insecurity and Homelessness

3. Access to Care
4. Workforce Development
5. Chronic Disease
6. Social Isolation
7. Food Insecurity
8. Environmental Health

See Appendix 3 for the Providence Saint John's Health Center's CHNA Advisory Committee members.

2025 Priority Needs

The list below summarizes the top 3 significant health needs prioritized through the 2025 Community Health Needs Assessment process, ranked in order of priority:

BEHAVIORAL HEALTH (MENTAL HEALTH & SUBSTANCE USE)

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. Specific mental health needs in the Westside include availability of affordable services and reducing the stigma of having a mental health condition. Additionally, in the wake of the recent Palisades Fire, mental health for community members has been significantly affected with many individuals experiencing increased stress, anxiety, and trauma.

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/misuse includes the use of illegal drugs and the inappropriate use of legal substances, such as alcohol, prescription drugs and tobacco.

HOUSING INSECURITY AND PEOPLE EXPERIENCING HOMELESSNESS

Housing insecurity encompasses several challenges such as having trouble paying rent, overcrowding, moving frequently, staying with relatives, or spending the bulk of household income on housing. Households are considered "severely cost burdened" if spending more than 50% of household income on housing. The damage caused by Palisades Fire will limit the supply of affordable housing on the Westside. The damage caused by the Palisades Fire is expected to further constrain the already limited supply of housing on the Westside, increasing challenges for individuals and families seeking stable accommodations.

People experiencing homelessness lack a fixed, regular, and adequate nighttime residence; an individual or family who will imminently lose their primary nighttime residence; and any individual

or family who is fleeing, or is attempting to flee, domestic violence, has no other residence, and lacks the resources or support networks to obtain other permanent housing. Health and housing instability are inextricably linked. Health problems can cause a person to experience homelessness and being unhoused can exacerbate existing health issues.

ACCESS TO CARE

While the Saint John's service area has lower percentages of people without health insurance compared to the rest of LA County, access to care goes beyond health insurance coverage. Additional barriers identified specifically by community stakeholders in the Westside include limited appointment availability for primary and specialty care (especially for patients with Medi-Cal coverage), long travel distances or lack of transportation, culturally appropriate care, and care coordination.

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.

Providence Saint John's Health Center 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 in the service include the Department of Public Health, California Rehabilitation Institute LLC, Cedar-Sinai Marina Hospital, Kaiser Foundation Hospital - West L.A., Resnick Neuropsychiatric Hospital at UCLA, Ronald Reagan UCLA Medical Center, Santa Monica UCLA Medical Center and Orthopedic Hospital, the VA Medical Center, and Wadsworth 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 4 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 (Mental Health and Substance Use/Misuse), Access to Health Care and Preventive Care. This report evaluates the impact of the previous Community Health Improvement Plan (CHIP). Providence Saint John's Health Center 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.

Table 1. Outcomes from 2023-2025 CHIP

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Homelessness and Housing Insecurity	CHW Homeless Navigators	CHWs placed within our emergency department to specifically care for patients experiencing homelessness. They act as liaisons between homeless service providers and our Medical Centers to reduce avoidable emergency department visits and link patients with permanent and interim housing.	• Average of 342 unduplicated patients served per year • Average of 56 patients connected to shelter/housing after discharge per year • Average of 40 patients referred to LAHSA Hospital Liaison per year
Homelessness and Housing Insecurity	Grantmaking	Financial support to local partners across the continuum of homeless services, including: recuperative care, street medicine, and interim housing	Annual grantmaking to multiple non-profit organizations serving people experiencing homelessness
Behavioral Health	Child and Family Development Center: Perinatal Wellness Program	Bilingual perinatal and infant mental health specialist visits families weekly in their homes to provide individual, dyadic, couple, and/or family therapy. Ongoing weekly perinatal support groups are offered to reduce isolation and promote social engagement.	Average of 35 families served per year

Behavioral Health	Child and Family Development Center: Outpatient Therapy Program	Outpatient mental health services are available to children, teens, young adults and adults with developmental disabilities. Therapists offer targeted evidence-based treatment through a family focused lens that helps address problematic behaviors, thoughts and feelings with achievable goal-oriented strategies. Patients either have Medi-Cal or are uninsured.	556 annual patients provided with outpatient therapy services
Behavioral Health	Mental Health First Aid	Support prevention and early intervention by teaching the evidence-based MHFA curriculum. The skills-based course teaches participants how to identify, understand and respond to signs and symptoms of mental health and substance use challenges	196 participants trained and certified in Mental Health First Aid annually
Behavioral Health	Grantmaking	Financial support to local non-profit mental health providers to increase access to services	Annual grantmaking to multiple mental health non-profit organizations
Access to Health Care & Preventive Care	Grantmaking	Financial support to local agencies that provide healthcare to underserved populations, including Federally Qualified Health Centers	Annual grantmaking to multiple non-profits addressing access to care

Addressing Identified Needs

The Community Health Improvement Plan developed for the Providence Saint John's Health Center 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 Providence Saint John's Health Center 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 Providence Saint John's Health Center intends 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 Providence Saint John's Health Center 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 Providence Saint John's Health Center Community Ministry Board of the hospital on November 19, 2025. The final report was made widely available by December 28, 2025.

DocuSigned by:
Michael Ricks
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11/25/2025

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

DocuSigned by:
Laura K. Siart
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11/25/2025

Laura Siart — Date
Chair, Providence Saint John's Health Center Community Ministry Board

Signed by:
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12/2/2025

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

APPENDICES

Appendix 1: Quantitative Data

POPULATION LEVEL DATA

Saint John's Service Area Demographics

Demographic Category	Los Angeles County	Saint John's Service Area	Broader Service Area	High Need Service Area
Population by Age				
Total Population	9,848,406	701,791	343,046	358,745
Population Under Age 5	5.3% (518,797)	4.6% (32,589)	4.6% (15,910)	4.6% (16,679)
Population Under Age 18	20.9% (2,057,536)	15.8% (110,669)	16.0% (54,834)	15.6% (55,835)
Population Ages 18 to 34	24.8% (2,441,889)	28.4% (199,574)	28.1% (96,527)	28.7% (103,047)
Population Ages 35 to 54	27.2% (2,682,862)	26.9% (188,927)	27.4% (94,008)	26.5% (94,919)
Population Ages 55 to 64	12.4% (1,217,548)	11.7% (82,266)	11.6% (39,802)	11.8% (42,464)
Population Ages 65+	14.7% (1,448,571)	17.1% (120,355)	16.9% (57,875)	17.4% (62,480)
Population by Sex				
Female	50.5% (4,969,120)	52.0% (364,628)	51.7% (177,197)	52.2% (187,431)
Male	49.5% (4,879,286)	48.0% (337,163)	48.3% (165,849)	47.8% (171,314)
Population by Race				
American Indian Alaska Native	1.3% (125,310)	0.5% (3,219)	0.3% (1,046)	0.6% (2,173)
Asian	15.0% (1,480,146)	13.5% (94,714)	13.8% (47,322)	13.2% (47,392)
Black or African American	7.8% (769,139)	8.9% (62,374)	3.8% (13,060)	13.7% (49,314)
Native Hawaiian & Other Pacific Islander	0.2% (21,691)	0.1% (942)	0.1% (371)	0.2% (571)
Other Race Population	23.6% (2,320,096)	6.2% (43,760)	4.0% (13,677)	8.4% (30,083)
2 or more Races Population	16.7% (1,642,818)	12.4% (87,227)	11.3% (38,743)	13.5% (48,484)
White Population	35.4% (3,489,206)	58.4% (409,555)	66.7% (228,827)	50.4% (180,728)
Population by Ethnicity				
Hispanic Population	48.3% (4,753,369)	16.8% (117,765)	12.4% (42,505)	21.0% (75,260)

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	**Cerebrovascular diseases** 42.4	**Cerebrovascular 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	**Cerebrovascular 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

For the 2025 PIT Count, SPA 5 had an estimated 5,040 individuals who were experiencing homelessness, a decrease of 24.4% from 2023. 77.1% of those experiencing homelessness in SPA 5 were individual adults, 15% were members of families experiencing homelessness, and two individuals (0.04%) were unaccompanied minors. Sheltered homeless 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. The percentage of people experiencing homelessness in SPA 5 who were unsheltered increased by 1.8 percentage points from 2023 to 2025, and SPA-area individuals experiencing homelessness were less likely to be sheltered than the county average.

Population Experiencing Homelessness, 2023-2025 Comparison*

	SPA 5		Los Angeles County Continuum of Care *	
	2023	2025	2023	2025
Total experiencing homelessness	6,669	5,040	71,320	67,918
Sheltered	21.5%	19.7%	26.7%	34.6%
Unsheltered	78.5%	80.3%	73.3%	65.4%
Individual adults, aged 25+	83.0%	77.1%	81.3%	80.1%
Individual youth, aged 18-24	2.5%	7.8%	3.9%	3.3%
Unaccompanied minors (<18)	0.15%	0.04%	0.13%	0.08%
Families/family members	14.3%	15.0%	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 5, 38.6% were chronically homeless individuals, a decrease from 2023's 45.5% rate. Homelessness rates rose slightly, locally, for those with domestic violence experience, but otherwise the rates remained fairly stable for all subpopulation groups.

People Experiencing Homelessness Subpopulations*

	SPA 5		Los Angeles City and County CoC*	
	2023	2025	2023	2025
Individuals experiencing chronic homelessness	45.5%	38.6%	42.7%	38.1%
Family members experiencing chronic homelessness	2.2%	2.4%	2.2%	2.6%
Developmental disability	8.8%	8.3%	8.9%	8.3%
Domestic violence (DV) experience	43.7%	45.4%	34.5%	37.8%
Homelessness due to fleeing DV / intimate partner violence (IPV)	10.2%	10.4%	8.0%	8.9%
Persons with HIV/AIDS	1.4%	1.2%	2.1%	1.8%
Physical disability	20.1%	20.6%	17.2%	21.4%
Serious mental illness	23.6%	24.2%	22.4%	23.5%
Substance use disorder	23.4%	23.1%	27.1%	22.0%
Veterans	10.8%	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.*

Appendix 2: Community Input

METHODOLOGY: COMMUNITY STAKEHOLDER INTERVIEWS

Providence Saint John's Health Center completed 44 community stakeholder interviews in collaboration with Ronald Reagan UCLA Medical Center, UCLA Santa Monica Medical Center, Resnick Neuropsychiatric Hospital at UCLA, Cedars-Sinai Medical Center and Cedars-Sinai Marina Hospital. 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 5 and 6 from the Los Angeles County Department of Public Health as a stakeholder interviewee 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 Interview Participants

Organization	Name	Title	Sector
Children's Institute, Inc.	Catherine Atack	Chief External Officer	Youth
LA County Supervisor, Lindsey Horvath, District 3	Angelica Ayala, MPA	Senior Health Deputy	Government
Meals on Wheels West	Chris Baca	Executive Director	Food Insecurity
Community Corporation	Tara Barauskas	Executive Director	Housing
Cancer Support Community LA	Sigall Cahn, LCSW	Clinical and Program Director	Chronic Disease
Asian Americans Advancing Justice SoCal	Connie Chung Joe, JD	Chief Executive Officer	Advocacy
WISE & Healthy Aging	Molly Davies, LCSW	President and Chief Executive Officer	Older Adults
Mar Vista Family Center	Lucia Diaz	Chief Executive Officer	Social Services
Planned Parenthood LA	Sue Dunlap	President and Chief Executive Officer	Healthcare

Organization	Name	Title	Sector
Santa Monica College	Susan Fila, PhD, LCSW + Kasiani Gountoumas, MSN	Dean, Health and Wellbeing (interim); Family Nurse Practitioner, Health Center	Education
Santa Monica-Malibu Unified School District	Priscilla Guzman, BSN, RN, NCSN	Coordinating Nurse	Education
Los Angeles Housing Services Authority	Elizabeth Heger, LMFT + Emily Andrade, LCSW	Senior Advisor; Principal Advisor	Housing
Los Angeles LGBT Center	Joe Hollendoner	Director of Foundation Relations	LGBTQ+
LA County Homeless Initiative	Andrea Iloulian, MPP	Senior Manager System Optimization	Homelessness
Los Angeles County Department of Public Health	Jan King, MD, MPH	Regional Health Officer SPA 5 and SPA 6	Public Health
City of Santa Monica	Natasha Guest Kingscote, MPA	Acting Manager for Human Services	Government
Watts Healthcare Foundation	Olusheyi Lawoyin, PhD, MBA, MPH	Chief Operations Officer	Healthcare
LA Care Health Plan	Alex Li, MD	Chief Equity Officer	Healthcare
Los Angeles Metro Transportation Authority	Cris Libane, PE, ENV SP	Chief Sustainability Officer	Transportation
Unite LA	Ilia Lopez, JD	Associate Director, Inclusion and Community Partnerships	Economic Security
The People Concern	John Maceri	Chief Executive Officer	Homelessness
Alcott Center	Nick Maiorino, MA	Chief Executive Officer	Mental Health
Los Angeles Unified School District	Smita Malhotra, MD, FAAP	Chief Medical Officer	Education
Charles R. Drew University of Medicine and Science	Angela Minniefield, MPA	Senior Vice President of Advancement and Operations and Chief Operating Officer	Education
Didi Hirsch Community Mental Health Center	Lyn Morris, LMFT	Chief Executive Officer	Mental Health
USC Center for Elder Justice; Keck School of Medicine	Laura Mosqueda, MD, FAAFP, AGSF	Director; Professor of Family Medicine and Geriatrics	Older Adults
Westside Coalition	Darci Niva, MA	Executive Director	Homelessness
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	Mitesh Popat, MD, MPH	Chief Executive Officer	Healthcare

Organization	Name	Title	Sector
Westside Food Bank	Genevieve Riutort	President and Chief Executive Officer	Food Insecurity
Partners in Care Foundation	June Simmons, MSW + Marti Ferrara, MS	President and Chief Executive Officer; Marketing Communications Officer	Older Adults
St. Joseph Center	Ryan Smith, EdD	President and Chief Executive Officer	Homelessness
Social Justice Learning Institute	Nicole Steele	Health Equity Program Director	Education
Westside Infant-Family Network LA: WIN-LA	Tim Sweeney, MPA	Executive Director	Families
Community Clinic Association of Los Angeles	Nina Vaccaro, MPH	Chief Operating Officer	Healthcare
Unihealth Foundation	Jennifer Vanore, Ph.D	President and Chief Operating Officer	Philanthropy
California Community Foundation	Rose Veniegas, Ph.D	Director of Health Programs	Philanthropy
Officer of Supervisor, Holly Mitchell, District 2	Yolanda Vera, JD	Senior Deputy of Health and Wellness	Government
Greater Los Angeles County National Alliance of Mental Illness (NAMI)	Traute Winters	Executive Director	Mental Health

COMMUNITY STAKEHOLDER INTERVIEWEE SURVEY RESULTS

When asked about the level of importance the hospital should place on addressing the health issue, community stakeholder interviewees 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 Housing insecurity and People Experiencing Homelessness, Access to Care, Mental Health, Substance Use and Misuse, and Chronic disease.

Significant Needs	Priority Ranking (Total Possible Score of 4)
Housing Insecurity and People Experiencing Homelessness	3.78
Access to Care	3.77
Mental Health	3.77
Substance Use and Misuse	3.52
Chronic Disease	3.48
Overweight and Obesity	3.41
Food Insecurity	3.37
Preventive Practices	3.19
Community Safety (including intimate partner violence)	3.04
Economic Insecurity and Workforce Development	3.04
Environmental Conditions	2.89
Birth Indicators	1.77

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	76%	20%	68%
Birth Indicators	20%	8%	33%
Chronic Disease	40%	16%	60%
Community Safety (including intimate partner violence)	32%	20%	56%
Economic Insecurity and Workforce Development	72%	44%	88%
Environmental Conditions	40%	36%	76%
Food Insecurity	44%	48%	88%
Housing Insecurity and People Experiencing Homelessness	88%	80%	92%
Mental Health	76%	68%	88%
Overweight/Obesity (healthy eating and physical activity)	40%	32%	56%
Preventive Practices (i.e., vaccines, screenings, fall prevention)	32%	20%	44%
Substance Use/Misuse	60%	56%	88%

Source: Providence Westside Hospital Collaborative 2025 CHNA Community Stakeholder Interviewee Survey

METHODOLOGY: LISTENING SESSIONSI

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 6 listening sessions that included a total of 74 participants. The sessions took place between February 2025 and July 2025.

Population	Community Partner	Location	Date	Language
Social Service Workers	Westside Coalition	Mt. Olive Lutheran Church	2/27/2025	English
Latinx	Virginia Avenue Park/CFDC	Zoom	6/27/2025	Spanish
Santa Monica Residents	Virginia Avenue Park/CFDC	Virginia Avenue Park	6/30/2025	English
Seniors	Meals on Wheels West/WISE and Healthy Aging	WISE and Healthy Aging	7/8/2025	English
Latinx	Virginia Avenue Park (Familia Latinas Unidas)	Zoom	7/10/2025	Spanish
Black/African American, Faith-Based Leaders	FAME/Lincoln Memorial Church/The Sentinel	FAME Church	6/9/2025	English

Vision for a Healthy Community

Community members shared their vision for a healthy community:

In a healthy community, everyone is kind, empathetic, and respectful to one another. People help their neighbors and say hello when they see each other on the street. Community members enjoy volunteering and creating friendships across generations.

"It doesn't hurt to be kind" -Older Adult Participant

"A community becomes a community when people are kind and helpful to each other"—Older Adult Participant

People are aware of and openly discuss mental and emotional wellbeing. Mental health support is easily accessible, and there are community support systems such as hotlines and local programs. People acknowledge the difficulties in recognizing mental health conditions, and there is continuous dialogue and support.

"Without mental health, you do not have wellbeing." – Community Faith Leader

The community is a safe environment free of vandalism and crime. People feel safe while walking or being outside at night. Children can safely play outside. Parks and public areas are

well lit, and people feel comfortable and secure. Public infrastructure is designed to be safe and accessible to everyone, including people from diverse backgrounds and people with disabilities. Affordable housing supports families and individuals of all ages and backgrounds.

> *"I feel safe in my community when I walk in my neighborhood. No matter what race one is, here in my neighborhood we support each other."—Santa Monica Resident*

Everyone shares information about local resources with each other. Community health workers also help people understand available services. Residents know where to find helpers, food distributions, and pantries. People can easily access healthcare services and reach their appointments.

> *"Unity, information, and the support that we give to each other is valuable."—Santa Monica Resident*

There are ample opportunities for physical activities and exercise. Fitness classes and healthcare services are easily accessible. Residents can learn about nutrition and have access to grocery stores and healthy food.

The community cares about the health of their older adults. Older adults have dedicated facilities, and their health is prioritized. There are many activities and resources that help them stay active and independent. They can access technology and the internet. The community comes together to support and help older adults access the services they need.

Youth in the community are also engaged. There are plenty of resources and activities that are accessible and enjoyable to them. Organizations present opportunities and resources directly to teens. Parents are engaged in their children's lives and ensure they have the resources they need, especially behavioral health resources.

People appreciate art and culture in their community. They can practice their faith safely. There are multicultural and multiethnic spaces. These activities encourage engagement and connection. Community members find purpose and belonging through involvement in local events.

Unmet Health-Related Needs

Behavioral health challenges and access to care

Community members across listening sessions expressed a range of needs and challenges around mental health. Common themes included access to affordable therapy, family and community support, combatting loneliness, and addressing systemic barriers.

Residents are also feeling isolation and fear due to immigration enforcement actions. Community members stressed that while some services are available, cost, insurance, and stigma remain barriers to access. Community members discussed how more of the following services provided in an accessible and affordable format in the community would help their emotional and mental wellbeing:

- Meditation and Mindfulness Classes
- Support Groups
- Therapy Services
- Family Counseling
- Wrap Around Services
- Sound Baths and other Stress Relief Activities
- Community Building activities

"I'm living with a lot of uncertainty in this moment and having access to more mental health opportunities might help." —Community Faith Leader

"When I think about health, it is sort of in a box. Wellbeing is spread across the board...mind, body, spirit." —Community Faith Leader

Populations most impacted by the lack of access to above services include:

- **Older adults**: There is limited funding for mental health therapy for older adults
- **People experiencing homelessness**: There is not enough mental health support, including wrap-around services, for people experiencing homelessness.
- **People with low income**: Financial hardship and overworking were noted as major contributors to poor mental health.
- **Parents**: Parents need more support and training on parenting under stress
- **People with undocumented status:** People with undocumented status and mixed-status families reported heightened stress due to enforcement actions, making behavioral health services especially difficult to access.

The aftermath of the Palisades Fire illustrated how these needs show up in practice. Community members described ongoing grief, isolation, trauma and anxiety following displacement, loss of homes, and loss of community ties. Weeks after the disaster, emotional impacts became more visible as people navigated temporary housing and long-term recovery.

Affordable Housing and Homelessness

Shelter and housing options: Community members stressed the need for more shelters and resource centers for people experiencing homelessness that provide both immediate safety and connections to services. They also called for expanded temporary and transitional housing options, paired with supportive services such as job skills training, food, clothing, mental health care and rehabilitation. There is also a need for more accountability from housing agencies to ensure funding is used responsibly and to move people into housing. Some community members noted that people experiencing homelessness impacts their feeling of safety in the community and can prevent people from utilizing parks or walking in their neighborhoods. Community members suggested mobile solutions, including designated spaces, RVs, cars, and trailers, along with mobile services like showers and laundry.

The Palisades fire intensified housing pressures by displacing residents and straining limited resources. The lack of winter shelters and limited shelter availability compounds these challenges.

Policy Changes: Community members emphasized the need for policy changes that expand housing access, such as zoning adjustments to follow more flexible housing models. There was strong agreement on the need for truly affordable housing, as many current developments labeled "affordable" remain out of reach for community members.

Neighborhood Integration: There was interest in resource sharing between affordable housing developments and surrounding neighborhoods to strengthen connections and improve access to services.

Barriers to Access: Stigma and fear of discrimination, especially for those who became unhoused due to the Palisades Fire, remain major barriers, discouraging people from seeking available services and housing assistance.

Populations disproportionately impacted include:

- People experiencing long term homelessness
- People with disabilities
- Older adults

Access to Health and Social Services

- **Health and Wellbeing Classes and Workshops**: Preventative education on self-care and chronic disease management.
- **Nutrition and exercise workshops:** Classes on exercise and nutrition to maintain physical health.
- **Access to Specialists**: More availability of specialty care for complex health needs.
- **Mobile Health Clinics:** Bringing healthcare services directly into neighborhoods to reduce reliance on distant healthcare providers.
- **Community Programs and Support Services**: Expanded workshops, support groups, and services hosted by schools, libraries, and nonprofits.

Community members discussed several barriers to accessing health and social services:

Distance to care: Long travel times to appointments

Systemic Barriers: Stigma, lack of familiarity with how to access services, and shortage of case managers and navigators

> *"Sometimes those resources or trusted messengers are there but they are in pockets and we don't know where those pockets are."—Community Faith Leader*

Infrastructural Challenges: Limited transportation options, language barriers, and bureaucratic inefficiency delay or prevent care.

Cost and Coverage Gaps: Insurance limitations, particularly lack of coverage for necessary medical equipment such as wheelchairs, oxygen tanks, and walkers.

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

"If you can't function mentally & physically, what good is all the other stuff" – Community Faith Leader

Immigration-related fear and misinformation: Fear and misinformation related to immigration policies have compounded these barriers, discouraging immigrant communities from accessing essential services. Widespread misinformation has further decreased attendance at medical appointments and community programs.

Populations disproportionately impacted:

- **Youth**: Youth who are in the LGBTQIA+ community and young people from immigrant families are increasingly disengaged from school and extracurricular activities due to stigma and fear.
- **People experiencing homelessness:** Remain underrepresented in service design and outreach, with unmet healthcare and social support needs.
- **Older Adults**

Safe and Clean environment

Safety and Security: Participants talked about safety concerns in their community. They want a drug-free area and support from the LAPD and LAFD. Electric bikes on sidewalks and car theft worry them. Many feel unsafe at night. They want better security and more public lighting in dark areas for a safer environment.

Clean Environment: Community members want clean streets that are free of vandalism. They want to reduce unpleasant smells, especially downtown. Caring for the environment matters to them for healthy living spaces.

Infrastructure and Accessibility: Residents want safe roads and sidewalks. They discussed the need for better walkability and pedestrian-friendly areas. They also emphasized the need for the development of good emergency plans to support them during crises.

Community Well-being: Beautification initiatives are recognized for enhancing the physical appearance of neighborhoods, fostering community pride, and attracting business investment. Ensuring parks and recreational spaces are safe and engaging for all community members is important. There is a strong call for civic leaders to prioritize safety in streets and public areas to enhance the overall sense of security in the community.

Public Engagement and Investment: Community members believe better-looking neighborhoods can bring business investment. They see engagement and participation in safety efforts as crucial for security and pride among residents.

Community Involvement and Engagement

Community Engagement and Motivation: Community members discussed how awareness and motivation are key to improving engagement. Despite the availability of many activities, participation often remains low due to a lack of interest, awareness, or time constraints. Suggestions to increase participation include raising awareness of available opportunities, holding more listening sessions, recognizing community leaders, and organizing monthly gatherings to encourage proactive dialogue on important local issues.

Family and Age-inclusive Activities: Community members discussed a desire for more activities that serve all age groups and bring families together. They highlighted the value of flexible scheduling to accommodate family routines, allowing more families to take part. Programs that are family-oriented and intergenerational can strengthen community bonds while providing artistic and creative opportunities for everyone.

Cultural and Artistic Programs: There was strong recognition of the importance of cultural and artistic programs. Community members noted the need for more art classes and flexible creative spaces. Expanding these opportunities can help nurture local talent, encourage participation, and foster cultural enrichment across the community.

Community Events and Social Opportunities: Regular community events, such as concerts at parks and free farmer's markets, were described as essential for fostering engagement and building connections. These events allow residents to meet new people, strengthen community ties, and create a stronger sense of belonging. Community members discussed how local gathering areas could be made more inclusive and family friendly through affordable pricing, ensuring accessibility and enjoyment for all.

Transportation: Community discussed the need for more public transportation options to be able to attend activities.

Populations especially impacted include:

- **Latino/a community:** A need for more inclusive programming and outreached tailored to Latino residents
- **Parents:** Support for parents to feel more engaged in community life
- **Young people**: Calls for greater inclusion of young adult voices and opportunities for youth participation
- **People with disabilities**: Community members discussed how there is a lack of free services, activities and access to special education resources for people with disabilities.

Economic Security, Education, and Job Training

Educational Access and Improvement: Community members discussed a need for more literacy programs and tutoring to support educational outcomes. Participants express that there are not enough teachers from their neighborhood. There is a need for diversifying education beyond STEM to include trade skills such as automotive and welding. Low expectations and inequities in funding and the quality of education students receive can contribute to young

people leaving school early without necessary skills. However, opportunities for learning these trade skills have become limited due to budget cuts affecting inner-city programs.

"There is not enough representation from our neighborhood, to teach our neighborhoods' children"- Community Faith Leader

"But the masses? Masses don't have opportunities to learn a trade"- Community Faith Leader

Technology Access and Skills: There is a need for improved access to technology and the internet within the community. Community members needing support in learning how to use digital devices and resources, highlighting existing gaps in technological skills. Technology access, particularly internet connectivity, remains a significant concern.

Job Training and Employment: Community members indicate a strong demand for job training and skill development programs that cater to both youth and retired individuals, improving their employability. Attendees report a lack of accountability and follow-up from employers, especially those promising immediate hiring.

Financial Education and Support: There is a need for financial literacy education to aid in loss recovery and empower individuals economically. There is a specific demand for programs to improve financial knowledge and skills, particularly accessible options for those who cannot afford standard offerings.

Resource Awareness and Navigation: Individuals are looking for better communication and awareness of available resources and programs. A proposed concierge service could assist community members in navigating and scheduling these services efficiently.

Advocacy and Collaboration: Collaboration between political stakeholders and community members is seen as beneficial to amplify voices and create opportunities.

Economic insecurity has increased due to widespread job loss following the Palisades Fire, affecting sectors like caregiving, retail, restaurant, and service. Recent policies have intensified economic insecurity, particularly among immigrant and undocumented communities. Fear of enforcement or policy changes have discouraged people from participating in services, while misinformation has amplified anxiety around job loss. Government employees have also voiced concerns about job stability, impacted by shifting policies and funding priorities.

"Our [immigrant] community is facing a lot of uncertainty, our future here in this country is uncertain, not many people want to set foot outside out of fear."– Santa Monica Resident

Populations disproportionately impacted:

- People looking for employment
- Immigrant communities
- People with undocumented status
- People who work for the government

Aging Adult Well Being

Supporting Older Adults: Community members discussed supporting older adults by assisting with daily routines, promoting social inclusion, and providing therapy for life transitions. They wish for more social activities to include older adults. Therapy is also needed for handling life changes. Pairing older adults with shelter cats can improve social connections and reduce loneliness. They also discussed the need for mobile grooming services to help older adults access grooming and self-care.

Accessibility and Outreach: Community members need services that reach out to older adults rather than waiting for them to ask for help. They hope for better access to outdoor spaces, like walking trails, to make movement easier and to support outdoor activities.

Animal Companionship: Participants suggested programs to help older adults adopt or foster pets. They want financial help for pet food and vet care. They discussed developing fostering arrangements that might reduce adoption costs and help older adults find companionship with animals.

Mental Health and Therapy Support: Community members notice that funding for mental health therapy for seniors is limited. They want to expand support to better meet the mental health needs of older adults.

"Santa Monica was built for seniors but it doesn't cater to them"—Older Adult Participant

Community Advocacy

Cultural Unity and Education: Participants shared ideas to bring different cultural communities together. They suggested cultural exchanges and learning languages to understand each other better and grow together.

Arts as a Unifier: Community members talked about how music and arts connect people. They see these creative activities as ways to bring the community closer and bridge gaps.

Representation and Advocacy: Participants wanted better representation in their neighborhood. They planned to join meetings at city, county, and coalition levels to support housing, health, and food access. They focused on non-partisan advocacy, especially concerning possible cuts to programs like SNAP.

Additionally, community members wanted to share personal stories about recent challenges. They felt sharing experiences could raise awareness and should be done respectfully. They believe people should be compensated for their contributions. Storytelling was seen as a way to correct misconceptions about the Westside's needs and highlight the challenges faced by residents throughout the region.

Appendix 3: Providence Saint John's Health Center CHNA Advisory Committee

Community Health Needs Assessment Committee Members

Name	Title	Organization	Sector
Alicia Nishimura	LCSW Lead/Case Management	Providence Saint John's Health Center	Hospital
Dan Hudson	Interim Chief Mission Integration Officer	Providence Saint John's Health Center	Hospital
Ali Jamehdor, DO	Emergency Dept Medical Director	Providence Saint John's Health Center	Hospital
Fred Dolgin	Chief Operations Officer	Venice Family Clinic	Health Care Safety Net
Genevieve Riutort	Chief Executive Officer	Westside Food Bank	Food Insecurity
Jeff Schaffer	President	JMC Philanthropic Advisors	Philanthropy
John Maceri	Chief Executive Officer	The People Concern	People Experiencing Homelessness
Kathryn Jeffery, Ph.D.	President Board Member	Santa Monica College	Education
Michael Robinson	Chief Community Health Officer	Providence Saint John's Health Center	Hospital
Mina Kang, MD	Chief Medical Officer	Providence Saint John's Health Center	Hospital
Molly Davies	President & CEO	Providence Saint John's Health Center	Hospital
Natasha Kingscote	Housing and Human Services Dept Manager	Wise and Healthy Aging	Aging
Rose Pelikan	Executive Director Critical Care	Providence Saint John's Health Center	Hospital
Ruth Canas	Director, Child and Family Development Center	Providence Saint John's Health Center	Hospital

Appendix 4: Community Resources Available to Address Significant Health Needs

Providence Saint John's Health Center cannot address all of the significant community health needs by working alone. Improving community health requires collaboration across community partners and with community engagement. Below outlines a list of community resources potentially available to address identified community needs.

Community Resources Available to Address Significant Health Needs

Significant Health Needs	Community Resources
Access to care	Asian American Pacific Islander Equity Alliance, Asian Americans Advancing Justice Southern California, Asian Pacific Health Care Venture, Being Alive, Charles R. Drew University of Medicine & Science, Chinatown Service Center, Claris Health, Community Clinic Association of Los Angeles County, Disability Community Resource Center, Eisner Health, Homeless Health Care Los Angeles, Jewish Family Service Los Angeles, Kheir Clinic, Los Angeles Christian Health Centers, Los Angeles County Department of Health Services, Los Angeles County Department of Public Health, Los Angeles Unified School District, Mar Vista Family Center, Men's Health Foundation, MLK Community Healthcare Clinics, Northeast Valley Health Center, Planned Parenthood Los Angeles, ReFresh Spot, Saban Community Clinic Los Angeles, Santa Monica College Student Health & Wellness Center, St. John's Community Health, St. Joseph's Center, T.H.E. (To Help Everyone) Health and Wellness Centers, Los Angeles LGBT Center, The People Concern, The Wellness Center at the Historic General Hospital, UCLA Veteran Family Wellbeing Center, Universal Community Health Center, Venice Family Clinic, Watts Healthcare Corporation, West Los Angeles VA Medical Center, Westside Family Health Center
Birth indicators	Black Infant Health Program, Black Infants and Families Los Angeles, California Black Women's Collective Empowerment Institute, Children's Institute, Inc., CinnaMoms: Breastfeeding Los Angeles, LA Best Babies Network, Maternal Mental Health Now, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
Chronic diseases	AIDS Healthcare Foundation, California Food is Medicine Coalition, Cancer Support Community Los Angeles, Charles R. Drew University of Medicine & Science, City of West Hollywood Older Adults Advisory Board, Claris Health, Eisner Health, Helping Hands Senior Foundation, Homeless Health Care Los Angeles, Jewish Family Service Los Angeles, Los Angeles Christian Health Centers, Los Angeles County Department of Health Services, Men's Health Foundation, Martin Luther King Community Healthcare, Northeast Valley Health Center, Project Angel Food, Saban Community Clinic Los Angeles, SmartAirLA, St. John's Community Health, St. Joseph's Center, Los Angeles LGBT Center, UCLA Alzheimer's and Dementia

Significant Health Needs	Community Resources
	Care Program, Universal Community Health Center, Venice Family Clinic, West Los Angeles VA Medical Center, Westside Family Health Center, WISE & Healthy Aging
Covid-19	Charles R. Drew University of Medicine & Science, Los Angeles Caregiver Resource Center, Los Angeles County Department of Public Health Together Toward Health
Economic insecurity and workforce development	Alliance for Housing and Healing, American Legion, Basic Income Guaranteed: Los Angeles Economic Assistance Pilot (BIG LEAP), California Black Women's Collective Empowerment Institute, Coalition of Urban and Metropolitan Universities, Compton Community Health Professional Program Pathway, Chrysalis, Department of Social Services, Harbor Interfaith Services, HOPICS, Imagine LA, Jewish Family Service Los Angeles, Jewish Vocational Service, Korean American Family Services, Koreatown Youth + Community Center, LIFT Los Angeles, Little Tokyo Service Center, Local Initiatives Support Corporation (LISC) Los Angeles, Los Angeles Urban League, City of Los Angeles Workforce Investment Board, Mutual Aid LA Network, National Council of Jewish Women, Partners in Care Workforce Development Training Center, Pathways Out of Poverty – United Way, Pilipino Workers Center, Project Ropa, ReFresh Spot, Special Service for Groups, Inc. (SSG), St. Joseph's Center, The People Concern, Trans Wellness Center, Upward Bound Study Center, Village for Vets, Watts Labor Community Action Committee, WISE & Healthy Aging
Environmental conditions	API Forward Movement, California Environmental Justice Alliance (CEJA), Friends of Ballona Wetlands, Heal the Bay, Los Angeles County Bicycle Coalition, Los Angeles Food Policy Council, Los Angeles County Metropolitan Transportation Authority, National Climate Assessment, Safe Clean Water LA, SmartAirLA, Social Justice Learning Institute, TreePeople
Food insecurity	API Forward Movement, AIDS Project Los Angeles Health (APLA), CalFresh, California Food is Medicine Coalition, Catholic Charities of Los Angeles, Inc., City of Santa Monica, City of West Hollywood, Food Forward, H.E.L.P.E.R. Foundation, Hollywood Food Coalition, HOPICS, Inglewood Community Table, Jewish Family Service Los Angeles, Los Angeles Regional Food Bank, Los Angeles Unified School District, Meals on Wheels West, MOA Wellness Center, Project Angel Food, Seeds of Hope (Episcopal Diocese of Los Angeles), Social Justice Learning Institute, St. Joseph Center, St. Mark Food Pantry, St. Paul's Commons Food Pantry, Sustainable Economic Enterprises of Los Angeles: Sustainable Economic Enterprises (SEE-LA), Los Angeles LGBT Center, Mar Vista Family Center, The People Concern, Venice Family Clinic, West Los Angeles VA Medical Center, Westside Food Bank, World Central Kitchen (WCK), The Karsh Center at Wilshire Boulevard Temple
Housing insecurity and homelessness	APLA Health, Ascencia, Asian Americans Advancing Justice Southern California, Asian Pacific Health Care Venture, Inc., Community Corporation of Santa Monica, Harbor Interfaith Services, Homeless Health Care Los Angeles, Homeless Outreach Program Integrated Care System (HOPICS), Los Angeles County Health Services

Significant Health Needs	Community Resources
	Housing for Health, Inner City Law Center, Inside Safe, Legal Aid Foundation of Los Angeles, Level Up LA, Los Angeles County Department of Health Services, Los Angeles Homeless Services Authority (LAHSA), Martin Luther King Community Healthcare, My Friend's Place, People Assisting the Homeless (PATH), ReFresh Spot, Saban Community Clinic Los Angeles, Operation Safehouse, Safe Place for Youth, Santa Monica Task Force on Homelessness, St. Joseph Center, Step Up, The Center, Los Angeles LGBT Center, Mar Vista Family Center, The People Concern, The TransLatin@Coalition, Union Station Homeless Services, Venice Family Clinic, Watts Labor Community Action Committee, Weingart Center, Bet Tzedek, Jewish Free Loan Association
Mental health	Airport Marina Counseling Services, Alcott Center for Mental Health Services, APLA Health, Asian Pacific Counseling and Treatment Centers, Being Alive, California Black Women's Health Project, California Department of Developmental Services (DDS) Regional Centers, Korean American Family Services, Charles R. Drew University of Medicine & Science, Chinatown Service Center, Community Coalition, Didi Hirsch Mental Health Services, Edelman Westside Mental Health Center, Exodus Recovery, Inc., Vista Del Mar Child and Family Services, Give an Hour, Harvest Home, Healthy Brain Los Angeles, Jewish Family Services Los Angeles, Korean American Family Services, Koreatown Youth + Community Center, Los Angeles County Military Veterans Affairs Veteran Peer Access Network, Los Angeles County Department of Public Health, Maple Counseling, Maternal Mental Health Now, Mental Health Advocacy Services, Mental Health First Aid, Martin Luther King Community Healthcare, National Alliance on Mental Illness (NAMI), OUR HOUSE Grief Support Center, Pacific Clinics, Painted Brain, Planned Parenthood Los Angeles, Saban Community Clinic Los Angeles, Santa Monica-Malibu Unified School District, South Asian Network, Special Service for Groups, Inc., St. Elmo Village, St. John's Community Health, St. Joseph Center, Southern California Counseling Center, Step Up, Sycamores, Los Angeles LGBT Center, The People Concern, The Trevor Project, The Village Family Services, U.S. VETS, UCLA Veteran Family Wellbeing Center, Venice Family Clinic, Westside Infant-Family Network (WIN), WISE & Healthy Aging
Overweight and obesity	Boys & Girls Clubs of America, California Food is Medicine Coalition, Community Coalition, Healthy African American Families, Jewish Family Service LA, Los Angeles Christian Health Centers, Project Angel Food, Saban Community Clinic Los Angeles, Seeds of Hope (Episcopal Diocese of Los Angeles), Social Justice Learning Institute, Mar Vista Family Center, Venice Family Clinic, Westside Family Health Center, Young Men's Christian Association (YMCA)
Preventive care	Alzheimer's Association, American Heart Association, Black Women for Wellness, Claris Health, Essential Access Health, Homeless Health Care Los Angeles, Los Angeles County Health Services Housing for Health, Kheir Clinic, Latino Equality Alliance, Los Angeles Christian Health Centers, Los Angeles County Department of Health Services, Los Angeles County Department of Public Health, Men's Health Foundation, Northeast Valley Health Center, Partners in Care Foundation, Planned

Significant Health Needs	Community Resources
	Parenthood Los Angeles, Saban Community Clinic Los Angeles, Community Health Los Angeles LGBT Center, Universal Community Health Center, Venice Family Clinic, West Los Angeles VA Medical Center, Westside Family Health Center
Community safety and violence	Asian Americans Advancing Justice Southern California, California Black Women's Collective Empowerment Institute, Boys & Girls Clubs of America, California Partnership to End Domestic Violence, City of West Hollywood Security Ambassador Program, City of West Hollywood Social Justice Advisory Board, Downtown Women's Center, Homeboy Industries, Jenesse Center, Inc., Jewish Family Service Los Angeles, LA vs. Hate, Los Angeles County Department of Public Health Trauma Prevention Initiative, Los Angeles County Department of Parks and Recreation Parks After Dark, South Asian Helpline and Referral Agency (SAHARA), Southern California Crossroads, Los Angeles LGBT Center, The People Concern, The Positive Results Corporation, The TransLatin@ Coalition, UCLA Stuart House and Rape Treatment Center, Watts Labor Community Action Committee, Westside Infant-Family Network (WIN), YMCA
Substance use and misuse	Airport Marina Counseling Services, Alcoholics Anonymous, Alta Med Health Services, APLA Health, Asian American Drug Abuse Program (AADAP), Awakening Recovery, Clare Matrix, Didi Hirsch Mental Health Services, Exodus Recovery, Inc., Homeless Health Care Los Angeles, HOPICS, Los Angeles County Department of Health Services, McIntyre House, Narcotics Anonymous, Pacific Clinics, Special Service for Groups, Inc., St. Joseph Center, Tarzana Treatment Centers, Inc., Twin Town Treatment Centers, UCLA Integrated Substance Abuse Programs, Venice Family Clinic, Vista Del Mar Child and Family Services, Watts Health Center, Wesley Health Centers
Transportation	Access LA, Alliance for Community Transit (ACT-LA), Ambiance Medical Transportation, Big Blue Bus, Butterfli Transportation, City of West Hollywood, Jewish Family Services LA, Los Angeles Department of Transportation Cityride, Los Angeles Department of Transportation LAnow On-Demand Shared Ride, Los Angeles Metropolitan Transportation Authority, People for Mobility Justice, Road to Recovery American Cancer Society, TLC Medical Transport, WISE & Healthy Aging