2025

Community Health Needs Assessment

Los Angeles-San Fernando Valley:

Providence Holy Cross Medical Center (Mission Hills)
Providence Saint Joseph Medical Center (Burbank)
Providence Cedars-Sinai Tarzana Medical Center (Tarzana)

To provide feedback on this CHNA or obtain a printed copy free of charge, please email Anthony Ortiz-Luis at Anthony.OrtizLuis@providence.org.

Providence

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Understanding and Responding to Community Needs

The Community Health Needs Assessment (CHNA) is an opportunity for Providence Holy Cross Medical Center, Providence Saint Joseph Medical Center, Providence Cedars-Sinai Tarzana Medical Center (hereto known as "Providence San Fernando Valley hospitals") 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.

This report is a joint CHNA and reflects the hospitals' collaborative efforts to identify the significant health-related needs in the community and the community strengths. The hospitals participating in this joint CHNA share a service area and community served. The 2025 CHNA was approved by the Los Angeles Valley Service Area Community Ministry Board of Directors on October 9th, 2025 and by the Providence Cedars Sinai Tarzana Medical Center Board of Managers on November 18, 2025 and made publicly available by December 28, 2025.

Gathering Community Health Data and Community Input

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

Key findings from community engagement resulted in identification of top health priorities:

- Access to care and preventive resources is a top priority and concerns include difficulty accessing primary care providers and specialists, affordability, and reduced coverage for vulnerable populations
- Behavioral health, mental health, and substance use/misuse continues to be a major concern for individuals experiencing trauma, domestic violence, and social isolation among children, adults, and seniors
- Chronic diseases like cancer, diabetes, dementia, hypertension, and other chronic diseases disproportionately affect communities of color and vulnerable populations that lack screenings and preventive resources

Providence San Fernando Valley hospitals 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.

Measuring Our Success: Results from the 2022 CHNA and 2023-2025 CHIP

This report evaluates the impact of the 2022-2025 CHIP. Providence San Fernando Valley hospitalsresponded to community needs by making investments of direct funding, time, and resources to internal programs and external partners dedicated to addressing the previously prioritized needs using evidence-based and industry leading practices. In addition, we invited written comments on the 2022 CHNA and 2023-2025 CHIP, made widely available to the public. No written comments were received on the 2022 CHNA and 2023-2025 CHIP.

The Community Health Needs Assessment (CHNA) is an opportunity for Providence San Fernando Valley hospitals 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.

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

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 San Fernando Valley hospitals leadership, the Providence San Fernando Valley Hospitals Mission Community Health Committee and Executive Leadership Teams 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 key informant survey prioritization score
- Service area health indicator data, compared to county, state, or national benchmarks
- Opportunity to impact: current Community Benefit programs
- Opportunity to Impact: external partnerships
- Alignment with Providence health system strategies

The committee and executive leadership teams took a vote on the top three needs for Providence San Fernando Valley hospitals to prioritize over the next three years. Below are the resulting health needs priorities, based on the CHNA Advisory Committee's process, ranked in order of priority.

- Access to care and preventive resources is a top priority and concerns include difficulty accessing primary care providers and specialists, affordability, and reduced coverage for vulnerable populations
- Behavioral health, mental health, and substance use/misuse continues to be a major concern for individuals experiencing trauma, domestic violence, and social isolation among children, adults, and seniors
- Chronic diseases like cancer, diabetes, dementia, hypertension, and other chronic diseases disproportionately affect communities of color and vulnerable populations that lack screenings and preventive resources

Results from the 2022 CHNA and 2023-2025 CHIP

Providence San Fernando Valley hospitals 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: Access to Health Care and Preventive Services,

Homelessness and Housing Instability Behavioral Health, including Mental Health and Substance Use/Misuse).

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

- Hospital based community health workers and/or navigators focused on providing mental health, housing instability, homelessness, and social drivers of health resources continue to meet the needs of patients and their families.
- Providence Community Health San Fernando Valley expanded its reach to provide Mental Health First Aid training to schools, faith-based organizations, businesses, and nonprofit organization to more organization across the San Fernando Valley region.
- Strengthening partnerships with community-based organizations, schools, senior centers, housing services providers, and food banks to meet basic and social needs continues to be a focus area to meet the needs of the communities we serve.

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 San Fernando Valley Medical Centers include Providence Holy Cross Medical Center, Providence Saint Joseph Medical Center, and Providence Cedars-Sinai Tarzana Medical Center are acute care hospitals located in the San Fernando Valley within Los Angeles, California. Collectively, the three Medical Centers have 1,072 licensed beds, a staff of more than 5,378 caregivers and professional relationships with more than 2,465 medical staff. Major programs and services offered to the community include cancer care, emergency and trauma services, heart and vascular care, maternity care, neuroscience, NICU, orthopedics and sports medicine, stroke care, and women and children's services.

Providence Holy Cross Medical Center was founded in 1961 to provide healing and health care to the San Fernando, Santa Clarita and Simi valleys. A 377-bed, not-for-profit facility, the medical center offers both inpatient and outpatient health services, including a state-of-the-art cancer center, a heart center, orthopedics, neurosciences and rehabilitation services, women's and children's services, as well as providing our communities with a Level II Trauma Center. Providence Holy Cross Medical Center, strategically located near the intersections of the 405, 5, 118 and 210 freeways, serves both the North San Fernando and Santa Clarita valleys. We offer a full continuum of health care, from inpatient and outpatient services to home health care, health education and community outreach programs.

Providence Saint Joseph Medical Center is a faith-based, non-profit, acute-care hospital in Burbank, California. Established by the Sisters of Providence in the 1940s, Providence Saint Joseph provides exceptional care and is one of the San Fernando Valley's most respected and technologically advanced hospitals. Our five core values of Compassion, Dignity, Excellence, Justice and Integrity are the guiding principles for everything we do. Whether for the birth of a baby, life-saving surgery or a routine mammogram, Saint Joseph continues to set the standard for medical care and offers the community the most comprehensive array of services and programs.

Providence Cedars Sinai Tarzana Medical Center is a faith-based, non-profit acute care hospital in Tarzana, California. providing high-quality compassionate care in the San Fernando Valley since 1973. Now, with the partnership of Providence and Cedars-Sinai, we're transforming into a full-service, ultramodern medical campus. From our pediatric- and stroke-approved emergency department to our highly rated heart, vascular, orthopedic, cancer, pediatric and women's services, Providence Cedars-Sinai Tarzana Medical Center is proud to provide world-class care, close to home.

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

Joint CHNA

This is a “joint CHNA report,” within the meaning of Treas. Reg. § 1.501(r)-3(b)(6)(v), by and for Providence including Providence Holy Cross Medical Center, Providence Saint Joseph Medical Center, and Providence Cedars-Sinai Tarzana Medical Center. This report reflects the hospitals’ collaborative efforts to identify the significant health-related needs in the community as well the community strengths. The hospitals participating in this joint CHNA share a service area and community served. This CHNA engaged with and sought input from that community.

Collaborating Community Partners

Providence San Fernando Valley hospitals developed a list of community stakeholders, invited community stakeholder participation and agreed upon an interview protocol for qualitative data collection.

Providence San Fernando Valley hospitals are 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 San Fernando Valley hospitals 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.

Equity Practices in the CHNA

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

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

To ensure that equity is foundational to our CHNA, we have developed an equity framework that outlines the best practices that each of our hospitals will implement when completing a CHNA.

These practices include, but are not limited to the following:

Approach

Share equity practices in the CHNA

Highlight community strengths

Use people first and non-stigmatizing language

Community Engagement

Use multiple methods to engage with community members

Implement equitable practices for community participation

Share findings back with communities

Quantitative Data

Report data at the local level to avoid masking

Disaggregate data when responsible

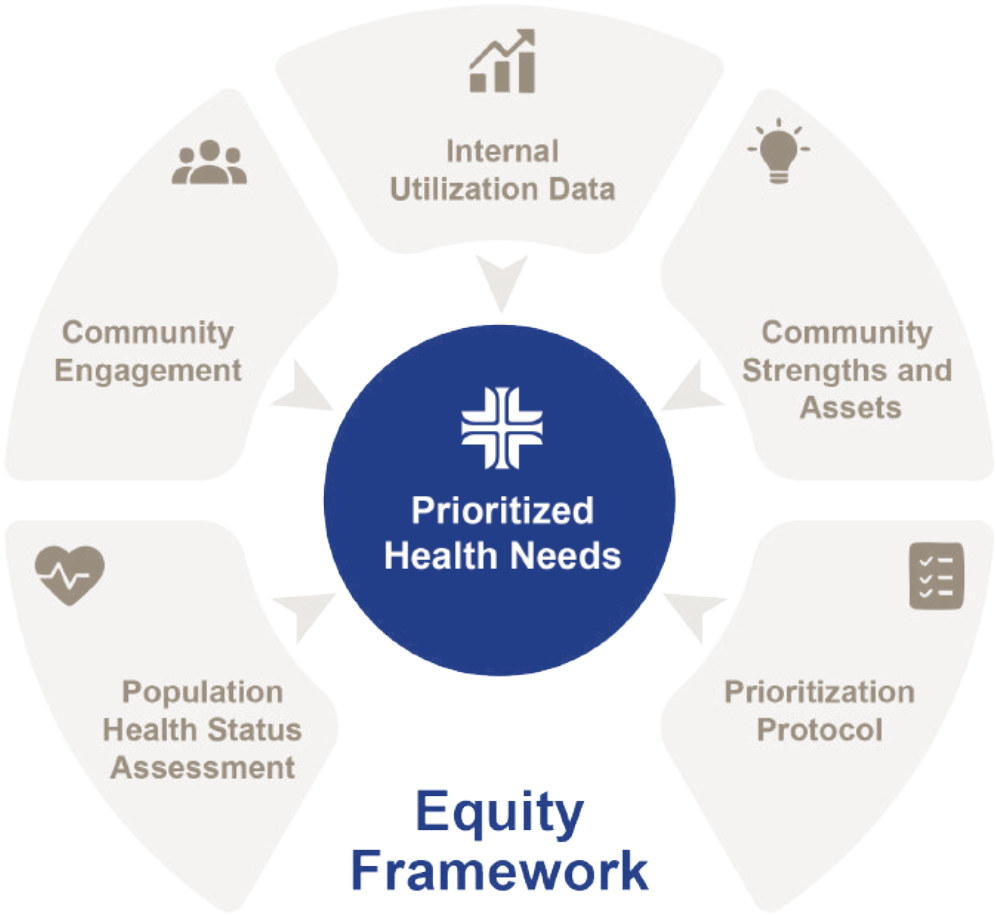
Acknowledge inherent bias in data and screening tools

In this year's CHNA, there was an effort to expand the hospital service areas to include underserved communities outside of the typical hospital service areas and include community partners that serve vulnerable populations in those new areas. Providence also ensured that we

conducted listening sessions in Spanish and engaged with community stakeholders in their safe spaces. We conducted listening sessions in the community at trusted spaces.

CHNA Framework

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



*Modified MAPP Framework

Data Sources

In gathering information on the communities served by the hospital, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. In addition, we recognize that there are often geographic areas where the conditions for supporting health are poorer than nearby areas. Whenever possible and reliable,

data are reported at census tract level. These smaller geographic areas allow us to better understand the neighborhood level needs of our communities and better address inequities within and across communities. We reviewed data from the following sources:

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

Data Limitations and Information Gaps

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

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

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

Written comments were solicited on the 2022 CHNA and 2023-2025 CHIP reports, which were made widely available to the public via posting on the internet in December 2022 (CHNA) and

May 2023 (CHIP), as well as through various channels with our community-based organization partners. No comments to the 2022 CHNA and 2023-2025 CHIP reports were received.

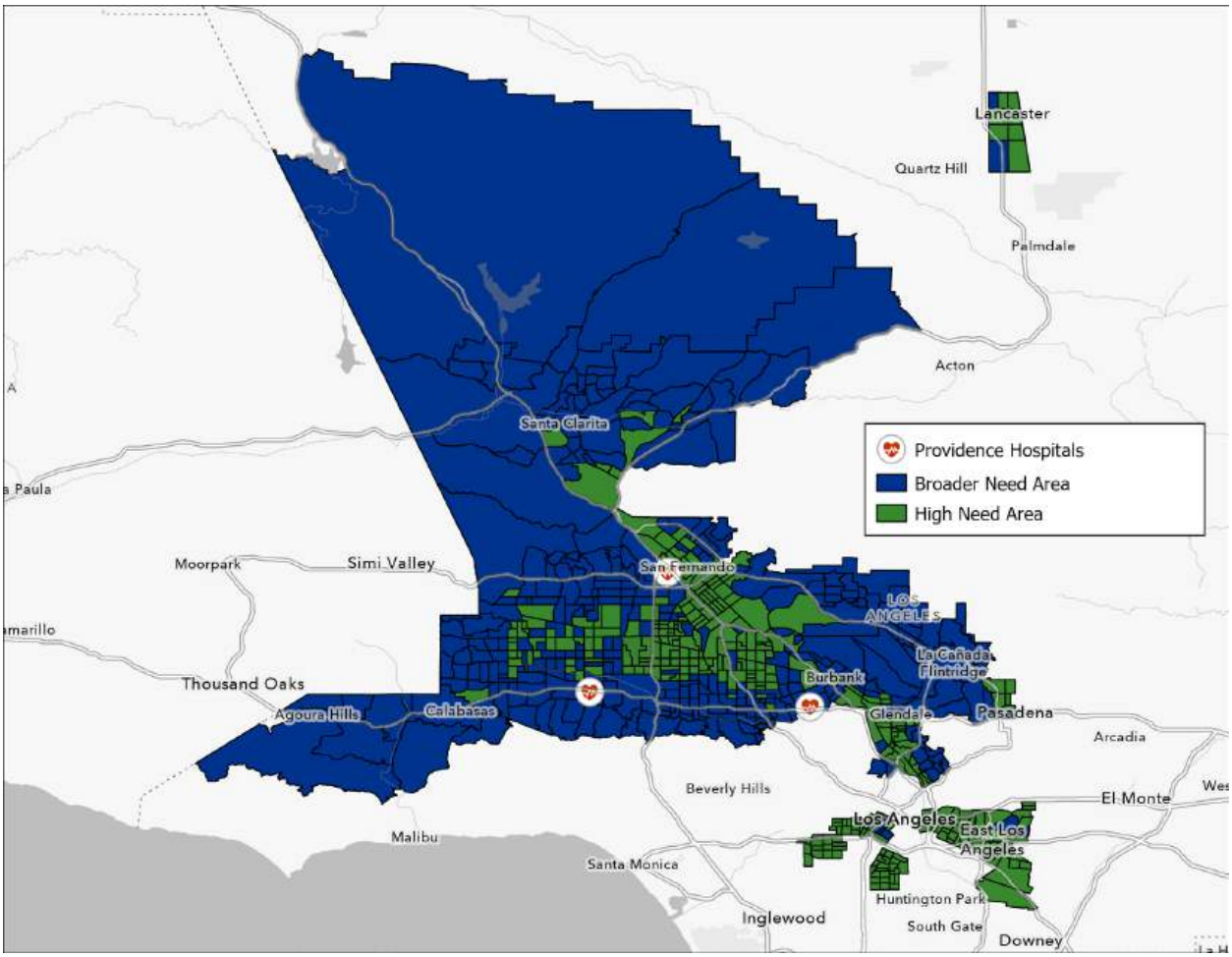
CHNA Service Area

In defining its community for purposes of this report, we used the most recent Community Health Needs Assessment, conducted by Providence San Fernando Valley hospitals in 2022. We considered the location of the hospital and the surrounding communities, and the zip codes reported in addresses of our patients on entry into the hospital for services.

The three Providence San Fernando Valley medical centers share a common geographic service area because of their close proximity to each other. Based on the availability of data, geographic access to these facilities, and other hospitals in neighboring counties, the San Fernando Valley, as outlined in the map, serves as the boundary for the service area.

The overall service area remained similar to that used in 2022, although we added ZIP Codes corresponding to partner organizations. Notably, two ZIP Codes on the east side of the service area include very large census tracts that are primarily Angeles National Forest. The centers of those two census tracts fall outside of the ZIP Code and therefore were not included (this accounts for the reduced geography when comparing the ZIP Codes to the census tracts).

Figure 1: Providence San Fernando Valley Hospitals Service Area Map



Environmental Justice Index

Providence uses the Center for Disease Control's (CDC) Environmental Justice Index (EJI) to identify communities of higher need within our service areas. Census tracts that score higher than the median EJI score are classified as "high need" and are depicted in green. All other census tracts are labeled "broader need" and are shown in blue. The median 2024 EJI score for census tracts in the San Fernando Valley Service Area is 0.658.

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 service area and how the high need area compares to the broader service area. The Providence-developed data hub maps some service area data at the census tract level: 2025 San Fernando Valley CHNA Datahub.

See the tables and figures below that illustrate selected demographic data.

Table 1: Total Population San Fernando Valley Service Area

Geographic Designation	Population
High Need	1,359,427
Broader Need	1,399,623
Total Service Area	2,759,050
Los Angeles County	9,848,406

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

Population by Age Groups by Geography

The San Fernando Valley Service Area has similar age category distributions as compared to Los Angeles County, however there are some noticeable differences for the High Need and Broader Need Service Areas. The Broader Need Service Area has a higher percentage of population ages 35 to 54, 55 to 64 and ages 65 and older as compared to the Los Angeles County, High Need Service Area and San Fernando Valley Service Area. The High Need Service Area has a higher percentage of population under age 18 and ages 18 to 34 as compared to the Los Angeles County, Broader Need Service Area and San Fernando Valley Service Area.***Figure 2: Population Age by Geography***

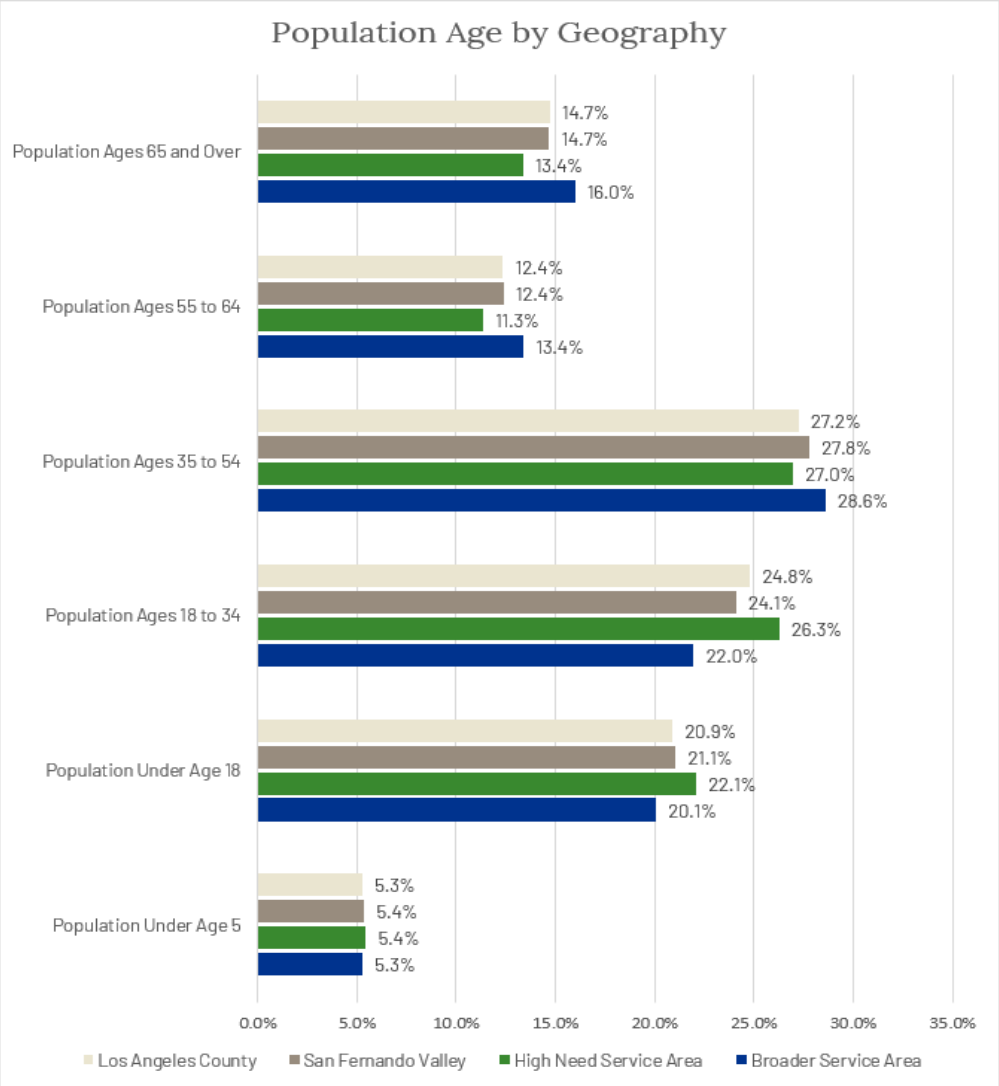


Figure 2 Source: U.S Census Bureau, 2019 – 2023 American Community Survey 5-Year Estimates, Tables B01001, B02001 and B03003

Population by Race by Geography

The High Need Service Area has a larger portion of it's population identifying as Some Other Race (36.2%) and Two Or More Races (18.1%) than Los Angeles County. Population identifying as White (55.0%) is the largest segment of the Broader Need Service Area population and is much higher than Los Angeles County (35.4%) and the High Need Service Area (30.0%).***Figure 3: Population Race by Geography***

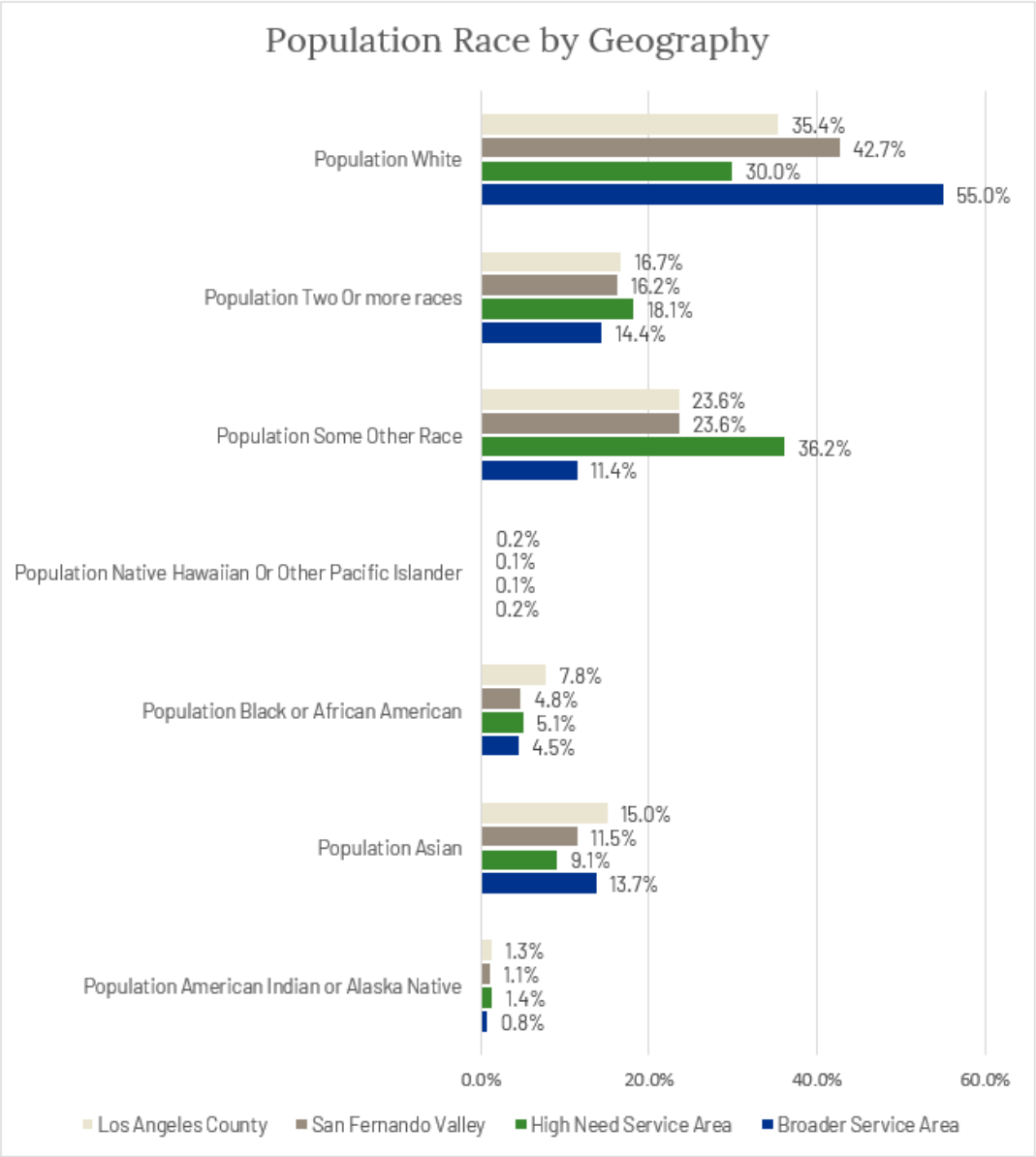


Figure 3 Source: U.S Census Bureau, 2019 – 2023 American Community Survey 5-Year Estimates, Tables B01001, B02001 and B03003

Population by Ethnicity by Geography

The Hispanic population is highest by percentage in the High Need Service area, with 65.0% of that population identifying as Hispanic compared to 27.7% in the broader service area and 46.1% in San Fernando Valley Service Area.

Figure 4: Population Ethnicity by Geography

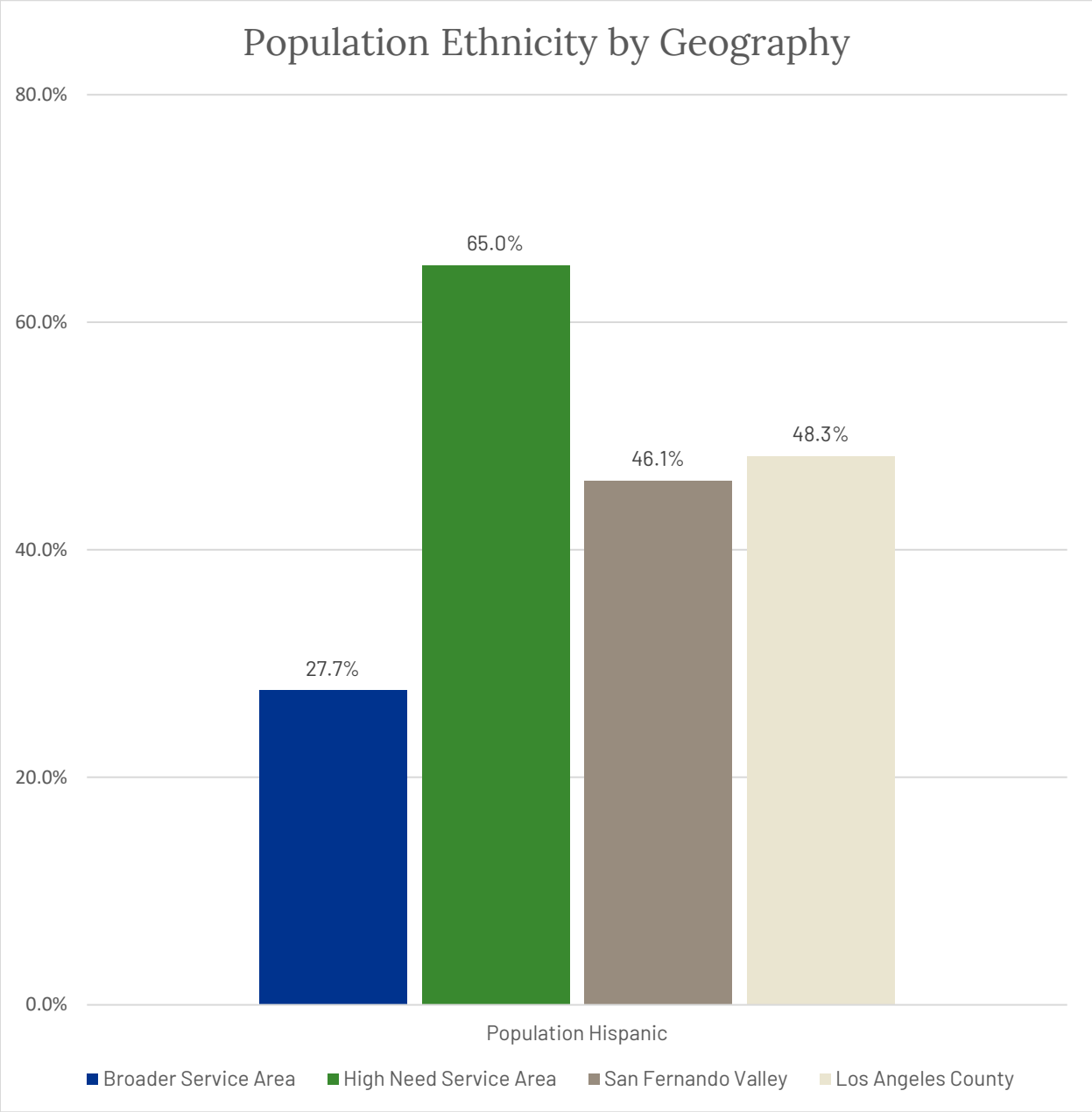


Figure 4 Source: U.S Census Bureau, 2019 – 2023 American Community Survey 5-Year Estimates, Tables B01001, B02001 and B03003

Median Income

Household median incomes include the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not.

Because many households consist of only one person, average household income is usually less than average family income.

The High Need Service Area has a median income of $67,906, which is $52,450 lower than the Broader Need Service Area ($120,356), and $26,225 less than the Total Service Area ($94,131)

Table 2: Median Household Income

Geographic Designation	Median Income
High Need	$67,906
Broader Need	$120,356
Total Service Area	$94,131
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 factor. For reference, in 2022, 200% Federal Poverty Level was equivalent to an annual household income of $55,500 or less for a family of four in the contiguous United States and $69,380 in the state of Alaska. (More info here)

The High Need Service Area has 43.3% of the population below 200% FPL, which is 23.4 percentage points higher than the Broader Need Service Area (19.9%). The High Need Service Area also exceeds Los Angeles County (31.1%) by 12.2 percentage points and California (27.5%) by 15.8 percentage points.

Table 3: Federal Poverty Level

Geographic Designation	Percent Below 200% FPL
High Need	43.3%
Broader Need	19.9%
Total Service Area	31.6%
LA County	31.1%
CA	27.5%

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

Supplemental Nutrition Assistance Program (SNAP)

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

The High Need Service Area has a much higher rate of SNAP participation (20.8%) compared to the Broader Need Service Area (7.8%), a difference of 13.0 percentage points.

Table 4: Households Receiving SNAP

Geographic Designation	Percent SNAP
High Need	20.8%
Broader Need	7.8%
Total Service Area	14.3%
LA County	13.0%
CA	11.4%

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

Limited English Households

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

The High Need Service Area (20.4%) has the highest percent of limited English speaking households which is 8.3 percentage points higher than Los Angeles County and 12.7 percentage points higher than the Broader Need Service Area.

Table 5: Limited English Households

Geographic Designation	Percent Limited English
High Need	20.4%
Broader Need	7.7%
Total Service Area	14.1%
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 three hospitals (Providence Holy Cross Medical Center, Providence Saint Joseph Medical Center – Burbank and Providence Cedars-Sinai Tarzana Medical Center) are not located in an HPSA, but Providence Holy Cross is located just outside of the boundaries of both a Primary Care HPSA and a Mental Health HPSA, and Providence Saint Joseph Medical Center is approximately 1.5 miles outside the boundaries of a Primary Care HPSA and Providence Cedars-Sinai Tarzana Medical Center is located just outside the boundaries of a Dental Care HPSA

The following nine (9) Primary Care HPSAs are partially or entirely located within the boundaries of the hospitals' service area: :

- Six (6) Low-Income-Population HPSAs: San Fernando West, Pacoima East/Sun Valley, North Hollywood Central, Exposition Park/Leimert Park, and City Terrace East
- Three (s) High-Needs Geographic HPSAs: Lancaster Central/Palmdale North Central, Downtown Southeast, and South Central Northeast

The following 11 Mental Health HPSAs are partially or entirely located within the boundaries of the hospitals' service area:

- Three (3) Low-Income-Population HPSAs: San Fernando West, Glendale Southeast, and East Los Angeles
- One (1) Geographic HPSA: Lancaster Palmdale
- Seven (7) High-Needs Geographic HPSAs: Acton, Crenshaw/Culver City East, Exposition Park/Leimert Park, Downtown Southeast, South Central Northeast, Boyle Heights Central, and Bell Northeast

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

- Two (2) Low-Income-Population HPSAs: Exposition Park/Leimert Park and South Central Northeast
- Three (3) Medicaid-Eligible-Population HPSAs: Lancaster Central/Palmdale North Central, Reseda South/Van Nuys Southwest, and Downtown Southeast/Florence North.

Health Indicators Data

Please refer to the 2025 San Fernando Valley CHNA Datahub to review each of the following health indicators mapped at the census tract level. The hub provides data on each indicator in SPA 2 in Los Angeles County, high need and broader need service areas, and California, as well as information about the importance of each indicator.

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 minorities account for over half of the uninsured population. The San Fernando Valley High Need Service Area is higher (12.2%) than the Broader Need, Total Service Area, LA County and California.

Table 7: Health Insurance

Geographic Designation	Percent without Insurance
High Need	12.2%
Broader Need	5.8%
Total Service Area	9.0%
LA County	8.7%
CA	6.9%

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

Chronic Diseases

Asthma: According to the Center for Disease Control, “Compared to persons without asthma, persons with asthma are more likely to report depression, be unemployed, spend more days sick in bed, and have limitations or inability to conduct normal work.” Asthma rates in the San Fernando Valley Service Area are higher than Los Angeles County and California rates.

Diabetes: According to the Center for Disease Control, “Multiple long-term complications of diabetes can be prevented by managing blood glucose, blood lipids, and blood pressure regularly, eating healthy foods, being physically active, and screening and early treatment for eye, foot, and kidney abnormalities.” Diabetes rates in the San Fernando Valley Service Area are higher than California rates.

Heart Disease: According to the Center for Disease Control, “Approximately 20.5 million adults aged ≥20 years have CHD (about 7.1%) (NHANES 2017–2020) with men (8.7%) more

commonly affected than women (5.8%). CHD is the largest category of heart disease mortality with 371,506 people killed in 2022. Timely, effective treatment for heart attacks can reduce the risk for long-term disability and death." Heart Disease rates in the San Fernando Valley Service Area are slightly higher than Los Angeles County and California rates.

COPD: According to the Center for Disease Control, "Major risk factors include tobacco smoking, occupational and environmental exposures, respiratory infections, and genetics. Although there is no cure for COPD, it can be treated and managed to slow declining lung function, improve exercise tolerance, and prevent and treat exacerbations." COPD rates in the San Fernando Valley Service Area are higher than Los Angeles County and California rates.

Obesity: According to the Center for Disease Control, "Many adults in the United States have obesity. Adults with obesity have higher risks for stroke, many types of cancer, premature death, and mental illness such as clinical depression and anxiety. Obesity-related stigma and discrimination can also lead to health problems. Evidence suggests that intensive behavioral interventions that use more than one strategy — like group sessions and changes in both diet and physical activity — are an effective way to address obesity." Obesity rates in the San Fernando Valley Service Area are higher than Los Angeles County rates.

Table 8: Chronic Diseases

Chronic Disease	San Fernando Valley Service Area	LA County	California
Asthma	9.7%	9.1%	8.7%
Diabetes	12.2%	12.3%	11.5%
Heart Disease	5.6%	5.4%	5.3%
COPD	5.5%	4.8%	4.7%
Obesity	27.1%	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 Centers for Disease Control, "Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults and older adults, physical activity can lower the risk of early death, coronary heart disease, stroke, high blood pressure, type 2 diabetes, breast and colon cancer, falls, and depression. The second edition of the Physical Activity Guidelines for Americans states that adults should move more and sit less throughout the day. 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."

The San Fernando Valley High Need and Total Services Areas show higher rates of physical inactivity than Los Angeles County and California rates.

Table 9: Physical Inactivity

Geographic Designation	Physical Inactivity Prevalence Estimates
High Need	30.6%
Broader Need	18.9%
Total Service Area	24.7%
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

According to the Center for Disease Control, "Depression causes severe symptoms that affect how you feel, think, and handle daily activities, such as sleeping, eating, or working. In 2022, an estimated 54 million U.S. adults (21%) reported they had been told by a doctor they had a depressive disorder, including depression, major depression, dysthymia, or minor depression in their lifetime." The San Fernando Valley Service Areas show higher rates of people with depression than Los Angeles County and California rates.

Table 10: Depression Prevalence

Geographic Designation	Depression Prevalence Estimates
High Need	22.6%
Broader Need	21.5%
Total Service Area	22.1%
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: According to the Center for Disease Control, FMD is used to identify individuals with more severe or persistent mental health problems in the previous month. “Many chronic diseases can impact general health status, including mental distress. Practicing healthy behaviors (e.g., not smoking, eating healthy, being active, and limiting drinking) can reduce the likelihood of getting a chronic disease and improve the odds of staying well, feeling good, and living longer.” The San Fernando Valley High Need and Total Service Areas show higher rates of FMD than Los Angeles County and California rates.

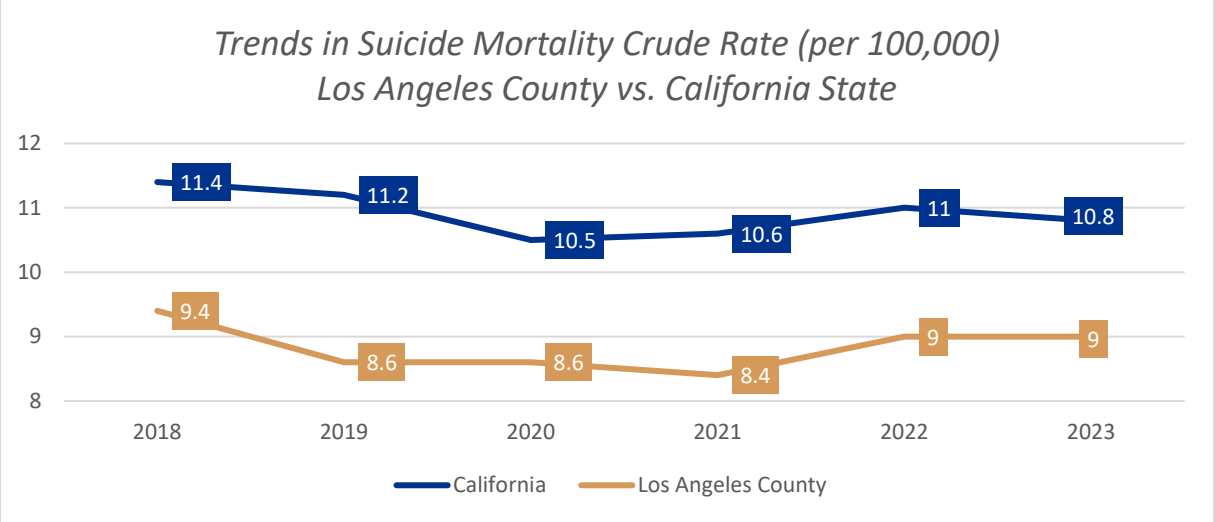
Table 11: FMD Prevalence

Geographic Designation	FMD Prevalence Estimates
High Need	19.6%
Broader Need	15.5%
Total Service Area	17.5%
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 show 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 Center for Disease Control, "Excessive drinking —which includes binge drinking —is associated with many health problems including unintentional injuries, violence, sexually transmitted diseases, poor pregnancy outcomes, fetal alcohol spectrum disorders, and chronic diseases (e.g., high blood pressure, cancer). Evidence-based alcohol policies, such as those recommended in the Community Guide, can be effective in preventing excessive alcohol use, including binge drinking. violence, suicide, chronic conditions, sexually transmitted diseases, unintended pregnancy and fetal alcohol disorders."

The San Fernando Valley Broader Need and Total Service Areas show higher rates of binge drinking than Los Angeles County and California rates.

Table 12: Binge Drinking Prevalence

Geographic Designation	Binge Drinking Prevalence Estimates
High Need	17.5%
Broader Need	19.0%
Total Service Area	18.2%
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 San Fernando Valley High Need and Total Service Area experience severe housing cost burden than in California and Los Angeles County.

Table 13: Households Experiencing Severe Housing Cost Burden

Geographic Designation	Percent Severe Housing Cost Burden
High Need	28.7%
Broader Need	22.4%
Total Service Area	25.6%
LA County	23.4%
CA	19.4%

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

Persons Experiencing Homelessness: Service Planning Area (SPA) 3

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 2 had an estimated 10,766 individuals who were homeless. 78.1% of those experiencing homelessness in SPA 2 were individual adults, 19.3% were members of families experiencing homelessness. 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 percent of homeless persons in SPA 2 who were unsheltered decreased by 15.0 percentage points from 2023 to 2025.

Table 14: Persons Experiencing Homelessness

Persons Experiencing Homelessness (PEH)	SPA 2		Los Angeles County Continuum of Care *	
	2023	2025	2023	2025
Total persons experiencing homelessness	10,443	10,766	71,320	67,918
Sheltered	22.7%	37.8%	26.7%	34.6%
Unsheltered	77.2%	62.2%	73.3%	65.4%

*Source Table 14: Los Angeles Homeless Service Authority, 2023 and 2025 Greater Los Angeles Homeless Count. *These data represent the homeless counts from the Los Angeles County Continuum of Care, which does not include Glendale, Long Beach and Pasadena homeless counts.*

See Appendix 1 to review more data on PEH in SPA 2 and Los Angeles County.

Leading Causes of Death

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

Table 6: Leading Causes of Death, Los Angeles County Compared to California (Crude Rates per 100,000 population)

	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 Drivers of Health (SDOH) Screening Data

Providence implemented SDOH screenings for all admitted adult inpatients. Data from SDOH screenings Jan 1-Dec 31, 2024 showed the following:

- 4.9%, 4.2%, and 6.2% of patients screened positive for at least one need at Providence St. Joseph Medical Center, Providence Cedars Sinai Tarzana Medical Center, and Providence Holy Cross Medical Center, respectively.
- Housing was the greatest need reported at all three hospitals, followed by food, transportation, and utilities, which were reported at similar percentages by hospital.

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 San Fernando Valley hospitals:

- 33.0% of all ED visits were considered potentially avoidable in 2024 which is a slight decline from 34.9% of avoidable visits in 2023.
- The top diagnosis groupings for avoidable ED visits were the following: bronchitis and other upper respiratory disease, urinary tract infections, skin infection and acute otitis media sinusitis.
- Patients with the following demographics had higher percentages of avoidable ED visits than the patient population overall (i.e., looking at what percentage of ED cases for each population were considered potentially avoidable):

  <u>Providence Holy Cross Medical Center:</u>

  - patients under 18 (41.3%) had higher avoidable ED cases than patients overall (34.8%) by patient age groups
  - patients with Medicaid coverage (37.7%) had the highest percentages of avoidable ED visits by payor

- 1.6% 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: patients 18-39 years (2.2%) and patients 40-64 (2.1%)
- The top three diagnosis groupings for behavioral health related ED visits were the following: anxiety and personality disorders, substance use disorders and mood disorders

Providence Saint Joseph Medical Center:

- patients under 18 (37.4%) had higher avoidable ED cases than patients overall (31.1%)
- patients with Medicaid coverage (35.5%) and those who are self-pay (33.2%) had slightly higher avoidable ED cases than patients overall (31.1%)
  3.5% 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: patients 18-39 years (5.1%) and ages 40-64 (3.9%)
-
- The top three diagnosis groupings for behavioral health related ED visits were the following: substance use disorders, anxiety and personality disorders and mood disorders

Providence Cedars-Sinai Tarzana Medical Center:

- patients under 18 (35.7%) ages 18-39 (32.8%) had higher avoidable ED cases than patients overall (32.2%)
- patients with Medicaid coverage (37.1%) and those who are self-pay (35.3%) had higher avoidable ED cases than patients overall (32,2%)
- 2.2% 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: patients 18-39 years (3.7%), patients ages 40-64 (2.8%) and patients who are self-pay (5.5%)

- The top three diagnosis groupings for behavioral health related ED visits were the following: substance use disorders, anxiety and personality disorders and mood disorders

Source: Providence Epic, 2024

Summary of Community Input

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, Providence San Fernando Valley worked in partnership to conduct 30 interviews with community stakeholder organizations and leaders and seven (7) listening sessions with community members between June and August of 2025.

Community stakeholders have broad interests in the community, as well as specific experience and expertise with health and wellbeing in Los Angeles County, and in the San Fernando Valley 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.

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

FINDINGS FROM LISTENING SESSIONS

Vision for a Healthy Community

Community members shared their vision for a healthy community:

- **Community engagement and unity:** In almost every listening session, participants shared that people care for one another and are engaged in a healthy community. There is a sense of unity; people know and communicate with their neighbors and people respect one another. People of all ages gather in community spaces participating in events and programming.

> *"Community is reliant on each other… shared values, acceptance, joint efforts."—Listening Session Participant*

> *"Community has always meant people who take care of each other."—Listening Session Participant*

> *"Community should be about the people...people-oriented."—Listening Session Participant*

> *"If a community is unhealthy, you are scared of your neighbors."—Listening Session Participant*

- **Clean environment with green spaces:** Healthy communities are clean and appear well-kept, with green spaces. In clean, well-kept communities there are no encampments, litter, poorly maintained sidewalks, or water contamination.
- **Physical health and recreation**: People are active and engaged in caring for their physical health and can be seen enjoying recreational opportunities. In healthy communities, kids are outdoors playing and not overweight and there are free youth

activities and sports available. People can enjoy walking their dog outside and it is easy for people to take care of their physical health and maintain healthy habits.

- **Safety**: In a healthy community, people feel safe to be out walking and gathering with one another. There are low crime rates and people are not afraid. People are safe to practice their faith and trust their neighbors. In healthy communities, there is no bias or judgment from law enforcement and emergency response personnel are well educated in evidence-based practices on how to safely support all community members, regardless of immigration status, substance use/misuse, etc.

"You have people you can trust. You feel safe walking in your neighborhood when you know who lives where."—Listening Session Participant

"Practice faith safely without having to worry about having a church bombed."—Listening Session Participant

"Lack of pandemic, riots, and fear."—Listening Session Participant

- **Access to resources and services**: In healthy communities, there are many resources and services available to community members and people know how to access them. There is information available to support those who need help.

"When I think about a healthy community, I think about robust resources that are available."—Listening Session Participant

- **Adequate housing**: Healthy communities have adequate housing for everyone, and people are not living unsheltered or in encampments.
- **Mental, emotional and spiritual health**: People are emotionally well and holistic health is prioritized in healthy communities, meaning there is support for physical, mental, and emotional health. People have the freedom to practice their faith or religion and people are generally happy. Mental health is prioritized and seen as foundational to well-being.

"There must be a correlation between the happiest cities in the U.S. and the healthiest cities."—Listening Session Participant

"Without mental health, you do not have well-being."—Listening Session Participant

- **Access to health care services:** Everyone has access to health care services and health insurance regardless of ability to pay in a healthy community. Free clinics are available to provide care and people know how to access the services they need.
- **Basic needs are met for transportation, food, and education:** People can meet their basic needs and access transportation, healthy food, and educational opportunities. People have access to affordable and healthy foods to meet their nutritional needs and there are good quality schools for all children. Free transportation is available to support people accessing services.

Unmet Health Needs in the Community

Across all listening sessions, unmet health needs, were discussed and outlined, along with populations most impacted and potential programs, services and partnerships that could be leveraged to improve community health:

- Access to health care services
- Advocacy and representation
- Behavioral health challenges and access (mental health and substance use/misuse)
- Affordable housing and homelessness
- Community connection and engagement
- Community resources and outreach
- Food security
- Economic security, including jobs and education
- Recreation and green spaces
- Clean and well-maintained environment

See Appendix 2 for a summary of the listening sessions community input.

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 in the San Fernando Valley 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 stakeholders, especially those who provide programs and services to populations with vulnerabilities, were forthcoming with their views and experiences. See themes and quotes from community stakeholder interviews below.

Access to Care Themes

- Immigrant populations fear coming in for care.
- Provider shortages mean long waits for appointments and increase ED usage for healthcare.
- Navigating Medi-Cal and health insurance is challenging.
- Culturally competent care and multilingual care is lacking.
- Transportation challenges keep people living in remote areas from seeing the doctor.
- Racism and distrust keep people from seeing their doctors.

Quotes from stakeholders:

"There is kind of a terrorist feeling in the community right now. People are just trying to keep their heads down and out of sight."

Chronic Disease Themes

- Stress and meeting basic needs is taking priority over managing health.
- Changes to Medi-Cal will make it too expensive to seem chronic disease care for many.
- Chronic diseases become multipliers of other chronic disease.
- Poverty and insufficient resources make it difficult to manage chronic disease.

- African American communities have high rates of chronic diseases.

Quotes from stakeholders:

"People are under a lot more stress in general now with housing costs and working more than one job to meet the bills. Who has time to exercise? There is not a lot of work life balance with the lower income populations."

"If you can control diabetes, sometimes you can also control the hypertension. But if nutrition training is eliminated or food bank resources, the most vulnerable will not have access to control chronic diseases."

Environmental Health Themes

- Extreme heat waves, wildfires, landfills, gas leaks, illegal trash dumping – all impact health in the region.
- The 405 running through the region is a big source of pollution.
- Silicosis is preventable, with more attention to diagnosis and treatment.

Quotes from stakeholders:

"It's becoming more frequent that extreme heat waves go on for more than a day, and that impacts the very old or those with more comorbidities that make them susceptible to the extreme heat."

"We would hope that when hospitals see these patients that they can more readily identify those at higher risk and maybe do a chest x-ray and maybe follow-up with CT scans if it is warranted when they are in the clinic or ED. It will save dollars down the line because the care of these patients is extremely high. It's about average $1.2 million per transplant. As far as health care dollars, it's really in the best interest of everybody to have early diagnosis of silicosis."

Food Insecurity Themes:

- More families are food insecure and need for support is growing.
- Seniors are particularly vulnerable for food insecurity.
- The high cost of living adds to food insecurity.
- Immigrant populations fear coming in for food and services.

Quotes from stakeholders:

"More people are needing more resources and they are needing it more often. And when people can't afford things, they buy cheaper, less nutritious foods."

"We used to get food for up to 200 people plus. Now we can only provide for 100."

"We have seen a decrease of people coming to our services with immigration fears. People are afraid to leave their homes. Also, we have seen a decrease in our resources." "All the YMCAs in the San Fernando Valley started doing home deliveries because we've heard from our community that there is a population that is scared to go out right now."

Healthy Eating and Physical Activity Themes

- Poverty and healthy eating and physical activity are linked.
- Overweight and obesity is impacted by the cost of healthy food.
- Families and kids don't feel safe outside for physical activity, leading to too much screen time.

Quotes from stakeholders:

"How likely fresh fruits and vegetables are available, or if there is a a recreation center with classes and physical activity offerings and summer class offerings – a lot of that is tied to the wealth of a community."

"It can be hard to advocate outside exercise when people are afraid to go out in some of these neighborhoods with gang violence and other violence."

"Our youth are more into their phones or their iPad. They are not as engaged and physically active."

"Food costs make it difficult in some cases for patients to eat healthier."

Housing and Homelessness Themes

- More affordable housing is needed. Current housing availability is insufficient.
- Older adults, college students, those fleeing domestic violence are especially vulnerable.
- Health and housing are intertwined.

Quotes from stakeholders:

"We used to have 140 housing vouchers from the federal government. With this year's budget cut, we were reduced to 10 vouchers."

"The rents in northeast San Fernando Valley are the same as West Los Angeles. But here, there may be 7-9 family members all living in that dwelling."

"We are also seeing seniors falling into homelessness because they cannot survive the cost of living."

Mental Health Themes

- More mental health providers, and culturally competent mental health providers are needed. The workforce shortage drives wait-times and access. Access is particularly challenging for pediatric population, youth and young adults.
- Worries about deportation are exacerbating mental health issues.
- Youth are still traumatized from the effects of Covid, and the stresses of daily life.

Quotes from stakeholders:

"We have a lot of clients who have severe mental health needs and all too often, there's a waitlist. The system just seems to be overwhelmed, at all times."

"We have seen increased mental health issues and domestic violence in families. And there is increased stress and reactivity. People are more overwhelmed."

"We have kids whose parents are locked in their house, not working or making money, afraid over their immigration status. That is traumatizing to kids." "There is a lot of social isolation now because people are sheltering in place again out of fear of being snatched on the street. There is PTSD, as if you have been to war."

Preventive Services Themes

- Immigrant populations fear coming in for care
- There is extensive mistrust of vaccines, along with disinformation.

- Budget cuts are a looming reality for preventive care, including but not limited to: all kinds of vaccines, cancer screenings, Sexually Transmitted Infections care, and more.
- Navigating health insurance and preventive care is challenging, especially for when people believe that you only should see a doctor when you're sick.

Quotes from stakeholders:

"With the fires California experienced, now a lot of private foundations have shifted towards fire recovery and are not funding early childhood programs anymore. And with immigration issues, many funders are shifting in that direction. So there are a lot of competing needs that affect health care and prevention funding."

"As Medi-Cal gets cut and the fear of showing up someplace and being detained increases, you're going to find more people not taking advantage of preventive screenings. You're going to find people who are afraid to come into a clinic to follow up on an abnormal screening of any sort."

Senior Health Themes

- Older adults are socially isolated, often homebound. Many older adults are experiencing loneliness.
- Older adults are challenged with meeting their basic needs because of their financial circumstances.
- More specialized training is needed for working with the older adult population.
- Many older adults do not know how to navigate the system and therefore cannot prioritize their health.

Quotes from stakeholders:

"Often seniors do not understand what resources are available to them, nor do they know how to navigate systems. There may be additional barriers like they are recent immigrants and do not understand the language, or that social programs even exist."

"With older adults, we get calls all the time, they say they are in fear of their future, whether it is housing or other resources."

"Our workforce is not really trained on how to deal with our aging population and some of the unique dynamics of providing health and social support services to that population."

Review of Primary and Secondary Data

After a careful review of the quantitative data, we developed a preliminary list of identified community health needs. Interview participants then completed a survey which included a weighted ranking process; and community members' input was organized by theme, which added to the prioritization process.

The Providence San Fernando Valley Mission Community Health Committee reviewed the quantitative and qualitative data collected for each of the following community health-related needs:

- Access to Care
- Chronic diseases
- Environmental health
- Food insecurity
- Healthy eating and physical activity
- Housing and people experiencing homelessness
- Mental health
- Preventative practices (e.g. screenings/vaccines)
- Senior health
- Substance use and misuse

Identification and Prioritization of Significant Health Needs

Community needs were prioritized with input via surveys with community stakeholders. The following criteria were used to prioritize the significant needs:

- The perceived severity of a health or community issue as it affects the health and lives of those in the community -
  - Housing and people experiencing homelessness, and Mental health were perceived with the most severity affecting health.
- Improving or worsening of an issue in the community -
  - Housing and people experiencing homelessness, and Mental health were the highest scoring as issues for worsening in the community.
- Availability of resources to address the need -
  - Housing and people experiencing homelessness, Mental health and Substance use and misuse were ranked the highest 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 Access to healthcare, Mental health, Chronic diseases, Preventive practices, and Senior health.

See Appendix 1 to review survey data.

Using a compilation of the quantitative and qualitative data, Providence San Fernando Valley Community Health leadership presented to the Providence San Fernando Valley Mission Community Health Committee. The 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
- Key Stakeholder Survey Prioritization Score
- Service Area Rates Worse Than County, State, or National Benchmarks (Quantitative Data)
- Opportunity to Impact: Current Community Benefit Programs
- Opportunity to Impact: External Partnerships
- Alignment with Providence System Strategies

The committee took a vote on the top three needs for the Providence San Fernando hospitals of Providence Holy Cross Medical Center, Providence Saint Joseph Medical Center, and Providence Cedars Sinai Tarzana Medical Center.

2025 Priority Needs

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

Access to care and preventive resources is a top priority and concerns include difficulty accessing primary care providers and specialists, affordability, and reduced coverage for vulnerable populations

Behavioral health, mental health, and substance use/misuse continues to be a major concern for individuals experiencing trauma, domestic violence, and social isolation among children, adults, and seniors

Chronic diseases like cancer, diabetes, dementia, hypertension, and other chronic diseases disproportionately affect communities of color and vulnerable populations that lack screenings and preventive resources

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 that fall withing the Providence San Fernando Valley Service Area include the following facilities:

3C Community Clinic
AAA Comprehensive Healthcare Inc.
All for Health Health for All Inc.
All-Inclusive Community Health Center
Altamed Health Services Corporation
AMH Comprehensive Medical Centers
Center for Family Health & Education Inc.
Comprehensive Community Health Centers Inc.
El Proyecto del Barrio Inc.
Family Health Care Centers of Greater Los Angeles Inc.
Health Access For All Inc.
Gracelight Community Health
JWCH Institute Inc.
Kedren Community Health Center Inc.
LAC+USC Medical Center
Los Angeles Christian Health Centers
Mission City Community Network Inc.
Noalab Clinic Inc.
Northeast Valley Health Corporation
Olive View - UCLA Medical Center
Pediatric and Family Medical Foundation
Samuel Dixon Family Health Center Inc.
San Fernando Community Hospital
Santo Nino Health Center
SFV Health Center Inc.
So-Cal Community Health Center
South Central Family Health Center
Southern California Medical Center Inc.
Tarzana Treatment Centers Inc.
Theodore Roosevelt School
United American Indian Involvement Inc.
Valley Community Healthcare
Via Care Community Health Center
White Memorial Community Health Center A CA Nonprofit Public Benefit Corporation

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

SECTION VI: EVALUATION OF 2023-2025 CHIP

The 2022 CHNA and 2023-2025 CHIP priorities were the following: **Access to Health Care, Housing and Homelessness and Mental Health, including Substance Use/Misuse.** This report evaluates the impact of the previous Community Health Improvement Plan (CHIP). Providence San Fernando Valley Hospitals 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 2. Outcomes from 2023-2025 CHIP

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Access to Health Care	Community Health Insurance Program	Bilingual (English/Spanish) Community Health Workers who advise and assist consumers to enroll in public programs like Calfresh, MediCal, and Covered CA.	Assisted over 3000 individuals with insurance applications and over 1300 individuals with CalFresh applications
Access to Health Care	Community Health Worker Academy	The CHW Academy is a workforce development program designed to create long-term job placements for Community Health Workers in hospital and clinical settings.	Completed 8 cohorts with a total of more than 100 interns completing the program
Homelessness	Homeless Care Coordination	Community Health Workers are trained to link patients who experience homelessness with housing and case management services.	Assisted 1090 patients experiencing homelessness with linkages to housing resources and services
Mental Health	Mental Health First Aid	Mental Health First Aid (MHFA) is an evidence based, public education program where Community Health Workers and Health Education Specialists are trained and certified as instructors.	Over 1200 individuals completed Mental Health First Aid Training for Youth and Adults

Addressing Identified Needs

The Community Health Improvement Plan developed for San Fernando Valley 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 San Fernando Valley Hospitals plan to address the health needs. If the hospitals do not intend to address a need or plans to have limited response to the identified need, the CHIP will explain why. The CHIP will not only describe the actions Providence San Fernando Valley Hospitals intend to take, but also the anticipated impact of these actions and the resources the hospital plans to commit to address the health need.

Because partnership is important when addressing health needs, the CHIP will describe any planned collaboration between Providence San Fernando Valley Hospitals 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 LA Valley Service Area Mission Community Health Committee[1] of the hospital on October 9, 2025. The final report was made widely available by December 28, 2025.

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[1] **See Appendix 4: Providence San Fernando Valley Hospital Community Health Needs Assessment Committee**

Appendix 1: Quantitative Data

POPULATION LEVEL DATA

San Fernando Valley Service Area Demographics

Demographic Category	Los Angeles County	San Fernando Valley Service Area	Broader Service Area	High Need Service Area
Population by Age				
Total Population	9,848,406	2,759,050	1,399,623	1,359,427
Population Under Age 5	5.3% (518,797)	5.4% (147,890)	5.3% (73,819)	5.4% (74,071)
Population Under Age 18	20.9% (2,057,536)	21.1% (580,969)	20.1% (280,761)	22.1% (300,208)
Population Ages 18 to 34	24.8% (2,441,889)	24.1% (664,623)	22.0% (307,493)	26.3% (357,130)
Population Ages 35 to 54	27.2% (2,682,862)	27.8% (766,682)	28.6% (400,279)	27.0% (366,403)
Population Ages 55 to 64	12.4% (1,217,548)	12.4% (341,703)	13.4% (187,503)	11.3% (154,200)
Population Ages 65 and Over	14.7% (1,448,571)	14.7% (405,073)	16.0% (223,587)	13.4% (181,486)
Population by Sex				
Female	50.5% (4,969,120)	50.3% (1,387,245)	50.4% (705,267)	50.2% (681,978)
Male	49.5% (4,879,286)	49.7% (1,371,805)	49.6% (694,356)	49.8% (677,449)
Population by Race				
American Indian and Alaska Native	1.3% (125,310)	1.1% (29,715)	0.8% (11,181)	1.4% (18,534)
Asian Population	15.0% (1,480,146)	11.5% (316,052)	13.7% (191,847)	9.1% (124,205)
Black or African American Population	7.8% (769,139)	4.8% (131,813)	4.5% (62,928)	5.1% (68,885)
Native Hawaiian and Other Pacific Islander Population	0.2% (21,691)	0.1% (4,009)	0.2% (2,143)	0.1% (1,866)
Other Race Population	23.6% (2,320,096)	23.6% (652,018)	11.4% (160,032)	36.2% (491,986)
Two or more Races Population	16.7% (1,642,818)	16.2% (447,850)	14.4% (201,120)	18.1% (246,730)
White Population	35.4% (3,489,206)	42.7% (1,177,593)	55.0% (770,372)	30.0% (407,221)
Population by Ethnicity				
Hispanic Population	48.3% (4,753,369)	46.1% (1,270,846)	27.7% (387,054)	65.0% (883,792)

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	Cerebrovascular 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 2 had an estimated 10,766 individuals who were homeless, an increase of 3% from 2023. 80.7% of those experiencing homelessness in SPA 2 were individual adults, 19.3% were members of families experiencing homelessness, and six individuals (0.05%) 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 (e.g., cardboard). The percent of persons experiencing homelessness in SPA 2 who were unsheltered stood at 62% compared to 38% sheltered. ,

Population Experiencing Homelessness, 2023-2025 Comparison*

	SPA 2		Los Angeles City and County CoC*	
	2023	2025	2023	2025
Total homeless	10,443	10,766	71,320	67,918
Sheltered	23.0%	38%	26.7%	34.6%
Unsheltered	77.0%	62%	73.3%	65.4%
Individual adults, aged 25+	88%	86%	81.3%	80.1%
Individual youth, aged 18-24	4%	3%	3.9%	3.3%
Unaccompanied minors (<18)	0.00%	0.00%	0.13%	0.08%
Families/family members	12%	19.3%	14.7%	16.5%

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

Among persons experiencing homelessness in 2025 in SPA 3, 40.9% were chronically homeless individuals, a slight decrease from 2023's 41.1% rate. Homelessness rates fell locally for those who were homeless due to fleeing a domestic violence situation and/or those who have a substance use disorder (people can be members of numerous sub-groups), but rose for all other subpopulations, including a substantial rise for those with those reporting a physical disability.

People Experiencing Homelessness Subpopulations*

	SPA 2		Los Angeles City and County CoC*	
	2023	2025	2023	2025
Chronically homeless individuals	45%	38.7%	42.7%	38.1%
Chronically homeless family members	1.85%	2.9%	2.2%	2.6%
Developmental disability	6.7%	6.8%	8.9%	8.3%
Domestic violence (DV) experience	34.9%	36.5%	34.5%	37.8%
Homeless due to fleeing DV / intimate partner violence (IPV)	7.2%	7.7%	8.0%	8.9%
Persons with HIV/AIDS	1.25%	1.8%	2.1%	1.8%
Physical disability	19%	19.6%	17.2%	21.4%
Serious mental illness	23.3%	19.6%	22.4%	23.5%
Substance use disorder	27.5%	21.5%	27.1%	22.0%
Veterans	3.9%	NR	5.4%	NR

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

https://www.lahsa.org/news?article=1043-2023-greater-los-angeles-homeless-count-data and https://www.lahsa.org/news?article=1043-2025-greater-los-angeles-homeless-count-data

PRIMARY DATA COLLECTION SURVEY RESULTS

When asked about the level of importance the hospital should place on addressing the health issue, community stakeholders scored the health needs according to the table below, on 4 point scale. The top five health needs that were prioritized by community stakeholders were Access to healthcare, Mental health, Chronic diseases, Preventive practices and Senior health.

Significant Needs	Priority Ranking (Total Possible Score of 4)
Access to healthcare	3.84
Mental health	3.80
Chronic diseases	3.67
Preventive practices (e.g. screenings/vaccines)	3.53
Senior health	3.47
Substance use and misuse	3.45
Housing and homelessness	3.20
Healthy eating and physical activity	3.11
Food insecurity	3.00
Environmental health	2.74

Source: Providence San Fernando Valley 2025 CHNA Community Stakeholder Survey

Appendix 2: Community Input

METHODOLOGY: LISTENING SESSIONS

Listening Session Participants

The hospital completed 6 listening sessions that included a total of 74 participants. The sessions took place between June 2025 and August 2025.

Community Input Type	Population	Community Partner	Location	Date	Language
Listening session	MediCal population, Latinx households	San Fernando Community Health Center	Clinic site	June 2025	English
Listening session	BIPOC community members	FAME Church	Church site	June 2025	English
Listening session	Migrant households, families with children	North Valley Caring Service	Partner site	July 2025	Spanish
Listening session	Patients experiencing behavioral health and substance use disorders	Tarzana Treatment Centers	Clinic site	July 2025	English
Listening session	Seniors, older adults	ONEgeneration	Senior center	July 2025	English
Listening session	Hospital leadership team members	Providence Holy Cross Medical Center	Hospital	July 2025	English
Listening session	Hospital leadership team members	Providence Saint Joseph Medical Center & Providence Cedars Sinai Tarzana Medical Center	Hospital	July 2025	English

FINDINGS FROM LISTENING SESSIONS

Unmet Health-Related Needs

Community members were asked to discuss community health-related needs. Needs that were talked about in detail in a majority of the sessions were prioritized as high priority, while those that were talked about in four or fewer sessions were identified as medium priority. The following themes emerged:

High priority unmet health-related needs

- **Access to health care services:** Improving access to care so that all people can care for their physical well-being is critical for addressing other needs.

  "If you cannot function mentally and physically, nothing else matters. In my opinion, health care should be free. Period."—Listening Session Participant

  Participants emphasized a variety of barriers to accessing quality, affordable care, including the following:
  - Cost of care and insurance: Many participants noted needing more affordable medical care and medication. They shared anecdotes of cancer patients cancelling appointments due to the cost of medication. Even with insurance, people may have difficulties affording their care, particularly if services are denied for coverage.

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

  "Medicare covers part, but they don't cover everything. Services get denied."—Listening Session Participant

  - Long wait times for care: People shared there are long wait times for accessing primary, specialty, and urgent care. People may also have to wait to schedule surgeries. Delays in receiving care mean patients end up seeking care in the Emergency Department.

  "I see a lot of long lines outside the urgent care… people waiting to receive help."—Listening Session Participant

  - Comfort navigating resources and technology: Many people may not be comfortable navigating the complexity of health care, including many of the online systems. Patients may need paper copies of information, rather than having to navigate applications or complex websites, particularly if their primary language is other than English.

  "We need to be mindful of how fast tech is moving. People still aren't caught up with how to navigate smartphones."—Listening Session Participant

  - Transportation: Without reliable transportation, people may cancel their appointments.

  Participants shared the following community needs to improve access to care and address barriers:

  - Mobile health clinics and more creative ways of reaching people where they are: People may be afraid to come to hospitals or clinics due to immigration concerns or lack of trust. They may also have transportation barriers. There is a need to

meet people where they are and to provide more services outside the walls of hospitals and clinics, where people are comfortable and feel safe.

"I see you. This is the place where you're residing. I'm bringing care to you."—Listening Session Participant

"Think of people who have needs and have a fear of a traditional emergency room. Then, this issue is so acute… and we could have been out there, so it is safer for them in that network of community."—Listening Session Participant

"The people that you are trying to reach… you need to go to them. They may not come to you."—Listening Session Participant

- Care navigators and Community Health Workers (CHWs): More CHWs and care navigators are needed to build trusted relationships with people in the community and provide valuable support in helping them advocate for themselves. These health workers are also able to provide care to people in spaces where they feel safe and comfortable.
- Linguistically matched services: More care providers that speak the languages of the people they serve, including Spanish and Tagalog, are needed to ensure people receive care in their primary language, ideally from providers that live within the community.

"It makes a difference when providers live in the community they serve."—Listening Session Participant

- Health education and training: Health care leadership would like to see more education on strokes, advanced directives, and community health. More CPR training is also needed to ensure there is community response to emergencies.

- **Advocacy and representation**: Community members shared that more advocacy and representation is needed to address needs collaboratively. Community representation, including youth, is needed to work with government representatives to advocate for reform, particularly related to immigration. A persistent theme is that many people are afraid to leave their home because of immigration raids, affecting people's mental health and causing significant stress. People are afraid to go to the hospital or go grocery shopping, sharing that many people are "on lockdown." Community members would like more information and resources about their legal rights and to be informed of community meetings where they can share their opinions with community advocates and leaders.

"I am just scared of the current administration deporting people without due process. Immigration raids in the neighborhood brought fear and a destruction of peace."—Listening Session Participant

"There are community signs that people don't feel safe to come in [to the hospital due to immigration fears.]"—Listening Session Participant

"Where I live, we are basically on lockdown due to immigration issues."—Listening Session Participant

"It's my responsibility to make my community better."—Listening Session Participant

- **Behavioral health challenges and access (mental health and substance use/misuse)**: Most listening sessions discussed the importance of addressing behavioral health needs in the community, including providing more emotional support to individuals. There is a strong need for more behavioral health services, including community health clinics with mental health services, particularly for people experiencing homelessness and people with substance use disorders. Participants were particularly concerned about young people due to increased rates of suicidality and older adults due to social isolation. Participants shared more mobile mental health services, addiction programs, pediatric services, and routine mental health screenings are needed to support these populations. Social media content and bullying also affect mental health, particularly for young people. More community education and awareness related to mental health, particularly for parents, is needed to normalize discussions on the topic.

"We are consuming too much technology due to work and school. And at times it affects us negatively due to all the harsh topics we're exposed to online."—Listening Session Participant

"Bullying can turn into suicide."—Listening Session Participant

Medium priority unmet health-related needs

- **Affordable housing and homelessness**: Participants were concerned about homelessness in their community, stating that all people should be safely housed. They noted that homelessness affects their feeling of safety in the community and can prevent people from utilizing parks or walking in their neighborhoods. They would like to see more affordable housing and rent control in areas of the San Fernando Valley. They also noted there needs to be more homelessness services available, including supportive housing with wraparound services, job skills training, and provision of food and clothing. Treating people experiencing homelessness with dignity and reducing judgment and stigma on using these services is critical. There is also a need for more accountability from housing agencies to ensure funding is used responsibly to move people into housing and more government support for addressing homelessness.

"[People experiencing homelessness] deserve housing."—Listening Session Participant

"Porque en California hay muchas personas sin hogar?" ("Why are there so many people without homes in California?")—Listening Session Participant

"Provide solutions for the unhoused, like job skills; need training, provide resources. Wrap around services."—Listening Session Participant

"Sometimes people experiencing homelessness are too embarrassed to come get resources simply because they don't have clean clothes. That's why it is important to approach them with compassion, respect, and dignity."—Listening Session Participant

"People say they're helping people [get housing], but they're not. There is no accountability."—Listening Session Participant

- **Community connection and engagement**: To promote community involvement and engagement, participants shared there needs to be a centralized hub where community members feel safe gathering. These gatherings are important for fostering more unity within communities and helping people connect across cultures and languages. More free park events, as well as communication about those events, is needed to get people involved. Community members also noted they would like to see more volunteer opportunities and people treating each other with respect and kindness by taking care of one another and looking out for their neighbors. This is particularly important in times when people are feeling afraid and isolated.

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

"We can't quickly make our government better suited to serve us (state or country), but we can start with our communities and offer a helping hand to a neighbor in need as a good start."—Listening Session Participant

- **Community resources and outreach:** Community members shared that while there are resources available in the community, there is a strong need for more communication and outreach to the community to ensure people know how to access those resources. They suggested more intentional outreach to engage with all populations by providing information in churches, medical offices, and community events. They shared that there needs to be free internet services to help people access information online, as well as more printed flyers and resources for people that may not use social media or have a smart phone. Other community members shared social media could be used more effectively to enhance awareness. Community members noted many resources and events are not well publicized or well attended.

"We need more flyers through social media to inform and educate the community of all events."—Listening Session Participant

"There's resources that exist. They're just not well publicized."—Listening Session Participant

- **Food security**: Community members discussed the need for more grocery stores, farmers markets, and community gardens to increase access to affordable, healthy food options in the community. People noted having to travel out of their neighborhood to access a large grocery store with healthy options, while they have easy access to fast food restaurants. They would like to see markets with vendors from within the community and nutrition programs that teach families to how to prepare healthy meals on a budget. There is also a need for access to better food at food banks, with individuals wanting to be able to choose the items they receive and concerns for expired or unrelated items in food distribution bags. More information about what food resources exist in the community is also needed.

"There's too many [fast food restaurants]. We need more grocery stores."—Listening Session Participant

"We need a list of food insecurity programs and what they provide."—Listening Session Participant

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

"We need job trainings and skill development."—Listening Session Participant

"Learn a trade and you'll never be broke."—Listening Session Participant

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

"We have third graders that can't write, spell, or even read."—Listening Session Participant

- **Recreation and green spaces:** To encourage people to be active and outside, community members would like to see more parks and recreational classes and

centers. Importantly, they would like parks for families, as well as dog parks for animal lovers. More hiking and walking trails would also be beneficial. More community recreational centers, with youth programs, art and exercise classes, and sports leagues are also needed, ideally free or low cost. These opportunities would encourage people to prioritize their health and well-being and increase community engagement.

"Parks would be nice to walk around and take the kids."—Listening Session Participant

"It could be expensive for a single mother of four to place all children in sports leagues."—Listening Session Participant

- **Clean, well-maintained environment**: Participants would like to see more efforts to keep their community clean and well maintained. They noted there is a need to pave roads, maintain sidewalks, increase sweet sweeping, and add trash cans to address litter and pet waste.

METHODOLOGY: COMMUNITY STAKHOLDER KEY INFORMANT INTERVIEWS

Providence San Fernando Valley Hospitals completed 30 community stakeholder key informant between June and August 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 Medical Director and Regional Health Officer for Service Planning Areas 1 & 2 from the Los Angeles County Department of Public Health, as well as a Community Liaison Public Health Nurse, as a key informant to ensure the input from a state, local, tribal, or regional governmental public health department.

Community Stakeholders/Key Informant Participants

Organization	Name	Title	Sector
All Inclusive Community Health Center	Meri Avanesyan	Managing Supervisor	Healthcare
Boys and Girls Club of San Fernando Valley	Nicole Chase	President and Chief Executive Officer	Youth
Hope the Mission	Ken Craft	Founder and Chief Executive Officer	People Experiencing Homelessness
Ascencia	Laura Duncan, Ph.D	Executive Director	People Experiencing Homelessness
All Inclusive Community Health Center	Marine Dzhgalyan	Chief Executive Officer	Healthcare
Los Angeles County Public Health	Eric El-Togby, MD	Regional Medical Director SPA 1 & 2	Government
Los Angeles County Public Health	Amber Fayton, RN, PHN	Community Liaison Public Health Nurse	Government

Organization	Name	Title	Sector
North Valley Caring Services	Manny Flores	Executive Director	Food Insecurity
Kids Community Dental Clinic	Dale Gorman	Executive Director	Healthcare
Child Development Institute	Tessa Graham, MS, LMFT, BCBA	President and Chief Executive Officer	Youth
ONEgeneration	Jenna Hauss, MSW	President and Chief Executive Officer	Older Adults
California State University Dominguez Hills	Tiffany Herbert, Ph.D	Associate Vice President, Health and Well-Being	Education
Home Again LA	Albert Hernandez	Chief Executive Officer	People Experiencing Homelessness
California State University Dominguez Hills	Mi-Sook Kim, Ph.D	Dean, College of Health, Human Services, and Nursing	Education
Los Angeles County Department of Public Health	Seira Kurian, MD, MPH	Regional Health Officer SPA 1 & 2	Government
Watts Healthcare Foundation	Olusheyi Lawoyin, Ph.D, MBA, MPH	Chief Operations Officer	Healthcare
Comprehensive Community Health Centers, Inc.	David Lontok	Chief Executive Officer	Healthcare
Unite LA	Ilia Lopez, JD	Associate Director, Inclusion and Community Partnerships	Workforce Development
MEND Poverty	Janet Marinaccio	President and Chief Executive Officer	Social Services
Northeast Valley Health Corporation	Missy Nitescu, MS, RDN, CHSP	Chief Executive Officer	Healthcare
California State University Dominguez Hills	Thomas A. Parham, Ph.D, MA	President	Education
African American Leadership Organization, Inc.; El Proyecto del Barrio, Inc.	Marlene Rowlett	Co-Founding Member; Director, Outreach & Community Relations	Healthcare
Tarzana Treatment Centers	Jose C. Salazar, DrPH, MPH	Vice President and Chief Operating Officer	Mental Health
Armenian American Medical Society of Western USA	Sarmen Sarkissian, MD	Licensed Member; Hematologist-Oncologist	Healthcare

Organization	Name	Title	Sector
Antelope Valley Partners for Health	Tiara Sigaran, MPH	Director of Community Impact	Healthcare
San Fernando Community Health Center	Audrey Simons, MSHA	Chief Executive Officer	Healthcare
African American Leadership Organization, Inc.	Jessica R. Sullivan	Executive Director	Black Population
Armenian Relief Society, Inc.	Melanie Vartabedian	Director of Social Services	Social Services
The Village Family Services	Claudia Zamora	Program Manager, Drop-in Center	People Experiencing Homelessness
YMCA of Metropolitan Los Angeles	Lionnel Zaragoza	Senior Vice President	Social Services

Facilitation Guides

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

For the key informant interviews, Providence developed a facilitation guide that was available for use across all hospitals completing their 2025 CHNAs:

- The community served by the key informant's organization
- The community strengths
- Prioritization and discussion of unmet health related needs in the community, including social determinants of health
- Suggestions for how to leverage community strengths to address community needs
- Successful community health initiatives and programs
- Opportunities for collaboration between organizations to address health equity

Training

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

Data Collection

Key informant interviews were conducted virtually, and information was collected based on a recording of the interview with the participant's permission. 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 data were coded into themes, which allows the grouping of similar ideas across the interviews, while preserving the individual voice.

If applicable, the recorded interviews were sent to a third party for transcription, or the notes were typed and reviewed. The key informant names were removed from the files and assigned a number to reduce the potential for coding bias. The files were imported into Atlas.ti. 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 eight domains relating to the topics of the questions: 1) name, title, and organization of key informant, 2) population served by organization, 3) greatest community strength and opportunities to leverage these strengths 4) unmet health-related needs, 5) disproportionately affected population, 6) effects of COVID-19, 7) successful programs and initiatives, and 8) opportunities to work together.

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.

This process was repeated for the listening sessions using a merged set of notes. The analyst coded three domains related to the topics of the questions: 1) vision, 2) needs, and 3) strengths.

Limitations

While key informants and listening sessions participants were intentionally recruited from a variety of types of organizations, there may be some selection bias as to who was selected as a key informant. Multiple interviewers may affect the consistency in how the questions were asked. Multiple note-takers may affect the consistency and quality of notes across the different sessions.

Some listening sessions were conducted virtually, which may have created barriers for some people to participate. Virtual sessions can also make facilitating conversation between participants more challenging.

The analysis was completed by only one analyst and is therefore subject to influence by the analyst's unique identities and experiences.

Appendix 3: Community Resources Available to Address Significant Health Needs

Providence San Fernando Valley Hospitals cannot address all of the significant community health needs by working alone. Improving community health requires collaboration across community key informants and with community engagement. Below outlines a list of community resources potentially available to address community needs.

Community Resources Available to Address Significant Health Needs

Significant Health Needs	Community Resources
Access to care	African American Leadership Organization Inc., All-Inclusive Community Health Center, Central Neighborhood Christian Health Clinics, Clinica Bienestar, Comprehensive Community Health Centers Inc., Eisner Health, El Proyecto del Barrio, Inc., Kids' Community Dental Clinic, MEND Poverty, Mid Valley Comprehensive Health Center, Northeast Valley Health Corporation, ONEgeneration, San Fernando and Santa Clarita Valleys African American Infant & Maternal Mortality (AAIMM), San Fernando Community Health Center, Valley Care Community Consortium Antelope Valley Resources: AHF Healthcare Center, Antelope Valley Community Clinic, Antelope Valley Health Center, Antelope Valley Partners for Health, Bartz Altadonna Community Health Center, Catalyst Foundation, Lake Los Angeles Community Clinic Littlerock Community Clinic, Planned Parenthood, Tarzana Treatment Centers, Wesley Health Centers
Chronic disease	African American Leadership Organization Inc., All Inclusive Community Health Center, Central Neighborhood Christian Health Clinics, Clinica Bienestar, Comprehensive Community Health Centers Inc., Eisner Health, El Proyecto del Barrio, Inc., , Glendale Healthier Community Coalition, MEND Poverty, Mid Valley Comprehensive Health Center, Northeast Valley Health Corporation, ONEgeneration, San Fernando Community Health Center, SFV Burbank Non-Profit Executive Directors Coalition, YMCA of Metropolitan Los Angeles Antelope Valley Resources: AHF Healthcare Center, Antelope Valley Community Clinic, Antelope Valley Health Center, Antelope Valley Partners for Health, Bartz Altadonna Community Health Center, Lake Los Angeles Community Clinic,

Significant Health Needs	Community Resources
	Littlerock Community Clinic, Planned Parenthood, Tarzana Treatment Centers, Wesley Health Centers
Environmental health	California Communities Environmental Health Screening Tool, California Environmental Protection Agency, California Outdoor Equity Grants Program, Healthy Places Index Tool, Los Angeles County Department of Public Health, Nature For All, Pacoima Beautiful, San Fernando Calles Verdes Project, TreePeople Antelope Valley Resources: Antelope Valley Air Quality Management District, CalEnviroScreen, California Environmental Justice Alliance, Delta Conveyance Project, Earth Justice Desert Citizens Against Pollution, LARC: Los Angeles Regional Collaborative for Climate Action and Sustainability, Pure Water AV
Food insecurity	All Peoples Community Center, Burbank Temporary Aid Center, Catholic Charities of Los Angeles, Inc., El Proyecto del Barrio, Inc., Family Rescue Center, First Christian Church NOHO, Food Forward, Holy Family Church Giving Bank, Jewish Family Services LA, Loaves and Fishes Van Nuys, Making it Happen Inc., MEND Poverty, North Valley Caring Services, ONEgeneration, Salvation Army San Fernando Valley Corps, San Fernando Valley Rescue Mission, Santa Clarita Valley Food Pantry, South Antelope Valley Emergency Services (SAVES), SOVA Community Food & Resource Program, The Village Family Services, Valley Storefront Community Resource Center, West Valley Food Bank, YMCA of Metropolitan Los Angeles Antelope Valley Resources: Antelope Valley Partners for Health, Grace Resources, Iglesia El Lirio de los Valles, Los Angeles Regional Food Bank, Penny Lane Centers, SALVA, Salvation Army, South Antelope Valley Emergency Services SAVES, St Vincent de Paul, Sycamores, The Highlands, Turning Point
Healthy eating, active living and obesity	Boys and Girls Club of San Fernando Valley, Kids' Community Dental Clinic, MEND Poverty, Northeast Valley Health Corporation, ONEgeneration, YMCA of Metropolitan Los Angeles Antelope Valley Resources: Antelope Valley Boys & Girls Club, Antelope Valley Community Clinic, Antelope Valley Family YMCA, Antelope Valley Health Center, Antelope Valley Partners for Health, Bartz Altadonna Community Health Center, Lake Los Angeles Community Clinic, Littlerock Community Clinic, Wesley Health Centers
Housing and homelessness	All Peoples Community Center, Ascencia, Bridge to Home, Brownson House Community Services Center, Burbank Housing Corporation, Burbank Temporary Aid Center, Children of the Night, Chrysalis, Coalition for Responsible Community Development (CRCD), Department of Public Social Services, Door of Hope, Downtown Women's Center, El Nido Family Centers, Family Promise, Glendale YMCA, Haven Hills, Home Again L.A., Hope the Mission, Jewish Family Services LA, LA Family Housing, Los Angeles Homeless Services Authority (LAHSA), MEND Poverty, New Direction Community

Significant Health Needs	Community Resources
	Programs, New Economics for Women, NOHO Home Alliance, North Valley Caring Services, ONEgeneration, Penny Lane Centers, Safe Parking LA, Salvation Army San Fernando Valley Corps, San Fernando Valley Community Mental Health Center Inc., San Fernando Valley Rescue Mission, South Antelope Valley Emergency Services (SAVES), The Village Family Services, Valley Storefront Community Resource Center Antelope Valley Resources: Catalyst Foundation, Child & Family Center, Los Angeles Homeless Services Authority, Mental Health America of Los Angeles, Penny Lane Centers, Personal Involvement Center Inc., Pure Hearts R US, The People Concern, Turning Point, Valley Oasis Shelter
Mental health	All Inclusive Community Health Center, Catholic Charities of Los Angeles, Inc., Central Neighborhood Christian Health Clinics, Clinica Bienestar, Didi Hirsch, Eisner Health, El Nido Family Centers, El Proyecto del Barrio, Inc., Family Services Agency Burbank, Jewish Family Services LA, Leeza's Care Connections, NAMI San Fernando Valley, Pacific Clinics, Penny Lane Centers, San Fernando Community Health Center, San Fernando Mental Health Center, San Fernando Valley Community Mental Health Center Inc., Tarzana Treatment Centers, The Village Family Services, Valley Family Center, West Valley Counseling Center Antelope Valley Resources: Alafia Mental Health Institute, Antelope Valley OUTreach Center, Antelope Valley Partners for Health, Antelope Valley Vet Center, Bartz Altadonna Community Health Center, Behavioral Health Urgent Care Center, Change Lanes Youth Support Services, Child & Family Center, Families United: New Beginnings, iPrevail, Mental Health America of Los Angeles, NAMI Antelope Valley, Paving the Way, Penny Lane Centers, Personal Involvement Center Inc., Planned Parenthood, SALVA, Sycamores, Tarzana Treatment Centers, Turning Point, Two Lifestyles, Wesley Health Centers
Preventive services	African American Leadership Organization Inc., All Inclusive Community Health Center, California Primary Care Association, Central Neighborhood Christian Health Clinics, Child Development Institute, Clinica Bienestar, Comprehensive Community Health Centers Inc., Didi Hirsch, Eisner Health, El Proyecto del Barrio, Inc., Kids' Community Dental Clinic, Mid Valley Comprehensive Health Center, Northeast Valley Health Corporation, San Fernando Community Health Center Antelope Valley Resources: AHF Healthcare Center, Antelope Valley Community Clinic, Antelope Valley Health Center, Antelope Valley Partners for Health, Bartz Altadonna Community Health Center, Lake Los Angeles Community Clinic, Littlerock Community Clinic, Planned Parenthood, Tarzana Treatment Centers, Wesley Health Centers
Senior health	All Inclusive Community Health Center, All Peoples Community Center, Catholic Charities of Los Angeles, Inc., Central Neighborhood Christian Health Clinics, Clinica Bienestar, Eisner Health, El Proyecto del Barrio, Inc., Heritage Clinic,

Significant Health Needs	Community Resources
	Jewish Family Services LA, Northeast Valley Health Corporation, ONEgeneration, San Fernando Community Health Center, San Fernando Valley Community Mental Health Center Inc., YMCA of Metropolitan Los Angeles Antelope Valley Resources: Antelope Valley Adult Day Health Center, Antelope Valley OUTreach Center, Antelope Valley Senior Center, Helping Hands Senior Foundation, MomsHouse, Palmdale Legacy Commons, St Vincent de Paul
Substance use and Misuse	All Inclusive Community Health Center, Central Neighborhood Christian Health Clinics, Clare Matrix, Clinica Bienestar, CRI-Help Inc., Didi Hirsch, El Proyecto del Barrio, Inc., L.A. Community Health Project, Pacific Clinics, Penny Lane Centers, Principles Inc. Impact House, Prototypes Women's Center, Pueblo y Salud, San Fernando Valley Community Mental Health Center, Inc., San Fernando Valley Rescue Mission, Social Model Recovery Systems, Socorro Cri-Help Inc., Tarzana Treatment Centers, The Teen Project, Total Restoration Ministries, Western Pacific Med Corp. Antelope Valley Resources: Change Lanes Youth Support Services, Child & Family Center, Mental Health America of Los Angeles, Paving the Way, Penny Lane Centers, Tarzana Treatment Centers, Turning Point, Wesley Health Centers

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Appendix 4: Providence San Fernando Valley Mission Community Health Committee

Mission Community Health Committee Members

Name	Title	Organization	Sector
Teresa David	Chief Operations Officer	Facey Medical Foundation	Healthcare
Kevin Deegan	Interim Chief Mission Officer/Spiritual Care Manager	Providence Saint Joseph Medical Center	Healthcare
Dale Gorman	Executive Director	Kids Community Dental Clinic	Healthcare
Jenna Hauss	CEO/President	ONEgeneration	Social Services
Shawn Kiley	Chief Mission Officer	Providence Cedars Sinai Tarzana Medical Center	Healthcare
Sister Rosa Nguyen	Chairperson	Providence	Healthcare
Anthony Ortiz Luis	Director, Community Health, LA Valley Service Area	Providence Health and Services	Healthcare
John Paul Ramirez	Interim Chief Mission Officer	Providence Holy Cross Medical Center	Healthcare
Audrey Simons	CEO/President	San Fernando Community Health Center	Healthcare
Judy Umeck	Mission Integration Manager	Providence Health and Services	Healthcare
Terry Walker	Director, Administrative Operations	Providence Saint Joseph Medical Center	Healthcare
Judie Wilkie	Member	Providence Valley Service Area Community Ministry Board	Healthcare
Anna Maria Young	Member	Providence Saint Joseph Medical Center Foundation	Healthcare
Lionnel Zaragoza	Senior Vice President	YMCA of Metropolitan Los Angeles	Social Services