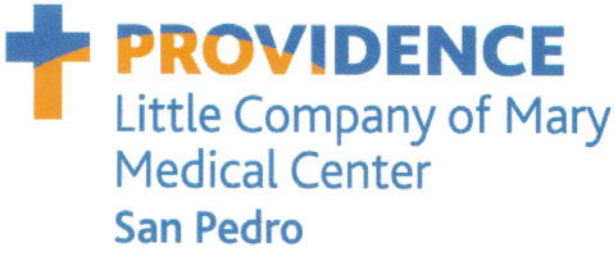
2013 TRIENNIAL COMMUNITY HEALTH NEEDS ASSESSMENT

And 2012 Annual Update

Submitted to OSHPD May 19, 2014 by



Adopted November 23, 2013 by :

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PROVIDENCE LITTLE COMPANY OF MARY MEDICAL CENTER, SAN PEDRO

PROVIDENCE LITTLE COMPANY OF MARY MEDICAL CENTER, TORRANCE

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I. Executive Summary

Mission and Purpose. As part of a continuing commitment to live out the Mission and continue to pay **special attention to the poor and vulnerable,** this 2013 Community Health Needs Assessment is jointly sponsored by:

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

For a number of years, the Providence Little Company of Mary Community Ministry Board of Directors (hereafter PLCM CMB) has delegated oversight of Community Benefit programs to a Standing Committee of the Board, the Mission Committee, while retaining oversight of the triennial needs assessment and annual update to the state regulatory agency, the Office of Statewide Health Planning and Development (OSHPD).

With the passage of the Patient Protection and Affordable Care Act, the IRS was granted expanded authority over the Community Health Needs Assessment (CHNA) process. As part of its governing responsibility, the PLCM CMB requested a briefing on what changes, if any, should be considered in the conduct of the 2013 CHNA. Ultimately, the Board approved the formation of an ad hoc Board Committee on Community Benefits (hereafter BCCB) to assure that both Medical Centers continue to stay in the forefront of Community Benefit reporting, programs, and partnerships. The Board defined the composition of the Committee and the scope of its work as: 1) Review and revise the plan for the implementation of the needs assessment, 2) Consider the needs assessment findings, and 3) Make recommendations to PLCM CMB on the adoption of priority health needs for 2014-2016.

On November 26, 2013, the Board adopted the priorities recommended by the BCCB, and separately after discussion, adopted the 2014-16 Implementation Strategy—which includes five strategies and 20 specific measurable objectives.

Providence Little Company of Mary (PLCM) outreach is based on the notion that diversity of language, culture and perspectives is an asset and that disparities can be reduced through collaboration and advocacy among stakeholders as well as resources targeted to communities with the greatest need. Collaboration with community partners and direct services to meet identified needs are the underpinnings of PLCM progress in underserved communities. Five existing programs that have accomplished specific outcomes are representative of the evolution that occurs when a commitment exists to pay special attention to the poor and vulnerable: 1) Partners for Healthy Kids, 2) Creating Opportunities for Physical Activity, 3) Community Health Insurance Project, 4 Get Out and Live and 5) Vasek Polak Health Clinic.

The Providence Little Company of Mary Community. The two Providence Little Company of Mary Medical Centers share a common governing board, overlapping geography and complementary service lines. At its July, 2013 meeting, the PLCM CMB adopted a proposed plan to conduct a joint community health needs assessment for Providence Little Company of Mary Medical Center, San Pedro and Providence Little Company of Mary Medical Center, Torrance. The two Medical Centers agreed to use a common definition of the community served and directed staff to conduct the needs assessment in the name of both Medical Centers on all forms, letters and inquiries related to the conduct of the needs assessment. The PLCM Service Area includes 14 separate municipalities and encompasses 26 distinct zip

codes in the South Bay/Harbor area of Los Angeles County with a resident population of 866,146.

Methods & Process. On August 27, 2013, the BCCB convened the first of two meetings at Providence Little Company of Mary Medical Center, Torrance. The Committee was provided a detailed accounting of 2012 Community Benefit Expenses, by Medical Center, related to 1) charity care, 2) Community Benefit Services (following Catholic Health Association guidelines) and 3) Unpaid Costs of Medi-Cal. They were briefed on the evolution of outreach to underserved communities and given a report on the ever increasing expectations that non-profit hospitals demonstrate evidence of the impact of their community benefit programs in local communities. The Committee then split into breakout sessions and engaged in discussion around three separate topics designed to provide a framework for the implementation of the needs assessment: 1) focus on economically disadvantaged communities, 2) collaboration and 3) capacity building. The Committee was also provided draft copies of the survey measures and was asked for input or suggestions prior to the onset of data collection.

The second meeting of the BCCB was convened by the PLCM CMB Board Chair on November 14th, 2013 at Providence Little Company of Mary Medical Center, San Pedro. The initial presentation summarized the four categories of data collected: 1) Secondary data from State and County sources, 2) Primary data including local nonprofits safety net organizations, a telephone survey of underserved clients and a parish survey in the Hawthorne, 3) Community input from schools, clinics, CBOs, faith based organizations and representatives of elected officials, and 4) Input from three operating units within the Los Angeles County Department of Public Health.

Results/Findings. In an effort to further refine our understanding of the top health needs in underserved communities, we employed multiple primary data collection techniques to seek input from our partners, residents of underserved communities and from community leaders in the South Bay as well as those with a Countywide perspective. Our consideration of this input, and our use of secondary data to confirm the highest need gives us strong confidence that the choices made help both Providence Little Company of Mary Medical Center in Torrance and Providence Little Company of Mary Medical Center in San Pedro be even more effective at addressing significant community health needs. Finally, our extended conversations with key informants provided us specific and concrete things we can do to improve the health care safety net in the South Bay and will lead to new resources and collaborative partners to work together and positively impact the health of our high need communities.

BCCB Recommendations to Community Ministry Board. The BCCB affirmed the need to continue with the five existing PLCM developed programs that have a track record of meeting established annual goals and objectives (Vasek Polak Clinic, Partners for Healthy Kids, Get Out And Live, Community Health Insurance Project and Creating Opportunities for Physical Activity). Understanding that resources are limited, the Committees decided that several significant needs were, in light of all the factors, not deemed a priority: assistance with affordable housing, addressing cultural and language barriers, dental care, and acute mental health care and expanding the number of providers who accept Medi-Cal

The Committee was very supportive of continued emphasis and even expansion of preventive/educational services and ranked the following significant needs, in order of priority, for inclusion in the Implementation Strategy, even if the starting point is simply related to improved collaboration: 1) Services that allow seniors to live at home, 2) Mental Health Education/ Coping Skills, 3) Skills to Navigate the Health System and 4) Parenting Education.

The Board Committee on Community Benefits made their recommendations to the Providence Little Company of Mary Community Ministry Board of Directors the priorities, which adopted their recommendations after discussion.. At its November 2013 Board meeting, the Community Ministry Board adopted the triennial community health needs assessment priorities recommended by the Board Committee on Community Benefits. After a further presentation of proposed **measureable objectives** for the next three years, composed of five objectives, or strategies, and 20 specific benchmarks linked to the five strategies, the Board approved the plan for the next three years.

One of the fundamental principles of the PLCM Community Benefit Plan is the desire to return the **value of the organization's tax exemption** to the community. For non profit hospitals in California, the value of the tax exemption is the sum of those taxes that would have been paid to the federal government, the State of California, local property tax and tax exempt bond financing. In monitoring whether the Medical Centers are giving back to local communities the value of their tax exemption, most hospital monitor three categories of expense: 1) charity care, 2) community benefit expense (consistent with CHA Community Benefit guidelines)[1] and 3) Medi-Cal shortfall. Using this standard, PLCM community benefit expense has exceeded the value of the tax exemption for the last three years by 391%, 369% and 366%, respectively. Providence Health and Services has set a more rigorous internal definition of Community Benefit for all of its local ministries by excluding Medi-Cal shortfall in determining the value of resources given back to local communities. Even under this higher self imposed standard, PLCM community benefit expense has exceeded the value of the tax exemption for all three calendar years, 2011, 2012 and 2013 by 197%, 125% and 149%, respectively.

The purpose of establishing measurable benchmarks linked to the Community Health Needs Assessment objectives is to challenge our Medical Centers to make a clear difference in South Bay communities where significant health, income and educational disparities exist across the region.The concept of committing to three year benchmarks was first approved by the governing board in 2007, as part of our triennial needs assessment and was repeated at the time of adoption of the Community Health Needs Assessment in 2010. This approach was followed again as part of the 2010 needs assessment and the result for the most recent triennial cycle documents that 72% of benchmarks were accomplished in 2011, 77% were accomplished in 2012 and 88% were accomplished in 2013. When compared to the prior 2008-2010 cycle, the most recen results were slightly improved for each of the three years 2011-2013.

[1] The Catholic Health has been in the forefront of standardized public reporting of community benefit for more than 20 years and has continued to revise its *Guide for Planning and Reporting Community Benefit, including the most recent 2012 edition, which incorporates ACA legislative requirements and CHNA requirement promulgated by the IRS, under its Rulemaking authority*

II. Mission and Purpose

A. Evolving Organizational Structures Retain Core Mission Principles

The Mission of the Little Company of Mary Sisters is reflected in the historical significance of their name: that small group of women who stood with Mary at the foot of the cross as her son Jesus lay dying. From the beginning, the Sisters' commitment to the poor and vulnerable has manifested itself through outreach to underserved communities and care of the sick and dying. In 1982, Little Company of Mary Hospital voluntarily adopted a social accountability budget and, when the organization expanded during the 1990's to include San Pedro Hospital, the commitment continued. Today, these two non profit Medical Centers:

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

have agreed to jointly sponsor this Community Health Needs Assessment (hereafter CHNA), as part of the continuing commitment to live out the Mission.

During the 1990's, the Sisters of Little Company of Mary recognized that across the American Province, their diminishing numbers threatened to undo core mission commitments and, following a period of discernment in 1998, entered into a joint sponsor agreement with the Providence Health System. During the transition years, the Sisters retained their Mission statement and, when Providence Health System merged with Providence Services in 2006, the Sisters finalized the transfer of assets and joined in the creation of Providence Health and Services. Today, the two Little Company of Mary Medical Centers are part of Providence Health & Services, Southern California and are fully aligned with both the Mission and Core Values of the Seattle based Providence Health & Services:

MISSION

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

The Providence Mission statement emphasis on special attention for the **poor and vulnerable** reinforced the original portion of the Mission of the Sisters of Little Company of Mary that spoke to ***meeting the health care needs of our communities***. In a world of interest groups and separateness the Providence Mission statement is more inclusive because it does not discriminate on a social level (*As people of Providence we reveal God's love for **all**)* and specifically directs attention to the care of the poor and vulnerable. This statement of organizational purpose reaffirms the organization's commitment to underserved communities.

B. Governing Board Involvement in Community Benefits

Like most governing boards, the Providence Little Company of Mary Community Ministry Board of Directors (hereafter PLCM CMB) has multiple standing committees that oversee hospital functions like Finance, Construction, Medical Staff, etc. As the times and organizational structures have changed, changes in standing committees has occurred. However, the Mission Committee has remained a standing committee of PLCM CMB for more than 20 years, which is a reflection of the significance the Mission has to the everyday work of employees, patients and members of local communities. The role and function of the Mission Committee, which is chaired by a Board Member of the PLCM CMB, is to oversee both internal and external Mission activities, provide a forum for community stakeholders who share our Mission commitments, and participate in and foster the work of the two Providence Little Company of Mary Medical Centers.

The Mission Committee is a group of 25 internal and external stakeholders that meets six times a year and is composed of a mix of disciplines, including representatives from health and social services agencies in the South Bay area of Los Angeles County. The Committee is always chaired by a member of the Board of Directors and includes physicians, interfaith clergy, and individuals with expertise in charity care, foundations, community-based primary care and health education. The Chair of the Mission Committee attends all meetings of the Board of Directors, reports on the activities of the Committee, and arranges for staff to brief the full board on specific programs, annual updates and the triennial needs assessment.

California Legislation Related to Community Benefit.

The passage of Senate Bill (SB) 697 in 1994 initiated a requirement that non-profit Hospitals in California conduct a triennial community health needs assessment (CHNA). The legislative history makes the point that not-for-profit hospitals such as Providence Little Company of Mary Medical Center, Torrance and Providence Little Company of Mary Medical Center, San Pedro "assume a social obligation to provide community benefits in the public interest" in exchange for their tax-exempt status. SB 697 set a new standard to gather, track, document and disseminate how not-for-profit hospitals in California provide community benefit. Even prior to these legislative requirements, Providence Little Company of Mary Hospital made efforts to measure their impact on the local community impact when they first adopted a Social Accountability Budget in 1982. While the California regulations have remained static in the intervening years, the two Providence Little Company of Mary Medical Centers have:

- raised the bar in the collection and comparison of primary and secondary data that describes and defines the most significant health needs in the South Bay region,
- reaffirmed that community outreach resources should be directed to the communities with the greatest need,
- required evaluation of community outreach programs to further inform program development and leverage results to attract new resources to underserved communities,
- placed the quality of relationships with community partners at the very top of the priority list so that collaboration is a standard rather than a platitude.

Federal Legislation Related to Community Health Needs Assessments.

With the passage of the Patient Protection and Affordable Care Act (hereafter ACA) and the expanded IRS authority over the CHNA process, the PLCM CMB requested a briefing on what changes, if any, should be considered in the conduct of the 2013 CHNA. At its July 23, 2013 meeting, the Board considered a number of factors that are part of the new regulations. The biggest changes, in the context of existing practices followed by PLCM, are around greater emphasis on transparency and in the description of the methods and processes used to conduct the CHNA. This includes how "significant" needs are identified and how input from multiple stakeholders is collected, including the local Public Health Department. In addition, the Board was advised that the IRS recommends—and the Providence Health & Services System Board has adopted—a standard of placing the CHNA on the website of each individual Medical Center in the Providence Health and Services System. The PLCM CMB was further advised that IRS enforcement authority includes a $50,000 fine per hospital facility when determined to be out of compliance with IRS regulations, in addition to potential loss of tax exempt status.

After discussion, the Board approved the formation of an ad hoc Board Committee on Community Benefits (hereafter BCCB) to assure that both Medical Centers continue to stay in the forefront of Community Benefit reporting, programs, and partnerships. The Board directed that the composition of the Committee include up to 14 members, and to the greatest extent possible, half of the members should be from the community and half from relevant Departments of both Medical Centers. The scope of the BCCB's work was defined as:

1) Review and revise the plan for the implementation of the needs assessment,
2) Consider the needs assessment findings, and
3) Make recommendations to PLCM CMB on the priority health needs for 2014-2016.

At its November 26, 2013 the Chair of the PLCM CMB (who also chaired the BCCB) introduced two staff who, using the common definition of communities served by the two Medical Centers, described the community characteristics and disparities, presented the CHNA findings, and described the process of how the CHNA was conducted and how the identified health needs were prioritized by the BCCB (See Appendix 1—Community Health Needs Assessment Timeline). After Board questions and discussion, the Chair moved to adopt of the CHNA and the PLCM CMB adopted it unanimously.

The Board then asked for the presentation of the three-year Implementation Strategy which consists of five strategies and 20 specific measurable objectives to be accomplished over the next three years. The implementation strategy will be separately published on the website of both Medical Centers. After further discussion, the Board Chair moved approval and the Implementation Strategy was also adopted unanimously.

C. Incorporating Mission Philosophy into Community Benefit

Central to our community outreach is the notion that diversity of language, culture and perspectives is an asset and that disparities can be reduced through collaboration, advocacy among stakeholders and resources targeted to communities with the greatest need. The Community Health Department, a diverse group of PLCM employees who work across the South Bay, is charged with living out the Mission in underserved communities. First and foremost are

strong relationships among stakeholders and the delivery of high quality services that are responsive to specific needs identified by the community health needs assessment in multiple community sites. (See Appendix 2—Maps of PLCM Program Delivery Sites.)

PLCM plays an active role in collaborating with a broad range of stakeholders across Los Angeles County and the South Bay which includes: three public school districts in the underserved communities; community based organizations such as clinics, churches and social groups; and public sector organizations including the Los Angeles County Department of Public Health, Los Angeles County Department of Health Services and the First 5 LA Commission. For PLCM, collaboration is a process and includes relationship building, capacity building, and strengthening partnerships with community stakeholders that share our values. The Community Health Department is composed of 46 employees (18 of whom are part time), who deliver program services in underserved communities and work with community partners to:

- Collect information about community health needs through interviews, surveys, focus groups and program evaluations which confirm and refine community health needs on an ongoing basis.
- Build new relationships and strengthen existing relationships across multiple community sectors, including: local schools (Hawthorne, Los Angeles, Lawndale and Torrance Unified School Districts), health care safety net providers (Department of Family Medicine, Harbor UCLA Medical Center, South Bay Family Health Care Center, Wilmington Community Clinic, Harbor Community Clinic, and Northeast Community Clinic), CBOs (Moneta Gardens Improvement, Inc., Harbor Interfaith Services, Wilmington YMCA, Toberman Neighborhood Center, Boys and Girls Club of Los Angeles Harbor, Richstone Family Center, Masada Homes, Training and Research Foundation, etc), and churches across the PLCM Service Area that are located in high need communities (Holy Family, St. Joseph's, Mary Regina, Sts. Peter and Paul, Faithful Central Bible Church, Islamic Center of Hawthorne, Harbor Christian Church, First United Methodist of San Pedro) .
- Work together on projects that develop capacity to sustain new programs in underserved communities (Energy Boosters, Healthy Kids Express, Lawndale After-School programs and local Neighborhood Action Councils).

A critical component of successful collaboration is the ability to provide resources that document the existence of high need communities or neighborhoods, with disparities that community Stakeholders have long suspected but do not have the data and/or expertise to confirm their beliefs. As part of this community health needs assessment, PLCM has sponsored and facilitated two local surveys that break out identified needs in specific communities that often get lost in the large data sets compiled by the County of Los Angeles or even the City of Los Angeles. With the exception of Beach Cities Health District, local municipalities or government entities generally do not collect information about the health status, attitudes or behaviors of their residents. The Results section of this report summarizes those findings and also includes other areas of need identified through key informant interviews. These information

sources, which we share with local stakeholders, further informs gaps in the safety net and promotes development of non-duplicative resources and services to address those gaps.

PLCM staff have particular expertise that strengthen existing community capacity (resources) through the delivery of program services located in underserved communities. At the same time, there is a long term objective to strengthen existing community infrastructure by encouraging other community partners to take the next step in building a network of services in underserved communities. We call this idea "capacity building" which simply means that PLCM will take the lead, when we have the expertise, to develop, operate jointly, and/or hand over programs that meet the needs of residents. These successes take time and do not come easily but when successful they create new infrastructure and simultaneously strengthen the bonds between PLCM and community organizations. Four examples of community capacity building that have occurred since 2001:

Program	PLCM Role	Handover Date/Partner	Current Status
Lawndale After School	Wrote State funding for multi-year, after school program at 6 sites, 5 days a week.	May 2001; Lawndale School District/ Richstone Family Center	8 sites currently operating (middle schools added)
Retinal Telemedicine	Lead agency for screening PPP patients for retinopathy at 3 clinic sites	December 2004; Dept. of Family Medicine Harbor UCLA Medical Center	Camera operates in Wilmington
Healthy Kids Express	Set up mobile clinics in four Hawthorne schools	December 2007; van donated to local FQHC (SBFHC)	FQHC operates
Energy Boosters Project	Wrote federal grant for school district to assure continued improvement in school day physical activity levels	October 2010; PLCM currently coordinates school wide projects, including teacher access to extranet site	All 6 sites up and operating

D. Sustaining Direct Service Programs in Underserved Communities

The problem with limiting community outreach programs to acute health care problems is that unhealthy behaviors never get addressed. When the intervention is limited to "fixing" a medical problem, the opportunity to prevent unhealthy behaviors is lost. Central to successful outreach is a dual focus on direct services for acute healthcare needs and skills based prevention services that address disparities and create health improvements in underserved communities.

The steps to developing sustainable services are: 1) to design a program with stakeholder input, 2) implement a successful pilot intervention, 3) achieve measurable results and, 4) seek out new resources to expand the program to additional high need communities. Our ability to complete this cycle is directly linked to successful results. Time and again, the two Providence Little Company of Mary Medical Centers and the PLCM Foundation have provided the initial pilot funding and we then leverage our results to attract new financial resources from private foundations and government entities, and program expansion. This cycle has repeated itself multiple times. Between 1998 and 2008, there was a 100% increase in the operating budget of community outreach programs. Since 2008, the Community Health operating budget has ranged between $3-3.5 Million annually. For 2014, the budget has been approved at $ 4.1 Million.

Five programs illustrate this process and demonstrate the value of continuing with the top priorities identified in the needs assessment:

Name	Partners for Healthy Kids
Purpose	Improve access to acute and preventive health care service
Scope of Service	Free medical care for uninsured children, 0-18, including medication, immunization, coordination of ancillary tests, screening for insurance, and referrals for specialty care
# People Served	2,429 children in 2012
Communities Reached	Wilmington, San Pedro, Lawndale, Gardena
Operating Budget	$600,000
Program Evolution	In 1994, PFHK began a mobile clinic at one LAUSD elementary school and quickly expanded to four full day sites by the end of the first school year, offering free episodic care to children in advance of the federal CHIPRA benefit. As increasing numbers of children gained subsidized insurance, the number of school sites expanded to 8, then 10, by offering half day clinics at the same schools throughout the school year. As access to medical homes for children has improved, PFHK has expanded access to immunizations for children (Tdap/HPV), in collaboration with the LAC Immunization Program. PFHK currently registers 100% of immunizations into the California Immunization Registry within 30 days of shot administration. PFHK has recently begun to pilot sub population clinical/educational interventions for children with a medical home that have a chronic condition (obesity/asthma primarily). The focus of this new path is to provide pre-post monitoring of the clinical condition based on a school based educational intervention

Name	Creating Opportunities for Physical Activity (COPA)
Purpose	To create a culture of daily physical activity in elementary schools by introducing peer coach services during the school day, after school and with parents, families and adults who are part of the life of their local schools.
Scope of Service	Physical education training for 200 teachers during the school day; Direct service after school activity programs for sub populations; Outreach to community stakeholders to support school physical activity goals
# People Served	5,254 children and adults in 2012
Communities Reached	Lawndale, Hawthorne
Operating Budget	$591,000
Program Evolution	COPA began in 2001 as separate pilot projects at two schools in Lawndale (school day) and one school in San Pedro (after school). As a successful track record was established, the after school program was expanded to 5 schools in 2005 and then with a large federal grant targeting 13 schools in 2007, the after school program was merged with the school day program and continues to operate. Outcomes of the COPA intervention validated increases in students' California Department of Education Healthy Fitness Zone performance results. As teacher training grants came to a close in Lawndale, the School District and the Medical Centers share the cost of a Physical Education Specialist and two instructors who sustain progress through school wide special events, teacher access and a new PLCM extranet site accessible to teachers for ongoing dialogue and support. Most recently, new funds have been received from US Department of Education to implement COPA across all 7 elementary schools in Wilmington, the community with the greatest needs in South Bay.

Name	Community Health Insurance Project
Purpose	Enroll children in Medi-Cal and subsidized health insurance
Scope of Service	Enrollment assistance to parents;
# People Served	1,098 children in 2012
Communities Reached	50 community partner sites throughout the South Bay
Operating Budget	$270,000
Program Evolution	Health insurance outreach and enrollment services initially began as part of services offered through the mobile clinic, Partners for Healthy Kids. In 2007, as part of a CMS funding announcement, PLCM was given a two year demonstration project to enroll children in Medi-Cal and Healthy Families, using a mobile promotora/community health worker work force. This model proved highly effective, due in part to the willingness of community partners to provide a meeting site to help parents enroll their children. Annual enrollments have averaged 800-1000 and when the grant funding ended, the Medical Centers picked up the cost of the program. During this year of transition to ACA coverage, the promotoras have been enrolling adults in Healthy Way LA (the transition coverage program for adults who meet Medi-Cal eligibility criteria for ACA) and have been trained by Covered California to enroll children and adults in ACA coverage.

Name	Get Out and Live (GOAL)
Purpose	Teach adults with diabetes how to effectively manage their diabetes, through a self care curriculum
Scope of Service	Pre-post clinical visit, followed by Stanford self-care diabetes curriculum (6 classes) and 3 additional group visit classes interspersed across the curriculum.
# People Served	208 in 2012
Communities Reached	Wilmington, San Pedro, Harbor City, Gardena, Lawndale Hawthorne & Inglewood and specified LA zip codes
Operating Budget	$287,000
Program Evolution	Community Health staff were trained in the Stanford curriculum and began offering the program initially at the Vasek Polak Health Clinic as a pilot program and then as part of educational programs offered to residents of a Wilmington housing project. As significant changes were achieved, a more formalized process of adding some "nuts and bolts" conversations with clinicians at the Clinic site and more detailed physical activity and nutrition routines at the community sites attracted funding from the California Community Foundation to develop a more formalized monitoring of GOAL outcomes. Over the past two years, the clinic patient component has sustained an average 1.5% drop in Hemoglobin A1C for a group of 200 patients. In addition, we have begun to pilot a collaboration with a local FQHC related to training their staff in delivery methods for their population of patients with uncontrolled diabetes.

Name	Vasek Polak Health Clinic
Purpose	Using a hybrid retail clinic model, establish a patient centered medical home for uninsured adults and improve access to episodic care for uninsured adults.
Scope of Service	Primary care, wellness education, self care management for chronic conditions, coordination of referrals beyond scope of primary care, insurance enrollment for eligible children and/or adults
# People Served	4,637 in 2012
Communities Reached	Primarily communities in and around Hawthorne
Operating Budget	$928,456
Program Evolution	Between 2003 and 2005, the closure of a County primary care clinic and an acute non-profit hospital in an area known as the Inglewood Health District, resulted in a significant increase in non urgent care at local Emergency Rooms. For Providence Little Company of Mary Medical Center, Torrance this resulted in a 100% increase in this category of care from the communities of Hawthorne, Lawndale and Gardena. This obvious need for new primary infrastructure care lead to the development of a primary care clinic practice that incorporated educational and linkage services for adults without insurance. Critical to keeping a low cost, high quality philosophy, the clinic uses a basic cost structure of 3 predictable prices, nurse practitioner staffing and linkage to low cost medications. Insurance is not accepted, thereby eliminating billing overhead expense. Central to the success of the clinic is the principle that patients share in the cost of their care and that clinicians and support staff link people to services beyond the scope of the clinic. In 2007, its first year of operation, the Clinic saw 1,919 patients and in 2012, 4,637 patients, a 141% increase over 5 years. Currently, the Clinic is seeking to pilot expanded physician coverage of complex cases and partnership opportunities with private specialty physicians and the County to improve continuity of care for the subpopulation of adults who are ineligible or not enrolled in ACA coverage and have specialty care needs for evaluation and/or ongoing management of their condition. In addition, the Clinic will expand self care education classes beyond diabetes in 2014.

Repeatedly, PLCM has worked to sustain the ongoing community initiatives highlighted above that are currently provided in low income, high need communities throughout the South Bay. Our success is directly linked to our collaboration with community partners, a dedicated group of employees, and government/private philanthropy partners that support the work we do. This 2013 needs assessment is designed to look at primary and secondary data in the areas we are working in, to examine whether the areas we are engaged in continue to be areas of identified need. Simultaneously, the needs assessment will be used to investigate other high priority needs that are within the scope of our expertise, resources and support from community partners, to determine what our plan will be for the next three years.

III. The Providence Little Company of Mary Community

The two Providence Little Company of Mary Medical Centers share a common governing board, overlapping geography and complementary service lines. Even before joining Providence Health and Services in 1998, the Providence Little Company of Mary Medical Centers, San Pedro and Torrance shared a common governing board and Service Area. Collectively, these two PLCM Medical Centers have a broad continuum of services and each specializes in different health care services.

At its July 23, 2013 meeting, the Providence Little Company of Mary Community Ministry Board (hereafter PLCM CMB) considered and adopted a proposed plan to conduct a joint community health needs assessment for Providence Little Company of Mary Medical Center, San Pedro and Providence Little Company of Mary Medical Center, Torrance. Consistent with IRS regulations, the two Medical Centers agreed to use a common definition of the community served by the Medical Centers and directed staff to conduct the needs assessment in the name of both Medical Centers on all forms, letters and inquiries related to the conduct of the needs assessment.

The PLCM Service Area includes 14 separate municipalities and encompasses 26 distinct zip codes in the South Bay/Harbor area of Los Angeles County[2], with a resident population of

[2] The 14 communities and their zip codes are as follows: El Segundo-90245; Hawthorne-90250, Gardena 90247,90248,90249; Lawndale- 90260, Manhattan Beach-90266, Hermosa Beach-90254, Redondo Beach-90277,90278; Torrance 90501, 90502, 90503, 90504, 90505; Harbor City-90710; .- 90717; Carson- 90745,90746,90747; Wilmington-90744; San Pedro-90731, 90732; Palos Verdes Peninsula-90274,90275

866,416. The communities served include the Cities of Hawthorne and El Segundo on the North, to the Los Angeles Harbor communities of Wilmington and San Pedro on the South, and the communities of Gardena and Carson on the East. The western boundary is the Pacific Ocean The coastal area includes upper income and affluent communities, while the communities along the northern and southern boundaries of the Service Area are among the most impoverished in Los Angeles County.

The Service Area map also highlights six separate communities which historically have reflected significant disparities—when compared to the remaining eight communities that make up the region—in terms of poverty, educational attainment, ethnicity, and the percentage of the population that owns or rents their home. These factors, called "social determinants of health" in the public health sector, are linked to health status and the prevalence of chronic conditions. Since the 1998 Community Health Needs Assessment, the Community Benefits program of PLCM—consistent with its Mission—has paid special attention to these six underserved communities: Wilmington, Harbor City, San Pedro (90731), Hawthorne, Lawndale and Gardena. As a result, significant program infrastructure and collaborative relationships have been developed for the benefit of residents of these communities.

With the formation of the ad hoc Board Committee on Community Benefit the PLCM CMB asked that the Board Committee consider this past history, and determine whether the needs assessment and implementation strategy should continue to follow a strategy of targeting available community outreach resources to these six underserved South Bay communities in light of all the relevant facts and circumstances.

IV. Methods & Process

A. The Board Committee on Community Benefits (BCCB)

The PLCM CMB formed an ad hoc Board Committee on Community Benefits (BCCB) at its July 23, 2013 meeting to assure a broad input in the community health needs assessment process from multiple community sectors. For many years, the Mission Committee of PLCM CMB has been a standing Committee that oversees the Community Benefit program and regularly reports to the PLCM CMB in terms of program accomplishments and relationships with community stakeholders. The Mission Committee Chair, who is a Member of the Board, provides continuing reports about progress towards defined goals and objectives established by each triennial needs assessment.

Since 1998, the PLCM CMB has remained strongly supportive of a distinct, separately organized Community Health Department working on behalf of both Medical Centers, responsible for reporting on the Community Benefit program to the State agency and implementing Community Benefit outreach programs in underserved communities. However, in light of new IRS regulations related to the CHNA process, the PLCM CMB asked to review the structure of the existing Community Benefit program and directed that the ad hoc Committee:

1) Review the plan for the implementation of the needs assessment
2) Review the needs assessment findings, and
3) Make recommendations to the PLCM CMB on the priority health needs and Implementation Strategy for the 2014-16 needs assessment cycle.

The PLCM CMB directed that the Committee be composed of up to 14 members, with approximately half as internal representatives from both Medical Centers and that external stakeholders represent a broad spectrum of community input, including CBO's, the faith based community, FQHC's, private foundations, local public schools, government officials and, as required by new IRS regulations, the Los Angeles County Department of Public Health. The PLCM Board Chair offered to lead the BCCB. By limiting the scope of the BCCB deliberations to two meetings, the intention was to attract a knowledgeable, diverse and experienced group of individuals, coming from local and county wide perspectives, to review the current status of the Community Benefits program, review and offer suggestions to the community health needs assessment plan, and review the results of the assessment as a group so that difficult decisions about prioritizing community health needs would truly reflect the expertise and diversity of opinion of those participating on the BCCB.

PLCM staff approached representatives of seven different organizations, including school districts, community based organizations, federally qualified health centers, faith based organizations, elected officials and the Los Angeles County Public Health Department, all of whom agreed to participate. In consultation with the Chief Executives at both Medical Centers and the Regional Chief Mission Integration Officer, seven different internal stakeholders from both Medical Centers were selected for the Committee. Internal representatives came from the Mission, Finance, Administration, Emergency and Social Work departments. Each participant received a letter from the PLCM CMB Board Chair and the Director of Community Partnerships that explained the scope of the Committee charge, a summary of the new IRS changes, and a formal request to participate in the committee. None of the Committee members were compensated for their time. (See Appendix 3—Letter of Invitation and BCCB Composition)

B. BCCB Review of Community Health Needs Assessment Plan.

On August 27, 2013, the BCCB convened the first of two meetings at Providence Little Company of Mary Medical Center, Torrance, lead by the Chair of the PLCM CMB—Michael Beaupre, who thanked everyone for attending. The members of the BCCB were encouraged to speak freely and give their honest feedback to help PLCM remain in the forefront of CHNA reporting, program development and community partnerships—particularly those communities with the greatest need. This initial meeting provided the group an opportunity to review and comment on the 2013 needs assessment plan during and after a presentation by PLCM staff and interns from the UCLA Fielding School of Public Health. The Chair noted the governing board would rely upon the expertise of individuals representing multiple perspectives across the County and the South Bay to reach points of consensus for guiding the community health needs assessment process, and that their final recommendations would be carefully considered in the Board's decision-making. He noted that the BCCB recommendations would be presented at the November 26, 2013 meeting of the Board. He also noted that the Board may consider adoption of the 2014-16 Implementation Strategy at the same meeting although technically that decision could be made as late as May 2014, based on IRS regulations.

To start, the Committee was provided a detailed accounting of 2012 Community Benefit Expenses by Medical Center and the three elements of the Community Benefit Report: 1) charity care, 2) Community Benefit Services (following Catholic Health Association guidelines) and 3) Unpaid Costs of Medi-Cal. Afterwards, they were briefed on the evolution of outreach to underserved communities by PLCM, including the specific programs that exist for children and adults related to access to health care, wellness education and linkage to community resources. They then were given a report on the ever increasing standard that non-profit hospitals are expected to reach and a developing public expectation that hospitals have a mechanism to demonstrate evidence of the impact of their community benefit programs in local communities. Specific examples from the draft IRS regulations related to Community Health Needs Assessment were provided to the Committee to further their understanding of the importance of transparency in the process, including a requirement that stipulates the general public have a mechanism to provide written comments about the Community Health Needs Assessment and Implementation Strategy. Finally, the group heard about the strongest accomplishments by PLCM outreach programs, including pre-post outcomes in three areas:

- Increase in physical activity levels in elementary age school children across 13 elementary schools in three urban, public school districts,
- Reductions in Hemoglobin A1C levels, on average, by 1.5% for 200 adults participating in a self care diabetes management program
- Enrollment of 800-1000 children annually in subsidized health insurance programs (Medi-Cal and Healthy Families), using a mobile promotora/ community health worker staffing model.

In the second hour, the Committee split into breakout sessions and engaged in three separate topics designed to provide a framework for the implementation of the needs assessment. Specifically defined so that each group would have a common understanding to work from—as well as an understanding of the rationale from a public health perspective—these topics sparked a lively discussion amongst the Committee members. Comments during the discussion were recorded by Providence Mission Leaders, and each participant had the opportunity to rotate into

all three discussion topics. At the end of these three rotations, the Mission Leaders summarized the discussion for the entire group, noted the points of consensus and reported out any topics the group thought merited further investigation during the needs assessment.

The committee was in accord that the CHNA should be consistent with the PLCM Mission—to pay special attention to the poor and vulnerable—by targeting available outreach resources to economically disadvantaged communities, reaffirming the longstanding practice of the two Medical Centers. The committee recommended PLCM continue collaborating and identifying new community partners like CBO's, FQHC's and churches to further strengthen the PLCM community safety net and to leverage capacity building to promote new leadership roles that support infrastructures for low income residents (Appendix 4—Minutes of the August 27, 2013 BCCB Meeting.) Finally, the Committee was provided draft copies of the primary data collection measures for input or suggestions for further review and consideration.

C. Review of Findings and Priority Setting

The BCCB was charged with making recommendations to the PLCM CMB on how to prioritize the needs that PLCM will address and develop an implementation strategy for focusing PLCM resources and services in those identified areas for the next three years. During this process they also had the responsibility to make a collective decision on what needs were not going to be addressed in the implementation strategy.

The second meeting of the BCCB was convened by the PLCM CMB Board Chair on November 14th, 2013 at Providence Little Company of Mary Medical Center, San Pedro. The Board Chair reviewed the first meeting and briefly talked about the challenges the Committee would face in prioritizing identified needs and balancing existing programs with new areas of consensus identified by primary and secondary data collected over the summer. The Director of Community Partnerships presented a video that described the evolution of the physical activity initiative sponsored in local school districts by PLCM. This served as an illustration about how a sustained primary prevention effort has yielded continuing documented improvements in the physical activity levels of elementary school children and in the quality of physical education instruction by classroom teachers. The results have been leveraged to attract substantial grant funding to broaden both the scope of physical activity services and an increase in the number of schools who have begun to make the changes that lead to a culture of daily physical activity.

The Director of Community Partnerships then presented to the committee a summary of the four categories of data collected during the three-month process. He noted that for this CHNA cycle, much greater emphasis and resources were placed on the collection of primary data, which yielded even better quality information than had been collected in prior needs assessment cycles and better informs on the existing health needs. He broadly identified the four categories of data collected:

1) Secondary data from State and County sources,
2) Primary data including local nonprofits safety net organizations, a telephone survey of underserved clients and a parish survey in the Hawthorne,
3) Community input from schools, clinics, CBO's faith based organizations and representatives of elected officials, and
4) Input from three operating units within the Los Angeles County Department of Public Health.

Before turning to the findings, the Director noted that the meeting presentation would focus on selecting the data that was most relevant to identified needs and useful for decision making by the BCCB. The survey that was sent to the nonprofit community partners identified 30 possible choices across three categories (Access to primary & specialty care, wellness education and connecting people to services) and asked the respondent to identify the top 3 priorities for each category. Using the scored rankings from the survey of nonprofit safety net organizations (see next section for how rankings were determined), the staff identified 15 health needs. In every case there was strong evidence in broader data sets that each of these were, in fact, among the top health needs that have been identified across Los Angeles County. The Director of Community Partnerships then returned to review the key informant interview process, the individuals who were interviewed, and the opportunities for collaboration and capacity building that came about by conducting key informant interviews.

The attention of the group was then directed to a Health Needs Priorities Worksheet (See Appendix 5—Health Needs Priorities Worksheet) which was prepared to help the group set priorities. After extended discussion identified a pared down list of 15 specific identified health needs that emerged as the result of primary care surveys (described below) of local stakeholders, with further confirmation from secondary data sources that each of these identified needs were supported by data sources assembled by respected agencies such as the Los Angeles County Department of Public Health, the California Department of Education, or the American Community Survey (U.S. Census). The worksheet also identified existing PLCM infrastructure for each of the identified needs and made a judgment that six areas were strengths and that 9 were areas of weakness. Furthermore, for each of the 15 areas a determination was made—based upon stakeholder interviews and organization surveys—whether there were any current identified opportunities for collaboration in the future.

What is Primary and Secondary Data?

Primary data is collected by the investigator during a study or project. In this CHNA, the information collected through the End User Phone Survey, the Community Organization Survey, and the Key Informant Interviews is considered primary data.

Secondary data is information collected by someone other than the user (data that is already available). Secondary Data is essential in most studies due to resource constraints and the need to have past information for comparison purposes.

With that structure explained to the Committee, there was a time period for extensive discussion on 1) which areas should NOT be part of the Implementation Strategy for 2014-16, 2) which of the programs or collaborations identified as current strengths should be continued, and 3) of the remaining identified health needs, the Committee was asked to rank how the Medical Centers should proceed in addressing these significant health needs for which there are few, if any, strong programs or collaborations in the communities defined as part of the Community Benefit program for the two PLCM Medical Centers.

The Committee then engaged in extensive discussion related to existing programs, newly identified needs, the importance of the Medical Centers providing leadership in local communities among non profit stakeholders and the value of collaboration among individuals and organizations that share a common purpose. The result of the two meetings served to form a final recommendation by the BCCB for the PLCM Board to approve the Community Health Needs Assessment (see Section VI: BCCB Recommendations to Community Ministry Board).

D. Summary of Primary Data Collection Methods

The new IRS regulations place particular emphasis on seeking out input from people who represent the broad interests of the community, including those with special knowledge of or expertise in public health. To give meaning to this new requirement, the 2013 Community Health Needs Assessment sought out input from low income residents, particularly those who reside in the six underserved communities, safety net organizations who are working with residents and a variety of thought leaders with on the ground expertise in Los Angeles County, including the Los Angeles County, Department of Public Health.

Survey of Community Organizations

A survey was sent to individuals and organizations across the South Bay who serve disadvantaged populations. Respondents were given the option to either answer through an online Survey Monkey version or mail back a paper version. (See Appendix 6—Community Organization Survey). Respondents were asked their opinion of the greatest healthcare gaps in communities they serve. Forty-six responses were returned with rankings. The survey was arranged so that respondents could rank the top three healthcare gaps for the population(s) they work with most closely: Children, Adults (age 18-64), and seniors (age 65+). Those that served all three populations were instructed to rank each age group separately. For each age grouping, respondents were asked for the top three rankings related to: Access to Primary/ Specialty Care, Wellness Education, and Connecting People to Services. There were 30 different identified needs that respondents could select from to rank and each section allowed the respondent to identify new or emerging needs. Each survey was scored in the following manner: a ranking of "1" received 9 points, a ranking of "2" received 6 points and a ranking of "3" received 3 points. The total possible points for each category were 18 points. Survey respondents were also given the opportunity to answer open-ended health related questions.

Using this ranking method, the 30 original health needs were reduced to 15. Additional primary data sources (described below) were used to better describe the top health care for deliberations by the BCCB. Further, each of these 15 significant health needs were confirmed by secondary data sources, either through zip code demographics, and/or government data maintained by City, County, State or federal data sources, or a combination of data sets.

Phone Surveys of Underserved, Low Income and Minority Populations

PLCM staff administered a telephone survey (Appendix 7—Phone Survey Questionnaire) of adults within the defined PLCM communities. Seven PLCM Community Health Department employees attended a two-hour training session to administer surveys in English and Spanish. The survey questionnaire was created using questions from the 2011 Los Angeles County Health Survey (LACHS) and selected questions from the Commonwealth Fund, a national advocacy organization formed to promote a high performing health care system—particularly for the most vulnerable populations. All questions had either forced choice or likert scale responses and addressed: health status, places where healthcare is accessed, health insurance, nutrition or physical activity, mental health, dental care, and demographics.

A randomized sample of residents was drawn from a phone list of approximately 10,000 residents who used PLCM community benefit services within the last two years. The list was organized into three zip code categories directly linked to the three underserved communities in the north (Gardena, Lawndale and Hawthorne), three undeserved communities in the south (Wilmington, San Pedro 90731 and Harbor City) and the remaining nine primarily middle/upper

communities (Coastal Communities). In total, 321 surveys were completed: 119 from the Underserved North, 103 from the Underserved South, and 99 from the Coastal Communities.

St. Joseph's Church Health Survey

In August 2013, PLCM, in collaboration with the St. Joseph's Church Community Health Coalition in Hawthorne CA, surveyed 715 parishioners, asking questions about access to care, prevalence of chronic conditions, fruit and vegetable consumption, interest in wellness programs and basic demographics. Through an entire schedule of six Sunday masses parishioners were asked during the announcement section of the Mass to participate in the survey. Before each mass, surveys and pens were placed in each pew for parishioners to pick up if they decided to participate. During the announcement segment, a coalition member stood at the podium and explained the purpose of the survey, provided instructions and encouraged participation. Parishioners were given 5-8 minutes to complete the survey; 6 staff members walked the aisles and provided help. Staff collected the completed surveys as parishioners left the mass. The goal of the survey was to assess behaviors and needs of St. Joseph's parishioners to further direct local planning to improve the health of the community. (Appendix 8—St. Joseph Survey Questions)

Key Informant Interviews

Key informant interviews of local leaders and stakeholders were conducted in order to take into account input from a broad spectrum of community experts, including the new IRS requirement to seek input from those with special knowledge or expertise in public health. In addition, since these interviews were conducted by PLCM staff, it provided an opportunity for feedback on the relationship between PLCM and the individuals representing multiple community sectors. The BCCB was highly supportive of the plan to include a broad base of input represented among multiple sectors within the community and all seven external BCCB representatives were included in the list of those to be interviewed. These sectors included:

- Community Based & Faith Based Organizations
- Private Foundations
- Federally Qualified Health Centers
- Government Officials
- LA County Department of Public Health
- Public School Districts

The Director of Community Partnerships contacted a network of partners, and 19 separate interviews were scheduled. In some cases, multiple individuals from the organization attended so a total of 26 people gave input. At least two people from each of sector participated and in some areas (Public Health, FQHC's and school districts) a more intensive outreach resulted in additional interviews. Each interview lasted approximately 90 minutes and was structured around a set list of questions. The primary purpose of each interview was to 1) clearly understand the area(s) of focus of the organization, 2) seek their input on the areas of greatest need 3) understand the organization's strategic priorities going forward, 4) explore opportunities to strengthen areas of collaboration and 5) learn about other organizations, experts or reports that further inform the needs assessment process. The full list of those who were interviewed between September 23 and November 6, 2013, are as follows:

Key Informant Interviews--List of Completed Interviews			
Name	**Title**	**Organization**	**Sector**
Alex Monteiro	Executive Director	Moneta Gardens Improvement	CBO
Tahia Hayslet*	Executive Director	Harbor Interfaith Services	CBO
Fr. Greg King*	Pastor	St. Joseph Church	Faith based
Mary Odell	President	Unihealth Foundation	Foundations
Rose Veniegas, PH.D.	Program Officer for Health Care	California community Foundation	Foundations
Christopher Lau, MD	CEO	Northeast Clinic	FQHC
Dee Clay & Judith Kraft, MD	CEO; CMO	Wilmington Community Clinic	FQHC
Jan Lee	CEO	South Bay Family Health Care	FQHC
Tamra King, Dahina Hernandez	CEO	Harbor Community Clinic	FQHC
Richard Espinosa*	Health Deputy	Office of Supervisor Don Knabe	Government
Yolanda Vera	Health Deputy	Office of Supervisor Mark Ridley Thomas	Government
Alex Li, MD, MPH	Chief Executive	Office of Ambulatory Care Network, Los Angeles County Dept of Health Services	LAC DHS
Laurel Fowler, MPH	Deputy Director	Los Angeles County Dept of Public Health--Immunization Program	Public Health
Linda Aragon, MPH	Chief of Programs and Policy	Los Angeles County Department of Public Health,	Public Health
Paul Simon MD,MPH* , and Tony Kuo MD, MSHS	Director and Deputy Director	Division of Chronic Disease and Injury Prevention , Los Angeles County Department of Public Health	Public Health
Suzanne Bostwick	Director, Maternal Child Health	Maternal, child and Adolescent Health, Los Angeles County Dept of Public Health	Public Health
Ellen Dougherty Ed.D.	Superintendent	Lawndale Elementary School District	Schools
Helen Morgan,Steve Tabor* Brian Makarian	Superintendent; Assistant Supt(2)	Hawthorne School District	Schools
Kim Uyeda MD, MPH, Dee Apodaca, RN	Director, Student Medical Services & Nursing Services	Los Angeles Unified School District	Schools
* External Member of Board Committee on Community Benefits			

E. Summary of Secondary Data Collection Methods

State and national data trends, as well as County survey data, consistently document that health disparities and health status are linked to income, educational attainment and ethnicity. The South Bay, like other areas of Los Angeles County, reflects a similar trend of geographically contiguous communities with disparate socioeconomic and ethnic divides. These stark disparities provide a clear rationale, consistent with the PLCM Mission to pay special attention to the poor and vulnerable, that explains why Community Benefit outreach resources are targeted to the most underserved communities in the Providence community. A primary purpose of this 2013 Community Health Needs Assessment is to look closely at available secondary data from local, County, State and national organizations to confirm that where we target our resources currently continues to be the communities most in need.

Data was collected from national, state and county sources regarding population demographics and health indicators. These reports and datasets are compiled from a diverse set of organizations including both private and public organizations. They include:

- Truven Health Analytics Database
- Los Angeles County Department of Public Health, 2011 Health Survey Data by Health District
- Los Angeles County Department of Public Health, LAMB (Los Angeles Mommy and Baby) Project
- California Department of Education Physical Fitness Testing Program
- Los Angeles Homeless Services Authority
- American Community Survey
- California Health Interview Survey Data by Service Planning Area

Socioeconomic demographics provided by Truven were broken out for every zip code in the defined Providence Little Company of Mary Community. This database has been used across previous triennial needs assessments and allows for more reliable tracking of trends because data collection methods and definitions remain the same. Providence Little Company of Mary has had a history in targeting community benefit resources into the six most underserved communities within the service area and the BCCB encouraged the staff to continue with that focus in assessing the needs of the PLCMSA. Therefore, to examine disparities of geographic communities within the service area, the data was grouped into communities previously identified by PLCM as having the greatest economic need. Gardena, Hawthorne and Lawndale make up the "Underserved North"; Wilmington, Harbor City and the 90731 zip code of San Pedro compose the "Underserved South"; and the remaining municipalities in the service area are labeled as the "Coastal Communities".

Further secondary data was collected on the health status indicators of morbidity, mortality, health behaviors and access to care. At the most localized level, most of the databases produce statistically significant results down to the SPA (Service Planning Area) level of Los Angeles County. Though, a notable exception is the LA County DPH Health Survey, which provided findings that were further broken down into the smaller Health Districts within SPAs. All of the communities within the PLCMSA are within SPA 8, with the relevant Health Districts being the Torrance, Inglewood and Harbor Health Districts. When applicable, this needs assessment also highlights rates for LA County or California as a comparison benchmark.

A limitation to the data collected from these secondary sources is that the way that the data is organized can mask disparities between underserved communities and the more affluent ones. In the field of public health, evidence demonstrates that in general the lower an individual's socioeconomic position the worse their health[3]. But the organization of published secondary data is structured around geographic and political groupings that do not accurately represent neighborhoods of need. For example, one of the most economically disadvantaged areas (Wilmington) and most affluent (Palos Verdes) are both located within the Harbor Health District, and the co-location of these two communities diminishes the magnitude of data results that would otherwise be identified as areas of need in Wilmington. In response to this limitation, PLCM conducted local primary data collection at the zip code level.

Community Needs Index

The Community Needs Index (CNI), is an additional tool that was first used in the 2010 CHNA to examine which communities within the PLCMSA have the greatest need. The latest CNI results were used once again to determine whether any evidence was available that showed changes in need that would cause us redirect our community benefit resources. The CNI was developed through a partnership between health data provider Truven Health and Dignity Health (a nonprofit California based health care system) and is available at no cost throughout the country.

The CNI aggregates five factors long known to contribute to health need — income, education culture/language, housing status, and insurance coverage for every ZIP code in the United States. The 2012 data set includes 2010 Census data. The developers of this needs assessment tool have concluded that the greatest potential for this standardized tool is the opportunity to target preventive health care services in areas where they are most needed. This conclusion is based upon a statistical comparison of the CNI scores with hospital admission rates for conditions where outpatient care could prevent or reduce the need for hospital admission. That analysis found that communities with the highest CNI score had admission rates 97% higher than low need communities for these manageable, preventable conditions.

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3 http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/index.html

VI. Results/Findings

A. Overview

At the local level, we implemented a variety of primary data collection techniques to seek input from our partners, residents of underserved communities and leaders on the ground in the South Bay as well as those leaders with a Countywide perspective. By seeking out these stakeholders and looking at secondary data we have a high confidence level that the choices we make going forward will help both Providence Little Company of Mary Medical Center in Torrance and Providence Little Company of Mary Medical Center in San Pedro live out our Mission in the communities of greatest need. Finally, outreach to key informants have provided a list of specific and concrete things we can do to improve the health care safety net in the South Bay delivery and will also lead to new resources and partners to work alongside us to positively impact the health of our highest need communities.

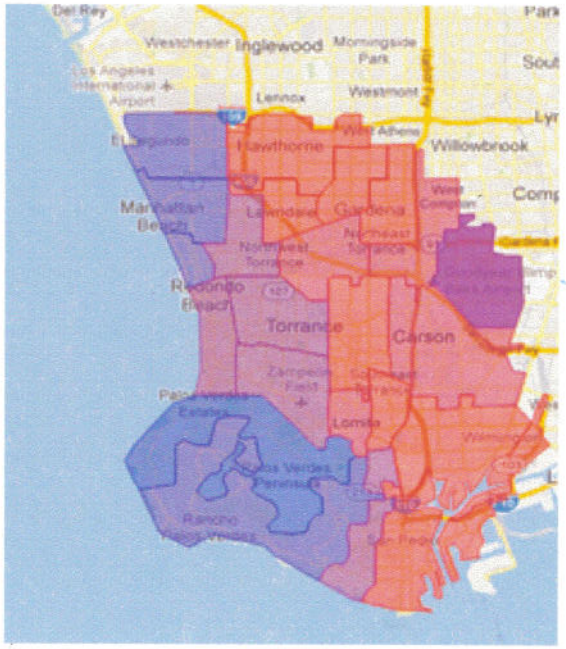
PLCM Community Health traditionally has placed special emphasis on focusing the resources into the six underserved communities within the service area. Within this report, the service area will be framed into three different regions based upon geographic and socioeconomic similarities; the Underserved North includes the three communities of Gardena, Lawndale, Hawthorne; the Underserved South consists of Wilmington, Harbor City and San Pedro 90731; and the Coastal Communities make up the remaining municipalities which typically have middle/upper income demographics.

In examining the data from the LA County Department of Public Health Survey, the data is broken into three Health Districts from within the Providence Little Company of Mary Service Area: Harbor HD, Inglewood HD, Torrance HD. The Harbor Health District is a mix of both high need (Wilmington) and low need (Palos Verdes) municipalities. The Inglewood HD has similar socioeconomic demographics to the Underserved North and South Regions, while the Torrance HD can be viewed similarly to the Coastal Communities Region. (See Appendix 9 for the full list of 2011 LA County Health Survey Results.)

The following population demographics of the Providence Little Company of Mary Service Area have been prepared to give an overall profile of the entire area and highlight the disparities that exist between and among communities in the South Bay (see Methodology section). The key findings of secondary data that are highlighted in this section were guided by the identified needs from the Community Organization Survey in conjunction with the most frequently recommended health metrics in the Center for Disease Control and Prevention's report, *Community Health Assessment for Population Health Improvement: Resource of Most Frequently Recommended Health Outcomes and Determinants*. This CDC report conducted a systematic literature review of existing Community Health Assessment guidance and resources in an effort to develop a common set of health outcome and determinant metrics that can be used by hospitals across the country. The source references included two Institute of Medicine reports, three published reports, three sets of web-based resources developed and maintained by state health departments, and two sets of web-based resources developed and maintained by professional organizations.

B. Community Needs Index Results

The CNI aggregates five factors long known to contribute to health need — income, education culture/language, housing status, and insurance coverage for every ZIP code in the United States. The 2012 data set includes 2010 Census data. The developers of this new needs assessment tool have concluded that the greatest potential for this standardized tool is the opportunity to target preventive health care services in areas where they are most needed. The index clearly re-affirmed that the six communities where we have targeted our resources, since 1997, continue to be the communities in the South Bay with the greatest need: San Pedro 90731, Wilmington, Harbor City, Hawthorne, Gardena and Lawndale. The average CNI score for these communities was 4.5 (compared to 4.6 in 2010), which means they are in the highest quintile in the country. Wilmington had the highest score with 4.8 (a decrease compared to 5 in 2010), and three zip code regions—Hawthorne, San Pedro 90731 and Gardena 90247— were ranked closely behind at 4.7. In contrast, the other regions within the Coastal Communities group had an overall average ranking of 3.0 in the mid-quintile for barriers to health care access. The range of ranking for these low to moderate need communities was 1.6 (Palos Verdes Peninsula) to a ranking of 4 (Torrance 90501, 90504 and Carson 90745). See Appendix 10 for the CNI Scores of PLCM Communities. This distribution of scores provides further affirmation of the geographic disparities within the South Bay communities. When the CNI rankings are overlaid upon the PLCM defined community, it is clear that the targeted six communities (outlined in black on the map on the left) coincides with the areas of highest need (areas in red on the map on the right).



C. Community Organization Survey Key Findings

Representatives from community based organizations selected from a 30 possible health care gap choices as well as provide open ended responses to the most significant health care issues or gaps in the South Bay. The list was narrowed down to 15 topics based upon the rankings of 46 community organizations who returned the survey by completing it online or a hard copy survey. The organizations who completed the survey and provided name and contact information (10 were not filled in) are as follows:

Organization	Name of Person Responding	Title
Richstone Family Center	Jolie Laurent	Director of Programs
Healthy African AmFamilies&CDUniv	PluscediaWilliams	Outreach Specialist & Instructor
YWCA Harbor Area & South Bay	Luz Flores	Director of Operations
Harbor Community Benefit Foundation	Mary Silverstein	Executive Director
South bay Family Healthcare	John Merryman	Senior Director
Saint Johns Well Child Family Center	Elena Fernandez	Director, Behavioral Health
Training and Research Foundation	Cynthia Littles	Health Manager
Public Health Foundation Entp—WIC	Sagario Nielsen	Area Manager
Toberman Neighborhood Center	Linda Matlock	CEO
Rainbow Services	Mario Venegas	
Behavioral Health Services, Inc	Michael Ballue	Chief Strategy Officer
Harbor UCLA Medical Ceneter	Dan Castro, MD	Dept Chair, Family Medicine
Fries Aveneue Elementary, LAUSD	Blanca Cantu	Principal
Hawaiian Avenue Elementary, LAUSD	Luis Rivera	Principal
Harbor UCLA Family Medicine	Gilbert Granado MD	Assistant Professor and Director
Gulf Avenue Elementary, LAUSD	David Kooper	Principal
Lawndale Elementary School District	Marc Milton	Director, Food Services
Wilmington YMCA	Yolanda Delatorre	Director
Hawaiian Ave. Elementary, LAUSD	Lucia Ten Have	School Nurse
Beach Cities Health District	Lisa Santora, MD	Chief Medical Officer
Eucalyptus Elementary, Hawthorne	Jorge Avila	Principal
Zela Davis STEM Prep	Kathy Carbajal	Principal
Abode Communities-Wilm Twnhomes	Angelica Escalante	Computer Instructor
NAMI, South Bay Affiliate	Paul Stansbury	Director
Kornblum School, Hawthorne	LaTima Jones	Principal
Twain Elementary School, Lawndale	Libby Barr	Principal
Toberman Neighborhood Center	Christine Jordan	Program Director
Jefferson Elementary, Hawthorne	Wendy Ostensen	Principal
S.B. Coalition for the Homeless	Nancy Wilcox	Co-Chair
Lawndale Elementary School District	Jorge Arroyo	Director, Student Supp. Services
Hawthorne School District	Brian Markarian	Asst. Supt., Educational Services
William Green Elementary, Lawndale	Jenny Padilla	Principal
FR Roosevelt Elementary, Lawndale	Denise Appell	Principal
So. Cal. Regional Occupational Center	Victoria Westerkov	Administrator
City of Refuge Church	Toy Phillips	Community Advocate

The 15 items below are ranked according to a point system that allocated the maximum points to a "1" ranking (9 points), the mid range of 6 points for a "2" ranking and the minimum (3 points) for a "3" ranking. Using this scoring, the following is a list of the top 15 identified health needs prioritized by community organizations:

Access to Care

1. Primary care medical services (a regular place to go for health care that is accessible and affordable)
2. Dental care that is affordable
3. Acute mental health services
4. Screening for acute/chronic conditions

Wellness Education

1. Mental health education/coping skills
2. Self care education programs after diagnosis (e.g. diabetes, B/P, asthma)
3. Physical activity/physical fitness (goal setting, classes, etc.)
4. Nutrition skills education (counting carbs, reading labels, etc.)
5. Parenting education
6. Education about navigating the health care system

Connecting People to Services

1. Affordable housing
2. Outreach and enrollment into health insurance
3. Cultural & language barriers to obtaining health care
4. Providers who accept Medi-Cal and Healthy Families
5. Services that allow seniors to live at home

Three general statements can be made when the complete results were tallied from the community organization survey:

1) In each of the three categories that respondents were asked to provide ratings, there was one identified need that was in the top three rankings, **across all three age groups** (0-17, 18-64, 65+): Access to primary care (access to primary & specialty care), mental health/coping skills (wellness education) and affordable housing (connecting people to services).
2) When asked an open ended question about specific issues or gaps that need to be address in the South Bay, the results were completely consistent with the point based rankings.
3) As a group, the respondents see considerable strengths across the South Bay that contribute to good health, which reinforces the notion of the importance of collaboration and capacity building.

The charts that follow on the next page and the accompanying analysis, summarize the responses received from nonprofit organization related to the healthcare needs for children, adults (18-64) and seniors:

Within the **Access to Care** category, access to primary care was identified as the top gap for each of the three of the age groups (children, adults, and seniors), out of 11 possible access to care choices. In fact, the top three needs that organizations identified for both children and adults mirrored each other, as they found both groups also having difficulty accessing dental care and mental health services, respectively. These are not surprising results, however, as it is commonly understood that the local area has a weak infrastructure of dental and mental health care providers. For the senior population, which often has more complex health conditions, access to specialty care was the next highest identified need, with screenings as the # 3 ranking:

Stakeholder Survey Rankings of Top Three Health Care Access Needs					
Children	**% of points**	**Adults 18-64**	**% of points**	**Seniors**	**% of points**
Access to Primary Care	25.6%	Access to Primary Care	24.7%	Access to Primary Care	17.5%
Dental Care	21.0%	Dental Care	20.0%	Specialty Medical Services	16.5%
Acute Mental Health Services	20.6%	Acute Mental Health Services	12.6%	Screening for Acute/Chronic Conditions	13.5%

In the category of **Wellness Education,** there were 9 wellness education choices for respondents to select and the rankings reveal the differing educational needs for different age groups. For children, mental health education & coping skills and physical activity/fitness mirror the developmental needs of children, as well as the increase in childhood obesity and sedentary behaviors. For adults, the availability of parenting education and mental health/ coping skills reflect the needs of young parents who are raising children and the beginnings of the needs to learn how to better manage chronic health conditions. Finally the wellness education of seniors reflect the need for assistance with managing chronic conditions, followed by the need to learn how to navigate the increasingly complex health care system. The growing prevalence of childhood obesity in the Providence community coincides with the physical activity rankings (21.4%), closely followed by the need for nutrition education (18.3%), which rounds out the remaining top three needs for children.

Stakeholder Survey Rankings of Top Three Wellness Education Needs					
Children	**% of points**	**Adults 18-64**	**% of points**	**Seniors**	**% of points**
Mental Health/Coping Skills	22.6%	Parenting Education	19.0%	Self Care Education	27.8%
Physical Activity/fitness	21.4%	Mental Health/ Coping Skills	17.1%	Navigating the Health Care System	20.2%
Nutrition Education	18.3%	Self Care Education	17.1%	Mental Health/Coping Skills	18.7%

There were 10 choices available in the **Connecting People to Services** category, and affordable housing was a common response by respondents across all the age groups. The senior population's top rated need of "services that allow seniors to live at home" was the # 1 need for this age group whereas for children and adults 18-64, cultural and language barriers were in the top three identified needs. Health insurance for adults has been historically been a healthcare gap, and it will be worthwhile to monitor the impact of the expansion of coverage options due to the Affordable Care Act as the end of this needs assessment cycle in 2016.

Stakeholder Survey Rankings of Top Three Needs for People who Need Services					
Children	**% of points**	**Adults 18-64**	**% of points**	**Senior**	**% of points**
Cultural/Language Barriers for Healthcare	22.3%	Affordable Housing	19.9%	Services That Allow Seniors to Live at Home	19.8%
Providers who accept Medi-Cal	21.4%	Health Insurance	18.9%	Affordable Housing	17.1%
Affordable Housing	13.5%	Cultural/Language Barriers for Healthcare	18.4%	Linkage to affordable prescriptions	14.4%

Open Ended Responses

Respondents were also given the opportunity to answer two open ended questions:

- In your opinion, what are the specific issues or gaps in the South Bay that need to be addressed?
- What part of your community contributes to good health (Ex. Neighborhood associations, volunteer groups, accessible parks, etc)?

These qualitative responses were grouped together to identify any common trends and the results primarily reaffirmed the results of the ranking section. Access to healthcare and mental health services, along with language barriers were frequently mentioned. The most common gaps identified in the section were (amount of times mentioned in parentheses):

- "Access to affordable health care services and follow up. (7)
- "Affordable mental health services. Both for prevention and treatment." (7)
- "Low income/non-English speaking households not understanding what benefits are available." (6)
- "Education/information regarding affordable or no cost health care in multiple languages" (6)

The community stakeholders revealed the impact that non-healthcare service organizations can also have on the community's health. This reinforces the need for PLCM to collaborate and build capacity with community groups such as schools, faith-based organizations and volunteer groups in order to address health needs at the preventive level. Top responses for community assets that contribute to good health were:

- "Accessible parks, schools." (10)
- "Volunteer groups, neighborhood associations, churches, community collaboration, on issues" (7)
- "Growing collaboration from service providers, including free health fairs and festivals helps create a sense of community. Working together, we do more, with less, for the greater benefit of our residents." (5)
- "Other local non profits, ties to schools." (5)
- "Programs available through the Y, Clinics like Providence, Wilmington Community Clinic, Accessibility to parks." (5)

See Appendix 11—for the full Community Organization Survey Results.

D. Secondary Data Results

Population

Since 2001, there has been a 2.6% growth in population across the 14 municipalities that make up the PLCM community. With the exception of Torrance and Manhattan Beach, at 6.7% and 3.3% respectively, the other middle/upper income communities were at or below the growth rate, with the greatest decrease (4.7%), occurring in Palos Verdes. In contrast, the underserved communities saw a growth in population, ranging from 1.7% in Gardena to 11.5% in Lawndale.

The change in population from 2010 to 2011 saw a 2.6% decline, from 889,561 to 866,416. Nine communities saw a population decrease, ranging from -8.05% to -1.07% and five increased, ranging from .19% to 1.98%. The City with the largest percentage increase in population was Lawndale (1.98%). The City with the largest percentage decrease was Harbor City (-8.05%).

Of the three groupings of communities used in this needs assessment (Coastal, Underserved North, and Underserved South) , the Coastal Communities makes up 59.6% of the service area population at 516,277; the Underserved North is 24.5% with 211,988 residents; and the Underserved South is 15.9% with 138,151 people. Collectively, the underserved communities represent just over 40% of the population, and this ratio is unchanged from the 2010 needs assessment.

Population of Communities from 2001-2011

	2001	2004	2007	2010	2011	%Increase since 2010
El Segundo	16,130	16,547	16,877	16,684	16,716	0.19%
Gardena	82,381	86,601	87,673	87,572	83,792	-4.32%
Hawthorne	88,571	98,177	97,333	98,159	93,443	-4.80%
Hermosa Beach	19,390	19,246	20,006	19,589	19,696	0.55%
Lawndale	30,667	35,309	34,630	34,077	34,753	1.98%
Manhattan Beach	34,027	35,682	37,625	38,150	35,149	-7.87%
Palos Verdes	70,482	67,610	69,249	66,317	67,150	1.26%
Redondo Beach	74,737	73,634	76,789	76,601	75,782	-1.07%
Torrance	164,594	172,936	178,037	174,847	175,628	0.45%
Harbor City	24,064	26,669	27,339	26,804	24,645	-8.05%

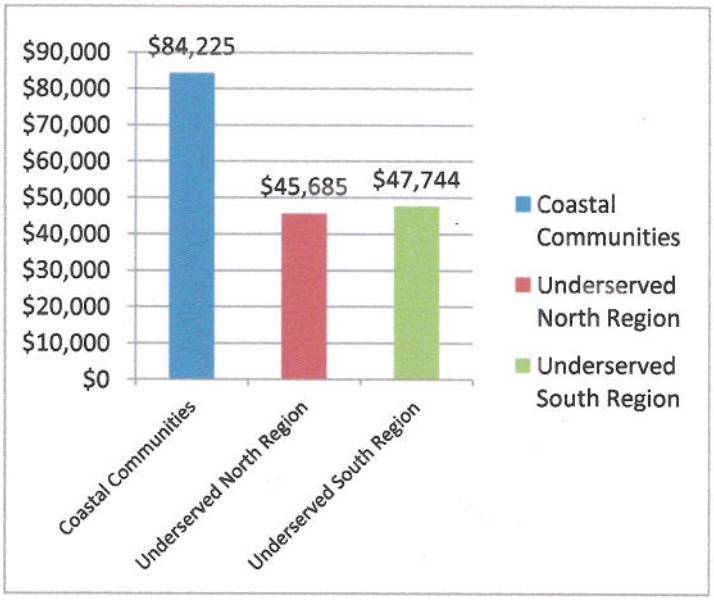
Lomita	24,192	21,022	21,599	22,431	21,787	-2.87%
San Pedro	80,741	82,245	83,480	84,720	80,664	-4.79%
Wilmington	51,162	54,012	55,623	56,888	53,891	-5.27%
Carson	82,475	84,004	87,415	86,712	83,320	-3.91%
Total Pop. Gain	**844,587**	**873,694**	**893,676**	**889,561**	**866,416**	-2.60%
Coastal Communities Region					**516,277**	*Source: Truven 2011*
Underserved North Region					**211,988**	
Underserved South Region					**138,151**	

Median Household Income

The median household income is nearly twice as high in the Coastal Communities as compared to the underserved regions. The community with the highest income is Palos Verdes Peninsula ($131, 441) and the community with the lowest income is Wilmington ($38,365) and the midpoint for all 14 communities is $73,761. These income disparities are not dissimilar from the 2010 needs assessment, with Wilmington and Hawthorne at the low end of the spectrum and Palos Verdes and Manhattan Beach at the upper end of the spectrum.

Zip	Community	Median HH Income
90245	El Segundo	$85,523
90254	Hermosa Beach	$92,969
90266	Manhattan Beach	$121,777
90274	Palos Verdes Peninsula	$131,441
90275	Palos Verdes Peninsula	$107,986
90277	Redondo Beach	$84,583
90278	Redondo Beach	$91,814
90501	Torrance	$58,313
90502	Torrance	$62,986
90503	Torrance	$70,229
90504	Torrance	$68,022
90505	Torrance	$71,720
90717	Lomita	$60,427
90732	San Pedro	$82,097
90745	Carson	$62,858
90746	Carson	$71,320
90247	Gardena	$39,726
90248	Gardena	$53,211
90249	Gardena	$53,178
90250	Hawthorne	$43,825
90260	Lawndale	$51,609
90710	Harbor City	$57,524
90731	San Pedro	$44,987
90744	Wilmington	$38,365

Source: Truven 2011

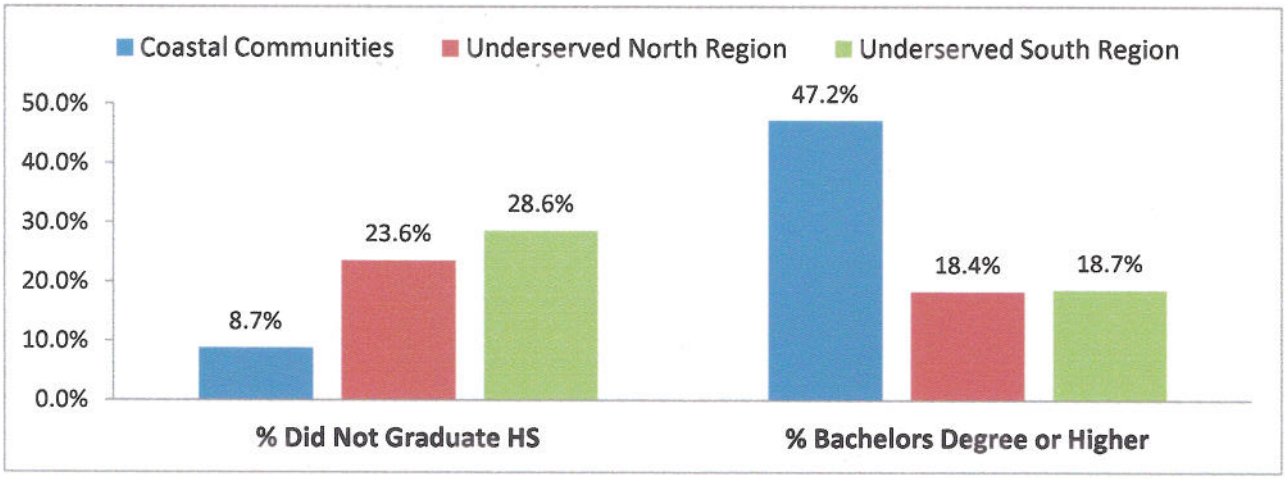


These findings are strongly linked to health status indicators and within the public health community, there is broad agreement that disparities in income and educational attainment are strong predictors for health status disparities. The Centers for Disease Control reports, "People who live and work in low socioeconomic circumstances are at increased risk for mortality, morbidity, unhealthy behaviors, reduced access to health care, and inadequate quality of care (2013). Furthermore, the most underserved neighborhoods with lowest income are clustered together geographically. This clustering can add additional burden on residents by requiring

farther travel to access health care, community services, better schools, grocery stores and recreational opportunties (Senterfitt, Long, Shih, & Teutsch, 2013)[4].

Education

There is a dramatic disparity among the Underserved North and South, compared to the Coastal Communities. At the top of the spectrum, 47.2% in the Coastal Communities have a college degree as compared to approximately 18% in the underserved regions. In contrast, residents of the Underserved North or South are at least three times as likely to not have graduated high school compared to people from the Coastal Communities.



It is well establised by population health data that the level of educational attainment has a profound correlation to health status. According to a study by Cutler and Lleras-Muney of the National Bureau of Economic Research, "an additional four years of education lowers five-year mortality by 1.8 percentage points." Furthermore, better education is linked with differences in chronic disease prevalence. Better educated people are less likely to be hypertensive, or suffer from emphysema or diabetes. It also reduces the risk of heart disease by 2.16%, and the risk of diabetes by 1.3%. The better educated are substantially less likely to report themselves in poor health, and less likely to report anxiety or depression[5].

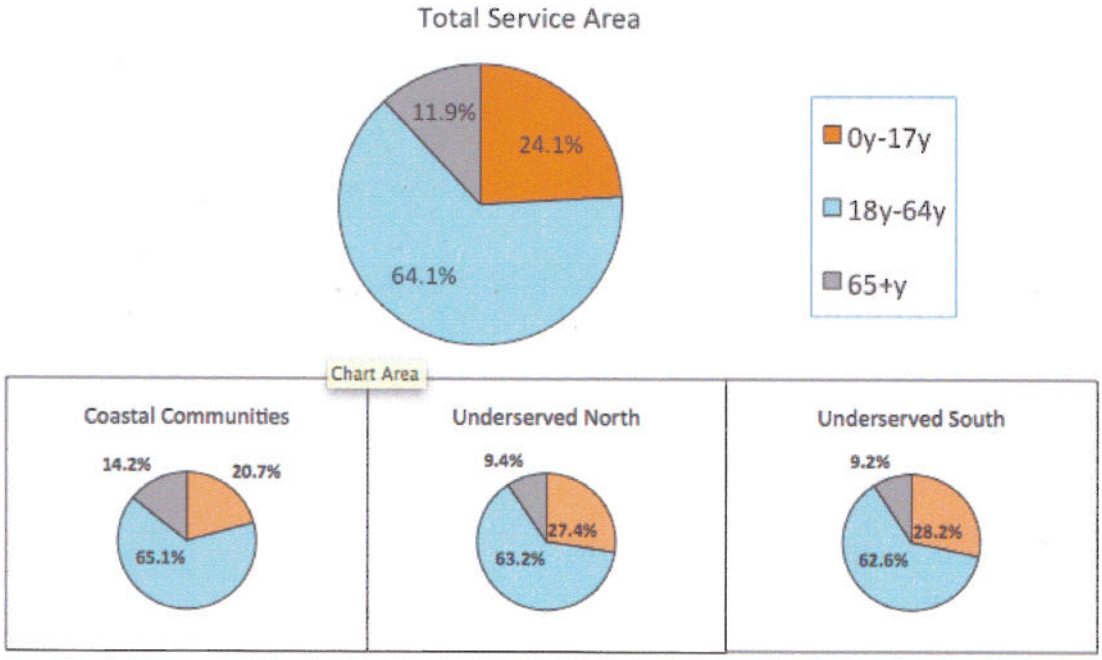
Age

The Coastal Communities are an older population with fewer children (20.7%) and more seniors (14.2%) than both the Underserved North (27.4% and 9.4% respectively) and Underserved South (28.2% and 9.2% respectively). Once again, the characteristics of the underserved communities are almost identical and the differences with the coastal communities are pronounced. The higher percentage of children in the underserved regions indicates that there are many more families that need help with both childcare and parenting education resources. For the Coastal Communities, the concentration of senior services speaks to the need

[4] Senterfitt JW, Long A, Shih M, Teutsch SM. How Social and Economic Factors Affect Health. Social Determinants of Health, Issue no.1. Los Angeles: Los Angeles County Department of Public Health; January 2013

[5] House, J., R. Schoeni, G. Kaplan, and H. Pollack (eds.) Making Americans Healthier: Social and Economic Policy as Health Policy. New York: Russell Sage Foundation, 2008.

for self care management resources for chronic conditions as well as services that allow senior to stay at home.



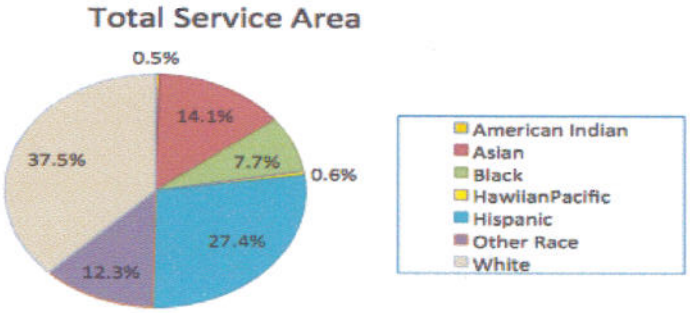
Source: Truven (2011)

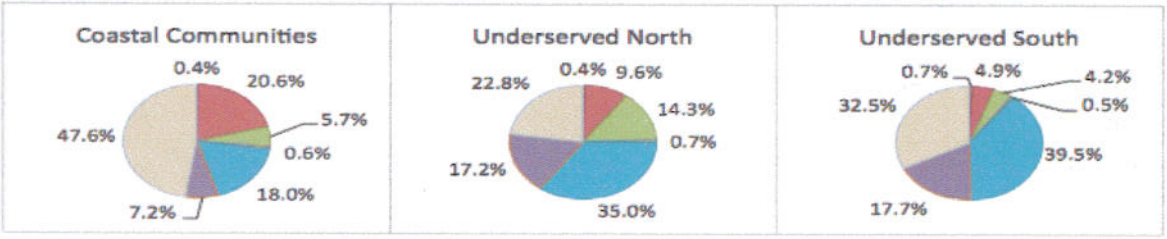
Race/Ethnicity

Overall the Providence community is ethnically diverse, with Whites being the largest ethnic group at 35.7%. The three breakout regions have distinctly different ethnic compositions: the majority racial group in the Coastal Communities is White (47.3%) while in the Underserved North and South Hispanics are the majority ethnic group (35.0% and 39.5%). The underserved north communities has a much strong Black presence (14.3%) compared to the Coastal Communities (5.7%) and the Underserved South (4.2%). The Asian community has a sizable presence (20.6%) in the Coastal Communities compared to the North (9.6%) and South (4.9%) communities and the Los Angeles County average (12.9%). This represents a 60% higher presence of Asians in the Coastal communities than the Countywide average. The ethnic breakdown by community is as follows:

	Asian	Black	Hisp	White	Other
Carson	23.1%	25.2%	36.9%	9.3%	5.6%
El Segundo	7.7%	1.3%	11.9%	73.9%	5.2%
Gardena	19.8%	24.7%	43.1%	9.3%	3.2%
Harbor City	13.6%	14.2%	46.8%	22.1%	3.3%
Hawthorne	5.3%	29.3%	51.0%	11.6%	2.9%
Hermosa Beach	4.9%	0.6%	6.1%	85.2%	3.2%
Lawndale	9.6%	12.1%	57.0%	17.7%	3.6%
Lomita	13.9%	4.5%	32.0%	44.4%	5.2%
Manhattan Beach	7.3%	0.6%	4.8%	84.2%	3.1%
Palos Verdes Peninsula	20.3%	1.0%	3.7%	71.5%	3.5%
Rancho Palos Verdes	30.2%	2.3%	6.0%	57.8%	3.7%
Redondo Beach	11.0%	2.8%	13.6%	68.0%	4.6%
San Pedro	4.7%	6.7%	45.9%	38.8%	3.9%
Torrance	31.2%	4.4%	23.0%	37.0%	4.4%
Wilmington	1.9%	3.0%	87.7%	5.4%	1.9%
TOTALS	14.1%	7.7%	27.4%	37.5%	4.0%

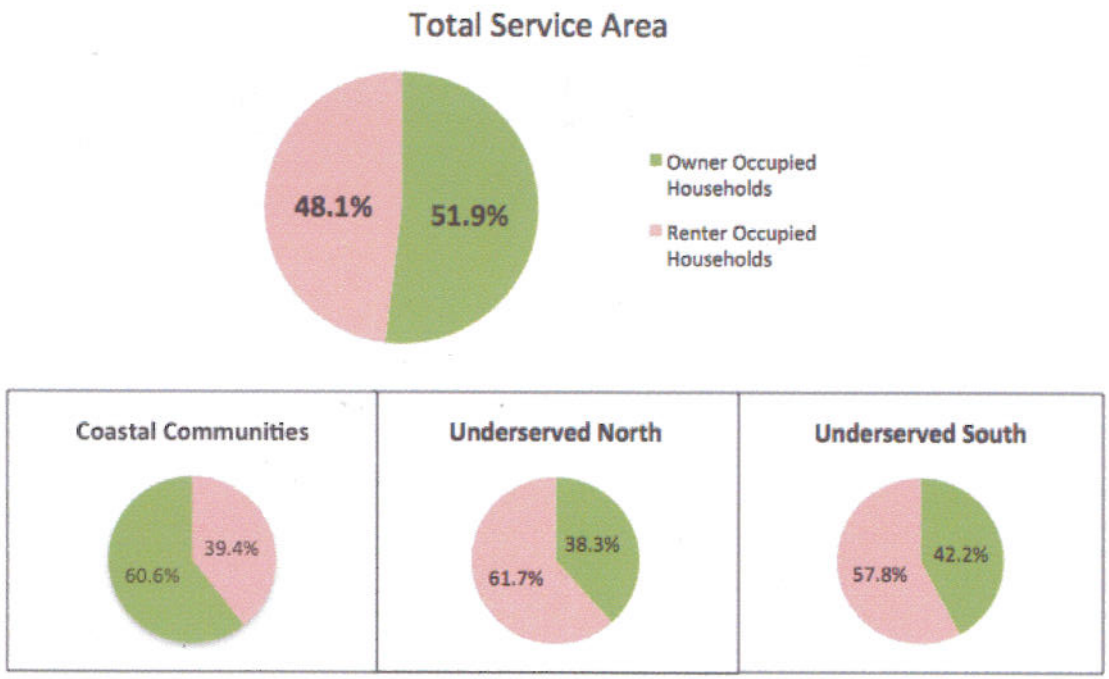
The significant Hispanic population in the Underserved communities and the primary language at home statistics reinforces the value of PLCM investments in programs that feature Spanish language services. The California Healthcare Foundation reported that Latinos in California are twice as likely as Whites to be uninsured, which reaffirms the rationale for outreach and enrollment for the Community Health Insurance Project.





Household Owners vs. Renters

In the Coastal Communities, the majority of households are owner occupied with approximately at 60/40 split. Contrastingly, the proportion for both of the Underserved Regions is the opposite with approximately 60% renters and 40% owners.



The proportion of owner occupied households to renter occupied households is another indicator of economic stability with homeownership signifying a substantial portion of a household's financial equity.

Mortality

Within Service Planning Area 8, the leading cause of death within the region was coronary heart disease with 2,029 deaths in 2009. This was more than the next four leading causes of death combined. Coronary heart disease was also the leading cause of premature death leading to 10,507 years lost. Within LA County as a whole, coronary heart disease was also the leading cause of death. The next leading causes of death for SPA 8 were lung cancer, stroke, emphysema/COPD, and Pneumonia/influenza.

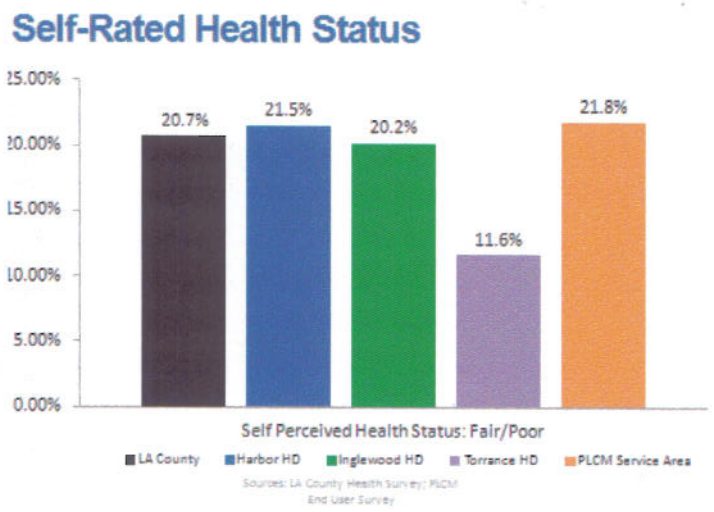
South Bay (SPA 8)
9,455 deaths
76,521 years of life lost

Leading causes of death				Leading causes of premature** death			
Rank	Cause of death	No. of deaths	Premature death rank	Rank	Cause of death	Years of life lost*	Death rank
1.	Coronary heart disease	2,029	1.	1.	Coronary heart disease	10,507	1.
2.	Lung cancer	541	3.	2.	Homicide	6,623	13.
3.	Stroke	510	8.	3.	Lung cancer	3,282	2.
4.	Emphysema/COPD	488	13.	4.	Drug overdose	3,222	18.
5.	Pneumonia/influenza	360	12.	5.	Liver disease	2,895	10.

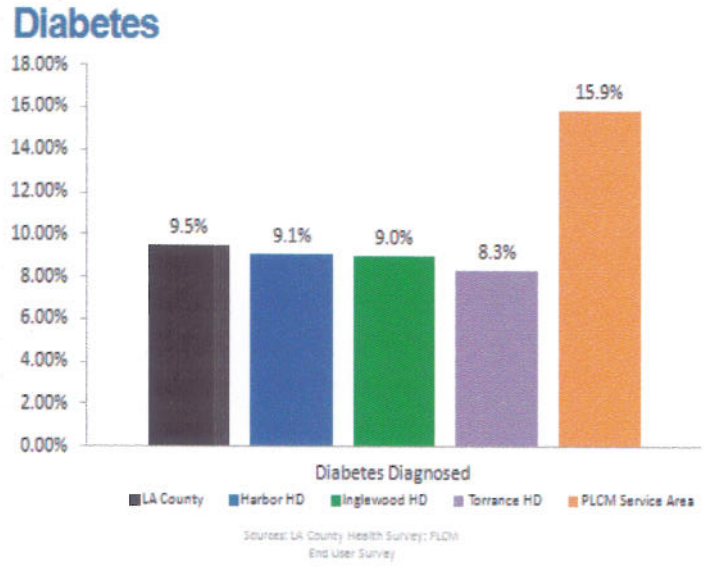
Source: LA County DPH Mortality Report (2009)

The presence of coronary heart disease (CHD) as the leading cause of death is not a new trend; rather this has been the case since across Los Angeles County since 1996. Similarly the leading cause of death, Countywide, since 1996, has been coronary heart disease. Even though CHD is the number 1 cause of death in SPA 8, it has still dropped 26.4% since 2003 from 2,758 deaths to 2,029. Similarly CHD as the leading cause of premature death has dropped 19.3% since 2003, from 13,026 years of life lost, to 10,507. This is further evidence of the need to further strengthen preventive health initiatives around physical activity and improved nutrition practices, which can further reduce the risk and impact of coronary heart disease.

Access to Care

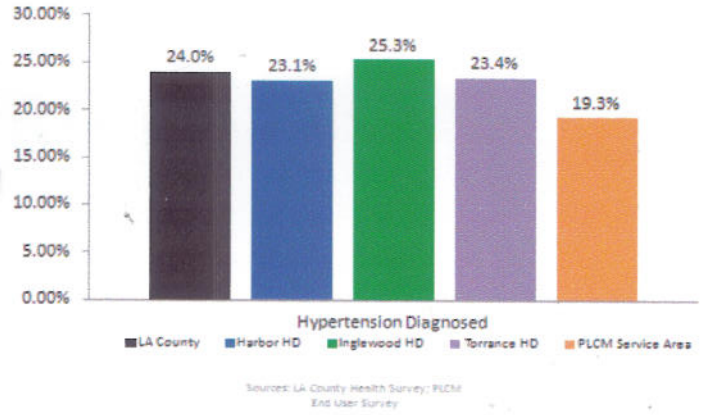


Self Rated Health: A key indicator of overall health status is the percentage of respondents who rate their health as fair/poor. The Harbor and Inglewood Health District both had 21.5% and 20.2% with fair/poor health ratings which is fairly comparable to the overall LA County rate. In contrast, the Torrance Health District only had 11.6% report fair/poor health status and the PLCM survey of underserved residents, at 21.8%. The St. Joseph survey found 34% of adults rated their health as "fair/poor", which increased to 43% for those who only spoke Spanish.



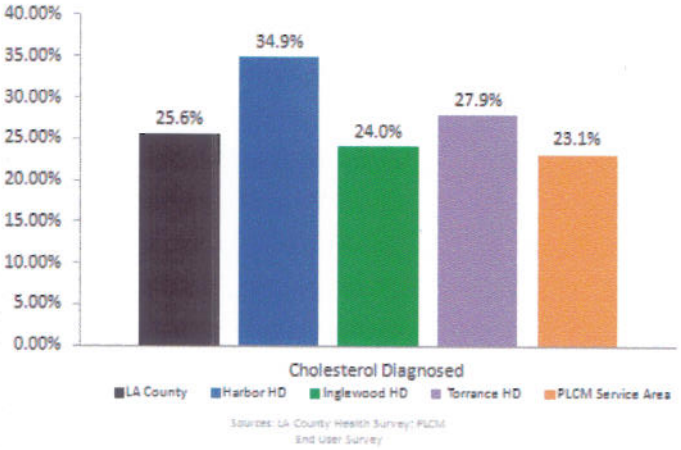
Diabetes: Secondary data shows that the health districts located in SPA 8 have a lower prevalence of diabetes than the overall LA County rate. This is likely because the geographic boundaries of the health districts do not distinguish the underserved populations within the regions. In comparison, the 15.9% of respondents in the PLCM Phone survey and 10% in the St. Joseph survey said they had been diagnosed with diabetes which gives a more complete picture of the disparities that exist in underserved communities. In context, over the past 15 years, the rate of age adjusted diabetes across L.A. County has steadily grown from 6.6% in 1997 to 9.9% in 2011.

Hypertension



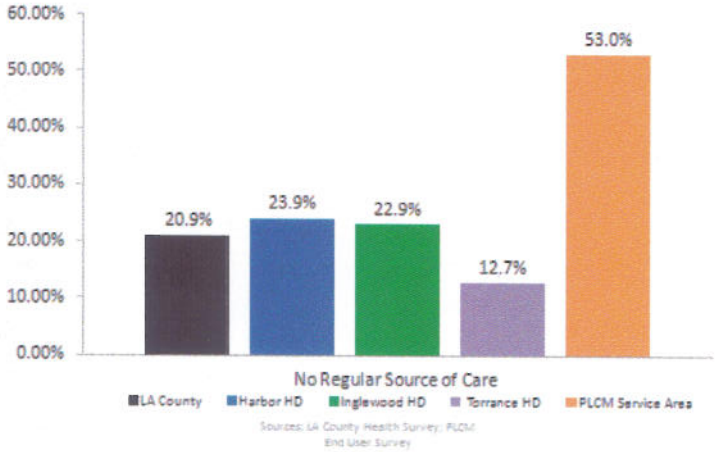
Hypertension: LA County Health Survey data shows that residents of the SPA 8 Health Districts and the County overall have a similar prevalence of diagnosed hypertension ranging between 23.1%-25.3%, yet in contrast the population from the PLCM phone survey showed a lower level at 19.3% and 20% in the St. Joseph survey. This data indicates, most likely, the need for screening of adults that are currently uninsured and asymptomatic.

Cholesterol



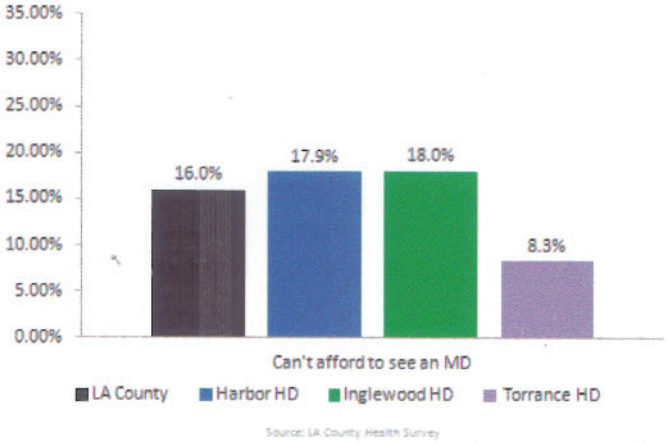
Cholesterol: High cholesterol was diagnosed in respondents less frequently in underserved areas. The Torrance HD, which closely resembles the Coastal Communities demographics, had 27.9% of the people having been diagnosed with high cholesterol, which is higher than the LA County rate of 25.6%. The Harbor HD which includes the lowest and highest need communities of Palos Verdes and Wilmington had a notably high rate at 34.9%.

No Regular Source of Care



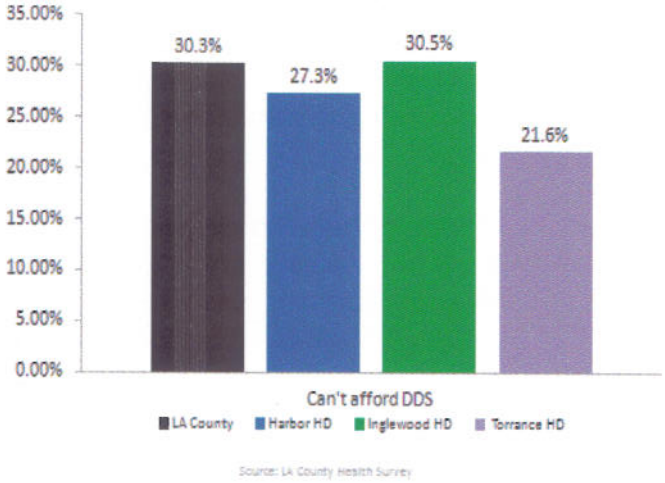
No Regular Source of Care: There is a wide disparity between the regions on having a regular source of care. Residents in the low-moderate region of the Torrance Health district (12.7%) are nearly half as likely as the other districts to have no regular source of care (23.9%, Harbor HD; 22.9%, Inglewood HD). In comparison, for the sample of adults from the phone survey who have utilized PLCM Community Health services, 53.0% responded that they did not have a regular source of care.

Can't Afford to See MD



Can't Afford to See MD: Once again there are markedly different results in the ability to afford seeing a medical doctor. The higher income Torrance HD (8.3%) is below the County rate at while both the Harbor HD and the Inglewood HD are above the rest of the County at 17.9% and 18.0% respectively.

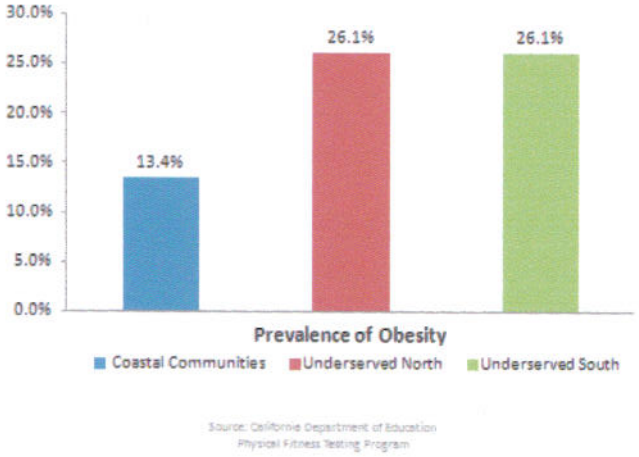
Can't Afford to see DDS



Can't Afford to See a Dentist: Across LA County, access to dental care is a significant need as 3 out of every 10 adults cannot afford to see a dentist. The Inglewood HD is fairly similar to the County with 30.5%. Though the Torrance HD has a lower percentage than the other Health Districts at 21.6%, this still represents a signification portion of adults; at least 1 in 5 adults in the Torrance HD cannot afford to see a dentist.

Access to care remains the top need in the underserved communities within the PLCM service area. A higher percentage of residents of the Harbor and Inglewood Health Districts do not have a regular source of care and cannot afford to see a medical doctor as compared to the overall LA County rate. Dental care access is also notable weakness in the health care delivery system as rates of people can't afford to see a dentist is higher than those who cannot afford to see a medical doctor. This also reflects the absence of low cost dental clinics for adults in these communities.

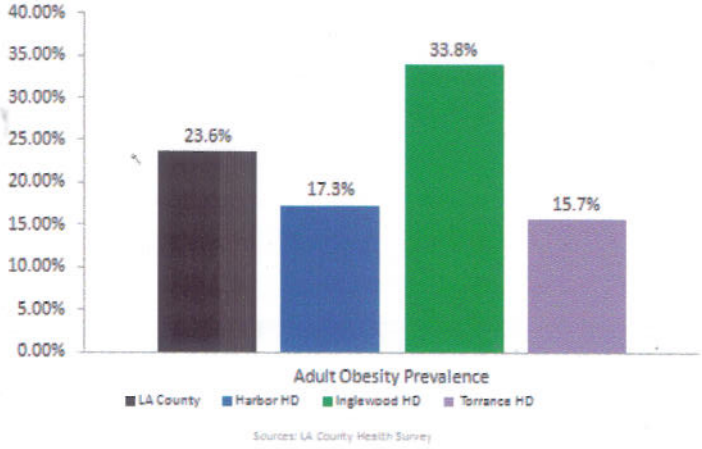
Obesity (Children)



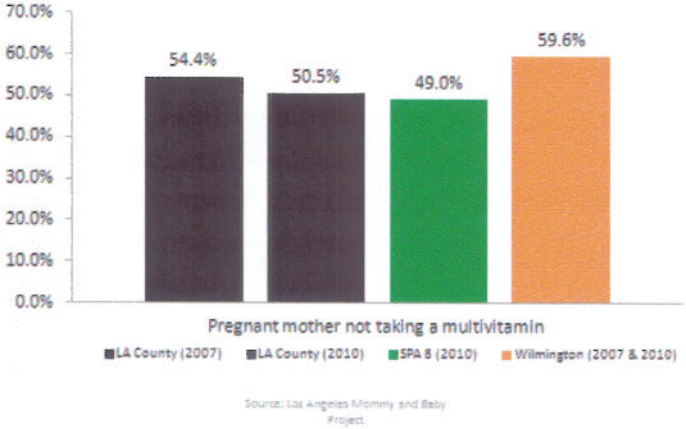
Wellness Education

Obesity (Children): Prevalence of childhood obesity shows a drastic disparity between the regions. Data from the California Department of Education showed that twice as many children in the Underserved North (26.1%) and Underserved South (26.1%) regions are obese than in the Coastal Communities

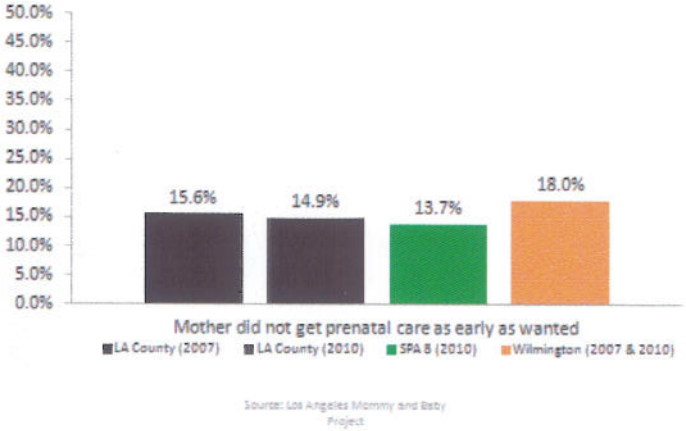
Obesity (Adults)



Parenting Education



Parenting Education



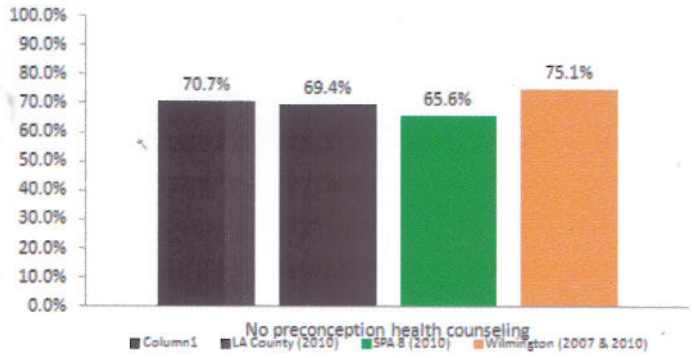
(13.4%) A special breakout of data for the Wilmington found that 40% of 5th graders are obese; a staggering 61% are considered overweight or obese (UCLA CHPR, 2010). The L.A. County Department of Public Health found that areas like Wilmington, have a higher prevalence of obesity, "…because the economic burden (higher poverty, lower educational attainment, more dependents, etc.) is greater, compared to other communities in the County." (2007).

Obesity (Adults): Results from the LA County Health Survey estimate that 33.8% of adults in the Inglewood Health District are obese compared to 17.3% and 15.7% in the Harbor and Torrance Health Districts. The higher need Inglewood HD is above the County average of 23.6%, while the other two Health Districts fall below the County's percentage. Again, the Harbor Health District includes the communities of Palos Verdes and San Pedro 90732, which skews the overall results for residents of Wilmington Harbor City and San Pedro 90731.

Parenting Education: Data from the Los Angeles Mommy and Baby Project conducted by the LA County Department of Public Health showed that mothers in Wilmington—one of the underserved communities in the PLCM service area—had worse results in a variety of maternal health indicators compared to the rest of Service Planning Area 8. These indicators included:

- "Pregnant mothers not taking vitamins" (59.6% Wilmington, 49.0% SPA 8)
- "No preconception health counseling" (75.1% Wilmington, 65.6% SPA 8)
- "Mother did not get prenatal care as early as wanted" (18.0% Wilmington, 13.7% SPA 8)

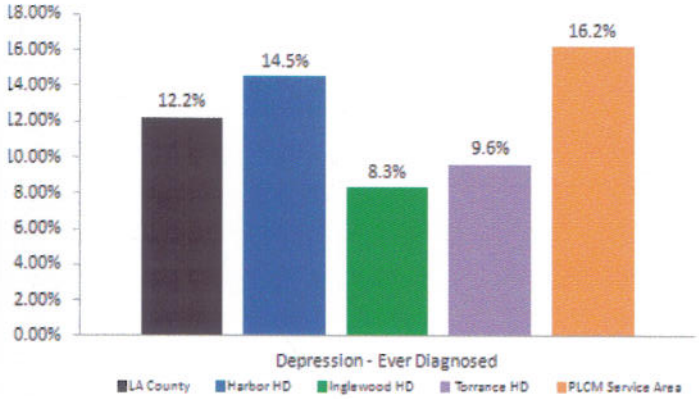
Parenting Education



Source: Los Angeles Mommy and Baby Project

The parenting education data was made available through the resources of First 5 LA which has identified Wilmington as one of 14 Best Start communities across Los Angeles County that are deserving of specials attention. Most likely, these findings would also hold true in the high need community of Hawthorne and possibly Lawndale and Gardena if it were collected by municipality. Clearly, this data establishes the need for resources to address these areas of parental education in future year.

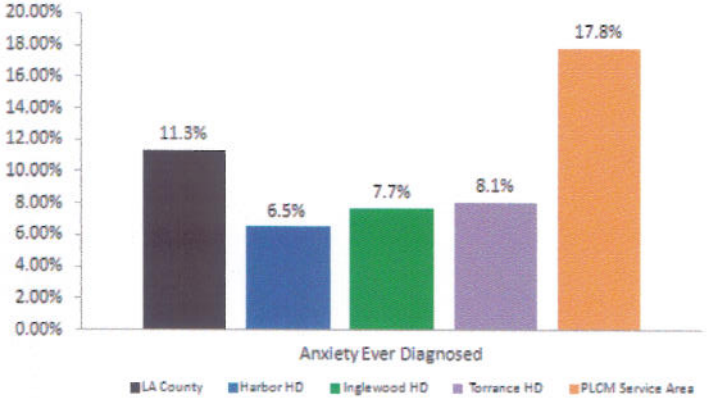
Depression



Sources: LA County Health Survey; PLCM End User Survey

Depression: In the Harbor HD, depression was diagnosed in 14.5% of the population compared to 8.3% in the Inglewood HD and 9.6% in the Torrance HD. Interestingly, both the lower income Inglewood HD and the higher income Torrance HD both had lower rates than the County average of 12.2%. PLCM asked the same question in their phone survey for comparison purposes and found that 16.2% of those they surveyed had been diagnosed with depression.

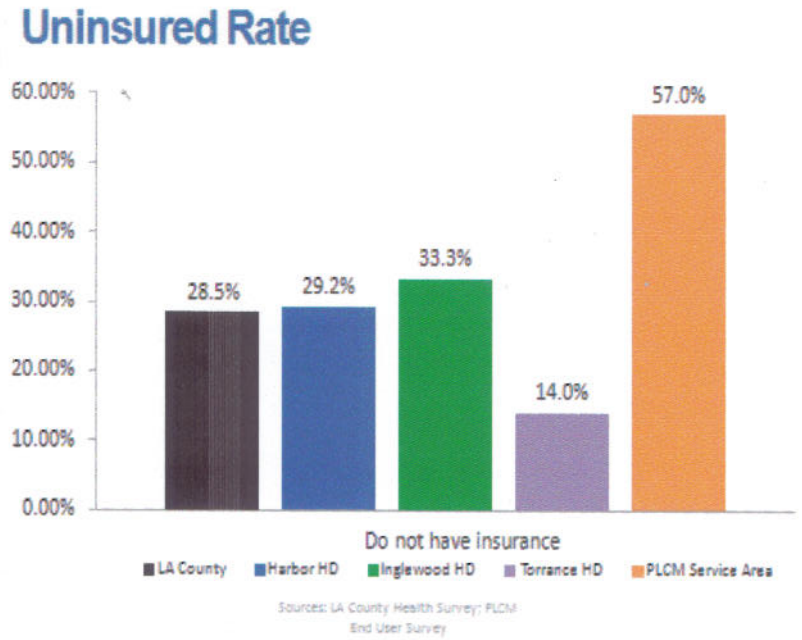
Anxiety



Sources: LA County Health Survey; PLCM End User Survey

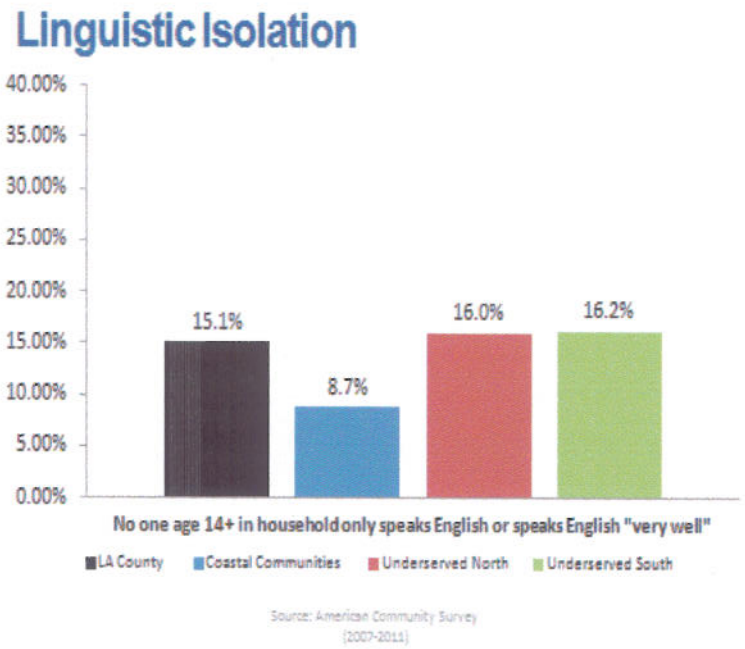
Anxiety: All of the Health Districts in SPA 8 had diagnosis rates of anxiety at 8.1% or below. These results were all lower than the 11.3% of adults in LA County. PLCM asked the same question in their phone survey for comparison purposes and found a much greater percentage of adults (17.8%) had been diagnosed with anxiety.

Connecting to Services



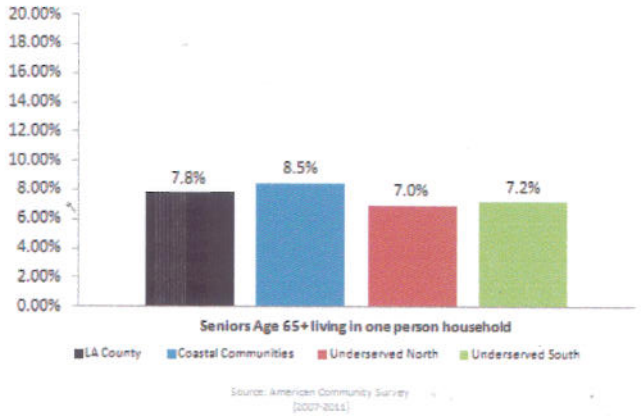
Uninsured: Data from the LA County Health Survey shows that the percentage of adults without insurance is directly correlated with socioeconomic status. In the higher income Torrance HD, only 14.0% of adults do not have insurance compared to 33.3% in the underserved Inglewood HD. The sample of adults served by PLCM Community Health who participated in the phone survey has a much higher percentage of uninsured at 57.0%.

As the eligibility requirement for health insurance changes in 2014, it is self evident that a large population of low income adults will become eligible to enrolled in health insurance, particularly Medi-Cal. In the next needs assessment, it will be noteworthy to examine the reduction in the percentage of uninsured adults as the result of ACA implementation in 2014.



Linguistic Isolation: The ethnic diversity of the PLCM communities also can mean there are language barriers for immigrant households. Data from the American Community Survey shows that more households in the Underserved North and South experience language barriers by not having people who speak English well. The percentage of people in the underserved communities is nearly twice as much as the 8.7% found in the Coastal Communities. This encourages the use of staff that speak other languages aside from English in PLCM programs, such as Spanish speaking community health workers to assist households in accessing care. This is confirmed as an identified need of "cultural and language barriers to obtaining care" from the results of the Community Organization Survey discussed in the following section.

Seniors Living Alone



Source: American Community Survey (2007-2011)

Seniors Living Alone: The number of seniors living alone corresponds with the larger population of adults over age 65 that live in the Coastal Communities compared to the Underserved North and South. 8.5% of seniors in the Coastal Communities live alone compared to 7.8% across LA County. It is likely that seniors with more financial resources have the ability to live independently. Nationally, this trend has steadily grown over the past 50 years from 5.5% in 1960 to 9.7% in 2011 (American Community Survey). Nationally, the long term premise of health care reform is that the ability to sustain cost effective health care is premised on two factors: 1) A shift to population health services designed to reduce reliance on expensive hospital care and related services, and 2) finding solutions to the large number of elderly adults who reside in skilled nursing facilities. With the surge of baby boomers upon us, solutions to this growing high need population requires a long term solution. These factors clearly demonstrate an immediate need to develop services that can assist the population of adults who are living longer to manage their health in their later stages of life. Mobilizing the development of innovative resources of the community will become an important part of the solution to this expensive and growing problem

Homelessness

	2013			2011			2011-2013	
	Total Homeless	Hidden Homeless	Shelter & Street Count Only	Total Homeless	Hidden Homeless	Shelter & Street Count Only	Changes in Total Homeless	Changes in Shelter & Street Count Only
LA County	53,798	18,274	35,524	45,422	10,800	34,622	+8,376 (+18.4%)	+902 (+2.6%)
SPA 8	5,811	3,644	2,167	6,788	4,143	2,645	-977 (-14.4%)	-478 (-18.1%)

Source: LAHSA

Homelessness: There is very limited local data on homelessness available. Data from the Los Angeles Homeless Services Authority showed that there was a total of 53, 798 total homeless in LA County. Within SPA 8 there was decrease of 14.4% in the amount of homeless people between 2011 and 2013. Most of the decrease can be attributed to a 44.4% decrease in sheltered homeless, while unsheltered homeless increased by 9.4%. Key informant interviews with a large homeless services organization provides evidence that the need for housing services, particularly permanent supportive housing far outstrips available community based resources.

E. PLCM Phone Survey Key Findings

(See Appendix 12 for full listing of PLCM Phone Survey Results)

Characteristics of Survey Participants

- A large majority of participants were women. 73% were female and 26% were male.
- 75% of the people who responded identified themselves as Hispanic. This is consistent with the large proportion of Hispanics served by PLCM programs. When Hispanics and Other races are combined the rate of response is more closely aligned with the presence of Hispanics in underserved communities.
- The level of educational attainment was low, when compared to data cited earlier for the PLCM community: 31% did not finish high school and 9% had a BA or higher.
- 67% had a household income less than $30,000. 78% had a household income less than $40,000.

Chronic Disease

- 16% reported they had been diagnosed with **diabetes**
- 19% reported they had been diagnosed with **hypertension**
- 23% reported they had been diagnosed with **high cholesterol**
- 18% reported they had been diagnosed with **anxiety**
- 16% reported they had been diagnosed with **depression**

Insurance Coverage

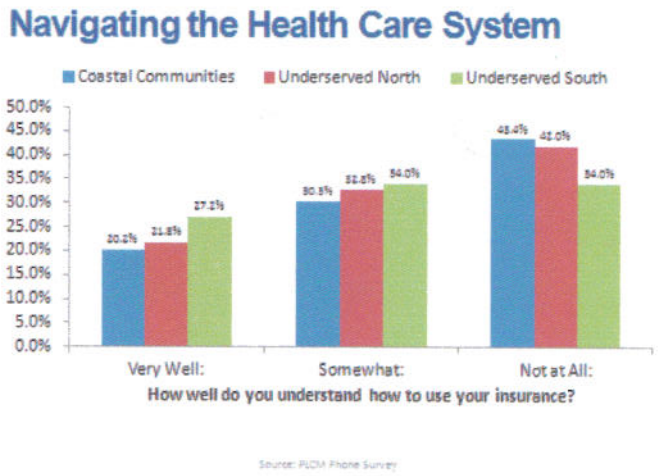
- 57% reported that they were uninsured.

Transportation Method for Medical Care

- 77% either drove themselves or had someone they knew drive them to access medical care. This reflects the geographic nature of Los Angeles that a car is a primary method of transportation. For populations without access to a car, they may experience a transportation barrier in accessing care.

Navigating the Health Care System

The Underserved North and Underserved South have more people who understand how to use their health insurance compared to those in the Coastal Communities. Taking into the context that the sample of people from the PLCM Phone Survey is all from underserved populations, the results make sense. The majority of the population sampled had a form of public health insurance such as Medi-Cal. Within the Undeserved Regions there is a stronger infrastructure of health care providers who care for lower socioeconomic patients.



Respondents from within the Coastal Communities who are enrolled in Medi-Cal may have had private insurance plans in the past that they are more accustomed to utilizing, and therefore are unfamiliar with how to access care through Medi-Cal.

F. St Joseph's Church Health Survey Key Findings

(See Appendix 13 for full listing of St. Joseph's Survey Results)

The health survey of parishioners at St. Joseph Church in Hawthorne yielded a clear picture of a majority Spanish speaking population with somewhat greater health needs and obstacles to health care and preventive health services than residents who participated in the PLCM telephone survey. This survey may have higher validity because a high percentage of those attending church responded to the survey.

Characteristics of Survey Participants

- Spanish was the dominant language group of the people surveyed. 35% of those surveyed responded back in English and 65% responded in Spanish.
- Nearly twice as many women participated compared to men. 66% of the participants were female compared to 34% males.
- 56% were residents of Hawthorne/Gardena. Lennox residents made up the second largest group (19%); 15% lived in Inglewood; and 20% were from Lawndale.
- 92% were between 18- 65.

Self-rating of Health

- 34% of respondents rated their health as either fair or poor; for Spanish speakers this result was 43%, for English speakers the result was 17%
- 36% of females rated their health as either fair or poor compared to only 27% of males.

Last Visited Doctor

- 35% had not seen a doctor in at least 1 year and 18% in at least two years.
- 23% of English speakers surveyed had not seen a doctor in at least 1 year, compared to 42% of Spanish speakers.

Where do you usually go for care?

- 20% reported that they had no regular place of care or that they used a hospital Emergency Room as a usual source of care.
- 24% of Spanish speaking respondents reported no regular place of care or that they used a hospital ER compared to only 11% of English speakers.
- The PLCM Phone Survey found similar results. 18% of those surveyed in the PLCM Phone Survey did not have a usual place of care or used the Emergency Room.

Nutrition

- 10% responded they ate 5+ fruits and vegetables the day before compared to 16.2% LA County.
- Only 74% reported access to fresh fruit and vegetables was somewhat easy or very easy. The percentage across the county was 89.7%. In comparison, the Harbor HD reported

78.4% while the Torrance HD had 98.6%. The question was also asked in the PLCM phone survey—83% reported somewhat easy or very easy access.

Chronic Disease

- 10% of adults reported that they had been told by a doctor or other health professional that they had diabetes.
- 20% reported that they had been diagnosed with high blood pressure or hypertension. This was consistent with the PLCM Phone Survey result of 19.3%.
- 23% reported that they had been told by a doctor that they had high cholesterol. This was similar to the 23.1% who reported high cholesterol in the PLCM Phone Survey.

G. Key Informant Interview Results

Public Health

The Los Angeles County Department of Public Health (hereafter DPH) is a large multi-faceted organization with an enormous challenge: Improve health and decrease disparities related to the occurrence, severity and consequences of chronic diseases for 10 million people. Our interviews with leaders across the Division of Chronic Disease Management and Injury Prevention as well as Maternal Child Health and the Immunization Project reflected the DPH view that partnering with local communities and organizations as a key strategy to accomplish their Mission. DPH seeks to provide technical assistance that will help community partners influence local policies that change norms, promote healthier behaviors, and address the underlying conditions that create or aggravate disparities.

This perspective reflects a shift away from the traditional health education services delivery model to a community change model that looks at political readiness and identification of local leaders who are passionate about public health issues. The DPH approach is to provide the tools and training to local individuals and organizations who share a common purpose of improving the health of the population and decreasing disparities within and across communities. They support organizations who continue to function as service delivery providers for individuals and groups through data, letters of support and participation in task forces. For example, joint use agreements between non profits and government entities, school districts and affordable housing corporations require significant consultation but once complex issues of risk are solved it opens up a range of physical spaces that can be used by local organizations to improve access to physical activity and nutrition education services, thereby supporting the DPH Mission.

Across DPH, staff identified during key informant interviews a number of specific areas of current interest:

- Joint Use related to active living (physical activity and nutrition)
- Healthy Hospitals (improvements in vending machine and cafeteria choices)
- Tobacco Free Hospital Campuses
- Baby Friendly designations (related to exclusive breastfeeding rates)
- Healthy Aging and alternatives for allowing seniors to live at home
- Recording of all immunizations for children in CAIR database
- Provider education related to ordering, administration and billing for immunizations

DPH also has a number of projects provided directly, or in collaboration, that address complex health issues that have shown to be susceptible to improvement, particularly in high need communities (i.e. Nurse Family Partnership program, Childhood Lead Poisoning, models to increase physical activity and nutrition practices among school age children, and Project LEAN).

DPH representatives expressed strong interest in collaborating on local initiatives, convening stakeholders to address priority needs and/or discuss best practices and acting as a neutral third party related to data exchange. Examples included collection, analysis and/or summary of hospital to improve coordination of health care for sub populations like frequent ER users, where the end result would be designed to demonstrate improved regional care coordination outcomes.

DPH staff provided the names of experts who could help facilitate an implementation strategy objective such as a Healthy Aging Scorecard, access to Countywide data sets (i.e. C-Section, flu shot, Tdap and HPV compliance) to establish baseline data for further consideration of new areas of interest in program development, collaboration or capacity building.

Federally Qualified Health Centers/Los Angeles County, Department of Health Services

The South Bay area of Los Angeles County, like many other regions, has a fragmented health care delivery system for low income residents resulting from a mix of historical trends, lack of a shared common identity among residents (compared to areas like Long Beach or San Fernando Valley), the presence of a County tertiary safety net hospital and a private sector that has long focused on the insured population. Over the past two decades, much of what has been familiar has changed irrevocably: the County Hospital no longer accepts most private hospital patient transfers; the PPO population has shifted to either a managed care/capitation model or multiple variants of consumer choice (high deductible health plans); and health care reform is causing major movement towards shifting primary care for the low income population to FQHC's, requiring hospitals/physicians to shift their mindset from a fee for service perspective to a prevention model that is community based.

Historically, since 1998, the County has had contractual relationships with community clinics (virtually all of whom have converted to FQHC's in the last 10 years) to provide a flat rate, primary care visit to low income, uninsured residents. Until clinics converted to FQHC status, specialty care for their patients was only available though LAC DHS specialty clinics. The federal government has pushed encouraged clinics to become FQHC's both to improve patient access throughout the County but also because the cost of primary care at an FQHC is significantly lower than through the County.

Within this Countywide context, there are four FQHC's that are present in the PLCM Service Area and they reflect various levels of growth and sophistication in a turbulent marketplace where access to primary care is difficult because of geography and transportation patterns. Across each organization, the needs of their patient population are remarkably similar: addressing the needs of higher acuity adults with chronic conditions and helping them to effectively manage their disease(s) is clearly the top priority for each FQHC, followed by access to specialty care, integrating mental health services into the primary care practice and the availability of community based prevention resources that support their patients trying to maintain or improve their health.

Each of the FQHC's identified varying levels of threat, based in large part on their relative size so that the larger FQHC's had greater concerns about managing financial risk while the smaller FQHC's were more concerned with patient volumes and visit rates. A looming

pressure point is the extent to which FQHCs access LAC DHS specialty clinics or shift those patients to an IPA that is governed by and contracted with the local Community Clinic Association of Los Angeles County. There is concern by all but one FQHC about this potential conflict but little expectation that it will be resolved in the near future. As a result, 2014-16 are likely to be years of coping with patient growth and which of the service delivery models prove to be financially sustainable.

On a more positive note, all of the FQHC's interviewed spoke highly of their existing relationship with PLCM and are prepared to collaborate on specific initiatives which match their individual strategic goals (i.e. Management of chronic conditions, data exchange, access to specialty care, health insurance enrollment/retention, identification of sub population disparities, etc). Two of the FQHC's were very interested in the capacity building concept and a number of topics were discussed during the interviews (ie. Workflow redesign, data collection, quality assurance consultation, etc.,) that might further strengthen the existing collaboration with PLCM. At this point in time, LAC DHS was unable to determine a specific collaboration but is prepared to consider specific proposals as the impact of new patients under health care reform becomes clearer.

Community and Faith Based Organizations

In contrast to the healthcare and public health sectors, the needs of community and faith based organizations are more concrete and specific. In every case, the organizations interviewed have a core purpose that is distinct from healthcare but which impacts their ability to achieve their core purpose when their constituency is sick and/or does not have appropriate access to health care. Generally speaking, each organization needs one or more of the following health related services to be effective at achieving their organizational purpose:

1) primary health care that is accessible and affordable for their clients/parishioners
2) mental health education and basic coping skills for everyday living
3) access to services for [primarily] adults with chronic health care conditions
4) assistance with linkage to survival resources, transportation and prenatal/child care

There was a consensus among these stakeholders that some of these issues could be resolved or improved simply through better coordination, which might include the formation of focused ad hoc task forces to clearly define where the gaps are, determine whether there is an existing safety net resources exists to close the gap and monitor any specific action items that come from these task force groups. At the same time, all of those interviewed felt that many of the specific gaps are due to the absence of service providers in accessible locations to provide the one-to- one or group services that are needed to resolve the identified needs.

Within the context of the specific needs identified, the key informants expressed a willingness to provide the space to carry out specific services if PLCM or other organizations could provide them on site. They recognized that health services must be provided in a clinic setting but that support, education and access to care services could be provided at their facilities and in many cases their client/ parishioner base would feel more comfortable with that type of arrangement, for a variety of transportation, cultural and in some cases, ideological reasons.

In each case, the key informant described the current relationship with Providence in strongly supportive terms and expressed a clear interest in continuing and building upon what has been accomplished so far. A portion of the interview also addressed the characteristics of

what makes for good partnerships and as part of that discussion, various positive attributes were attributed to the following safety net programs: St. Margaret Center, Lennox Health Center, DCFS Torrance, Richstone Family Center, Didi Hirsch Mental Health, south Bay Center for Counseling and Department of Family Medicine at Harbor UCLA

School Districts

Key informant interviews with the leadership of the three urban public school districts with whom PLCM has long standing relationships primarily described needs based upon their relative size: the LAUSD—second largest school district in the country—has a level of specialization and bureaucracy that is fundamentally different than the two smaller school districts. This has an impact on the relationship between the Districts and PLCM which has been navigated successfully over the years but does result in some disconnects as the LAUSD administration goes through continuing changes in how they are organized at the local District level in relationship to the downtown central office.

All three Districts share the needs for immunizing their students, programs that address the needs of teachers and students related to primary care, improvements in physical activity and nutritional behaviors, acute mental health services/ skills education for children and support for parents in a variety of health, mental health and parenting education services. Each District has substantially different needs and resources related to special populations, including foster children, homeless and special education students.

All three Districts describe a strong positive relationship with PLCM based on the long term history with the mobile clinic that visits their schools. Each pointed to the collaborative immunization clinics that occur routinely before, during and at the end of the school year and reported improved compliance for their District/sub area as a result of that collaboration. In addition, each expressed a sense of gratitude at the continual willingness of PLCM to seek out resources for the benefit of their students and families and believe it has strengthened the relationship. Each school district mentioned the strength of the teacher training model/physical activity initiative and the presence of promotoras providing health insurance outreach and enrollment.

The smaller school districts described a strong collaborative relationship with PLCM and a greater interest in future involvement and coordination with other community based organizations as a strategy to improve access to health and educational services, both for students and their adult family members. The smaller school districts have both adopted very clear goals and objectives related to health and so it is easier to define how PLCM can support them in achieving their strategic plans. Since the unmet need in LAUSD schools is akin to how LAC DPH attempts to meet the needs of communities with the greatest need because it is not feasible to address health and wellness consistently across the District, LAUSD is more dependent on PLCM being more proactive in communicating what programs and/or resources are within the scope of what PLCM can provide at LAUSD schools. LAUSD staff did indicate that it would improve the relationship if PLCM could provide more communication about specific services being provided at LAUSD schools, including putting the clinic appointment schedule on the LAUSD intranet.

When asked to identify organizations with whom they have strong relationships, the smaller districts identified a long list of organizations, including Richstone Family Center, South Bay Work Investment Board, South Bay Center for Counseling, SpaceX, Didi Hirsch, Starview, Schiernow Dental , the local law enforcement agency . LAUSD staff identified County systems

with whom they interface as their strongest partners, including Public Health, CHDP, and local FQHC's that have operating agreements with the School District.

Elected Officials and Private Foundations

The inclusion of representatives of private foundation and elected officials in the key informant interviews was designed to tap into what each sector is hears from constituents about the greatest healthcare needs of Los Angeles County residents. In both sectors, a clear understanding of the need facilitates implementation of programs, services and support systems that improve the health of individuals and communities. The interests of these two sectors diverge based upon the interests of their constituencies: for elected officials, the primary interest is the equitable distribution of available resources whereas in the private foundation sector it is about making choices around which grantees have the capacity to help the foundation accomplish their Mission.

In Los Angeles County, it is generally accepted that the health deputies of the individual members of the Board of Supervisors have a strong sense about the collective needs of County residents because their primary responsibility is to continually update their Supervisor as to what is going on at the ground level related to health that impacts the Supervisorial District. Both deputies interviewed recognize both the enormity of this challenge and the impact of social determinants on the health of individuals and communities. Health Deputies must keep on top of the problems and challenges encountered by individual constituents and organizations while at the same time trying to advance defined health priorities of their individual Supervisor. Both deputies identified multiple specialized multiple County resources they were aware of that might assist PLCM with data needs or specific implementation strategies being considered. Looking forward, they expect the primary health-related challenge will be to help residents understand that good health is not about specific health services but rather about how factors like work, physical activity, economic development and social cohesion all play a significant role in how healthy we are as children and into adulthood. Finally, when asked about the relationship between the County and a private hospital community benefit program, both deputies recommended regular email updates, attendance at Supervisor events, sharing data about the number of people impacted and the quality of results.

The private foundation sector tends to reflect the mission and core values of the individual foundations. During the key informant interview, each described the organization history and the strategies currently in place to accomplish their core purpose. As such, the Unihealth Foundation is primarily set up to support the work of hospitals in Los Angeles and Orange County and they support individual grantees, research related to critical health delivery issues and support for community benefit priorities of Hospitals. Both Foundations are strongly supportive of collaborative relationships and their relationships with Hospitals are meant to incorporate a partnership of common interests. The California Community Foundation (CCF) has a substantially broader funding portfolio beyond hospitals due in large part to its history and tradition of encouraging donor advised funds for which the Foundation functions as a fiduciary. In the area of Health, CCF places great importance on understanding the strategic direction of L.A. County, academic and health care institutions and staff work across the spectrum of these perspectives to advance improvements in health care delivery and a stronger nonprofit sector. Both foundations indicated their willingness to function as a convener, as appropriate, encouraged ongoing communication about PLCM priorities and provided specific resources and contacts that could provide support or technical assistance for PLCM implementation strategies

VII. BCCB Recommendations to Community Ministry Board

Through discussions and review of the CHNA findings at the November 14th meeting (See Appendix 14 for Minutes of the November 14, 2013 BCCB Meeting), the Committee affirmed the need to continue with the five existing fully developed programs (Vasek Polak Clinic, Partners for Healthy Kids, Get Out And Live, Community Health Insurance Project and Creating Opportunities for Physical Activity) that have a track record of meeting established annual goals and objectives. Understanding that resources are limited, the committee made a choice to focus resources on those needs that can be improved through collaboration and capacity building. Consequently some needs were deemed "not a priority" at the present time and were not included in the implementation plan. The areas not deemed as a priority were: assistance with affordable housing, addressing cultural and language barriers, dental care, and acute mental health care and expanding the number of providers who accept Medi-Cal). After considerable discussion, The BCCB came to a consensus that it was not prudent to address those needs because of the financial barriers to entry, the lack of PLCM expertise in the topic area and/or the balancing of both factors that made it unlikely for substantial progress to be made over the next three years in addressing the need. The Committee did note that dental care was a highly rated need in both the primary and secondary data and if a willing dental partner with the capacity to deliver dental services could be identified, that PLCM should consider donating its mobile clinic currently in operation when the replacement vehicle becomes available in 2014. The Committee was very supportive of continuing to place an emphasis on preventive and educational services based on the point of consensus that this is an important infrastructure to be built and maintained in underserved communities.

The Committee then turned its attention to areas where the needs assessment found identified needs that are not currently being address by the Medical Centers' Community Benefit Program but have potential opportunities for collaboration. After further discussion and weighing factors such as resource constraints, the relative ranking of the priority, whether other community organizations are currently or likely to address the need and the expertise of PLCM addressing the needs, the Committee recommended and ranked the following needs for possible program development, collaboration and/or capacity building and the Committee ranked those areas in the following order:

1) Services that allow seniors to live at home
2) Mental Health Education/ Coping Skills
3) Skills to Navigate the Health System
4) Parenting Education

For parenting education, the Committee concluded that based upon resources that will be available in the community of Wilmington and the Harbor area through First 5 LA funding, that Providence Little Company of Mary Medical Center, San Pedro, should take the lead in moving the parent education initiative. While parenting education for families of newborns is a clearly identified need, First 5 data documents that the Harbor area, especially Wilmington, has more risk factors than other areas of the South Bay. In addition to First 5 LA's research, the community of Hawthorne merits further exploration of this identified area of need based upon data from the Department of Children and Family Services.

VII. Measureable Objectives: 2014-2016

After the BCCB identified the priorities going forward, a three year plan was established with five objectives, or strategies, and 20 specific benchmarks to be accomplished over the next three years. At its November Board meeting, the Community Ministry Board adopted the triennial community health needs assessment, an implementation strategy composed of five strategies that are designed to address the priority needs recommended for attention by the BCCB. These 5 objectives and 20 specific benchmarks are set forth in full below:

Objective 1: Increased access--Increase access to free primary and subsidized health care, including insurance coverage through CH

Benchmarks

- By 2016, Enroll or renew 2000 children or adults annually.
- By 2016, Link 600 adults discharged from the ER to a medical home, as verified by kept appointments.
- By 2016, increase from 10 to 16 sites where mobile clinic regularly sees patients
- By 2016, increase the number of people receiving HPV immunizations over the 2013 baseline, by 20%
- By 2016, Improve identification and successful referral of Vasek Polak patients to GOAL diabetes project, by 20%, using 2013 as baseline
- By 2016, provide medical management for 150 uninsured adults at Vasek Polak, including subspecialty consults, advanced diagnostics and referral for those with ongoing chronic specialty conditions.

Objective 2: Primary/secondary prevention-- Strengthen existing primary and secondary prevention programs (COPA, GOAL and Welcome Baby)

Benchmarks

- By 2016, Increase physical activity in children by 10% over (March 2014) baseline, as measured by pedometers, SOFIT or Fitnessgram.
- By 2016, provide COPA consultative services to 10 new locations, verified by trainings or MOU/contracts with school districts or community based organizations.
- By 2016, Increase to 50 the number of chronic disease self care cohorts (6-9 lessons) offered throughout the PLCMSA.
- By 2016, Sustain 1.5% average decrease in A1C levels for 80% of GOAL participants.
- By 2016, (PLCMMC-SP only) Increase Welcome Bay prenatal enrollments by 40%, using 2013 as baseline.
- By 2016, (PLCMMC-SP only) increase exclusive breastfeeding for Welcome Baby clients by 20%, using the first six months of home visits operations as baseline.

Objective 3: External partnerships--Increase and strengthen partnerships with external stakeholders

Benchmarks

- By 2016, develop and sustain two collaborative task forces that address any of the top healthcare needs identified in the 2013 needs assessment AND that accomplish outcomes identified by the task force.
- By 2016, implement at least two capacity building projects that provide an infrastructure improvement for or in partnership with community partners (ie. Funding/ facilities/joint use agreement)

Objective 4: Address BCCB Priorities--Explore feasibility of program development/ stakeholder collaboration in three areas prioritized by Board Committee on Community Benefits

Benchmarks

- By 2016, Design, pilot and implement a new program that addresses one of three new priority areas identified by the BCCB:
  - Services that allow Seniors to live at home
  - Mental Health Education/Coping Skills
  - Skills to Navigate Health Care System
- By 2016, convene an internal collaborative task force that addresses one of the BCCB priorities

Objective 5—Monitor Community Benefit--Monitor Community Benefit programs and expenditure, consistent with Catholic Health Association guidelines

Benchmarks

- By 2016, increase charity care expense by 5%, using 2013 as baseline.
- By 2016, increase community outreach expense (non billed/negative margin) by 10%.
- By 2016, under the direction of the Mission Committee, conduct 6 site visits to explore client, stakeholder and employee satisfaction with specific programs provided by the Medical Centers' Community Health Department.
- By 2016, define, design and develop a data exchange project between PLCM and safety net and/or Public Health stakeholders

VIII. COMMUNITY BENEFITS AND ECONOMIC VALUE

A. Value of tax exemption

One of the fundamental principles of the PLCM Community Benefit Plan is the desire to return the value of the organization's tax exemption to the community. Our tax exemption serves as one benchmark to evaluate the effectiveness of our Community Benefit Program. The general rule among non profit hospitals in California has been to include three categories of expense in calculating community benefit expense: 1) charity care, 2) community benefit expense (consistent with CHA Community Benefit guidelines)[6] and 3) Medi-Cal shortfall. Using this standard, PLCM community benefit expense has exceeded the value of the tax exemption for the last three years by 391%, 369% and 366%, respectively. Providence Health and Services has set a more rigorous internal definition of Community Benefit by excluding Medi-Cal shortfall in determining the value of resources given back to local communities. Even under this higher self imposed standard, PLCM community benefit expense has exceeded the value of the tax exemption for all three calendar years, 2011, 2012 and 2013 by 197%, 125% and 149%, respectively.

CALCULATION OF TAX EXEMPTION VALUE			
	2011	**2012**	**2013**
Net Income	$13,323,000	$27,008,000	$28,629,784
Imputed Federal Income Tax @ 35%	$ 2,409,544	$ 6,883,934	$ 7,456,297
Imputed State Income Tax @ 8.8%	$ 664,391	$ 1,898,128	$ 2,055,947
Property Tax Exemption Value	$ 3,211,670	$ 2,974,605	$ 2,922,603
Tax exempt Financing	$ 2,595,597	$ 2,561,361	$ 2,449,860
VALUE OF TAX EXEMPT STATUS	**$ 8,881,202**	**$ 14,318,028**	**$14,884,707**

B. Community Benefit Expenditures

PLCM Community Benefit activities are classified into three broad expenditure categories consistent with standards established by the Catholic Health Associaiton: 1) charity care, 2) Community Benefit Services and 3) Unpaid Costs of Medi-Cal[7]. For OSHPD reporting purposes, we also identify the unpaid costs of Medicare but this statistic is not publicly reported. The chart below, which summarizes all community benefit expense for the last three years shows a 25% increase in charity care, a 14% increase in community benefit services and 116% increase in Medi-Cal shortfall.

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[6] The Catholic Health has been in the forefront of standardized public reporting of community benefit for more than 20 years and has continued to revise its *Guide for Planning and Reporting Community Benefit, including the most recent 2012 edition, which incorporates ACA legislative requirements and CHNA requirement promulgated by the IRS, under its Rulemaking authority*

[7] OSHPD issued guidance in 2006 notifying hospitals to report Medicare shortfall. Medicare shortfall is not publicly reported as a community benefit expense.

	2011	2012	2013
Charity Care	$12,395,824	$15,954,711	$15,952,378
Community Benefit Services	$ 14,062,499	$16,275,964	$16,140,019
Unpaid Costs of Medi-Cal	$ 17,199,914	$35,003,446	$37,262,675
TOTAL	**$43,658,327**	**$67,234,121**	**$69,355,202**
Unpaid Cost of Medicare	$ 8,561,327	$10,880,967	$9,173,895

Charity Care. Charity care saw a 25% increase over the 2011 baseline, which was sustained at approximately the same level in 2013 and broader dissemination across outpatient settings.

Unpaid Costs of Medi-Cal. Medi-Cal shortfall, the difference between the cost of providing care and the amount received from Medi-Cal rose dramatically in 2012, by slightly over 100% and increased an additional 6% in 2013, to $37, 262,675.

Community Benefit Services. Community Benefit Services combines all expenses of both Medical Centers, including Hospice and Vasek Polak Health Clinic, operated in affiliation with the Providence Medical Institute. This category combines seven specific elements, broken out in the next section of this report. Expenditures in this category increased, from $14 Million in 2011 to $16.1 Million in 2013. Using the 2011 expense as the baseline, there was a 15.7% increase over baseline in 2012 and a 14.7% increase in 2013

Year to Year Change in Community Benefit Services Expense: 2011-2013			
Calendar Year	**2011**	**2012**	**2013**
Total Expense	$14,062,499	$16,275,964	$16,140,019
% Change over prior year	baseline	15.7%	14.7%

Comparison of expenses with Community Benefit Services subcategories. Within the Community Benefit services category, there are seven subcategories: 1) Services to the broader community (community lectures & referrals to community agencies, Gathering Place, free community lectures, etc.), 2) Community education for people in poverty (COPA, CHIP, GOAL, SART, etc), 3) Community clinical services for people in poverty (pediatric mobile clinic, etc), 4) Medical Center support services for the people in poverty (Case management of uninsured/ underinsured, Post Discharge expense, Taxi & Transportation, etc) and 5) Health Professions education (preceptorships, CPE.) 6) Subsidized health services (Vasek Polak Health Clinic, Trinity Kids Hospice, Palliative Care Assessments, etc) and 7) financial and In Kind Services .

Total Community Benefit expense over the term of the 2011-2013 Plan increased 14.7%. As might be expected, within each of the seven categories there was year to year variation, due to the changing healthcare landscape. The *Broader Community* subcategory stayed essentially flat over the three year period but roller coasted up in 2012. Community education programs for

people in poverty stayed flat for the first two years and then bumped up 14.9% in 2013. This reflects some newly funded grants during the 2013 calendar year. Community Clinical Services for People in Poverty dropped 31% over three years which primarily reflect the transfer of a CPSP clinic in Harbor City to an FQHC that purchased the clinic site and added a new primary care clinic at the same location. This is an improvement in the presence of primary care access in an underserved community, represents a new FQHC entrant in Harbor City and stronger continuity of care for low income patients in and around Harbor City. For many years, both PLCM Medical Centers have invested substantial resources in post discharge expense for patients who are medically indigent and continue to need a level of care that allows them to return to good health. Over the past three years there was a 98% increase in this expense, primarily due to expanded hospitalist coverage in 2012 as well as related post discharge expense during the same year. Subsidized health services increase 20% over three years with a rollercoaster bump up in 2012. Financial and in kind services decreased 51% over three years, primarily due to the institution of a Medical Center committee composed of representatives of the Medical Centers, Community Benefit, Marketing and Mission Services, to review all request for community sponsorships and verify that the request was closely related to the community benefit purposes. Any donations outside of the CHA standards are excluded from community benefit expense.

The chart below illustrates the trend for each of the seven categories for the past three years:

Breakdown of Community Benefit Services, by CHA categories: 2011-2013			
	2011	**2012**	**2013**
Breakdown of Community Benefit Svcs			
Community Education--Broader Community	$ 734,293	$ 996,679	$ 769,909
Community Education--People in Poverty	$ 2,503,359	$ 2,505,158	$ 2,877,070
Community Clinical Svcs--People in Poverty	$ 1,597,238	$ 956,370	$ 1,102,065
Med Ctr Support Services--People in Poverty	$ 1,331,315	$ 2,827,423	$ 2,645,305
Health Professions Education	$ 1,814,576	$1,869,789	$2,147,558
Subsidized Health Services	$ 5,272,004	$6,554,061	$6,208,428
Financial and In Kind Services	$809,715	$566,689	$394,483
Total Community Benefit Services	**$14,062,500**	**$16,275,962**	**$16,140,019**

C. Number of Individuals Impacted by PLCM Community Benefit Programs

Between 2011-2013, there was a 6.7% reduction in the number of people who were impacted by Community Benefit programs, from 94,628 in 2011 to 88,245 in 2013. For different reasons, this downward trend showed up in the charity care and community benefit services category while the number of people impacted by Medi-Cal was stable, with a slight drop in 2012. For Community Benefit Services the downward trend was related a greater emphasis on achieving defined outcomes , improved record keeping that eliminated duplication of clients across programs and the end of several programs in 2012. Providence expanded eligibility for charity care in 2011, which caused a 300% increase over the 2010 baseline benchmark of 4,733. The total number of people impacted annually between 2011-2013 ranged between 15,387 to 16,994.

NUMBER OF INDIVIDUALS IMPACTED, BY COMMUNITY BENEFIT CATEGORIES			
	2011	**2012**	**2013**
Charity Care	16,994	15,971	15,387
Medi-Cal	25,615	23,462	25,250
Community Benefit Services	52,019	53,890	47,608
TOTAL	94,628	93,323	88,245

Strategic Mission Priorities

Consistent with the PLCM Mission Statement and the Ethical and Religious Directives for Catholic Healthcare Services, our Community Benefit Plan places a priority on community based outreach to the poor and vulnerable. We carefully track the number of individuals impacted by programs and services provide in underserved communities and seek to leverage PLCM resources with private and governmental support.

Individuals Served by Outreach Programs Located in Underserved Communities			
Outreach to Poor/Underserved Populations	**2011**	**2012**	**2013**
Community Health Insurance Program (CHIP)	1,230	1,098	1,883
COPA (School Day/After School Physical Activity)	5,236	5,434	5,287
Get Out and Live (GOAL Diabetes Education)	87	208	459
Partners for Healthy Kids (mobile clinic)	3,652	2,429	2,027
Promotora Linkage (ER) & health fair outreach	3,269	3,139	2,435
SART(Sexual Assault Response Team)	140	197	184
Trinity Kids Care	156	179	230
Vasek Polak Health Clinic	4,560	3,027	3,869
Women and Children's Clinic	1,962	1,246	0
X-Ray readings (FQHC patients)	360	923	941
Even Start/RFS/COAST/CAVA	1,800	0	0
Welcome Baby/Baby Friendly	0	41	149
TOTALS	**22,452**	**17,923**	**17,464**

IX. 2013 ANNUAL UPDATE: PROGRESS TOWARDS MEASUREABLE OBJECTIVES

The purpose of establishing measurable benchmarks linked to the 2010 Community Health Needs Assessment objectives is to challenge our Medical Centers to make a clear difference in South Bay communities where significant disparities that exist related to health care access, prevalence of chronic illnesses and levels of physical activity. The high need South Bay communities are the focus of our community outreach.

A. Establishing Benchmarks and Summary of 2013 accomplishments

The concept of committing to three year benchmarks was first approved by the governing board in 2007, as part of our triennial needs assessment and was repeated at the time of adoption of the Community Health Needs Assessment in 2010. In the first cycle, beginning in 2008, our success rate towards accomplishing our benchmarks was 52% (ie. 11 of 21 benchmarks accomplished). This success rate increased significantly in the second year, to 71.5% (15 of 21 benchmarks accomplished); in the third year the success rate increased to 81% (17 of 21 benchmarks accomplished).

The Providence Little Company of Mary 2010 triennial needs assessment adopted by the governing board established four measurable objectives with 18 specific benchmark to be addressed between 2011 and 2013. Benchmarks represent key performance indicators that provide evidence as to the likelihood that the objectives will be accomplished, as set forth in the 2010 Plan. The section of the Annual Update reports upon the progress made over the past three years.

In 2011, 13 of 18 benchmarks were accomplished, for a success rate of 72%. In 2012, this increased to 77% (14 of 18 benchmarks accomplished) and to 88.% in 2013 (16 of 18 benchmarks accomplished). These results are a good yardstick to hold ourselves accountable for improving health status indicators in underserved communities. In the absence of accepted standards of improvement, these benchmarks also measure the strength of the three year benchmarks (ie. realistic but not too easy to accomplish and continuing year-to-year improvement in results).The expectation is NOT that all benchmarks will be achieved because many factors can thwart a three year plan. The implementation of the ACA clearly impacted several benchmarks that previously were consistently met.

By sticking with the same benchmarks for a three year period, stakeholders gain an appreciation for the importance of achieving specific outcomes and the importance of continuous improvement. As a consequence, our Medical Centers, the 50+ PLCM Community Health employees and our community partners are more engaged in a collaborative process and reinforces working relationships built on trust and respect among Stakeholders.

The rest of this Section sets forth the original 2010 objectives, reports actual accomplishments, and comments on the result. Between 2011-13 four benchmarks were revised upwards (three in 2011 and one in 2012) based upon actual results that suggested that an unanticipated change would result in a higher performance level

B. Measurable Objectives Adopted by Governing Board in 2010

The Providence Little Company of Mary 2010 Community Benefit Plan adopted by the governing board, includes a single goal, with four measurable objectives, each of which has multiple benchmarks, or indicators, which collectively are expected to help us accomplish specific objectives:

GOAL: As people of Providence, we partner with community stakeholders, reach out to high need communities and build a path to better health, for children and adults, through improved access to primary care and involvement in skills-based health education programs.

Objective 1. Increase access to low cost/free primary care services.

Benchmarks

- Improve access to health care for uninsured children by providing free medical care to 2,800 children, including coordination of specialty/ancillary referrals for 250 children **(2 benchmarks).**
- Offer weekly clinics at 9 schools each week; pilot an alternate schedule that allows the clinic to add 10 new school clinics, at schools in the same four communities served by the mobile clinic on a twice a year basis to accommodate immunizations, Medi-Cal outreach and specialized medical clinics**(2 benchmarks).**
- Enroll/renew 600 children annually in subsidized health insurance programs.
- Improve access to primary care through a low cost, fixed price, midlevel practitioner service delivery model and increase, by 10%, the number of uninsured adults who utilize the Vasek Polak Health Clinic as their medical home.
- Sustain access to x-ray services for 500 patients at Inglewood FQHC clinic by providing low cost interpretation of on site X-rays.

Objective 2. Strengthen/expand physical activity & self-care disease management programs.

Benchmarks

- Provide ongoing school day physical education training to 150 teachers and 4,200 children in high need communities **(2 benchmarks).**
- Provide after school physical activity programs throughout the school year for 500 children and their adult family members
- Arrange 25 collaborative health and physical education learning events for children and adults in high need communities across the Service Area by involving PLCMSA employees, community based organizations and Community Health staff to organize, plan and implement events.
- 150 uninsured/underinsured adults will complete at least one of the following multi lesson diabetes management programs: self care management, group visits, physical activity/nutritional practices workshop or group visit protocol at the Vasek Polak Health Clinic or at community partner sites using PCLM curriculum.
- Increase physical activity levels 5%, on a pre-post basis, across all physical activity programs using at least one of the following methods: pedometer, accelerometer Fitnessgram, SOFIT observation or self-report.

Objective 3. Analyze and pilot new approaches to emerging health care service delivery needs, after consultation with internal and external Stakeholders.

Benchmarks:

- Explore feasibility and parameters of expanding scope of community outreach services to include one or more of the following:
  - Mental health education Project for children and/or adults
  - Patient navigator Project for seniors
  - Expansion of low cost, fixed price, mid-level practitioner primary care model
  - Strengthen ongoing needs assessment process through the development of academic internships with local School of Public Health

Objective 4. Measure PLCM Community Benefit Expenditures and Encounters

Benchmarks

- The number of individuals impacted by charity care programs will increase 5% over three years **[baseline = 4,733]**;
- The number of individuals impacted by community based outreach programs will increase 5% over 3 years **[baseline = 23,920].**
- Increase charity care expense by 5% over three years, through improved screening**[baseline =$3,770,000].**
- Using CHA guidelines, increase community based outreach expense (non billed/ negative margin) by 9% over 3 years **[baseline = $6,270,000]**

C. Progress Towards Three Year Benchmarks

MEASUREABLE OBJECTIVES
Objective 1. Increase access to low cost/free primary care services.

3 Year Benchmarks established by 2010 Community Benefit Plan	*Progress towards Three Year Objectives*			
	2011 Actual	*2012 ACTUAL*	*2013 Actual*	*Comment*
Improve access to health care for uninsured children by providing free medical care to 2,800 children, including coordination of specialty/ancillary referrals for 250 children.	**3,731**	2,564	2,429	The number of mobile clinic patients decreased, as anticipated, because Tdap immunization requirements that took effect in 2011 created unusual demand at middle school & high schools. CHIP enrollment activity has also reduced demand for medical visits on the mobile clinic as previously uninsured children find a medical home.
	119	123	57	Access to LAC DHS specialty clinics and to the LAC E-Consult referral process was denied, further reducing coordinated specialty referrals to Harbor UCLA. The mobile clinic is shifting its focus to strengthen skills based educational programs, immunization compliance and improved coordination with community based safety net providers. **Benchmarks not accomplished.**
Offer weekly clinics at 9 schools each week; pilot an alternate schedule that allows the clinic to add 10 new school clinics, at schools in the same four communities served by the mobile clinic on a twice a year basis to accommodate immunizations, Medi-Cal outreach and specialized medical clinics.	**9**	**10**	**11**	Partners for Healthy Kids, a mobile school based health clinic, provides weekly clinics for the following communities: San Pedro, Wilmington, Gardena & Lawndale. (LAUSD and LESD).
	2	**10**	**13**	13 follow an every other week or a special purpose clinic (ie. Immunizations, physicals, obesity intervention, etc) **5 of 6 benchmarks accomplished.**

Enroll/renew 800 children and adults, annually, in subsidized health insurance programs	**908**	**1,098**	**1,883**	With the implementation of ACA, the CHIP unit expanded the scope of its outreach and enrollment assistance to include adults eligible for Medi-Cal and Covered California. The CHIP unit also provided assistance to the County of Los Angeles in 2012 and 2013 to enroll eligible adults in Healthy Way LA and then became an enrollment entity with Covered Ca in 2013 which produced a dramatic expansion in outreach and enrollments **Benchmark accomplished all 3 years**
Improve access to primary care through a low cost, fixed price, midlevel practitioner service delivery model and increase, by 10%, the number of uninsured adults who utilize the VP Health Clinic as their medical home	**17.8%**	**19.8%**	-7.9%	The number of patients at Vasek Polak Health Clinic increased over the 2010 baseline (3,869) by 17.8% in 2011 and 19.8% in 2012. In 2013, total patients dropped 7.9% from baseline, due to enrollment in Medi-Cal or Covered California. The result for patients is an improvement because of new access to a medical home. The Vasek Polak Clinic is reviewing its long term purpose to determine whether the emphasis will be on developing a stronger Medi-Cal strategy or a renewed focus on access for those who are ineligible for Medi-Cal or Covered California health insurance coverage. **Benchmark accomplished in 2 of 3 years**
Sustain access to x-ray services for 500 patients at Inglewood FQHC clinic by providing interpretation of on site X-rays	**360**	**923**	**941**	Existing arrangements provide low cost readings, storage and retrieval of X-rays for Inglewood FQHC. **Benchmark accomplished 2 of 3 years.**
		Bold Statistics indicate 2010 benchmark accomplished		

MEASUREABLE OBJECTIVES

Objective 2. Strengthen/expand physical activity and self-care disease management programs.

3 Year Benchmarks established by 2010 Community Benefit Plan	*Progress towards Three Year Objective*			
Benchmarks	*2011 Actual*	*2012 ACTUAL*	*2013 Actual*	*Comment*
Provide ongoing school day physical education training to 150 teachers and 4,200 children in high need communities.	**160** **4,400**	**172** **4,644**	**196** **5,287**	**Benchmarks accomplished** **Benchmarks accomplished**
Provide after school physical activity programs throughout the school year for 500 children and their adult family members	**640**	**518**	**706**	**All benchmarks accomplished**
Arrange 25 collaborative health and physical education learning events for children and adults in high need communities across the Service Area by involving PLCMSA employees, community based organizations and Community Health staff to organize, plan and implement events.	3	17	**28**	Staff participated in six different type of school wide events (Walk-to-School, Family Night, bike Rodeo, Nutrition Night, Jogo-thon, Fitness gram testing) at 17 different events in the underserved communities of Hawthorne, Lawndale and Wilmington. **Benchmark accomplished 2013**
150 uninsured/underinsured adults will complete at least one of the following multi lesson diabetes management programs: self care management, group visits, physical activity/nutritional practices workshop or group visit protocol at the Vasek Polak Health Clinic or at community partner sites using PCLM curriculum	**87**	**162**	**160**	All 4 program components. 162 adults completed 9 week program. Average A1C reduction for the group, was 1.52%. A1C levels were reduced for 80.3% of participants. Improvements also noted in self reports of health, reduction in % with High blood pressure and cholesterol and improvement in self efficacy scores. **Benchmark accomplished in 2012 and 2013**
	Bold Statistics indicate 2010 benchmark accomplished			

Increase physical activity levels 5%, on a pre-post basis, across all physical activity programs using at least one of the following methods: pedometer, accelerometer Fitnessgram, SOFIT observation or self-report.		**9-26%**	**yes**	**External evaluation found multiple statistically significant physical activity improvements in a population of 5,298 K-5 students related to: reduction in BMI, increase in the amount of time students engagaged in MVPA during PE lesson, reduction in BMI for 5th grade boys and increase in aerobic capacity and % of students meeting physical fitness standards** **Benchmark accomplished in 2012 and 2013.**

MEASUREABLE OBJECTIVES

Objective 3. Analyze and pilot new approaches to emerging health care service delivery needs, after consultation with internal and external Stakeholders.

3 Year Benchmarks established by 2010 Community Benefit Plan	*Progress towards Three Year Objectives*			
	2011 Actual	*2012 ACTUAL*	*2013 Actual*	*Comment*
Expand community outreach to include one or more below: Mental health education Project for children and/or adults. **Patient navigator Project** Expansion of low cost, fixed price, mid-level practitioner primary care model **Strengthen needs assessment process through the development of academic internships with local School of Public Health**		**YES**	**YES** **YES**	Patient navigator project implemented at PLCM-San Pedro Medical Center that intervenes with patients who do not have a medical home and have repeated ER non urgent care visits. The UCLA School of Public Health assigned two student interns in 2013 to assist with the Joint Community Health Needs Assessment. They participated in all facets of the process (primary/ secondary data collection & analysis, inter face with Board Committee and governing board presentation. **Benchmark accomplished 2012 and 13**

MEASUREABLE OBJECTIVES

Objective 4. Measure PLCM Community Benefit Expenditures and Encounters

3 Year Benchmarks established by 2010 Community Benefit Plan	*Progress towards Three Year Objectives*			
	2011 Actual	*2012 ACTUAL*	*2013 Actual*	*Comment*
The number of individuals impacted by charity care programs will increase 5% over three years **[baseline = 14,199]**;	**16,994** **19.6%**	**15,971** **12.4%**	**15,387** **8.4%**	Due to a change that expanded charity care eligibility, the original bench-mark was revised upward in the 2011 Update, from 4,733 to 14,199 individuals . Annual increases were 19.6%, 12.4% and 8.4% over revised baseline. **BENCHMARK ACCOMPLISHED ALL 3 YEARS**
The number of individuals impacted by community based outreach programs in underserved communities will increase 5% over 3 years **[baseline = 23,920].**	21,002	22,683	22,840	There was an annual increase of people served (8% in 2012 and .7% in 2013 but insufficient to meet the baseline established in 2010. Two early childhood education programs which ended in 2010 contributed to this result. **Benchmark not met**
Increase charity care expense by 5% over three years, through improved screening**[original baseline: $3,770,000; revised upward to $12,395,824 in 2011].**	**228%**	**28.7%**	**29%**	Changes in charity care identification methods resulted in an upward revision of the charity care benchmark in 2011, from $3,770,000 to $12,395,824. Charity care expense was $15,954,711 in 2012 and $15,978,210 in 2013, a increase of 28.7% and 29%, respectively, over the revised benchmark . **Benchmark accomplished and sustained**
Using Catholic Healthcare Association guidelines, increase community based outreach expense by 9% over 3 years **[baseline = $2,519,242]**	-0.01	-0.01%	**14.2%**	Community outreach to underserved communities dropped below baseline in 2011 and 2012, then increased 14.2% in 2013, to $2,877,070 **Benchmark accomplished in 2013**
	Bold Statistics indicate 2010 benchmark accomplished			

PROVIDENCE LITTLE COMPANY OF MARY MEDICAL CENTERS, SAN PEDRO AND TORRANCE

Community Health Needs Assessment *Timeline*

Formation of PLCMSA Board Committee on Community Benefits

Committee Sets the Framework

PLCMSA Board Adoption
- Community Health Needs Assessment
- Implementation Strategy

Committee Oversight
- Review Findings
- Recommend Priority Needs
- Discussion of Strategic Priority Methods

AUGUST — SEPTEMBER — OCTOBER — NOVEMBER

2013

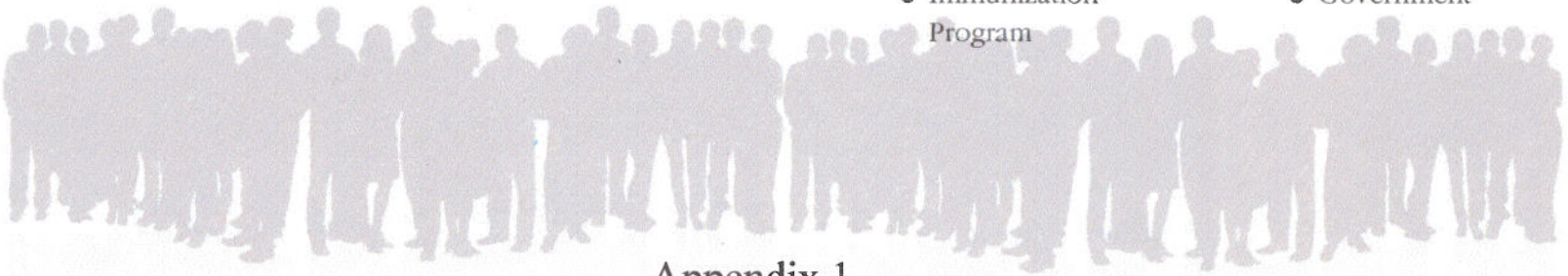
Data Gathering and Analysis

Secondary Data
- Morbidity
- Mortality
- Health Behaviors
- Access to Care

Primary Data
- End User Survey
- Organizational Survey

Public Health Input
- Chronic Disease and Prevention
- Maternal and Child Health
- Immunization Program

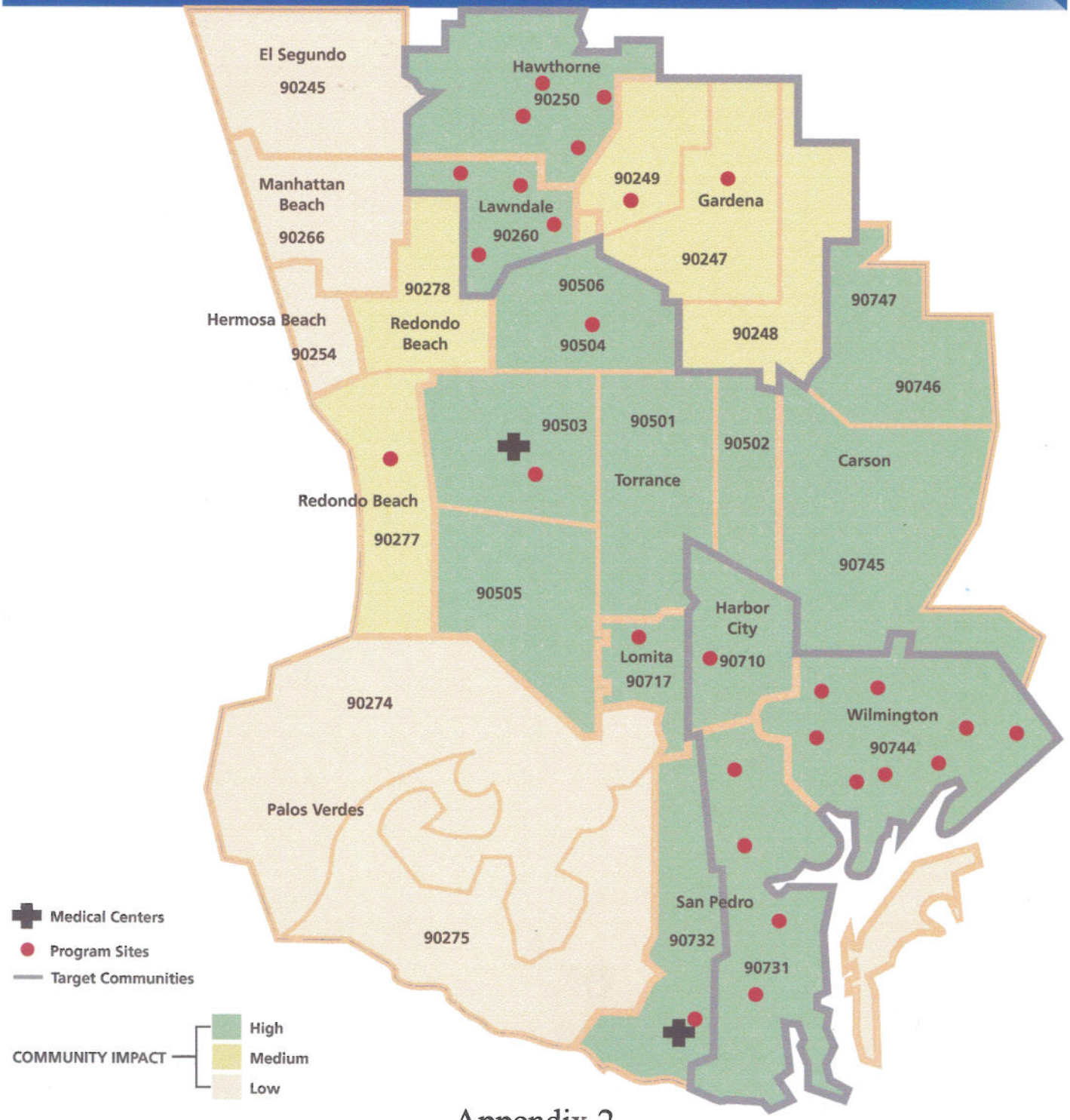
Community Input
- Schools
- FQHCs/CBOs
- Faith Based Organizations
- Government



Appendix 1

PROVIDENCE
Little Company of Mary
Medical Centers
San Pedro and Torrance

Community Health Insurance Project (CHIP)

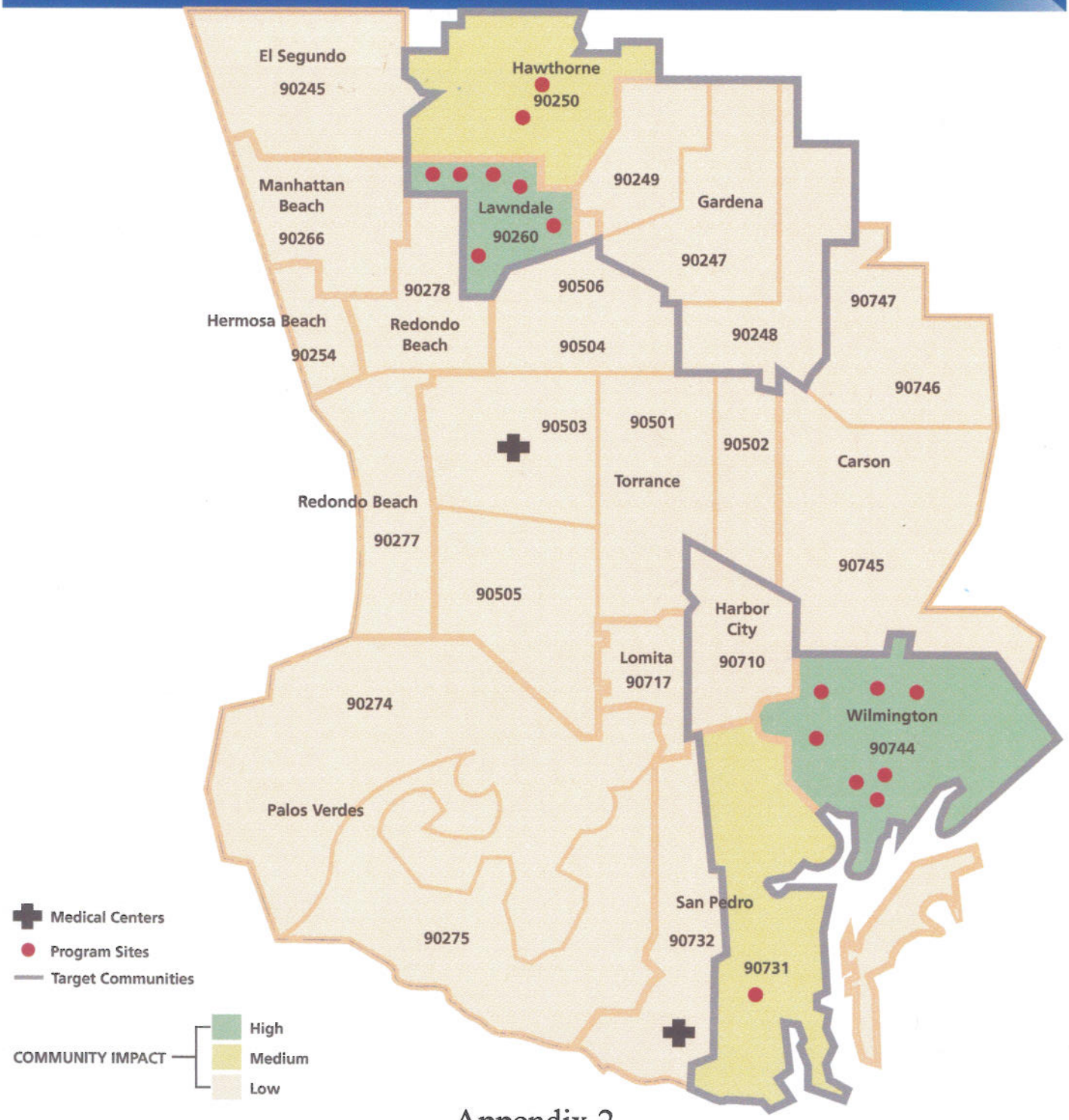


Appendix 2

Community Impact

PROVIDENCE
Little Company of Mary
Medical Centers
San Pedro and Torrance

Creating Opportunities for Physical Activity (COPA)



Appendix 2

PROVIDENCE
Little Company of Mary
Medical Centers
San Pedro and Torrance

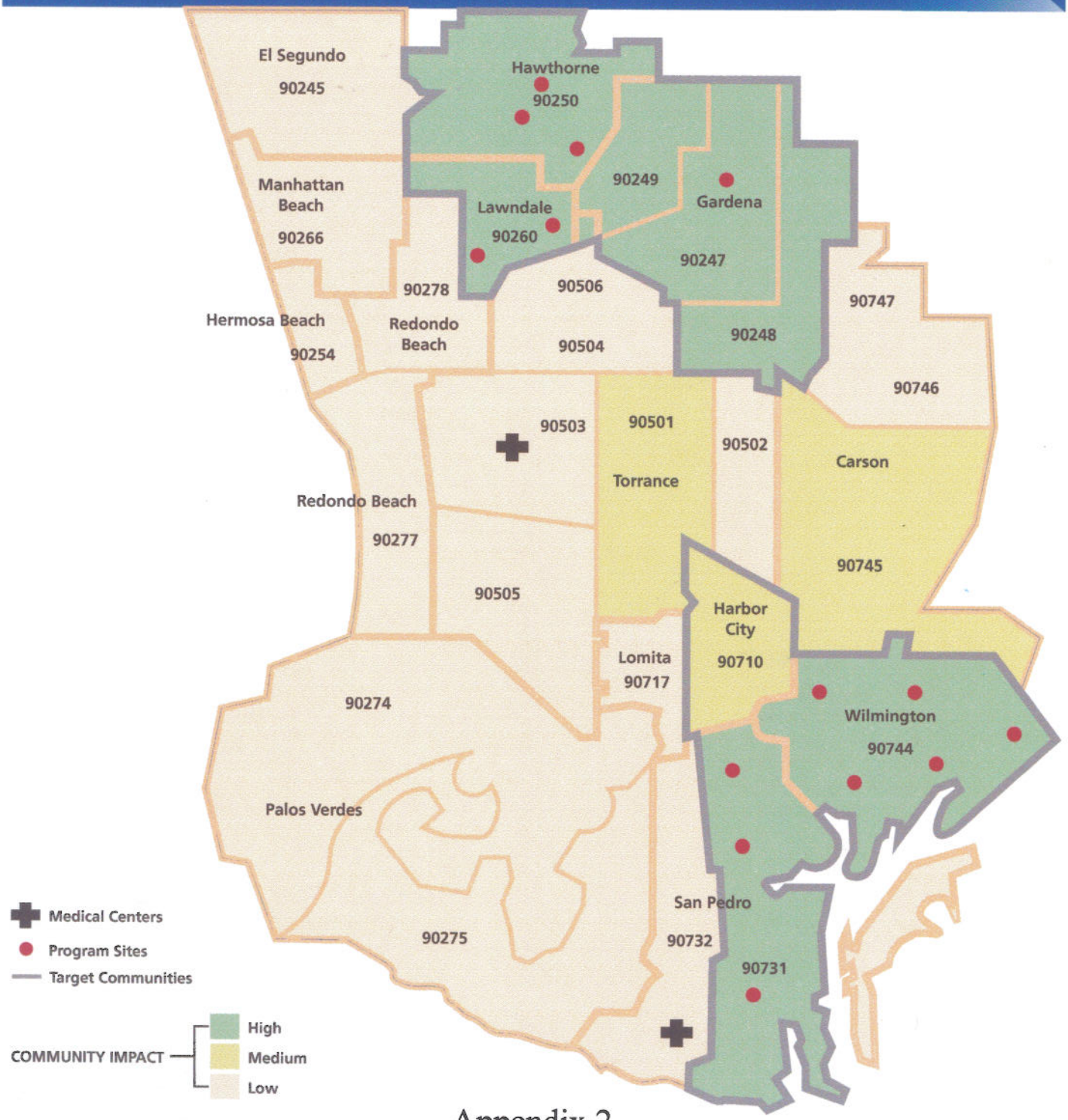
Get Out and Live (GOAL)

Appendix 2

Community Impact

PROVIDENCE
Little Company of Mary
Medical Centers
San Pedro and Torrance

Partners for Healthy Kids (PFHK)



Appendix 2

Community Impact

PROVIDENCE
Little Company of Mary
Medical Centers
San Pedro and Torrance

Vasek Polak Health Clinic (VPHC)

Appendix 2

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Torrance, CA 90505
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Community Health

August 14, 2013

Jan Brandmeyer
Chair, Mission Committee
Providence Little Company of Mary Medical Centers
2415 Via Campesina
Palos Verdes Estates, Ca 90274

Dear Ms. Brandmeyer,

On behalf of the Providence Little Company of Mary Medical Centers, San Pedro and Torrance, we are delighted that you have agreed to participate in the Board Committee on Community Benefits on **August 27, 2013 at 11:30 am**. Our meeting will be in the **Board Room of the Center for Health Education**, adjacent to the Medical Center in Torrance and lunch will be served. If you are unfamiliar with parking, we recommend valet parking located at the Outpatient Diagnostic Center and they will direct you to the meeting room location (a map is attached).

Since 1995, state law has required that non profit hospitals conduct a triennial community health needs assessment (CHNA) and a plan to address identified community health needs. The passage of health care reform granted new regulatory and enforcement authority to the IRS to monitor how CHNA's are conducted across the country and the implementation strategies adopted by non profit hospitals.

With these changes in mind and the expansion of health insurance coverage beginning in 2014, the governing board of the two Providence Little Company of Mary Medical Centers decided to form an ad hoc committee to oversee and provide input into the conduct of the needs assessment and to recommend back to the Board the priorities that should be adopted for 2014-2016. A committee of 14 members will hold two meetings, the second meeting date to be determined by the group at the August 27 meeting.

This Committee is composed of 14 people, half from our two Medical Centers and half from the community. At least one representative from each of the following community sectors will attend: public schools, L.A. County Public Health, Community Based Organizations, FQHC, a faith based organization and an elected official. The roles and responsibilities of the Committee are to give feedback, suggestions and input into our needs assessment plan (meeting # 1) and recommend priorities for 2014-2016 based on the data collected (meeting # 2). We expect that the needs assessment findings and the different perspectives represented on the Committee will lead to a discussion about the priority that should attach to collaboration, capacity building and service delivery programs. This discussion will shape the implementation strategy adopted by the governing board at its November 2013 Board meeting.

Thank you for taking the time to partner with us on this very important project. If you have any questions, please contact Jim Tehan at jim.tehan@providence.org or at 310.257.3586.

Sincerely,

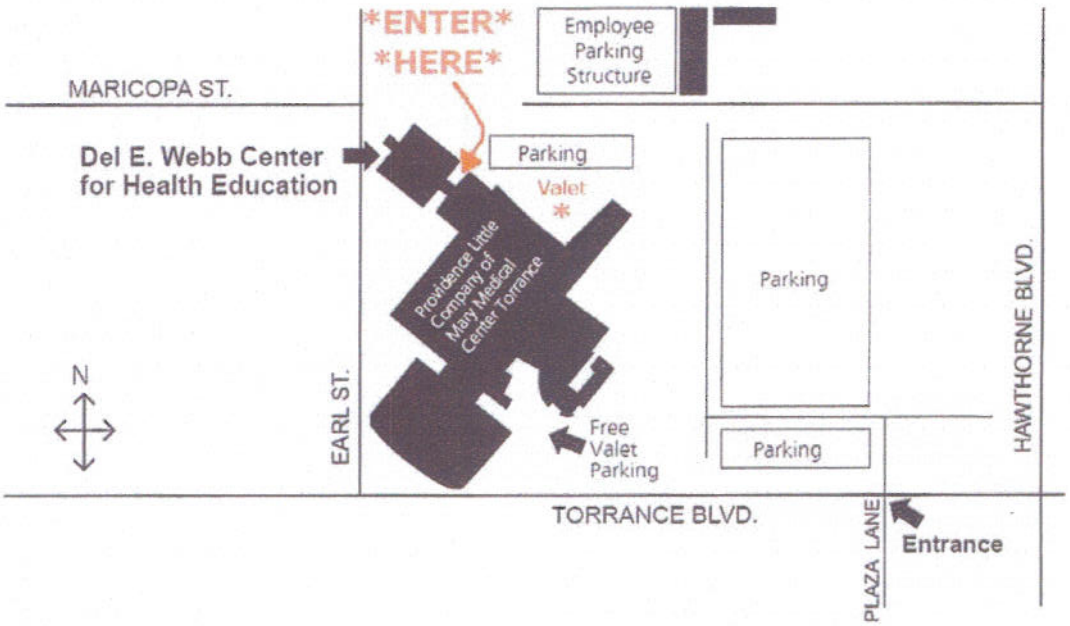
Michael Beaupre
Board Chair

Jim Tehan
Director, Community Partnerships

Encl. Map and Committee Members

Appendix 3

PROVIDENCE
Little Company of Mary
Medical Center
Torrance



Providence Little Company of Mary Medical Center Torrance
4101 Torrance Blvd. Torrance, CA 90503

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Del E. Webb Center for Health Education, located on the
west side of the hospital at the corner of Earl St. and Maricopa St.

Appendix 3

List of Confirmed Attendees
Board Committee on Community Benefits
August 27, 2013

Community Representatives

Paul Simon, MD MPH, Director, Division of Chronic Disease and Injury Prevention
Los Angeles County Department of Public Health

Rick Velasquez
Chief of Staff to Supervisor Don Knabe

Tahia Hayslet
Executive Director
Harbor Interfaith Services

Judith Kraft, MD
Chief Medical Officer
Wilmington community Clinic

Steve Tabor
Associate Superintendent
Pupil Personnel Services
Hawthorne School District

Betsy Hamilton
Assistant Superintendent
Educational Services
Lawndale Elementary School District

Fr. Greg King
Pastor
St. Joseph Church

Providence Representatives

Michael Beaupre, Board Chair
Providence Little Company of Mary Medical Centers

Jan Brandmeyer
Chair, Mission Committee
Providence Little Company of Mary

Elizabeth Zuanich
Chief Financial Officer
Providence Little Company of Mary

Paul Makarewicz
Director, Mission Leadership
Providence Little Company of Mary Medical Center, Torrance

Sr. Nancy Jurecki
Director, Mission and Spiritual Care
Providence Little Company of Mary Medical Center, San Pedro

Linda O'Neil, RN
Director of Case Management and Social Services
Providence Little Company of Mary Medical Center, Torrance

David Munoz, MD
Emergency Room Physician
Providence Little Company of Mary, San Pedro

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

Minutes from Board Committee on Community Benefits Meeting
August 27, 2013
11:30-1:30

Meeting Leaders: Mike Beaupre & Jim Tehan
Meeting Organizers: Justin Joe, Juan Mendez, Eric Aguillar, Monica Kline
Meeting Participants: Jan Brandmeyer, Betsy Hamilton, Tahia Hayslet, Sr. Nancy Jurecki, Fr. Greg King, Judith Kraft, MD, Paul Makarewicz, Linda O'Neil, Paul Simon, MD, MPH, Steve Tabor, Rick Velasquez(absent), Elizabeth Zuanich

1. Welcome

2. Reflection

3. Introduction-Mike Beaupre

4. Meeting Overview – Mike Beaupre

   a. Purpose of Committee-- Meeting Participants were provided with packets of informational documents about the rationale for the establishment of the Board Committee on Community Benefits by the Community Ministry Board.
   b. Scope of Authority—Mr. Beaupre advised that the Committee will meet in mid November to review the process that has been followed in collecting primary and secondary data related to community need, discuss the findings of the top help needs and provide recommendations on which needs to prioritize for 2014-16.

      Draft copies of measures were presented to the Committee for review. These documents will be used to collect local data and included cover letters, questionnaires and interview documents. The Committee was advised that there will be three methods of local data collection: 1) a telephone interview of community residents that have participated in at least one PLCM community outreach program, 2) a survey to local non profit organizations that provide health or social services to residents of underserved communities ,and 3) key informant interviews of community leaders who are knowledgeable and experienced with the needs of low income populations and the existing gaps in safety net services.

   c. Set Meeting Date – November 14, 2013

Appendix 4

5. Community Benefits –Jim Tehan-

   a. Community Benefit/Community Outreach defined
      PLCMSA' s detailed accounting of 2012 Community Benefit Expenses, by Medical Center was provided. Mr. Tehan discussed the three elements that are counted and reported annually to OSHPD, the State agency charged with collecting the triennial needs assessment and Annual Update. The three elements of the Community Benefits Expense Report are : 1) charity care, 2) Community Benefit Services (following Catholic Health Association guidelines) and 3) unpaid costs of Medi-Cal.

   b. Evolution of Programs related to Children and Adults—A Fact Sheet describing the scope of community outreach in underserved communities was provided.

   c. Raising the Bar for Community Benefit in the Future—Increasingly, non profit hospitals are expected to provide evidence that community benefit programs have a positive impact on local communities and the clear intent of IRS Regulations related to Community Benefit encourage particular attention to underserved communities. The Community Health Department pays considerable attention to defining specific, measurable goals and objectives related to community outreach programs and regularly reports progress to community stakeholders on an ongoing basis, as well as to OSHPD on an annual basis. The most important accomplishments to date are in the area of physical activity for children, reduction in A1C levels for adults with diabetes, and enrollment of children in Medi-Cal.

6. Living the Mission in the Community

   Topic 1- Targeting Economically Disadvantaged communities-Justin Joe
   Definition: Prioritize the allocation of available resources to communities with socioeconomic & health status disparities (based on primary and secondary data) .

   Rationale
   - Providence's Mission
   - Health Disparities Data
   - Social Determinants of health

   Issues for Discussion
   How do we identify people in need from outside of the economically disadvantaged communities... and link them to our services in place in the targeted communities?

Appendix 4

Topic 2- Collaboration-Juan Mendez

Definition: Two or more organizations working together on a common health issue to achieve an established defined goal.

Rationale:

- Health is a team sport
- Many social factors influence health
- Avoids duplication of services
- Leverage consensus to attract external resources

Issues for Discussion: In your opinion, what community heath issues could benefit from a collaborative project and whom would we follow up with?

Topic 3- Capacity Building in the Future

Definition: Providence within its expertise helps community partners take on new leadership roles that improve the scope or quality of the community partners' services.

Rationale: No one organization can meet all the needs of the community. New skill sets create a sustainable path that strengthens schools, churches, and community based organizations (CBO's).

Issues for Discussion: If you had technical assistance from Providence can you identify 1-2 improvements to the scope or quality of services you provide that would improve the health of your constituents?

7. Committee Breakout Sessions
   Committee was divided into small groups to answer each of the 3 Issues for Discussion mentioned above.

8. Report Back
   Team leaders:
   Jan Brandemeyer- Targeting Economically Disadvantaged Communities
   Paul Makarawicz -Collaboration
   Sr. Nancy Jurecki- Capacity Building

   Topic 1: Targeting Economically Disadvantaged Communities: How do we identify people in need from outside of the economically disadvantaged communities... and link them to our services in place in the targeted communities?

   During the breakout sessions, participants were asked to brainstorm ideas on how to identify people in need from outside the economically disadvantaged communities. They

Appendix 4

were then asked to discuss possible ways to link them to existing services in the target communities. The key theme that came from these discussions was, existing organizations from within and surrounding communities such as schools, local EMS providers, and DCHS need to communicate key information in order to identify people in need and reach out to them. It is through open communication and sharing of information that issues such as homelessness can be identified and linked to the proper channels. It was also discussed that the same collaboration and communication between existing organizations is needed to address unmet mental health needs in the community.

Topic 2: Collaboration: In your opinion, what community health issues could benefit from a collaborative project, and who would we follow up with?

During these discussions to identify health issues that could benefit from a collaborative project, the common health issues identified were increasing physical activity, unmet mental health needs, dealing with conditions such as diabetes, obesity, and asthma, and treating addiction and domestic violence. There seemed to be a consensus that education and training could improve these identified health issue. The follow-up parties identified were school officials, and community leaders. There was also a strong emphasis on continuing the existing services provided.

Topic 3: Capacity Building in the Future: If you had technical assistance from Providence can you identify 1-2 improvements to the scope or quality of services you provide that would improve the health of your constituents?
Responses:

During the breakout session, groups were asked to identify 1-2 improvements using capacity building to improve the existing scope and quality of services offered. The key theme that seemed to emerge was assistance with the creation and promotion of liaisons or patient advocates to help patient navigate the healthcare system and securing follow-up services. Technical assistance with improving education and training of school staff to deal with mental health issues and linking children and parents to appropriate services was the second major theme.

9. Input Re: Surveys, Interview Questions and List of Key informants (10 min) Jim Tehan

10. Wrap up (5 min) Mike Beaupre- Next Meeting November 14, 2013

Providence Little Company of Mary Medical Center, San Pedro
1300 W. 7th St
San Pedro, Ca. 90731

Appendix 4

Detail of Comments Recorded during Breakout Sessions

Responses For Targeting Economically Disadvantaged Communities:

Share information with: DCFS, school leaders, homeless and foster liaisons, local fire departments/EMS, juvenile detectives, and pharmacies

Looking at social determinants: Education (truancy, Asthma, keeping kids in school), Crime (gangs, violence, parks after dark)

Physical & mental geographic boundaries- stigma of different communities.

Identify mini communities (pockets)
Cut your data in different ways, not just census tracts.

Substance abuse

Faith based organizations for information

With the "left side" community there are people in need

Limited resources... are there enough to include people from outside?

Referrals- follow through

Communication loop between referring agencies

Organizations need to be aware of other organizations and services (community services directory)

Organizations in affluent communities have access to directory

Is it to ambitious to look outside of target communities?

Role of PLCM is to provide information at the outside community

Share information with counterparts in outside communities

Ex: homelessness exists in outside communities but is more hidden

People move between the communities

New population of homeless... example those who have worked for years

Appendix 4

Increase in health needs and free/reduced lunch, mental health, housing, less funding for schools, money for English leaners

3 groups: 1.Free reduced lunch, 2.Discipline incidence, and 3.Domestic violence

Assistant superintendent pupil services
-Increase in health related problems

Private school enrollment decreases

What's the difference in the clients you see today compared to years past? –Mental health

Responses for Collaboration:

Health education in schools hospitals, and recreation centers

Physical activity-promote more walking, biking, and swimming

Development of health education (diabetes, obesity, asthma) for children and adults, schools, community centers, senior centers, community clinics, Adult education, local businesses

Leads: City. Parks & Rec, school officials, community leaders, engage youth, Visit city council and have representatives from your staff (nurses, health ed. etc.) and promote programs

Smaller markets-corner markets
Reduce ER visits among repeat users, more collaboration with community clinics, caseworkers, etc.

Addiction (alcohol &drugs)

Domestic violence

Health workshops: nutrition stress management, housing shelter

Dental care: screenings, education, mobile dental clinic

Identify dentists who would like to get involved and donate time -TZU Chi Foundation, -USC Dental School

Mental health and hospitals, schools community centers.

Parents health education around mental health issues

Appendix 4

Train staff at schools, hospitals, and community centers

Use more social workers as liaisons between organizations (hospitals, schools, case managers, providers, community centers, etc.)

Health Education- domestic violence, addiction

Coping skills workshops,

Men's health-need more involvement in health care

Leads: St. Margaret's Center (Inglewood)
-Provide parent workshops, social services

-Sporting events

Parks and recs

Youth-High schools

Health education-engage high school students

Promote health

Needs early breast cancer detection

More communication with community clinics

More education

Leads: Every Woman Counts program –Early Cancer detection program

Google CCALAC for information in LA

Responses for Capacity Building

Patient Advocacy and assistance with navigating the healthcare system/ ensuring continuity of care of patients (ex: Medical Patients-access to specialists). (5)

Technical assistance for crating/improving coordination and collaborations between outside services. (Ex: DCHS, Mental health services). (2)

Creation of community liaisons to interface with parents (2)

Mental health education/ intervention (2)

Appendix 4

- Health nurse in the schools
- Teacher training on positive reinforcement
- Services to assist with securing housing
- Creation of a site to attain affordable/free T.B. testing
- Technical assistance with the creation of a website that links people to services.
- Linking dental services to schools.

Appendix 4

Health Needs Priorities Worksheet

Top Needs	Source of Data Confirmation	Existing PLCM Infrastructure		External Opportunities (for Collaboration/Capacity Building)	Let it Go	Confer & Rank
		Strength	Weakness			
Access to Care						
Primary care medical services (a regular place to go for health care that is accessible and affordable)	1, 2	**Vasek Polak**		**YES**		
Dental Care that is affordable	1,2		❖	**NO**		
Acute mental health services	1, 2, 4		❖	**NO**		
Screening for acute/chronic conditions (e.g. diabetes, b/p, asthma, cholesterol, osteoporosis, breast cancer, etc.)	1,2,3	**Partners for Healthy Kids**		**YES**		
Wellness Education						
Mental Health Education/Coping Skills	1, 2		❖	**YES**		
Self care education programs after diagnosis (e.g. diabetes, B/P, asthma)	1	**GOAL**		**YES**		
Physical activity/Physical fitness (goal setting, classess, etc.)	1, 6	**COPA**		**YES**		
Nutrition skills education (counting carbs, reading labels, etc.)	1	**COPA**		**YES**		
Parenting Education	7		❖	**YES**		
Education about navigating the health care system	2		❖	**YES**		
Connecting People to Services						
Affordable housing	5		❖	**YES**		
Outreach and enrollment into health insurance	1, 2	**CHIP**		**YES**		
Cultural & language barriers to obtaining health care	8		❖	**YES**		
Providers who accept Medi-Cal and Healthy Families	2		❖	**NO**		
Services that allow seniors to live at home	4		❖	**YES**		

Legend (Sources):

1 LA County Health Survey
2 PLCM End User Survey
3 LA County Morbidity Survey
4 Key Informant Interview
5 LA Homeless Services Authority
6 California Department of Education
7 OSHPD
8 American Community Survey

Appendix 5

PROVIDENCE
Little Company of Mary
Medical Center
Torrance

PROVIDENCE
Little Company of Mary
Medical Center
San Pedro

October 18, 2013

Dear Community Partner,

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

The information you provide us, along with quantitative data from government and private sources, will be used to identify the program areas of greatest need across the 14 South Bay communities that make up our Service Area. We also include local feedback from patients, clients, teachers and students who have actively participated in PLCM community outreach programs in the assessment. These multiple data sources and local feedback form the foundation of our analysis of community needs and help us refine our Community Benefit Plan for the next three years.

The name of the person completing this form, and the organization they represent, will be listed in our needs assessment report but none of your comments will be attributed to you, unless I personally request your permission. If you believe other representatives of your organization should participate in this survey, please email this letter and survey to them. Please return by November 6, 2013.

You can either respond by going to Survey Monkey and completing the questions on line at https://www.surveymonkey.com/s/2013HealthCareNeedsAssessment_or complete the attached form and either email it or mail back to me. If you have any additional questions beyond what the form allows, feel free to send them to me. If you have any further questions you would like to discuss, you can call me directly at 310.257.3586 or reach me through my email, james.tehan@providence.org

So, PLEASE, during this time of economic stress for many children, families and adults, take a moment to communicate your opinion of the greatest needs of the people you work with on a daily basis. Thank you so much for your time.

Sincerely,

Jim Tehan
Director, Community Health
2601 Airport Drive, Suite 220
Torrance, CA 90505
James.Tehan@providence.org
310.257.3586 (direct)
310.257.3599 (fax)

Providence Little Company of Mary Medical Centers, San Pedro & Torrance
2013 Health Care Needs Assessment

For each target age group that your organization works with, please **RANK** your opinion of the **TOP 3** healthcare gaps in **EACH CATEGORY** below: **Access to Primary and Specialty Care, Wellness Education and Connecting People to Services.**

ACCESS TO PRIMARY AND SPECIALTY CARE	Children (0-17)	Adults (18-64)	Seniors 65+
Abuse treatment (e.g. child, domestic, elder, sexual assault)			
Acute mental health services			
Advanced Diagnostic Procedures (MRI, CAT, ultrasound)			
Dental care that is affordable			
Screening for acute/chronic conditions (e.g. diabetes, b/p, asthma, cholesterol, osteoporosis, breast cancer, etc.)			
Home care, Hospice, Long Term Care			
Optometry services that are affordable			
Primary care medical services (a regular place to go for health care that is accessible and affordable)			
Specialty medical services (e.g. Cardiology, Dermatology, Orthopedics, Neurology etc.)			
Substance Abuse treatment programs			
Other (Please specify)_____			
WELLNESS EDUCATION	**Children (0-17)**	**Adults (18-64)**	**Seniors 65+**
Self care education programs after diagnosis (e.g. diabetes, B/P, asthma)			
Education about navigating the health care system			
Mental Health Education/coping skills			
Nutrition skills education (counting carbs, reading labels,etc)			
Parenting education			
Physical activity/physical fitness (goal setting, classes, etc)			
Substance abuse prevention programs			
Violence prevention/anger management programs			
Other? (specify)			
CONNECTING PEOPLE TO SERVICES	**Children (0-17)**	**Adults (18-64)**	**Seniors 65+**
Cultural & language barriers to obtaining health care			
Affordable housing			
Outreach and Enrollment into Health Insurance			
Services for persons with developmental disabilities			
Shelter and services for the homeless			
Providers who accept Medi-Cal and Healthy Families			
Services that allow seniors to live at home			
Affordable medical transportation			
Linkage to affordable prescriptions			
Other (Please Specify)_____			

2. In your opinion, what are the specific issues or gaps in the South Bay that need to be addressed?

What part of your community contributes to: ○ **Good health (Ex. neighborhood associations, volunteer groups, accessible parks, etc)** ○ **Poor health (Ex, crime, lack of parks, air quality**
Do you have any additional comments or suggestions that would improve health in the communities you serve?

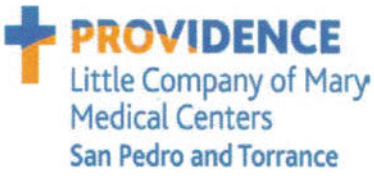
What South Bay communities does your organization serve? (List by city name)	
Briefly describe the purpose of your organization and who you serve, including the number of individuals served in 2012.	

Organization Name	
Address	
City/ Zip	
Phone	
Name/Title of Person Completing Survey	
What are the core services you provide to your clients?	
Populations served (Age)	

Please complete and return by email or mail to:

James Tehan
Providence Little Company of Mary
Community Health Department
2601 Airport Dr. Suite #220
Torrance, CA, 90505
James.tehan@providence.org

2013 CHNA END USER SURVEY



Date: _____
Survey #:_____

(INTERVIEWER: PLEASE READ SCRIPT AND FILL IN THE BLANKS WITH APPROPRIATE RESPONSES SUCH AS YOUR NAME.)

(SCRIPT 1A): Hello. I'm _____ and I'm calling from Providence Little Company of Mary Community Benefits Department. We are conducting a short survey from households that have used our services in the past three years. ***(CONTINUE TO SCRIPT 1B)***

(SCRIPT 1B) May I please speak with MR/MRS. _____

(NOTE: IF PERSON STATES THEY ONLY SPEAK SPANISH AND NO ENGLISH START OVER USING SPANISH SCRIPT.)

A. Yes
B. No
C. No one over 18 available
D. Person hung up

- IF NO OR NO OR PERSON NOT AVAILABLE CONTINUE TO SCRIPT 2.

- IF YES CONTINUE TO SCRIPT 3.

- IF PERSON HUNG UP PROCEED TO NEXT CALL.

(SCRIPT 2) When would be a better time to call back?

A. Schedule callback time: _____
B. Refused

(IF CALL BACK SCHEDULED READ SCRIPT 2B AND PROCEED TO NEXT CALL AND FOLLOW UP ON CALLBACK AS SCHEDULED.

IF REFUSED READ SCRIPT 2B THEN PROCEED TO NEXT CALL.)

(SCRIPT 2B) Thank you very much for your time.

(IF SPEAKING TO THE SAME PERSON WHO ANSWERED CONTINUE WITH SCRIPT 3.
IF SPEAKING TO A NEW PERSON RE-READ SCRIPT 1A THEN CONTINUE TO SCRIPT 3.)

(SCRIPT 3) We are calling to collect health and health service related information from a list of South Bay residents who have used our services. We are using this information for a community health needs assessment that will help us develop and improve community services that benefit South Bay residents. The survey is absolutely confidential and the answers given will not be identified with your household in any way except your zip code. If you have any questions about the survey you may contact the Director of Community Partnerships Jim Tehan at (310) 257-3586. The survey will take approximately 25-30 minutes. May I begin?

A. Yes
B. No
C. Person hung up

(IF YES PROCEED TO SCRIPT 4 FOLLOWED BY QUESTION 1.
IF NO GO BACK TO SCRIPT 2 - FOLLOW INSTRUCTIONS AND END CALL USING SCRIPT 2B.)

(SCRIPT 4) If you prefer not to answer any question please tell me and I will simply go on to the next question.

ABOUT YOUR HEALTH

(PLEASE READ) I would like to start by asking a few questions about your health.

1. First, can you please tell me your zip code? ***(INSERT 5 DIGIT ZIP CODE HERE)*** _____

2. In the past five years, has a doctor told you that you have any of the following health problems or conditions:***(NOTE: MARK RESPONSE AFTER READING EACH DISESE)*** Diabetes or sugar diabetes, High blood pressure, Asthma or lung conditions, remember in the past five years, Heart disease, High cholesterol, Depression, Post traumatic stress disorder, Anxiety?

	Yes	No	Don't know	Refused

(MARK RESPONSE BELOW)

Diabetes/ Sugar Diabetes				
High Blood Pressure				
Asthma/Lung Condition				
Heart Disease				
High Cholesterol				
Depression				
Post Traumatic Stress Disorder				
Anxiety				

3. In general, how would you rate your physical health? Is it excellent, very good, good, fair, or poor?
   A. Excellent
   B. Very Good
   C. Good
   D. Fair

E. Poor
F. Refused ***(DO NOT READ)***

4. In general, how would you rate your mental health, including your mood and ability to think? Is it excellent, very good, good, fair, or poor?
   A. Excellent
   B. Very Good
   C. Good
   D. Fair
   E. Poor
   F. Refused ***(DO NOT READ)***

(READ BEFORE ASKING QUESTION 5) I am going to read you the definition of social health before the next question. Social health is defined as the part of an individual's health that relates to how he/she gets along with other people, how other people react to him/her, and how he/she interacts with social institutions and societal moves.

5. In general, how would you rate your social health? Is it excellent, very good, good, fair, or poor?
   A. Excellent
   B. Very Good
   C. Good
   D. Fair
   E. Poor
   F. Refused ***(DO NOT READ)***

6. Thinking about your physical health, mental health, social health combined how would you rate your OVERALL health? Is it excellent, very good, good, fair, or poor?

A. Excellent
B. Very good
C. Good
D. Fair
E. Poor
F. Refused ***(DO NOT READ)***

PLACES WHERE YOU GET HEALTH CARE

(READ) Thank you, now I would like to ask you about places where you get health care.

7. In the last year, have you *(MARK RESPONSE BELOW AFTER READING EACH OF THE FOLLOWING THEN CONTINUE TO NEXT ONE)*: Visited a doctor or medical clinic for any reason, including check-ups, Visited an emergency room, or Stayed overnight in a hospital

	Visited a Doctor or medical clinic for any reason including checkups	Visited an emergency room	Stayed overnight in a hospital
Yes			
No			
Don't Know			
Refused ***(DO NOT READ)***			

8. Where do you USUALLY go when you are sick OR need health care?

(READ CHOICES BELOW, IF RESPONDENT SAYS HMO ASK WHERE VISIT OCURRED AND MARK ANSWER.)

A. Doctor's office or private clinic
B. Community health center or other public clinic
C. Hospital outpatient department
D. Hospital emergency room
E. Some other place
F. No regular place of care
G. Refused ***(DO NOT READ)***

9. **Do you have a regular doctor you usually go to when you are sick or need health care? Yes, no, or don't know, has more than one doctor?**

A. Yes
B. No
C. Don't know
D. Has more than one regular doctor
E. Refused ***(DO NOT READ)***

10. **How far do you have to travel to get to the place where you usually get medical care?** ***(READ ALL CHOICES BELOW)***

A. 0-2 miles
B. 2-5 miles
C. 6-10 miles
D. More than 10 miles
E. Refused ***(DO NOT READ)***

11. **When you travel to get to the place you usually get medical care do you:** ***(READ ALL CHOICES BELOW)***

A. Drive there
B. Have someone drive you
C. Take a bus
D. Take a taxi
E. Walk
F. Refused ***(DO NOT READ)***

HEALTH INSURANCE

***(READ)* Thank you, now I would like to ask you some questions about health insurance**

12. . Are YOU YOURSELF covered by health insurance or any other kind of health care plan? *(READ ALL CHOICES)*

***(IF NECESSARY SAY)*: This includes health insurance obtained through an employer, purchased directly, HMOs or pre-paid plans like Kaiser(KY-ZER), government programs such as Medicare, Medi-Cal, Medicaid, Healthy Families, military programs such as Champus, Champ VA, or the Indian Health Service.)**

A. Yes, Covered
B. No, NOT Covered
C. Don't Know
D. Refused ***(DO NOT READ)***

13. How well would you say you understand how to use your health insurance plan? *(READ ALL CHOICES)*

A. Very well
B. Somewhat
C. Not at all
D. Refused ***(DO NOT READ)***

14. **Where would you feel most comfortable learning about how to use health insurance? *(READ ALL CHOICES AND MARK ALL THAT APPLY))***

A. School
B. Clinic or Doctor's Office
C. Church
D. Place of Employment
E. Hospital
F. Health Fair
G. Other ***(PLEASE SPECIFY)***_____
H. Refused ***(DO NOT READ)***

YOUR NUTRITION/ PHYSICAL ACTIVITY

***(READ)* Thank you, now I would like to ask you some questions about your nutrition and physical activity.**

15. **How easy or difficult is it for you to get fresh produce such as fruits and vegetables? *(READ CHOICES)***

A. Very Difficult
B. Somewhat Difficult
C. Somewhat Easy
D. Very Easy
E. Don't Know
F. Refused ***(DO NOT READ)***

If answer to 15 is "Very Difficult" or "Somewhat Difficult" ask question 16. If reply is "Somewhat easy," "Very Easy," "Don't Know," or "Refused," go to question #17.

16. IS THIS BECAUSE *(READ ONE AT A TIME AND MARK ANSWER):* Stores in your neighborhood don't sell fresh fruits and vegetables, The quality of fresh fruits and vegetables where you live is poor, or Fresh fruits and vegetables are too expensive?

	Stores in your neighborhood don't sell fresh fruits and vegetables	The quality of fresh and vegetables where you live is poor	Fresh fruits and vegetables are too expensive.
Yes			
No			
Don't Know			
Refused ***(DO NOT READ)***			

17. In the LAST 12 MONTHS, did you or any other adults in your household ever have to cut the size of your meals or skip meals entirely because there wasn't enough money for food? Yes, No, or Don't know?

A. Yes
B. No
C. Don't Know
D. Refused ***(DO NOT READ)***

(IF ANSWER TO QUESTION 17 IS YES ASK 18. IF NO, DON'T KNOW OR REFUSED, GO TO QUESTION 19).

18. **How often did this happen? *(READ ALL THE CHOICES)***

A. Almost every month
B. Some months but not every month
C. Only one or two months?
D. Don't Know
E. Refused ***(DO NOT READ)***

19. **How often do you use walking paths, parks, playgrounds, or sports fields in your neighborhood? Would you say…*(READ ALL CHOICES)***

A. Every day
B. Most Days
C. Some days
D. Not at all
E. Refused ***(DO NOT READ)***

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20. How often do you feel unsafe walking or using playgrounds and parks in your neighborhood? *(READ ALL CHOICES)*

A. Always,
B. Usually,
C. Sometimes,
D. Never
E. Refused ***(DO NOT READ)***

YOUR MENTAL HEALTH

***(PLEASE READ)* Thank you now I am going to ask you a question about your mental health.**

21. **During the past 2 weeks, about how often have you been bothered by the following problems: *(READ A,B,C,D BELOW INDIVIDUALLY WITH RESPONSES- NOT AT ALL, SEVERAL DAYS…ETC AND MARK ANSWER BEFORE MOVING ON TO NEXT LETTER.)***

	Not at all	Several Days	Over half the days	Nearly every day	Refused ***(DO NOT READ)***
A. Little interest or pleasure in doing things					
B. Feeling down, depressed, or hopeless?					
C. Feeling nervous, anxious, or on edge?					
D. Not being able to stop or control worrying?					

DENTAL CARE

***(READ)* Thank you, now a few questions on your dental care.**

22. Was there a time in the last 12 months when you needed dental care?
(READ ALL CHOICES)

A. Yes
B. No
C. Don't Know
D. Refused ***(DO NOT READ)***

23. The most recent time you went without needed dental care, what were the main reasons? *(READ ALL CHOICES AND MARK ALL THAT APPLY, IF RESPONDENT WANTS TO GO TO THE NEXT QUESTION AFTER THEY PROVIDE AN ANSWER CONTINUE TO NEXT QUESTION.)*

A. I was worried about the cost
B. I didn't know where to go
C. I didn't have transportation
D. I didn't have childcare
E. The office wasn't open when I could get there
F. I thought I could handle it without treatment
G. I didn't think getting treatment would help
H. I haven't had to skip any needed care
I. Refused ***(DO NOT READ)***

DEMOGRAPHICS

***(READ)* Thank you now I am going to ask you a few questions to get a better idea of our community residents.**

24. **What is your Gender?** ***(READ ALL CHOICES)***

A. Male
B. Female
C. Refused ***(DO NOT READ)***

25. **What is your marital status?** ***(READ ALL CHOICES STOP IF RESPONDENT ANSWERS)***

A. Single
B. Married/Living as Married
C. Divorced/Separated
D. Widowed
E. Living with a partner
F. Refused ***(DO NOT READ)***

26. **Would you mind telling me what year you were born in?**
(NOTE: IF THEY REFUSE ASK IF THEY WOULD BE WILING TO SAY IF THEY ARE IN THEIR 20's, 30's, 40's, etc.)

A. Fill in response_____
B. Refused ***(DO NOT READ)***

27. **Are you employed full-time, part-time, retired, or not employed for pay?**
(IF ANSWER IS SELF EMPLOYED ASK IF FULL-TIME OR PART-TIME. NOTE: FULL TIME IS 35 HOURS A WEEK OR MORE.)

A. Full-time
B. Part-time
C. Retired
D. Not employed for pay
E. Disabled ***(DO NOT READ)***
F. Student ***(DO NOT READ)***
G. Other ***(DO NOT READ)***
H. Refused ***(DO NOT READ)***

28. **What is the last grade or class that you completed in school?**
(READ CHOICES STOP WHEN RESPONDENT ANSWERS, MARK ANSWER AND GO TO NEXT QUESTION)

A. Less than high school ***(READ IF NEEDED)*:grades 1-11, grade 12 but no diploma)**
B. High school graduate or equivalent ***(READ IF NEEDED)*** **example, GED.**
C. Some college but no degree (***READ IF NEEDED)*** **includes 2 year occupational or vocational program.**
D. College graduate (e.g. BA, AB, BS)
E. Postgraduate ***(READ IF NEEDED)*** **example MA, MS, MEng, MSW, MBA, MD, DDs, PhD, JD)**
F. Refused ***(DO NOT READ)***

29. **How would you describe your race? [ACCEPT MULTIPLE RESPONSES** ***READ ALL CHOICES IF REPONDENT ANSWERS, MARK ANSWER AND GO TO NEXT QUESTION)***]

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A. White
B. African American/Black
C. Asian
D. American Indian or Alaska Native
E. Native Hawaiian or Pacific Islander
F. Other **(SPECIFY)**_____
G. Refused ***(DO NOT READ)***

30. **Would you describe yourself as being of Hispanic or of Latino origin or descent?** ***(READ ALL CHOICES)***

A. Yes, Hispanic or Latino
B. No, not Hispanic or Latino
C. Refused ***(DO NOT READ)***

31. **Including yourself, how many family members counting adults and children, live in your household?**
(READ ALL RESPONSES BUT STOP WHEN RESPONDENT PROVIDES ANSWER, MARK ANSWER AND GO TO NEXT QUESTION.)

A. One
B. Two
C. Three
D. Four
E. Five
F. Six
G. More than six
H. Refused ***(DO NOT READ)***

32. **I am going to read some yearly income ranges. When I read the one that your 2012 total household income falls within say stop.**
(READ CHOICES BUT STOP WHEN RESPONDENT SAYS STOP,MARK ANSWER AND GO TO OPEN ENDED QUESTIONS SECTION.)

A. Less than 10,000
B. $10,000-$19,999
C. $20,000-$29,999
D. $30,000-$39,000
E. $40,000-$49,999
F. $50,000-$59,999
G. $60,000-$69,000
H. $70,000 or more
I. Refused ***(DO NOT READ)***

(CLOSING SCRIPT, READ): **This concludes the survey. Thank you very much for participating in this important survey for Providence Little Company of Mary and South Bay residents. Enjoy the rest of your day.**

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OPEN ENDED QUESTIONS

Thank you. Lastly, I just have a few questions I would like to get your feedback on.

33. **Do you think there are enough healthy eating choices available in your neighborhood?**
(IF NEEDED SAY) "FOR EXAMPLE, LIKE RESTAURANTS, GROCERY STORES, OR FARMERS MARKETS WHERE YOU CAN BUY HEALTHY FOODS."
(IF ONE WORD ANSWER SAY): "WHAT MAKES YOU FEEL THAT WAY?"

34. **Do you think there are enough spaces to walk, bicycle, exercise, or enjoy the outdoors in your neighborhood**
(IF NECESSARY SAY): "THINK ABOUT THE LAST TIME YOU WANTED TO USE ONE OF THESE PLACES."

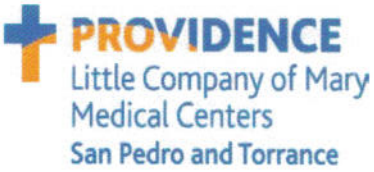
35. **Assuming there were enough parks, bicycle paths and farmers markets, what would it take for you to increase the use of them?**
***(IF NECESSARY SAY)*: "THINK ABOUT REASONS THAT MIGHT CAUSE YOU NOT USE THESE PLACES."**

36. **What do you think is the most important health problem or issue in your community?** ***(IF NECESSARY SAY): "THINK ABOUT THE HEALTH PROBLEMS YOU SEE IN YOUR COMMUNITY."***

37. **Can you identify the specific areas in your community where the issues you identified in the previous question are a major problem?**
IF NECESSARY SAY): "THINK ABOUT PLACES IN OR AROUND THE COMMUNITY WHERE YOU REALLY HAVE NOTICED THIS."

38. **Why do you think they are such a big problem in those areas**
(IF NECESSARY SAY): "WHAT DO YOU THINK IS CAUSING THE ISSUUES YOU DESCRIBED IN THOSE AREAS?"

ENCUESTA DE USUARIO FINAL
CHNA 2013



(POR FAVOR LLENE LAS LINEAS)

Fecha: _____
ID De Encuesta: _____

(ENTREVISTADOR: POR FAVOR LEA LOS GUIONES Y LLENE LOS ESPACIOS EN BLANCO CON RESPUESTAS APROPIADAS TAL COMO SU NOMBRE.)

(GUION 1A): Hola. Soy _____y estoy llamando desde Providence Little Company of Mary Departamento de beneficios de la comunidad. Estamos llevando a cabo una encuesta de hogares que han utilizado nuestros servicios en los últimos tres años.
(CONTINUE A GUION 1B)

(GUION 1B) ¿Podría hablar con el señor or señora _____?

A. Sí
B. No
C. Nadie mayor de 18 años disponible
D. Persona colgó

- (SI LA RESPUESTA ES NO O LA PERSONA NO ESTA DISPONIBLE, CONTINÚAN A GUION 2.

- S LA RESPUESTA ES SI, CONTINÚE A GUION 3.

- SI LA PERSONA COLGÓ PUEDE PROCEDER A LA PRÓXIMA LLAMADA.

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(GUION 2) ¿Cuándo sería un mejor momento para llamar?

A. horario de llamada hecha _____
B. Se negó

(SI VA A VOLVER A LLAMAR A LA PERSONA EN UN TIEMPO MEJOR LEA GUIÓN 2B Y PROCEDA A LA PRÓXIMA LLAMADA)

(SI LA PERSONA SE RECHAZÓ, ENTONCES PROCEDA A LA PRÓXIMA LLAMADA)

(GUION 2B): Muchas gracias por su tiempo.

(SI HABLA CON LA MISMA PERSONA QUE RESPONDIÓ CONTINÚE CON GUION 3)

(SI HABLA CON UNA NUEVA PERSONA VUELVA A LEER GUIÓN 1A Y CONTINÚE AL GUION 3)

(GUION 3): Estamos llamando para colectar infomacion sobre la salud y de servicios de salud relacionada de una lista de los residentes de South Bay que han utilizado nuestros servicios. Vamos a utilizar esta información para una evaluación de las necesidades de salud comunitaria que nos ayudará a desarrollar y mejorar los servicios comunitarios que benefician a los residentes del South Bay. La encuesta es totalmente confidencial y las respuestas dadas no se identificará con su familia de cualquier manera excepto su código postal. Si tienes alguna pregunta acerca de la encuesta puede comunicarse con el Director de asociaciones de la cominidad Jim Tehan al (310) 257-3586. La encuesta tomará aproximadamente 25-30 minutos. ¿Puedo comenzar?

A. Sí
B. No
C. Persona colgó

(EN CASO AFIRMATIVO PROCEDA A GUION 4 Y PROCEDA A LA PREGUNTA 1.
SI LA RESPUESTA ES NO VUELVA AL GUION 2 - SIGA LAS INSTRUCCIONES Y TERMINE LA LLAMA CON GUION 2B)

(GUION 4): Si usted prefiere no contestar cualquier pregunta por favor diga y yo simplemente procederé a la siguiente pregunta.

SOBRE SU SALUD

(Lea) **Me gustaría empezar con unas cuantas preguntas sobre su salud.**

1. ¿ Primero, podría por favor indicarme su código postal? ***(INSERTE AQUÍ EL CÓDIGO POSTAL DE 5 DÍGITOS)*** _____

2. En los últimos cinco años, un médico te a comentado que tiene cualquiera de los siguientes problemas de salud o condiciones:***(NOTA: MARCE LA RESPUESTA DESPUÉS DE LEER CADA PREGUNTA)*** Diabetes o diabetes de azucar, presion arterial alta o hipertensión, asma o afecciones pulmonares, recuerda en los últimos cinco años, cardiopatías, alto trastorno de estrés postraumático, depresión, el colesterol alto, ansiedad?

	Sí	No	No sé	Se negó

(MARCA LA RESPUESTA MÁS ABAJO)

Diabetes Diabetes de azúcar				
Presión arterial alta/hipertension				
Condición de asma pulmonar				
Enfermedades del corazón				
Colesterol alto				
Depresión				
Trastorno de estrés postraumático				
Ansiedad				

3. En general, ¿cómo definirías tu salud física? ¿Es excelente, muy buena, buena, justa o pobre?

A. Excelente

B. Muy buena

C. Buena

D. justa

E. Pobre

F. Rechazado *(NO LEA)*

4. En general, cómo calificaría su salud mental, incluyendo su estado de ánimo y la capacidad de pensar? Es excelente, muy bueno, bueno, justo o pobres?

A. Excelente

B. Muy bien

C. Buena

D. Justo

E. Pobre

F. Rechazado *(NO LEA)*

(LEA ANTES DE PREGUNTA 5) **Voy a leer la definición de salud social antes de la siguiente pregunta. Salud social se define como la parte de la salud de un individuo que se refiere a cómo reacciona con otras personas, cómo otras personas reaccionan a él/ella y cómo interactúa con las instituciones sociales y movimientos sociales.**

5. En general, ¿cómo definirías tu salud social? ¿Es excelente, muy buena, buena, justa o pobre?

A. Excelente

B. Muy bien

C. Buena

D. Justa

E. Pobre

F. Rechazado *(NO LEA)*

6. Pensando en su salud física, salud mental, salud social combinado cómo calificaría su salud general? Es excelente, muy buena, buena, justa o pobre?

A. Excelente

B. Muy bueno

C. Buena

D. Justa

E. Pobre

F. Rechazado *(NO LEA)*

LUGARES DONDE USTED RECIBIR ATENCIÓN MÉDICA

***(LEA)* Gracias, ahora me gustaría preguntarte sobre los lugares donde usted recibe atención médica.**

7. En el último año, tienes *(MARCA LA RESPUESTA ABAJO DESPUÉS QUE LEA CADA UNA DE LSS SIGUIENTES, DESPUÉS CONTINUE A LA SIGUIENTE EN EL SERIE)*: visitado un doctor o una clínica médica por cualquier razón, incluyendo chequeos, visitó la sala de emergencias, o pasado la noche en un hospital

	Visitó a un médico o una clínica médica	Visitó la sala de emergencias	Pasó la noche en un hospital

	por cualquier razón incluyendo chequeos		
Sí			
No			
No sé			
Rechazado *(NO LEA)*			

8. Donde suele ir cuando usted está enfermo o necesita atención médica?

(LEA OPCIONES ABAJO, SI DEMANDADO DICE HMO PREGUNTE DONDE VISITAR OCURRIDAS Y MARK RESPUESTA.)

A. Médico o clínica privada

B. Centro de salud comunitario u otra clínica pública

C. Departamento de consulta externa del hospital

D. Sala de emergencia en un hospital

E. Otro lugar

F. Ningún lugar regular de cuidado

G. Se negó *(NO LEA)*

9. ¿ Tienes un médico normal donde generalmente vas cuando usted está enfermo o necesita atención médica? ¿Sí, no, o no sé, tiene más de un médico?

A. Sí

B. No

C. No sé

D. Tiene más de un médico regular

E. Rechazado *(NO LEA)*

10. **¿Cuánto tienes que viajar para llegar al lugar donde suele recibe atención médica?** ***(LEA TODAS LAS OPCIONES DE ABAJO)***

A. 0-2 millas

B. 2-5 millas

C. 6-10 millas

D. Más de 10 millas

E. Rechazado ***(NO LEA)***

11. **Cuando viaja al lugar donde suele obtiene atención médica :** ***(LEA TODAS LAS OPCIONES ABAJO)***

A. Va en auto

B. alguien me lleva

C. Toma un autobús

D. Toma un taxi

E. Camina

F. Rechazado ***(NO LEA)***

SEGURO DE SALUD

(LEER) **Gracias, ahora me gustaría hacerle algunas preguntas sobre seguros de salud**

12. **¿ Esta usted cubierto por un seguro de salud o cualquier otro tipo de plan de atención médica?** ***(LEA TODAS LAS OPCIONES)***

(SI ES NECESARIO DIGA) **: Esto incluye seguro médico obtenido a través de un empleador, comprado directamente, HMO o planes de prepagos como Kaiser(KY-ZER), programas de gobierno tales como Medicare, Medicaid, Medi-Cal, Healthy Families, programas militares como Champus, Champ VA o el servicio de salud indio.)**

A. Sí, cubiertas

B. No, no cubierto

C. No sé

D. Rechazado *(NO LEA)*

13. **¿ Cómo diría que usted entiende cómo usar su plan de seguro de salud?** ***(LEA TODAS LAS OPCIONES)***

A. Muy bueno
B. Algo
C. En absoluto
D. Se negó ***(NO LEA)***

14. **Donde te sentirías más cómodo aprender sobre cómo usar el seguro de salud?** ***(LEA TODAS LAS OPCIONES Y MARQUEN TODOS LOS QUE APLIQUEN)***

A. Escuela
B. Clínica o consultorio
C. Iglesia
D. Lugar de trabajo
E. Hospital
F. Feria de la salud
G. Otros ***(por favor especificar)*** _____
H. Rechazado ***(NO LEA)***

SU NUTRICIÓN / ACTIVIDAD FÍSICA

(LEA) **Gracias, ahora me gustaría hacerle algunas preguntas acerca de su nutrición y actividad física.**

15. **¿Qué tan Fácil o difícil es conseguir productos frescos como frutas y verduras?** ***(LEA OPCIONES)***

A. Muy difícil
B. Algo difícil
C. Algo fácil
D. Muy fácil
E. No sé
F. Se negó ***(NO LEA)***

SI LA RESPUESTA DE PREGUNTA 15 ES "MUY DIFÍCIL" O "ALGO DIFÍCIL" CONTINUE A PREGUNTA 16. SI LA RESPUESTA ES "ALGO FÁCIL", "MUY FÁCIL", "NO SÉ" O "RECHAZADO", VAYA A LA PREGUNTA #17.

16. **¿Es porque *(LEA CADA UNO Y MARQUE LA RESPUESTA):* tiendas en su vecindario no venden frutas y verduras frescas, la calidad de las frutas y verduras donde usted vive es pobre, o frutas y verduras frescas son demasiado caras?**

	Tiendas en su vecindario no venden frutas y verduras frescas	La calidad de los frescos y verduras donde usted vive es pobre	Frutas y verduras frescas son muy costosas.
Sí			
No			
No sé			
Rechazado ***(NO LEA)***			

17. **En los últimos 12 meses, ¿usted o cualquier otro adulto en su hogar a tenido que reducir el tamaño de sus comidas o saltarse comidas totalmente porque no había suficiente dinero para comida? Sí, No, o no sabe?**

A. Sí
B. No
C. No sé
D. Rechazado ***(NO LEA)***

(SI LA RESPUESTA A LA PREGUNTA 17 ES SÍ PREGUNTE LA PREGUNTA 18. SI LA RESPUESTA ES NO, NO SÉ, O SE SE NEGÓ, VAYA A LA PREGUNTA 19).

18. **¿Cuántas veces ha ocurrido esto? *(Lea todas las opciones)***

A. Casi cada mes
B. Algunos meses pero no cada mes
C. Sólo uno o dos meses?
D. No sé
E. Rechazado ***(no leer)***

19. **¿Con qué frecuencia usas caminos publicos, parques, patios de recreo o campos de deportes en su barrio? Diría... *(LEA TODAS LAS OPCIONES)***

A. Todos los días

B. Casi todos los días

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C. Algunos días

D. En absoluto

E. Rechazado *(NO LEA)*

20. Con qué frecuencia te sientes inseguro caminar o usar parques y patios en tu vecindario? ***(LEA TODAS LAS OPCIONES)***

A. Siempre,

B. Por lo general,

C. A veces,

D. Nunca

E. Rechazado ***(no leer)***

SU SALUD MENTAL

(LEA) **Gracias ahora voy a hacer una pregunta sobre su salud mental.**

21. **Durante las últimas 2 semanas, acerca de cuántas veces has sido molestado por el siguientes problemas:**

(LEA: A, B, C, D ABAJO INDIVIDUALMENTE CON LAS RESPUESTAS, COMO NO EN TODOS, VARIOS DÍAS...ETC. Y MARQUE LA RESPUESTA ANTES DE PASAR A LA SIGUIENTE LETRA.)

	Para nada	Varios días	Más de la mitad de los días	Casi todos los días	Rechazado *(NO LEA)*
A. poco interés o placer en hacer cosas					
¿B. sensación					

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abajo, deprimido o desesperanzado?					
C. sentirse nervioso, ansioso o en el borde.					
¿D. no ser capaz de parar o controlar preocuparse?					

CUIDADO DENTAL

***(Leer)* Gracias, ahora algunas preguntas sobre su cuidado dental.**

22. ¿Hubo algún momento en los últimos 12 meses cuando necesitabas cuidado dental?

(LEA TODAS LAS OPCIONES)

A. Sí
B. No
C. No sé
D. Rechazado ***(NO LEA)***

23. La más reciente vez que te fuiste sin cuidado dental, ¿cuáles fueron las principales razones? *(LEA TODAS LAS OPCIONES Y MARQUE TODOS LOS QUE APLICAN, SI EL DEMANDADO QUIERE IR A LA SIGUIENTE PREGUNTA DESPUÉS QUE PROPORCIONAN UNA RESPUESTA CONTINUE A LA SIGUIENTE PREGUNTA.)*

A. Estaba preocupado por el costo
B. No sabía dónde ir
C. No tenía transporte
D. No tuve quien cuidar a los niños
E. La oficina estaba cerrada cuando conseguí cita
f el. Pensé que podía manejarlo sin tratamiento
G. No pensé que ayudaría obtener tratamiento
H. No tuve que omitir cualquier asistencia necesaria
i Rechazado ***(NO LEA)***

DEMOGRAFÍA

***(LEA)* Gracias ahora voy a hacerle unas preguntas para tener una mejor idea de los residentes de nuestra comunidad.**

24. **¿Cuál es tu género?** ***(LEA TODAS LAS OPCIONES)***

A. Macho
B. Hembra
C. Rechazado ***(NO LEA)***

25. **¿Cuál es su estado civil?** ***(LEA TODAS LAS OPCIONES PARE SI EL DEMANDADO CONTESTA)***

A. Soltero
B. Casado o viviendo como casado
C. Divorciados/separados
D. Viudo
E. Vive con mi pareja
F. Rechazado ***(NO LEA)***

26. **Me puedes decir en qué año naciste?**

(NOTA: SI SE NIEGAN, PREGUNTE SI PODRÍA ESTAR DISPUESTO A DECIR SI ESTÁN EN SUS AÑOS 20, 30, 40, ETC..)

A. Rellene response_____
B. Rechazado ***(NO LEA)***

27. **Estas empleado a tiempo completo, a tiempo parcial, retirado o no empleado por dinero?**

(PREGUNTE SI LA RESPUESTA ES "TRABAJO POR MI MISO" SI A TIEMPO COMPLETO O A TIEMPO PARCIAL. NOTA: TIEMPO COMPLETO ES DE 35 HORAS A LA SEMANA O MÁS.)

A. A tiempo completo
B. A tiempo parcial
C. Jubilado
D. No se emplea por dinero
E. Incapacitado (***NO LEA)***
F. Estudiante ***(NO LEA)***
G. Otro ***(NO LEA)***
H. Rechazado ***(NO LEA)***

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28. **¿Qual es el grado o la clase que completó en la escuela?**

(LEA LAS OPCIONES Y PARE CUANDO EL DEMANDADO RESPONDA, MARQUE LA RESPUESTA Y VAYA A LA SIGUIENTE PREGUNTA)

A. Menos que la escuela secundaria ***(LEA SI ES NECESARIO):*** **de los grados 1-11, 12 pero ningún diploma)**
B. Graduado de secundaria o equivalente ***(LEA SI ES NECESARIO)*** **, GED.**
C. De Alguna universidad pero sin grado (***LEA SI ES NECESARIO)*** **INCLUYE PROGRAMA OCUPACIONAL O VOCACIONAL DE 2 AÑOS.**
D. Graduado de la Universidad ***(POR EJEMPLO AB, BA, BS)***
E. Maestria o doctorado ***(LEA SI ES NECESARIO)*** **EJEMPLO MA, MS, MENG, MSW, MBA, MD, DDS, PHD, JD)**
F. Rechazado ***(NO LEA)***

29. **¿Cómo describirías tu raza? [ACEPTE MÚLTIPLES RESPUESTAS,** ***LEA TODAS LAS OPCIONES Y SI CONTESTA EL DEMANDADO MARQUE LA RESPUESTA Y SIGA A LA PRÓXIMA PREGUNTA)*****]**

A. Blanco
B. Americano africano/negro
C. Asian
D. Indio americano o nativo de Alaska
E. Nativo hawaiano o isleño del Pacífico
F. Otro **(ESPECIFICAR)** ___
G. Rechazado ***(NO LEA)***

30. **Se describiría como hispano o de origen Latino o descendente de Latinos?**

(LEA TODAS LAS OPCIONES)

A. Sí, hispano o Latino
B. No, hispano o Latino
C. Rechazado ***(NO LEA)***

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31. **Incluyéndolo a usted, cuántos miembros de la familia contando adultos y niños, viven en su casa?**

(LEA TODAS LAS RESPUESTAS PERO SI EL DEMANDADO CONTESTA MARQUE LA RESPUESTA Y VAYA A LA PRÓXIMA PREGUNTA).

A. Uno
B. Dos
C. Tres
D. Cuatro
E. Cinco
F. Seis
G. Más de seis
H. Rechazado ***(NO LEA)***

32. **Voy a leer algunas gamas de ingresos anuales. Cuando lea la gama en el que tu ingreso de hogar total del 2012 este digame que pare.**

(LEA LAS OPCIONES PERO PARADA CUANDO EL DEMANDADO DIGA QUE PARE, MARQUE LA RESPUESTA Y CONTINUE CON LAS PREGUNTAS DE TERMINO ABIERTAS).

A. Menos de 10.000
B. $10.000-$19.999
C. $20.000-$29.999
D. $30.000-$39.000
E. $40.000-$49.999
f el. $50.000-$59.999
G. $60.000-$69.000
H. $70.000 o más
I. Rechazado ***(NO LEA)***

(ULTIMO GUION): **Esto concluye la encuesta. Muchas gracias por participar en esta encuesta muy importante para Providence Little Company of Mary y los residentes del South Bay. Disfrute el resto de su día. Audios**

PREGUNTAS DE TERMINO ABIERTAS

Appendix 7

(LEA) Gracias. Por último, tengo unas preguntas de las que cual me gustaría obtener sus respuestas.

33. Crees que hay suficientes opciones saludables para comer disponibles en tu barrio? ***(SI NECESARIO DIGA) "POR EJEMPLO, COMO RESTAURANTES, TIENDAS, O MERCADOS AGRICULTORES DONDE SE PUEDEN COMPRAR ALIMENTOS SALUDABLES". (SI LA RESPUESTA ES UNA PALABRA LEA): "¿QUÉ TE HACE SENTIR ASÍ?"***

34. ¿Crees que hay suficientes espacios para caminar, andar en bicicleta, o disfrutar del aire libre en su vecindario ***(SI ES NECESARIO DIGA): "PIENSE EN LA ÚLTIMA VEZ QUE QUERÍA USAR UNO DE ESTOS LUGARES".***

35. Asumiendo que había suficientes parques, caminos de bicicleta, y mercados de agricultores, qué hace falta para que aumente el uso de ellas? (SI ES NECESARIO DIGA) : "PIENSE EN RAZONES QUE PODRÍAN OCASIONAR QUE NO UTILICE ESTOS LUGARES."

36. ¿Qué crees que es el más importante problema de salud o problemas en su comunidad? ***(SI ES NECESARIO DECIR): "PENSAR EN LOS PROBLEMAS DE SALUD QUE VES EN TU COMUNIDAD."***

37. Puede identificar las áreas específicas de su comunidad donde las razones que identificó en la pregunta anterior son un problema grave?
SI FUERA NECESARIO DIGA): "PIENSE EN LUGARES EN O ALREDEDOR DE LA COMUNIDAD DONDE USTED REALMENTE HA NOTADO ESTO."

38. ¿Por qué crees que son un gran problema en esas áreas ***(SI ES NECESARIO DIGA): "¿QUÉ CREES QUE ESTÁ CAUSANDO EL PROBLEMA QUE DESCRIBIÓ EN ESAS ZONAS?"***

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Code: _ _ _ _ _

St. Joseph's Community Health Coalition
Needs Assessment

The purpose of this survey is to allow St. Joseph's Community Health Coalition to coordinate church activities that promote healthy eating and motivate church members to have healthy diets, participate in regular physical activity, and seek preventive care. Please complete this survey to the best of your ability. Your participation in this anonymous survey will NOT affect your relationship with St. Joseph's Church and you may cease your participation at any time without penalty.

1. In general, would you say your health is:
   ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

2. How long has it been since you last saw a doctor, nurse, or other health care professional for any reason?
   ❑ Less than 12 months ❑ 1 year but less than 2 years ❑ 2 years but less than 5 years
   ❑ 5 or more years ❑ Never ❑ Don't know

3. How long has it been since you last visited a dentist or dental clinic for any reason?
   ❑ Less than 12 months ❑ 1 year but less than 2 years ❑ 2 years but less than 5 years
   ❑ 5 or more years ❑ Never ❑ Don't know

4. Where do you USUALLY go when you are sick OR need health care?
   ❑ Doctor's office or private clinic ❑ Community clinic or County clinic ❑ Hospital Outpatient department
   ❑ Hospital Emergency Room ❑ Some other place ❑ No regular place of care

5. Have you ever been told by a doctor or other health professional that you have...?
   ❑ Diabetes ❑ High blood pressure or hypertension ❑ High cholesterol
   ❑ Depression ❑ No, I've never been told by a doctor that I have any of the mentioned conditions

6. How many total servings of fruits and vegetables did you eat yesterday? (e.g., a serving would equal one medium apple, a handful of broccoli, or cup of carrots.)
   _____ # of servings

7. How difficult is it for you to get fresh produce (fruits and vegetables)?
   ❑ Very Difficult ❑ Somewhat Difficult ❑ Somewhat Easy ❑ Very Easy ❑ Don't Know

8. Where do you receive health information/news about the Lennox, Inglewood, and Hawthorne Area?
   ❑ Internet ❑ Email ❑ Phone ❑ Radio ❑ Friends ❑ Family members
   ❑ Church bulletin ❑ School ❑ TV ❑ Text messages ❑ Local newspaper ❑ Other_____

9. What health-related topics would you be interested in learning more about? (Please check all that apply)
   ❑ Diabetes ❑ Nutrition ❑ Exercise/Physical Activity ❑ High Blood Pressure ❑ Dental Health
   ❑ Cholesterol ❑ Mental Health ❑ Osteoporosis ❑ Stress management ❑ Other_____

10. What is the best day of week for you to attend health and wellness classes offered at St. Joseph's? (Please check all that apply)
    ❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday ❑ Saturday ❑ Sunday

11. What time of the day would be able to attend health and wellness classes offered at St. Joseph's? (Please check all that apply)
    ❑ Early morning 8am-10am ❑ Late morning 10am-12pm ❑ Early afternoon 12pm-2pm ❑ Late afternoon 2pm-4pm ❑ Early evening 4pm-6pm ❑ Evening 6pm-8pm

A little about you:

12. Gender: Are you? ❑ Male ❑ Female
13. What's your home zip code? _____
14. How old are you? ❑ 18-40 years old ❑ 41-64 years old ❑ 65 years old or more

Appendix 8

Para Uso Oficial Solamente

Código: _ _ _ _ _

Coalición de Salud Comunitaria de St. Joseph
Evaluación de Necesidades

El propósito de esta encuesta es para permitir que la Coalición de Salud Comunitaria de St. Joseph coordine actividades en la iglesia que promueven una alimentación saludable y que motivan a miembros de la iglesia a tener una alimentación saludable, participar en una actividad física regular y buscar atención médica preventiva. Por favor, complete esta encuesta al mejor de su capacidad. Su participación en esta encuesta anónima NO le afectara su relación con la iglesia de St. Joseph y puede dejar su participación en cualquier momento sin penalidad.

1. En general, diría que su estado de salud es:
   ❑ Excelente ❑ Muy Bien ❑ Bien ❑ Más o menos ❑ Malo

2. ¿Cuánto tiempo ha pasado desde la última vez que visitó a un doctor, enfermera, u otro profesional médico por cualquier razón?
   ❑ Menos de 12 meses ❑ 1 año pero menos de 2 años ❑ 2 años pero menos de 5 años
   ❑ 5 años o más ❑ Nunca ❑ No sé

3. ¿Cuánto tiempo ha pasado desde la última vez que visitó a una dentista o una clínica dental por cualquier razón?
   ❑ Menos de 12 meses ❑ 1 año pero menos de 2 años ❑ 2 años pero menos de 5 años
   ❑ 5 años o más ❑ Nunca ❑ No sé

4. ¿USUALMENTE dónde va usted cuando está enfermo O necesita ayuda médica?
   ❑ Consulta Médica o clínica privada ❑ Clínica comunitaria o clínica pública ❑ Departamento de tratamiento ambulatorio
   ❑ Sala de Emergencia del hospital ❑ Otro lugar ❑No tengo un lugar regular para recibir cuidado médico

5. ¿Alguna vez le ha dicho un doctor o profesional médico que usted tiene...?
   ❑ Diabetes ❑ Alta presión arterial o hipertensión ❑ Alto colesterol
   ❑ Depresión ❑ No, un doctor nunca me ha mencionado que padezco de estas enfermedades

6. ¿Cuántas porciones en total de frutas y verduras comió ayer? (ejemplo: una porción es equivalente a una manzana mediana, un puñado de broccoli, o una taza de zanahorias)
   _____ número de porciones

7. ¿Qué tan difícil es para usted conseguir productos frescos (frutas y verduras)?
   ❑ Muy difícil ❑ Poco difícil ❑ Poco fácil ❑ Muy fácil ❑ No sé

8. ¿Dónde recibe información o noticias actuales sobre Lennox, Inglewood, y Hawthorne?
   ❑ Red social ❑ Correo Electrónico ❑ Teléfono ❑ Radio ❑ Amigos ❑ Miembros de la familia
   ❑ Boletín de la iglesia ❑Escuela ❑ Televisión ❑ Mensajes de texto ❑ Periódico local ❑ Otro_____

9. ¿Qué temas relacionados con la salud estará interesado en aprender y obtener más información? (Por favor marque todos los que aplican)
   ❑ Diabetes ❑ Nutrición ❑ Ejercicio/Actividad Física ❑ Alta Presión Arterial ❑ Salud Dental
   ❑ Colesterol ❑ Salud Mental ❑ Osteoporosis ❑ Manejamineto de éstres ❑ Otro_____

10. ¿Cuál es el mejor día de la semana para asistir a clases de salud y bienestar ofrecidas en St. Joseph? (Favor marque los que aplican)
    ❑ Lunes ❑ Martes ❑ Miércoles ❑ Jueves ❑ Viernes ❑ Sábado ❑ Domingo

11. ¿Cuál es el mejor día de la semana para asistir a clases de salud y bienestar ofrecidas en St. Joseph? (Favor marque los que aplican)
    ❑ Temprano por la mañana 8:00 am-10:00 am ❑ Tarde por la mañana 10:01 am-12:00 pm ❑ Temprano en la tarde 12:01 pm-2:00 pm ❑ Al final de la tarde 2:01 pm-4:00 pm ❑ Temprano en la noche 4:01 pm-6:00 pm ❑ Noche 6:01 pm-8:00 pm

Un poco sobre usted:

12. Genero: ¿Es usted? ❑Hombre ❑ Mujer
13. ¿Cuál es su código postal? _____
14. ¿Cuántos años tiene? ❑18-40 años de edad ❑41-64 años de edad ❑65 años de edad o más

Appendix 8

2011 LA County Health Survey Results

Adults (18+ years old) for Los Angeles County, for Service Planning Area (SPA) 8, and for Selected Health Districts (Harbor, Inglewood and Torrance).

Los Angeles County Health Survey, 2011.

	LA County			Harbor			Inglewood			Torrance		
	Percent	95% CI	Est #	Percent	95% CI	Est #	Percent	95% CI	Est #	Percent	95% CI	Est #
Total	100.0%		7,252,000			145,000			294,000			347,000
Demographics												
Race/Ethnicity												
Latino	43.7%	42.1 - 45.2	3,159,000	46.0%	36.1 - 55.8	67,000	47.6%	40.2 - 55.1	140,000	18.6%	12.8 - 24.5	65,000
White	31.7%	30.4 - 33.0	2,295,000	39.8%	30.7 - 49.0	58,000	14.0%	9.7 - 18.3	41,000	43.3%	36.7 - 50.0	150,000
African American	8.6%	7.8 - 9.4	620,000	* 5.0%	2.0 - 8.0	7,000	26.8%	20.2 - 33.4	79,000	9.6%	5.7 - 13.4	33,000
Asian/Pacific Islander	15.6%	14.3 - 16.8	1,127,000	* 9.3%	3.5 - 15.0	13,000	* 11.0%	5.8 - 16.1	32,000	28.0%	20.4 - 35.6	97,000
American Indian/Alaskan Native	0.4%	0.2 - 0.6	N/A	-	- - -	-	-	- - -	-	-	- - -	-
Education												
Less than High School	23.2%	21.8 - 24.6	1,672,000	27.2%	17.0 - 37.5	39,000	25.1%	18.5 - 31.7	73,000	* 7.2%	3.2 - 11.3	25,000
High School	22.3%	20.9 - 23.7	1,607,000	23.9%	15.0 - 32.9	35,000	30.9%	23.4 - 38.3	90,000	20.4%	14.4 - 26.4	71,000
Some College or Trade School	27.9%	26.5 - 29.3	2,008,000	19.2%	12.4 - 26.1	28,000	28.4%	21.9 - 34.9	83,000	33.3%	26.4 - 40.3	116,000
College or Post Graduate Degree	26.6%	25.4 - 27.8	1,914,000	29.6%	22.3 - 36.8	43,000	15.6%	11.2 - 20.0	45,000	39.0%	32.4 - 45.6	135,000
Marriage												
Married	47.7%	46.2 - 49.3	3,416,000	51.2%	41.3 - 61.1	73,000	39.0%	31.8 - 46.2	112,000	52.0%	44.8 - 59.2	177,000
Domestic partners	2.4%	1.9 - 2.9	172,000	-	- - -	-	* 1.8%	0.0 - 3.6	5,000	* 1.3%	0.2 - 2.4	5,000
Not married but living together	7.8%	6.9 - 8.8	560,000	* 9.8%	1.6 - 18.0	14,000	* 7.2%	3.7 - 10.8	21,000	* 4.1%	0.0 - 8.4	14,000
Widowed	5.2%	4.7 - 5.7	373,000	* 4.8%	2.0 - 7.7	7,000	8.2%	4.5 - 11.8	23,000	6.0%	3.6 - 8.3	20,000
Divorced	8.6%	7.8 - 9.4	615,000	* 13.2%	6.0 - 20.4	19,000	* 8.9%	4.1 - 13.7	25,000	8.4%	4.8 - 12.0	29,000
Separated	3.3%	2.7 - 3.9	237,000	* 2.1%	0.3 - 4.0	3,000	* 2.9%	0.9 - 5.0	8,000	* 1.2%	0.0 - 2.5	4,000
Never married	24.9%	23.5 - 26.4	1,785,000	* 15.3%	8.0 - 22.5	22,000	32.0%	24.5 - 39.5	92,000	27.0%	19.8 - 34.2	92,000
Employment												
Employed (35+ hours per week)	41.9%	40.4 - 43.4	2,979,000	38.0%	28.7 - 47.3	54,000	47.2%	39.7 - 54.7	135,000	43.4%	36.5 - 50.4	149,000
Employed (<35 hours per week)	13.9%	12.8 - 15.0	991,000	* 15.2%	7.8 - 22.7	22,000	14.0%	8.0 - 20.0	40,000	* 11.9%	6.5 - 17.3	41,000
Employed (unknown hours)	0.6%	0.4 - 0.8	42,000	-	- - -	-	-	- - -	-	-	- - -	-
Unemployed	13.5%	12.4 - 14.7	962,000	* 16.1%	7.3 - 25.0	23,000	16.5%	10.4 - 22.6	47,000	8.7%	4.9 - 12.4	30,000
Not in Labor Force - Retired	11.6%	10.9 - 12.4	826,000	12.2%	7.7 - 16.7	17,000	9.3%	6.0 - 12.6	27,000	14.7%	11.0 - 18.5	51,000
Not in Labor Force - Disabled	3.8%	3.2 - 4.4	268,000	* 3.5%	0.1 - 6.8	5,000	* 0.7%	0.0 - 1.3	2,000	* 4.8%	1.4 - 8.3	17,000
Not in Labor Force-Other	14.6%	13.5 - 15.8	1,040,000	* 14.4%	7.2 - 21.7	21,000	12.0%	7.0 - 17.0	34,000	16.5%	10.0 - 22.9	57,000
Federal Poverty Level												
0-99% FPL	23.7%	22.3 - 25.1	1,721,000	24.5%	15.2 - 33.8	36,000	31.6%	24.2 - 38.9	93,000	7.0%	3.8 - 10.1	24,000
100%-199% FPL	23.1%	21.8 - 24.5	1,679,000	22.2%	12.6 - 31.8	32,000	23.4%	16.9 - 29.9	69,000	16.6%	10.2 - 23.1	58,000
200%-299% FPL	13.4%	12.3 - 14.4	969,000	* 11.3%	6.1 - 16.5	16,000	14.5%	9.6 - 19.3	43,000	11.8%	8.0 - 15.7	41,000
300% or above FPL	39.8%	38.3 - 41.2	2,884,000	42.0%	33.0 - 51.0	61,000	30.5%	24.2 - 36.9	90,000	64.6%	57.6 - 71.5	224,000
Health Behaviors												
Reported Having a Disability	19.40%	18.3 - 20.6	1,404,000	20.20%	12.8 - 27.5	29,000	15.00%	10 - 20.1	43,000	22.00%	16.9 - 27.2	76,000
Homelessness (past 5 years) among <300% Federal Poverty Level	7.50%	6.3 - 8.7	324,000	5.30%	0 - 11.6	4,000	12.90%	5.4 - 20.4	26,000	4.90%	0.8 - 8.9	6,000
Average # of Unhealthy (Mental/Physical) Days	5.4 days	5.2 - 5.7	-	5.3 days	3.4 - 7.3	-	4.4 days	3.3 - 5.5	-	4.6 days	3.5 - 5.7	-
HRQOL - Self Perceived Health Status Fair/Poor	20.70%	19.5 - 21.9	1,495,000	21.50%	13.5 - 29.5	31,000	20.20%	14.7 - 25.8	59,000	11.60%	7.3 - 15.9	40,000
Receive Sufficient (Always/Usually) Social & Emotional Support	64.00%	59.5 - 68.5	4,466,000	77.20%	58.1 - 96.2	91,000	59.10%	36.5 - 81.6	163,000	80.40%	67.3 - 93.5	279,000
Access to Fruits/Vegetables	89.70%	86.6 - 92.8	6,361,000	78.40%	52.7 - 100	88,000	90.10%	78.8 - 100	265,000	98.60%	97.1 - 100	342,000
Nutrition - Fast Food Consumption	39.95%	38.44 - 41.5	2,885,000	33.50%	24.8 - 42.1	48,000	39.80%	32.5 - 47.1	116,000	32.30%	25.9 - 38.6	112,000
Nutrition - Food Insecurity w/o hunger	17.90%	16 - 19.7	309,000	21.00%	4.8 - 37.2	8,000	22.60%	13.9 - 31.3	18,000	16.90%	7.3 - 26.5	9,000
Nutrition - Food Insecurity w/hunger	12.75%	11.1 - 14.4	221,000	10.70%	3 - 18.5	4,000	14.00%	3.6 - 24.4	11,000	9.70%	3.1 - 16.2	5,000
Nutrition - 5+ Servings of Fruits/Vegetables Eaten	16.20%	15.1 - 17.4	1,141,000	15.90%	9.8 - 22.1	23,000	16.50%	10.1 - 23	47,000	15.80%	10.6 - 20.9	53,000
Nutrition - Soda Consumption	35.50%	30.6 - 40.4	2,572,000	-	- -	-	-	- -	-	-	- -	-
Neighborhood Safety	84.30%	81.1 - 87.5	5,998,000	96.40%	91.2 - 100	140,000	89.50%	79.8 - 99.2	261,000	89.60%	77.9 - 100	311,000
Physical Activity (aerobic)												
Meets Guidelines	61.80%	60.3 - 63.3	4,391,000	59.70%	50 - 69.5	86,000	61.90%	54.7 - 69.1	180,000	64.30%	57.3 - 71.2	218,000
Does Not Meet Guidelines	26.20%	24.9 - 27.5	1,863,000	29.60%	20 - 39.1	43,000	24.00%	17.7 - 30.3	70,000	24.60%	18.2 - 31	84,000
No Activity	12.00%	11 - 13.1	856,000	10.70%	5.5 - 15.9	15,000	14.10%	9.1 - 19.1	41,000	11.10%	6.9 - 15.4	38,000
Walking Paths, parks, playgrounds, sports fields in neighborhoods												
Yes - Use walking paths, parks, playgrounds	51.50%	49.9 - 53	3,718,000	48.20%	38.5 - 57.8	70,000	49.80%	42.4 - 57.3	146,000	62.70%	55.9 - 69.5	218,000
No - Do not use	34.30%	32.9 - 35.8	2,481,000	37.00%	27.3 - 46.6	54,000	37.90%	30.7 - 45	111,000	29.50%	23.1 - 35.9	103,000
Neighborhood does not have	14.20%	13.2 - 15.2	1,026,000	14.90%	7.8 - 22	22,000	12.30%	7.4 - 17.1	36,000	7.80%	4 - 11.6	27,000

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Los Angeles County Health Survey, 2011.

	LA County			Harbor			Inglewood			Torrance		
	Percent	95% CI	Est #	Percent	95% CI	Est #	Percent	95% CI	Est #	Percent	95% CI	Est #
Health Insurance, Access, RSC												
Insurance (18 - 64 years)												
Medi-Cal	17.30%	15.9 - 18.6	1,052,000	0.193	8.6 - 30.1	24,000	0.176	11.6 - 23.6	45,000	0.116	5 - 18.2	32,000
Medicare	1.40%	1 - 1.7	83,000	-	- - -	-	-	- - -	-	-	- - -	-
Private	52.90%	51.2 - 54.6	3,218,000	0.505	39.4 - 61.6	62,000	0.481	40 - 56.3	124,000	0.73	64.6 - 81.4	201,000
No Insurance	28.50%	26.8 - 30.1	1,731,000	0.292	18.8 - 39.6	36,000	0.333	25.4 - 41.2	86,000	0.14	7.4 - 20.5	38,000
Do NOT have Dental Insurance	51.8%	50.3 - 53.3	3,704,000	55.00%	45.5 - 64.5	80,000	56.00%	48.6 - 63.3	162,000	39.20%	32.0 - 46.4	135,000
Can't afford to see an MD	16.0%	14.8 - 17.2	1,159,000	* 17.9%	9.2 - 26.7	26,000	18.0%	11.8 - 24.3	53,000	* 8.3%	3.8 - 12.8	29,000
Can't afford prescriptions	15.4%	14.2 - 16.5	1,111,000	* 14.1%	6.1 - 22.1	20,000	14.6%	9.1 - 20.2	43,000	11.6%	6.5 - 16.7	40,000
Can't afford DDS	30.3%	28.8 - 31.8	2,193,000	27.3%	17.6 - 37.0	40,000	30.5%	23.4 - 37.6	90,000	21.6%	14.9 - 28.3	75,000
Can't afford mental health	6.1%	5.3 - 6.8	439,000	2.0%	0.4 - 3.6	3,000	4.9%	1.2 - 8.5	14,000	4.5%	2.0 - 7.0	16,000
No Regular Source of Care	20.9%	19.5 - 22.2	1,508,000	23.9%	14.6 - 33.3	35,000	22.9%	16.1 - 29.8	67,000	12.7%	7.1 - 18.3	44,000
Chronic Conditions												
Cholesterol Diagnosed	25.6%	24.4 - 26.8	1,839,000	34.9%	25.9 - 43.9	51,000	24.0%	18.3 - 29.7	70,000	27.9%	22.3 - 33.6	96,000
Depression - Ever Diagnosed	12.2%	11.2 - 13.1	879,000	* 14.50%	7.2 - 21.9	21,000	* 8.30%	4.0 - 12.7	24,000	9.60%	6.2 - 13.0	33,000
Diabetes Diagnosed	9.5%	8.6 - 10.3	685,000	9.1%	4.1 - 14.0	13,000	9.0%	5.0 - 13.0	26,000	8.3%	4.7 - 12.0	29,000
Hypertension Diagnosed	24.0%	22.8 - 25.2	1,738,000	23.1%	15.9 - 30.3	33,000	25.3%	19.4 - 31.2	74,000	23.4%	18.4 - 28.5	81,000
Obesity	23.6%	22.3 - 24.9	1,616,000	17.3%	10.5 - 24.0	24,000	33.8%	26.4 - 41.3	94,000	15.7%	11.1 - 20.3	52,000
Overweight	37.1%	35.6 - 38.6	2,537,000	44.2%	34.3 - 54.1	60,000	45.3%	37.5 - 53.0	125,000	42.0%	34.5 - 49.5	139,000
Osteoporosis Diagnosed (Women 65+ years old)	26.7%	23.3 - 30.1	155,000	14.6%	2.9 - 26.4	2,000	18.6%	4.1 - 33.1	5,000	31.3%	16.2 - 46.3	10,000
Anxiety Ever Diagnosed	11.3%	10.4 - 12.3	820,000	6.5%	1.4 - 11.6	9,000	7.7%	3.7 - 11.8	23,000	8.1%	5.1 - 11.0	28,000
Preventive Care												
Flu shot in past year (18+ years old)	33.7%	32.3 - 35.1	2,427,000	33.7%	25.1 - 42.3	49,000	26.1%	20.1 - 32.1	76,000	37.9%	31.4 - 44.4	131,000
Mammogram - in the past 2 years (Women 50-74 years old)	79.8%	77.4 - 82.2	960,000	67.6%	45.8 - 89.4	17,000	71.6%	58.7 - 84.5	35,000	81.0%	72.8 - 89.2	56,000
Pap smear - within the past 3 years	82.8%	80.9 - 84.7	2,390,000	83.0%	70.6 - 95.3	57,000	85.9%	77.5 - 94.4	97,000	83.4%	74.1 - 92.6	100,000

Source: 2011 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health.

Note: Estimates are based on self-reported data by a random sample of 8,036 Los Angeles County adults, representative of the adult population in Los Angeles County. The 95% confidence intervals (CI) represent the variability in the estimate due to sampling; the actual prevalence in the population, 95 out of 100 times sampled, would fall within the range provided.

*The estimate is statistically unstable (relative standard error ≥23%) and therefore may not be appropriate to use for planning or policy purposes.

-For purposes of confidentiality, results with cell sizes less than 5 are not reported

1. Based on U.S. Census 2009 **Federal Poverty Level** (FPL) thresholds which for a family of four (2 adults, 2 dependents) correspond to annual incomes of $21,756 (100% FPL), $43,512 (200% FPL), and $65,268 (300% FPL). *[These thresholds were the values at the time of survey interviewing.]*

4. Weight status is based on Body Mass Index (BMI) calculated from self-reported weight and height. According to NHLBI clinical guidelines, a BMI < 18.5 is underweight, a BMI ≥ 18.5 and < 25 is normal weight, a BMI ≥ 25 and < 30 is **overweight**, and a BMI ≥ 30 is **obese**. [REFERENCE: National Heart, Lung, and Blood Institute (NHLBI) http://www.nhlbi.nih.gov/guidelines/obesity/ob_exsum.pdf]

5a. To meet **Physical Activity Guidelines overall:** Must meet aerobic activity (at least one of the following at least one of the following criteria must be fulfilled: 1) Vigorous activity for at least 75 minutes a week, 2) Moderate activity for at least 150 minutes a week, or 3) A combination of vigorous and moderate activity for at least 150 minutes a week) AND muscle-strengthening activities on 2 or more days a week that work all major muscle groups (legs, hips, back, abdomen, chest, shoulders, and arms). [REFERENCE: Physical Activity Guidelines Advisory Committee. *Physical Activity Guidelines Advisory Committee Report, 2008.* Washington, DC: U.S. Department of Health and Human Services, 2008. http://www.health.gov/paguidelines/pdf/paguide.pdf]

2011 LA County Health Survey Results

Children (0-17 years old) and Respondents for Los Angeles County, for Service Planning Area (SPA) 8, and for Selected Health Districts (Harbor, Inglewood and Torrance).

Los Angeles County Health Survey, 2011.

	LA County			Harbor			Inglewood			Torrance		
	Percent	95% CI	Est #	Percent	95% CI	Est #	Percent	95% CI	Est #	Percent	95% CI	Est #
Total	100.0%		2,394,000			51,000			109,000			100,000
CHILD CHARACTERISTICS												
Race/Ethnicity												
Latino	62.1%	60.0 - 64.1	1,469,000	60.8%	47.6 - 73.9	31,000	56.9%	46.6 - 67.1	61,000	37.5%	26.7 - 48.3	36,000
White	18.8%	17.3 - 20.3	445,000	19.2%	11.4 - 27.1	10,000	* 6.9%	0.0 - 13.8	7,000	32.4%	23.2 - 41.7	32,000
African American	8.3%	7.1 - 9.5	197,000	* 12.8%	1.4 - 24.2	7,000	28.6%	18.8 - 38.4	31,000	* 7.9%	2.4 - 13.3	8,000
Asian/Pacific Islander	10.5%	9.3 - 11.8	250,000	* 7.2%	2.6 - 11.9	4,000	* 7.7%	3.1 - 12.2	8,000	21.1%	13.1 - 29.0	20,000
American Indian/Alaskan Native	* 0.3%	0.1 - 0.5	N/A	-	- - -	-	-	- - -	-	-	- - -	-
RESPONDENT CHARACTERISTICS												
Federal Poverty Level												
0-99% FPL	33.2%	31.0 - 35.3	794,000	40.3%	25.4 - 55.3	21,000	47.2%	37.2 - 57.2	52,000	* 16.7%	7.2 - 26.3	17,000
100%-199% FPL	25.0%	23.0 - 26.9	597,000	* 20.2%	7.5 - 33.0	10,000	28.0%	19.2 - 36.7	31,000	11.9%	7.1 - 16.6	12,000
200%-299% FPL	10.7%	9.4 - 12.1	257,000	* 7.3%	3.0 - 11.6	4,000	* 10.0%	4.0 - 15.9	11,000	* 10.5%	4.5 - 16.4	10,000
300% or above FPL	31.1%	29.3 - 33.0	746,000	32.1%	21.5 - 42.7	16,000	14.9%	9.8 - 20.0	16,000	60.9%	50.8 - 71.1	61,000
Education												
Less than High School	26.2%	24.2 - 28.2	622,000	35.9%	20.3 - 51.4	18,000	27.7%	18.4 - 36.9	30,000	* 6.1%	3.0 - 9.2	6,000
High School	19.2%	17.4 - 20.9	455,000	* 15.9%	4.4 - 27.5	8,000	22.9%	14.8 - 30.9	24,000	* 14.9%	7.7 - 22.0	15,000
Some College or Trade School	23.2%	21.3 - 25.1	550,000	* 18.1%	9.6 - 26.7	9,000	25.9%	17.6 - 34.3	28,000	23.8%	13.8 - 33.7	24,000
College or Post Graduate Degree	31.4%	29.6 - 33.3	746,000	30.1%	19.7 - 40.4	15,000	23.5%	14.4 - 32.6	25,000	55.3%	44.9 - 65.7	55,000
Employment												
Full-time (35+ hours per week)	44.8%	42.6 - 46.9	1,026,000	34.3%	22.4 - 46.1	17,000	45.2%	35.2 - 55.2	48,000	62.8%	53.9 - 71.7	60,000
Part-time (< 35 hours per week)	15.6%	14.0 - 17.3	358,000	* 16.3%	1.9 - 30.7	8,000	* 11.3%	5.8 - 16.8	12,000	12.0%	7.2 - 16.8	11,000
Not at all	39.6%	37.5 - 41.8	908,000	49.4%	34.8 - 64.1	24,000	43.6%	33.2 - 53.9	46,000	25.2%	17.6 - 32.8	24,000
Marriage												
Married	63.3%	61.1 - 65.5	1,503,000	57.5%	42.5 - 72.6	29,000	54.5%	44.5 - 64.4	59,000	67.9%	56.6 - 79.1	67,000
Domestic partners	1.5%	1.0 - 2.1	37,000	-	- - -	-	-	- - -	-	-	- - -	-
Not married but living together	8.7%	7.3 - 10.0	206,000	* 14.8%	2.3 - 27.4	8,000	* 9.0%	3.3 - 14.7	10,000	* 1.7%	0.1 - 3.3	2,000
Widowed	2.0%	1.4 - 2.6	47,000	-	- - -	-	* 1.4%	0.0 - 3.2	2,000	* 7.8%	0.0 - 15.8	8,000
Divorced	6.9%	5.8 - 8.0	163,000	* 7.5%	1.2 - 13.9	4,000	* 4.5%	2.1 - 7.0	5,000	* 9.6%	1.8 - 17.4	10,000
Separated	4.4%	3.6 - 5.3	106,000	* 5.7%	0.0 - 11.5	3,000	* 4.6%	1.6 - 7.7	5,000	* 2.7%	0.1 - 5.3	3,000
Never married	13.2%	11.6 - 14.9	314,000	* 4.5%	0.8 - 8.2	2,000	24.6%	15.4 - 33.8	27,000	* 9.9%	1.6 - 18.2	10,000
Child Health												
Child Health Stats - Fair/Poor	5.80%	4.7 - 6.9	138,000	3.20%	0.3 - 6.1	2,000	12.40%	3.7 - 21	14,000	4.60%	0 - 9.5	5,000
ADD/ADH Diagnosis	6.0%	5.0 - 7.1	133,000	* 11.6%	4.4 - 18.9	5,000	* 5.8%	1.6 - 10.0	6,000	6.1%	0.4 - 11.9	6,000
Special Health Care Needs	15.8%	14.2 - 17.4	369,000	18.9%	10.8 - 27.0	9,000	13.4%	7.2 - 19.5	14,000	24.5%	13.8 - 35.1	24,000
HPV Vaccination (girls 13-17 years old)	44.6%	39.2 - 50.0	151,000	81.4%	64.3 - 98.4	4,000	34.1%	9.0 - 59.2	6,000	36.1%	15.4 - 56.8	5,000
Current Prevalence of Asthma	9.0%	7.6 - 10.3	214,000	12.4%	5.1 - 19.6	6,000	8.1%	2.9 - 13.4	9,000	12.8%	5.8 - 19.7	13,000

2011 LA County Health Survey Results

Children (0-17 years old) and Respondents for Los Angeles County, for Service Planning Area (SPA) 8, and for Selected Health Districts (Harbor, Inglewood and Torrance).

Los Angeles County Health Survey, 2011.

	LA County			Harbor			Inglewood			Torrance		
	Percent	95% CI	Est #	Percent	95% CI	Est #	Percent	95% CI	Est #	Percent	95% CI	Est #
Health Insurance, Access, RSC												
Type of Insurance												
Healthy Families	12.00%	10.6 - 13.4	284,000	5.90%	0 - 12	3,000	11.60%	6.6 - 16.7	13,000	5.60%	2.6 - 8.6	6,000
Medical	34.40%	32.2 - 36.6	814,000	45.20%	30.1 - 60.2	23000	44.50%	34.3 - 54.7	48000	18.00%	8.1 - 27.9	18000
Private	46.40%	44.3 - 48.6	1,099,000	45.30%	31.9 - 58.6	23,000	35.00%	26.1 - 43.9	38,000	74.90%	65.1 - 84.8	75,000
No Insurance	5.00%	4.1 - 6	119,000	1.30%	0.1 - 2.5	1,000	4.20%	1.5 - 6.8	4,000	0.80%	0 - 1.5	1,000
Healthy Kids	2.20%	1.5 - 2.8	51,000	-	- - -	-	4.70%	0 - 10.1	5,000	-	- - -	-
Do NOT have Dental Insurance	21.8%	20.1 - 23.6	511,000	27.80%	13.7 - 42	14,000	15.30%	8.9 - 21.7	16,000	12.10%	7.6 - 16.7	12,000
Can't afford dental care & check-ups	12.6%	10.9 - 14.2	264,000	7.6%	2.3 - 12.8	3,000	16.8%	7.1 - 26.6	17,000	10.5%	4.4 - 16.7	9,000
Could NOT afford a doctor for illness	6.1%	4.9 - 7.3	145,000	* 3.9%	0.9 - 7.0	2,000	10.4%	3.4 - 17.5	11,000	* 4.1%	0.0 - 8.8	4,000
No regular source of care	4.8%	3.9 - 5.7	115,000	4.2%	0.0 - 9.4	2,000	5.8%	1.9 - 9.6	6,000	5.1%	0.0 - 12.0	5,000
Child Routines												
Ate Breakfast (ages 2-17 years old)	84.50%	82.9 - 86.2	1,887,000	90.10%	84.2 - 96	41,000	82.60%	72.8 - 92.4	84,000	74.90%	63.6 - 86.2	70,000
Fast food at least ONCE a week	50.5%	48.3 - 52.6	1,201,000	* 42.6%	29.5 - 55.7	22,000	54.7%	45.0 - 64.4	60,000	47.2%	37.0 - 57.4	47,000
Consumed soda/sweetened beverage a day (1+)	38.30%	36.2 - 40.4	904,000	38.00%	24.7 - 51.2	19,000	41.60%	31.8 - 51.3	45,000	40.00%	29.6 - 50.5	40,000
Physical Activity (ages 6-17 years old)												
Meets: 1+ hr(s)/day, 7 days/wk	28.70%	26.3 - 31.1	433,000	35.90%	19.3 - 52.5	11,000	30.50%	19.2 - 41.7	21,000	26.10%	17.8 - 34.3	17,000
Participates	60.30%	57.8 - 62.9	908,000	60.40%	44.2 - 76.6	18,000	56.50%	43.9 - 69.2	40,000	68.70%	59.7 - 77.8	45,000
Does not participate	10.90%	9.4 - 12.5	165,000	-	- - -	-	13.00%	2.4 - 23.6	9,000	5.20%	1.7 - 8.7	3,000
3+ Hours of watching TV (ages 6 months - 17 years old)	22.30%	20.4 - 24.3	518,000	18.60%	9.5 - 27.6	9,000	23.60%	14.4 - 32.7	25,000	20.70%	9.8 - 31.6	20,000
Safe Park or Playground that is Easily Accessible	84.20%	82.5 - 85.8	1,941,000	92.40%	87.6 - 97.3	43,000	77.10%	67.8 - 86.4	81,000	88.90%	79.5 - 98.4	84,000
Prenatal to Postpartum												
Breastfed Child (ages 0-5 years old)	87.40%	84 - 90.8	433,000	85.30%	69.1 - 100	12,000	81.50%	66.7 - 96.3	18,000	91.40%	82.1 - 100	17,000
Child Care												
Difficulty obtaining childcare (ages 0-5 years old)	26.90%	22.6 - 31.1	156,000	-	- - -	-	36.50%	18.8 - 54.1	9,000	5.60%	0 - 11.5	1,000
Parent Health Risks/Behaviors												
Risk of Major Depression	9.20%	8 - 10.3	206,000	10.70%	2 - 19.4	5,000	10.60%	3.2 - 18.1	11,000	8.40%	2.5 - 14.4	8,000

Source: 2011 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health.

Note: The information presented is based on self-reported data from a randomly-selected, representative sample of 6,013 Los Angeles County parents/guardians. The 95% confidence intervals (CI) represent the margin of error that occurs with statistical sampling, and means that the actual prevalence in the population, 95 out of 100 times sampled, would fall within the range provided.

1. Based on U.S. Census Bureau, Housing and Household Economic Statistics Division, 2009 **Federal Poverty Level** (FPL) thresholds which for a family of four (2 adults, 2 dependents) correspond to annual incomes of $20,444 (100% FPL), $40,888 (200% FPL), and $61,332 (300% FPL). *[These thresholds were the values at the time of survey interviewing.]*

*The estimate is statistically unstable (relative standard error ≥23%) and therefore may not be appropriate to use for planning or policy purposes.

-For purposes of confidentiality, results with cell sizes less than 5 are not reported.

Community Needs Index

Zip	City	2013 Population	2013 CNI Score	2012 CNI Score	Poverty 65+	Poverty Children	Poverty Single w/kids	Income Quintile	Limited English	Minority	Culture Quintile	No High School Diploma	Education Quintile	Unemployed	Uninsured	Insurance Rank	Renting	Housing Quintile
Coastal Communities																		
90245	El Segundo	16,820	2.6	2.4	6.10%	1.54%	4.03%	1	1.93%	32.30%	4	4.07%	1	6.42%	10.69%	2	57.09%	5
90254	Hermosa Beach	19,829	3.0	2.0	8.29%	5.07%	18.50%	1	0.65%	19.73%	4	2.13%	1	6.51%	8.87%	2	55.35%	5
90266	Manhattan Beach	35,278	2.0	2.0	3.85%	2.39%	6.04%	1	1.14%	21.79%	4	1.42%	1	6.18%	5.77%	1	32.90%	4
90274	Palos Verdes Peninsula	25,865	1.6	1.6	3.20%	2.16%	11.68%	1	2.74%	31.11%	4	2.64%	1	4.28%	6.52%	1	11.08%	1
90275	Rancho Palos Verdes	42,004	2.4	2.0	4.67%	5.16%	15.33%	1	5.53%	45.60%	5	3.43%	1	6.21%	8.28%	2	20.14%	3
90277	Redondo Beach	35,914	3.0	2.8	9.67%	7.30%	30.84%	2	1.65%	29.02%	4	3.07%	1	5.63%	12.98%	3	53.28%	5
90278	Redondo Beach	40,950	2.8	3.0	8.05%	6.56%	11.97%	1	3.21%	40.30%	5	5.36%	1	7.05%	9.94%	2	42.24%	5
90501	Torrance	44,247	4.0	4.2	8.92%	15.94%	25.03%	2	13.15%	75.88%	5	18.83%	4	11.79%	17.30%	4	54.74%	5
90502	Torrance	18,177	3.4	3.6	4.24%	8.53%	14.57%	1	10.97%	81.96%	5	19.95%	4	12.07%	12.52%	3	28.05%	4
90503	Torrance	45,525	3.0	3.0	8.21%	6.78%	9.20%	1	9.42%	61.05%	5	5.79%	1	8.01%	12.08%	3	47.06%	5
90504	Torrance	33,182	4.0	4.0	11.32%	7.94%	21.04%	2	8.07%	70.52%	5	11.44%	3	10.89%	14.62%	4	38.79%	5
90505	Torrance	37,536	3.0	3.0	11.19%	5.59%	12.14%	1	7.26%	52.39%	5	5.85%	1	8.14%	12.85%	3	43.27%	5
90717	Lomita	21,627	3.8	4.0	6.62%	10.28%	24.91%	2	7.22%	59.64%	5	14.21%	3	6.26%	16.99%	4	52.81%	5
90732	San Pedro	20,838	3.0	3.0	5.97%	6.19%	13.71%	1	4.12%	44.04%	5	8.21%	2	8.59%	10.33%	2	28.14%	4
90745	Carson	58,735	4.0	4.0	10.75%	8.28%	21.31%	2	12.22%	92.80%	5	23.49%	5	12.63%	13.86%	4	28.16%	4
90746	Carson	25,371	2.6	2.6	6.54%	9.87%	16.98%	1	4.90%	94.73%	5	13.12%	3	11.61%	10.85%	3	13.44%	1
Underserved North																		
90247	Gardena	47,473	4.6	4.8	19.86%	23.50%	36.35%	3	18.14%	94.00%	5	23.28%	5	10.99%	27.29%	5	60.64%	5
90248	Gardena	9,938	4.0	4.0	10.40%	11.77%	22.92%	2	12.29%	89.48%	5	19.56%	4	11.77%	19.02%	4	28.92%	4
90249	Gardena	26,739	4.4	4.4	11.11%	19.17%	42.76%	3	11.82%	88.26%	5	18.72%	4	13.14%	20.85%	5	42.66%	5
90250	Hawthorne	94,318	4.6	4.8	15.53%	20.32%	32.09%	3	15.22%	88.76%	5	24.58%	5	8.94%	21.91%	5	69.34%	5
90260	Lawndale	34,978	4.2	4.4	9.71%	16.01%	21.43%	2	13.31%	82.68%	5	23.05%	5	14.02%	17.21%	4	59.83%	5
Underserved South																		
90710	Harbor City	25,696	4.2	4.4	8.41%	17.19%	31.99%	3	14.21%	79.54%	5	20.14%	4	10.33%	16.02%	4	43.55%	5
90731	San Pedro	60,753	4.8	4.8	14.72%	26.15%	43.99%	4	10.37%	68.28%	5	25.52%	5	11.12%	25.29%	5	66.94%	5
90744	Wilmington	54,362	4.8	5.0	18.29%	30.76%	44.20%	4	24.87%	95.58%	5	45.11%	5	16.83%	26.39%	5	60.36%	5

Community Organizational Survey

Providence Little Company of Mary Medical Centers, San Pedro & Torrance 2013 Health Care Needs Assessment

1. Rank the top 3 healthcare gaps amongst CHILDREN AGES 0-17 in their access to primary and specialty care: (Label 1,2,3, and leave the rest blank)

Answer Options	Responded 1	Responded 2	Responded 3	Weighted Value	%
Abuse treatment (e.g. child, domestic, elder, sexual	2	3	5	51	6.6%
Acute mental health services	13	5	4	159	20.7%
Advanced Diagnostic Procedures (MRI, CAT, ultrasound)	0	0	0	0	0.0%
Dental care that is affordable	5	14	12	165	21.5%
Screening for acute/chronic conditions (e.g. diabetes,	1	5	3	48	6.3%
Home care, Hospice, Long Term Care	0	0	0	0	0.0%
Optometry services that are affordable	2	4	13	81	10.5%
Primary care medical services (a regular place to go for	16	6	4	192	25.0%
Specialty medical services (e.g. Cardiology, Dermatology,	1	1	1	18	2.3%
Substance Abuse treatment programs	3	4	1	54	7.0%
Other	0	0	0	0	0.0%
answered question		45		768	
skipped question		1			

2. If you responded "Other," please specify:

Answer Options	Response Count	
	1	health Education / work shops
answered question	1	
skipped question	45	

3. Rank the top 3 healthcare gaps amongst ADULTS AGES 18-64 in their access to primary and specialty care: (Label 1,2,3, and leave the rest blank)

Answer Options	Responded 1	Responded 2	Responded 3	Weighted Value	%
Abuse treatment (e.g. child, domestic, elder, sexual	1	1	4	27	4.3%
Acute mental health services	5	2	8	81	12.9%
Advanced Diagnostic Procedures (MRI, CAT, ultrasound)	1	2	1	24	3.8%
Dental care that is affordable	6	11	3	129	20.6%
Screening for acute/chronic conditions (e.g. diabetes,	4	4	4	72	11.5%
Home care, Hospice, Long Term Care	0	0	0	0	0.0%
Optometry services that are affordable	1	2	5	36	5.7%
Primary care medical services (a regular place to go for	12	7	3	159	25.4%
Specialty medical services (e.g. Cardiology, Dermatology,	3	3	2	51	8.1%
Substance Abuse treatment programs	2	3	2	42	6.7%
Other	0	0	2	6	1.0%
answered question		37		627	
skipped question		9			

4. If you responded "Other," please specify:

Answer Options	Response Count	
	2	chronic mental health Family Theraphy
answered question	2	
skipped question	44	

Community Organizational Survey

Providence Little Company of Mary Medical Centers, San Pedro & Torrance 2013 Health Care Needs Assessment

5. Rank the top 3 healthcare gaps amongst SENIORS AGES 65+ in their access to primary and specialty care: (Label 1,2,3, and leave the rest blank)

Answer Options	Responded 1	Responded 2	Responded 3	Weighted Value	%
Abuse treatment (e.g. child, domestic, elder, sexual	0	0	6	18	3.1%
Acute mental health services	4	2	4	60	10.3%
Advanced Diagnostic Procedures (MRI, CAT, ultrasound)	3	1	1	36	6.2%
Dental care that is affordable	2	7	2	66	11.3%
Screening for acute/chronic conditions (e.g. diabetes,	5	4	1	72	12.4%
Home care, Hospice, Long Term Care	3	4	4	63	10.8%
Optometry services that are affordable	0	3	8	42	7.2%
Primary care medical services (a regular place to go for	9	4	0	105	18.0%
Specialty medical services (e.g. Cardiology, Dermatology,	5	6	4	93	16.0%
Substance Abuse treatment programs	1	1	1	18	3.1%
Other	1	0	0	9	1.5%
answered question		33		582	
skipped question		13			

6. If you responded "Other," please specify:

Answer Options	Response Count	
	2	chronic mental health CLASS - supportive services
answered question	2	
skipped question	44	

7. Rank the top 3 healthcare gaps amongst CHILDREN AGES 0-17 in their wellness education: (Label 1,2,3, and leave the rest blank)

Answer Options	Responded 1	Responded 2	Responded 3	Weighted Value	%
Self care education programs after diagnosis (e.g.	3	1	4	45	6.1%
Education about navigating the health care system	1	0	2	15	2.0%
Mental Health Education/coping skills	11	9	6	171	23.2%
Nutrition skills education (counting carbs, reading	7	8	7	132	17.9%
Parenting education	6	2	3	75	10.2%
Physical activity/physical fitness (goal setting, classes,	9	10	4	153	20.7%
Substance abuse prevention programs	2	2	4	42	5.7%
Violence prevention/anger management programs	2	9	11	105	14.2%
Other	0	0	0	0	0.0%
answered question		43		738	
skipped question		3			

8. If you responded "Other," please specify:

Answer Options	Response Count	
	1	mindful awareness
answered question	1	
skipped question	45	

Community Organizational Survey

Providence Little Company of Mary Medical Centers, San Pedro & Torrance 2013 Health Care Needs Assessment

9. Rank the top 3 healthcare gaps amongst ADULTS AGES 18-64 in their wellness education: (Label 1,2,3, and leave the rest blank)

Answer Options	Responded 1	Responded 2	Responded 3	Weighted Value	%
Self care education programs after diagnosis (e.g.	7	4	7	108	17.1%
Education about navigating the health care system	3	4	5	66	10.5%
Mental Health Education/coping skills	5	9	4	111	17.6%
Nutrition skills education (counting carbs, reading	6	3	6	90	14.3%
Parenting education	8	8	1	123	19.5%
Physical activity/physical fitness (goal setting, classes,	2	5	4	60	9.5%
Substance abuse prevention programs	1	1	4	27	4.3%
Violence prevention/anger management programs	3	1	4	45	7.1%
Other	0	0	0	0	0.0%
answered question		36		630	
skipped question		10			

10. If you responded "Other," please specify:

Answer Options	Response Count
	0
answered question	0
skipped question	46

11. Rank the top 3 healthcare gaps amongst SENIORS AGES 65+ in their wellness education: (Label 1,2,3, and leave the rest blank)

Answer Options	Responded 1	Responded 2	Responded 3	Weighted Value	%
Self care education programs after diagnosis (e.g.	12	5	6	156	27.1%
Education about navigating the health care system	6	9	4	120	20.8%
Mental Health Education/coping skills	5	7	6	105	18.2%
Nutrition skills education (counting carbs, reading	4	4	2	66	11.5%
Parenting education	0	1	0	6	1.0%
Physical activity/physical fitness (goal setting, classes,	5	5	9	102	17.7%
Substance abuse prevention programs	0	1	3	15	2.6%
Violence prevention/anger management programs	0	0	2	6	1.0%
Other	0	0	0	0	0.0%
answered question		33		576	
skipped question		13			

12. If you responded "Other," please specify:

Answer Options	Response Count
	0
answered question	0
skipped question	46

Community Organizational Survey

Providence Little Company of Mary Medical Centers, San Pedro & Torrance 2013 Health Care Needs Assessment

13. Rank the top 3 healthcare gaps amongst CHILDREN AGES 0-17 in their connection to services: (Label 1,2,3, and leave the rest blank)

Answer Options	Responded 1	Responded 2	Responded 3	Weighted Value	%
Cultural & language barriers to obtaining health care	11	6	6	153	22.9%
Affordable housing	5	6	4	93	13.9%
Outreach and Enrollment into Health Insurance	4	3	8	78	11.7%
Services for persons with developmental disabilities	5	3	3	72	10.8%
Shelter and services for the homeless	3	4	3	60	9.0%
Providers who accept Medi-Cal and Healthy Families	9	9	1	138	20.6%
Services that allow seniors to live at home	0	0	0	0	0.0%
Affordable medical transportation	1	2	2	27	4.0%
Linkage to affordable prescriptions	0	3	7	39	5.8%
Other	0	1	1	9	1.3%
answered question		40		669	
skipped question		6			

14. If you responded "Other," please specify:

Answer Options	Response Count
	4
answered question	4
skipped question	42

Community Health Workers (home education)
Transportation/Parent availability for child/teen services
Educational Support
Getting in for appts with medi cal

15. Rank the top 3 healthcare gaps amongst ADULTS AGES 18-64 in their connection to services: (Label 1,2,3, and leave the rest blank)

Answer Options	Responded 1	Responded 2	Responded 3	Weighted Value	%
Cultural & language barriers to obtaining health care	7	3	9	108	18.0%
Affordable housing	10	3	5	123	20.5%
Outreach and Enrollment into Health Insurance	6	8	5	117	19.5%
Services for persons with developmental disabilities	0	1	1	9	1.5%
Shelter and services for the homeless	2	9	1	75	12.5%
Providers who accept Medi-Cal and Healthy Families	4	6	3	81	13.5%
Services that allow seniors to live at home	0	1	0	6	1.0%
Affordable medical transportation	1	0	1	12	2.0%
Linkage to affordable prescriptions	4	2	7	69	11.5%
Other	0	0	0	0	0.0%
answered question		35		600	
skipped question		11			

16. If you responded "Other," please specify:

Answer Options	Response Count
	1
answered question	1
skipped question	45

Community Organizational Survey

Providence Little Company of Mary Medical Centers, San Pedro & Torrance 2013 Health Care Needs Assessment

17. Rank the top 3 healthcare gaps amongst SENIORS AGES 65+ in their connection to services: (Label 1,2,3, and leave the rest blank)

Answer Options	Responded 1	Responded 2	Responded 3	Weighted Value	%
Cultural & language barriers to obtaining health care	4	1	5	57	10.5%
Affordable housing	7	5	1	96	17.7%
Outreach and Enrollment into Health Insurance	2	7	2	66	12.2%
Services for persons with developmental disabilities	0	0	1	3	0.6%
Shelter and services for the homeless	0	1	2	12	2.2%
Providers who accept Medi-Cal and Healthy Families	6	1	1	63	11.6%
Services that allow seniors to live at home	6	5	6	102	18.8%
Affordable medical transportation	3	4	5	66	12.2%
Linkage to affordable prescriptions	3	5	7	78	14.4%
Other	0	0	0	0	0.0%
answered question		31		543	
skipped question		15			

18. If you responded "Other," please specify:

Answer Options	Response Count
	1
answered question	1
skipped question	45

Employment support

19. In your opinion, what are the specific issues or gaps in the South Bay that need to be addressed?

Answer Options	Response Count
	40
answered question	40
skipped question	6

20. What part of your community contributes to good health (Ex. neighborhood associations, volunteer groups, accessible parks, etc)?

Answer Options	Response Count
	39
answered question	39
skipped question	7

21. What part of your community contributes to poor health (Ex, crime, lack of parks, air quality)?

Answer Options	Response Count
	38
answered question	38
skipped question	8

Community Organizational Survey

Providence Little Company of Mary Medical Centers, San Pedro & Torrance 2013 Health Care Needs Assessment

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

Answer Options	Response Count
	24
answered question	24
skipped question	22

23. What South Bay communities does your organization serve? (List by city name)

Answer Options	Response Count
	37
answered question	37
skipped question	9

24. Briefly describe the purpose of your organization and who you serve, including the number of individuals served in 2012.

Answer Options	Response Count
	38
answered question	38
skipped question	8

25.Organization Information

Answer Options	Response Percent	Response Count
Organization Name:	100.0%	36
Address:	100.0%	36
City/Zip:	100.0%	36
Phone:	97.2%	35
Name/Title of Person Completing Survey:	97.2%	35
What are the core services you provide to your clients?:	94.4%	34
Populations served (Age):	100.0%	36
answered question		36
skipped question		10

Organizational Survey—Responses to Open Ended Questions

In your opinion, what are the specific issues or gaps in the South Bay that need to be addressed?

"Access to affordable health care services and follow up. (7)
"Affordable mental health services. Both for prevention and treatment." (7)
"Low income/non-English speaking households not understanding what benefits are available." (6)
"Education/information regarding affordable or no cost health care in multiple languages"(6)
"Overall healthy lifestyle promotion amongst parents and children (physical activity, nutrition, medical exams, and screenings, etc." (4)
"Quality recess and PE programs to keep kids active." (3)
"Transportation for aging adults: dental care for adults; access to Medi-Cal specialty provider: mental health, and substance abuse (affordable)." (3)
"Transportation- a bus costs $2.50 round trip. Very expensive for a family living on the edge, Mental Health." (2)
"Affordable housing and shelters mental health services & psychiatric services." (2)
"Substance abuse" (1)
"Mental health and the impact of violence and poverty." (1)
"Less fast food, more healthy affordable prepared food options."(1)

What part of your community contributes to good health (Ex. Neighborhood associations, volunteer groups, accessible parks, etc)?

"Accessible parks, schools." (10)
"Volunteer groups, neighborhood associations, churches, community collaboration, on issues" (7)
"Growing collaboration from service providers, including free health fairs and festivals helps create a sense of community. Working together, we do more, with less, for the greater benefit of our residents." (5)
"Other local non profits, ties to schools." (5)
"Programs available through the Y, Clinics like Providence, Wilmington Community Clinic, Accessibility to parks." (5)
"Grocery stores that offer healthy food options in lower income areas/Wilmington. After-school programs for children at the local parks. Limited ability of fast food businesses to expand in low income areas and instead bring improved grocery stores to the area." (3)
"Built environment and policy, civic engagement, strong social relationships." (2)
"Non existent within a 10 mile area." (1)

What part of your community contributes to poor health (Ex, crime, lack of parks, air quality)?

1.Crime (13)
2. Air quality (12)
3.Few healthy food options/ Availability of unhealthy foods (3)
Poverty/ Low income (4)
Lack of physical activity (5)
Lack of Parks (5)
Lack of affordable healthcare (3)
Poor eating habits (2)
Unsafe Parks (2)
Lack of education (2)
Lack of organized programs (1)
Misunderstood mental health problems (1)
Lack of transportation (1)
Lack of adult supervision (1)
Traffic (1)
Noise pollution (1)
Communication/Language barrier (1)

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

"Increase access to social systems that improve wellbeing." (6)
"Events to encourage active lifestyles." (4)
"Educating community by allowing collaboration with researchers, academia & government." (3)
"PLCM is an exceptional community partner. Keep up the great work." (2)
"It would be nice to structure neighborhood advocacy programs addressing social and health needs." (2)
"Continue to provide information as well as referrals for our constituents. Provide bilingual information." (2)
"More strict air quality measures." (1)
"Better linkages between primary and behavioral health." (1)
"Medical insurance for all who need it." (1)
"Chronic Diseases (Diabetes, obesity in all age groups) and lack of insurance are two of the greatest needs that I feel our community has." (1)

PLCM PHONE SURVEY RESULTS

Totals		
Region1: Underserved North RDM	119	Gardena, Hawthorne, Lawndale
Region2: Underserved South RDM	103	Harbor City, San Pedro 90731, Wilmington
Region3: Other SBSA RDM	99	Carson, El Segundo, Manhattan, Hermosa and Redondo Beaches, Lomita, Palos Verdes, San Pedro 90732, Torrance

Diabetes	R1	%	R2	%	R3	%	Total	%
Yes:	23	19%	13	13%	15	15%	51	16%
No:	90	76%	88	85%	80	81%	258	80%
Don't Know:	5	4%	2	2%	3	3%	10	3%
Refused:	1	1%	0	0%	1	1%	2	1%

High Blood Pressure	R1	%	R2	%	R3	%	Total	%
Yes:	27	23%	15	15%	20	20%	62	19%
No:	87	73%	86	83%	79	80%	252	79%
Don't Know:	5	4%	1	1%	0	0%	6	2%
Refused:	0	0%	1	1%	0	0%	1	0%

Lung Conditions	R1	%	R2	%	R3	%	Total	%
Yes:	10	8%	8	8%	14	14%	32	10%
No:	105	88%	92	89%	83	84%	280	87%
Don't Know:	2	2%	3	3%	2	2%	7	2%
Refused:	2	2%	0	0%	0	0%	2	1%

Heart Problems	R1	%	R2	%	R3	%	Total	%
Yes:	3	3%	1	1%	2	2%	6	2%
No:	108	91%	98	95%	96	97%	302	94%
Don't Know:	7	6%	3	3%	0	0%	10	3%
Refused:	1	1%	1	1%	1	1%	3	1%

High Cholesterol	R1	%	R2	%	R3	%	Total	%
Yes:	35	29%	15	15%	24	24%	74	23%
No:	73	61%	80	78%	74	75%	227	71%
Don't Know:	11	9%	8	8%	1	1%	20	6%
Refused:	0	0%	0	0%	0	0%	0	0%

Depression	R1	%	R2	%	R3	%	Total	%
Yes:	19	16%	16	16%	17	17%	52	16%
No:	94	79%	81	79%	82	83%	257	80%
Don't Know:	5	4%	6	6%	0	0%	11	3%
Refused:	1	1%	0	0%	0	0%	1	0%

PTSD	R1	%	R2	%	R3	%	Total	%
Yes:	10	8%	8	8%	7	7%	25	8%
No:	102	86%	85	83%	89	90%	276	86%
Don't Know:	6	5%	9	9%	3	3%	18	6%
Refused:	1	1%	1	1%	0	0%	2	1%

Anxiety	R1	%	R2	%	R3	%	Total	%
Yes:	19	16%	17	17%	21	21%	57	18%
No:	94	79%	83	81%	76	77%	253	79%
Don't Know:	6	5%	3	3%	2	2%	11	3%
Refused:	0	0%	0	0%	0	0%	0	0%

Self Rating Physical Health	R1	%	R2	%	R3	%	Total	%
1. Excellent	7	6%	15	15%	10	10%	32	10%
2. Very Good	29	24%	24	23%	25	25%	78	24%
3. Good	47	39%	48	47%	45	45%	140	44%
4. Fair	26	22%	9	9%	10	10%	45	14%
5. Poor	10	8%	6	6%	9	9%	25	8%
Refused:	0	0%	1	1%	0	0%	1	0%

Self Rating Mental Health	R1	%	R2	%	R3	%	Total	%
1. Excellent	24	20%	27	26%	28	28%	79	25%
2. Very Good	35	29%	34	33%	30	30%	99	31%
3. Good	42	35%	31	30%	29	29%	102	32%
4. Fair	14	12%	8	8%	9	9%	31	10%
5. Poor	3	3%	2	2%	3	3%	8	2%
Refused:	1	1%	1	1%	0	0%	2	1%

Self Rating Social Health	R1	%	R2	%	R3	%	Total	%
1. Excellent	24	20%	27	26%	27	27%	78	24%
2. Very Good	40	34%	29	28%	32	32%	101	31%
3. Good	48	40%	36	35%	32	32%	116	36%
4. Fair	5	4%	5	5%	6	6%	16	5%
5. Poor	0	0%	3	3%	1	1%	4	1%
Refused:	2	2%	3	3%	1	1%	6	2%

Self Rating Overall Health	R1	%	R2	%	R3	%	Total	%
1. Excellent	15	13%	19	18%	19	19%	53	17%
2. Very Good	31	26%	42	41%	33	33%	106	33%
3. Good	55	46%	35	34%	33	33%	123	38%
4. Fair	16	13%	2	2%	10	10%	28	9%
5. Poor	0	0%	4	4%	3	3%	7	2%
Refused:	2	2%	1	1%	1	1%	4	1%

Visited Doctor in last year	R1	%	R2	%	R3	%	Total	%
Yes:	102	86%	85	83%	84	85%	271	84%
No:	17	14%	17	17%	15	15%	49	15%
Don't Know:	0	0%	0	0%	0	0%	0	0%
Refused:	0	0%	1	1%	0	0%	1	0%

Visited Emergency Room in last year	R1	%	R2	%	R3	%	Total	%
Yes:	27	23%	32	31%	23	23%	82	26%
No:	91	76%	70	68%	75	76%	236	74%
Don't Know:	0	0%	0	0%	0	0%	0	0%
Refused:	1	1%	1	1%	1	1%	3	1%

Overnight Stay in Hospital in last year	R1	%	R2	%	R3	%	Total	%
Yes:	14	12%	17	17%	9	9%	40	12%
No:	104	87%	82	80%	89	90%	275	86%
Don't Know:	0	0%	0	0%	0	0%	0	0%
Refused:	1	1%	4	4%	1	1%	6	2%

PLCM PHONE SURVEY RESULTS

Usual Place for Healthcare	R1	%	R2	%	R3	%	Total	%
Doctors:	36	30%	26	25%	26	26%	88	27%
Health Center:	30	25%	37	36%	29	29%	96	30%
Outpatient:	2	2%	2	2%	1	1%	5	2%
Emergency:	12	10%	9	9%	9	9%	30	9%
None:	11	9%	10	10%	7	7%	28	9%
Refused:	1	1%	2	2%	2	2%	4	1%
Other:	27	23%	17	17%	25	25%	70	22%

Have a Regular Doctor	R1	%	R2	%	R3	%	Total	%
Yes:	47	39%	41	40%	40	40%	128	40%
No:	65	55%	52	50%	53	54%	170	53%
Don't Know:	2	2%	2	2%	1	1%	5	2%
More than 1:	4	3%	7	7%	5	5%	16	5%
Refused:	1	1%	1	1%	0	0%	2	1%

Usual Place for Healthcare--Distance Travelled	R1	%	R2	%	R3	%	Total	%
0-2 Miles:	43	36%	40	39%	34	34%	117	36%
2-5 Miles	44	37%	32	31%	41	41%	117	36%
6-10 Miles	20	17%	13	13%	15	15%	48	15%
10+ Miles	11	9%	9	9%	8	8%	28	9%
Refused:	1	1%	9	9%	1	1%	11	3%

Way Travelled	R1	%	R2	%	R3	%	Total	%
Drive There:	61	51%	45	44%	67	68%	173	54%
Someone:	28	24%	28	27%	19	19%	75	23%
Bus:	19	16%	15	15%	8	8%	42	13%
Taxi:	0	0%	0	0%	1	1%	1	0%
Walk:	11	9%	11	11%	3	3%	25	8%
Refused:	0	0%	4	4%	1	1%	5	2%

Insurance Coverage of any Kind	R1	%	R2	%	R3	%	Total	%
Yes:	46	39%	41	40%	41	41%	128	40%
No:	70	59%	58	56%	55	56%	183	57%
Don't Know:	2	2%	1	1%	2	2%	5	2%
Refused:	1	1%	3	3%	1	1%	5	2%

How well do you understand your insurance coverage	R1	%	R2	%	R3	%	Total	%
Very Well:	26	22%	28	27%	20	20%	74	23%
Somewhat:	39	33%	35	34%	30	30%	104	32%
Not at All:	50	42%	35	34%	43	43%	128	40%
Refused:	4	3%	5	5%	6	6%	15	5%

Most comfortable Place to learn how to use Insurance	R1	%	R2	%	R3	%	Total	%
School:	9	8%	8	8%	7	7%	24	7%
Clinic:	20	17%	16	16%	22	22%	58	18%
Church:	7	6%	8	8%	4	4%	19	6%
Employed:	11	9%	7	7%	12	12%	30	9%
Hospital:	20	17%	10	10%	10	10%	40	12%
Health Fair:	11	9%	16	16%	14	14%	41	13%
Refused:	1	1%	0	0%	6	6%	7	2%
Other:	40	34%	38	37%	24	24%	102	32%

Ease/Difficulty Getting Fresh Produce	R1	%	R2	%	R3	%	Total	%
Very Difficult:	8	7%	4	4%	5	5%	17	5%
SomewhatD:	12	10%	8	8%	2	2%	22	7%
SomewhatE:	28	24%	21	20%	18	18%	67	21%
Very Easy:	67	56%	61	59%	71	72%	199	62%
Don't Know:	4	3%	6	6%	3	3%	13	4%
Refused:	0	0%	3	3%	0	0%	0	0%

Because Stores Don't Sell Fresh	R1	%	R2	%	R3	%	Total	%
Yes:	8	40%	1	8%	5	71%	14	36%
No:	9	45%	11	92%	2	29%	22	56%
Don't Know:	0	0%	0	0%	0	0%	0	0%
Refused:	3	15%	0	0%	0	0%	3	8%

Because Quality is Poor	R1	%	R2	%	R3	%	Total	%
Yes:	6	30%	5	42%	1	14%	12	31%
No:	11	55%	6	50%	6	86%	23	59%
Don't Know:	0	0%	1	8%	0	0%	1	3%
Refused:	3	15%	0	0%	0	0%	3	8%

Because Too Expensive	R1	%	R2	%	R3	%	Total	%
Yes:	12	60%	10	83%	7	100%	29	74%
No:	4	20%	2	17%	0	0%	6	15%
Don't Know:	0	0%	0	0%	0	0%	0	0%
Refused:	4	20%	0	0%	0	0%	4	10%

Skipped Meals due to not enough money	R1	%	R2	%	R3	%	Total	%
Yes:	18	15%	28	27%	16	16%	62	19%
No:	94	79%	65	63%	78	79%	237	74%
Don't Know:	5	4%	5	5%	1	1%	11	3%
Refused:	2	2%	5	5%	4	4%	11	3%

If Meals Were Skipped, how often	R1	%	R2	%	R3	%	Total	%
Almost Every:	5	4%	8	8%	4	4%	17	27%
Some:	6	5%	13	13%	7	7%	26	42%
1-2 Months:	5	4%	4	4%	4	4%	13	21%
Don't Know:	1	1%	3	3%	1	1%	5	8%
Refused:	1	1%	0	0%	0	0%	1	2%

Use Parks, Playgrounds, Etc.	R1	%	R2	%	R3	%	Total	%
Every Day:	17	14%	12	12%	13	13%	42	13%
Most Days:	25	21%	17	17%	19	19%	61	19%
Some Days:	60	50%	60	58%	43	43%	163	51%
Not at All:	16	13%	11	11%	24	24%	51	16%
Refused:	1	1%	3	3%	0	0%	4	1%

Feel Unsafe Using Parks	R1	%	R2	%	R3	%	Total	%
Always:	17	14%	9	9%	10	10%	36	11%
Usually:	9	8%	13	13%	4	4%	26	8%
Sometimes:	43	36%	43	42%	33	33%	119	37%
Never:	49	41%	33	32%	52	53%	134	42%
Refused:	1	1%	5	5%	0	0%	6	2%

PLCM PHONE SURVEY RESULTS

Mental Health: How Often Little Interest	R1	%	R2	%	R3	%	Total	%
Not at All:	85	71%	65	63%	68	69%	218	68%
Several Days:	19	16%	25	24%	17	17%	61	19%
Over Half:	9	8%	6	6%	5	5%	20	6%
Nearly Every:	6	5%	4	4%	7	7%	17	5%
Refused:	0	0%	3	3%	2	2%	5	2%

Mential Health: How Often Feeling Down	R1	%	R2	%	R3	%	Total	%
Not at All:	84	71%	66	64%	67	68%	217	68%
Several Days:	24	20%	24	23%	13	13%	61	19%
Over Half:	10	8%	6	6%	13	13%	29	9%
Nearly Every:	1	1%	4	4%	4	4%	9	3%
Refused:	0	0%	3	3%	2	2%	5	2%

Mental Health: How Often Feeling Nervous	R1	%	R2	%	R3	%	Total	%
Not at All:	83	70%	68	66%	61	62%	212	66%
Several Days:	23	19%	21	20%	18	18%	62	19%
Over Half:	8	7%	6	6%	13	13%	27	8%
Nearly Every:	4	3%	5	5%	6	6%	15	5%
Refused:	1	1%	3	3%	1	1%	5	2%

Mental Health: Not Able To Control Worrying	R1	%	R2	%	R3	%	Total	%
Not at All:	81	68%	67	65%	66	67%	214	67%
Several Days:	22	18%	16	16%	11	11%	49	15%
Over Half:	9	8%	15	15%	16	16%	40	12%
Nearly Every:	7	6%	2	2%	4	4%	13	4%
Refused:	0	0%	3	3%	2	2%	5	2%

Needed Dental Care in Last 12 Months	R1	%	R2	%	R3	%	Total	%
Yes:	73	61%	52	50%	64	65%	189	59%
No:	40	34%	38	37%	29	29%	107	33%
Don't Know:	6	5%	5	5%	3	3%	14	4%
Refused:	0	0%	8	8%	3	3%	11	3%

Most Recent Time Gone Without Dental: Why?	R1	%	R2	%	R3	%	Total	%
Worried:	84	71%	74	72%	66	67%	224	70%
Where?:	11	9%	9	9%	7	7%	27	8%
No Trans:	2	2%	4	4%	3	3%	9	3%
No Childcare:	1	1%	3	3%	0	0%	4	1%
Wasn't Open:	2	2%	2	2%	1	1%	5	2%
Handle:	11	9%	5	5%	1	1%	17	5%
No help:	6	5%	4	4%	0	0%	10	3%
Haven't Skip:	22	18%	19	18%	23	23%	64	20%
Refused:	3	3%	4	4%	3	3%	10	3%

Gender	R1	%	R2	%	R3	%	Total	%
Male:	29	24%	27	26%	27	27%	83	26%
Female:	89	75%	73	71%	71	72%	233	73%
Refused:	1	1%	3	3%	1	1%	5	2%

Marital Status	R1	%	R2	%	R3	%	Total	%
Single:	25	21%	24	23%	28	28%	77	24%
Married:	71	60%	49	48%	45	45%	165	51%
Divorced:	12	10%	5	5%	18	18%	35	11%
Widowed:	2	2%	2	2%	1	1%	5	2%
Partner:	8	7%	16	16%	3	3%	27	8%
Refused:	1	1%	7	7%	4	4%	12	4%

Age	R1	%	R2	%	R3	%	Total	%
18-30	18	15%	21	20%	14	14%	53	17%
31-50	61	51%	62	60%	44	44%	167	52%
51+	34	29%	14	14%	37	37%	85	26%
Refused:	6	5%	6	6%	4	4%	16	5%

Employment Status	R1	%	R2	%	R3	%	Total	%
Full Time:	28	24%	25	24%	20	20%	73	23%
Part Time:	23	19%	22	21%	33	33%	78	24%
Retired:	10	8%	1	1%	6	6%	17	5%
Unemployed:	51	43%	44	43%	28	28%	123	38%
Disabled:	2	2%	4	4%	6	6%	12	4%
Student:	3	3%	1	1%	2	2%	6	2%
Refused:	0	0%	6	6%	2	2%	8	2%
Other:	2	2%	0	0%	2	2%	4	1%

Educational Attainment	R1	%	R2	%	R3	%	Total	%
<High School:	46	39%	37	36%	17	17%	100	31%
High School:	34	29%	37	36%	31	31%	102	32%
~ College:	30	25%	21	20%	33	33%	84	26%
College:	8	7%	3	3%	15	15%	26	8%
Postgrad:	1	1%	0	0%	1	1%	2	1%
Refused:	0	0%	5	5%	2	2%	7	2%

Race	R1	%	R2	%	R3	%	Total	%
White:	9	8%	8	8%	25	25%	42	13%
Black:	4	3%	3	3%	2	2%	9	3%
Asian:	2	2%	1	1%	3	3%	6	2%
Am. Indian:	0	0%	0	0%	0	0%	0	0%
Pac. Islander:	0	0%	1	1%	0	0%	1	0%
Hispanic:	100	84%	81	79%	60	61%	241	75%
Refused:	1	1%	6	6%	4	4%	11	3%
Other:	3	3%	3	3%	5	5%	11	3%

PLCM PHONE SURVEY RESULTS

Hispanic	R1	%	R2	%	R3	%	Total	%
Yes:	100	84%	81	79%	60	61%	241	75%
No:	15	13%	15	15%	34	34%	64	20%
Refused:	4	3%	7	7%	5	5%	16	5%

Family Members in Household	R1	%	R2	%	R3	%	Total	%
One:	5	4%	4	4%	12	12%	21	7%
Two:	23	19%	10	10%	17	17%	50	16%
Three:	23	19%	16	16%	13	13%	52	16%
Four:	31	26%	24	23%	22	22%	77	24%
Five:	22	18%	29	28%	15	15%	66	21%
Six:	9	8%	9	9%	8	8%	26	8%
More Than 6:	6	5%	6	6%	9	9%	21	7%
Refused:	0	0%	5	5%	3	3%	8	2%

Annual Income	R1	%	R2	%	R3	%	Total	%
Less than $10k	28	24%	20	19%	13	13%	61	19%
$10,000+	37	31%	36	35%	24	24%	97	30%
$20,000+	23	19%	19	18%	14	14%	56	17%
$30,000+	13	11%	6	6%	17	17%	36	11%
$40,000+	5	4%	6	6%	3	3%	14	4%
$50,000+	4	3%	1	1%	3	3%	8	2%
$60,000+	3	3%	2	2%	5	5%	10	3%
$70,000+	2	2%	5	5%	11	11%	17	5%
Refused:	4	3%	5	5%	11	11%	17	5%

St. Joseph's Community Health Coalition

Needs Assessment

[sample]

In general would you say your health is:	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Excellent	**27**	**7%**	**5**	**7%**	**11**	**10%**	**5**	**4%**	**48**	**7%**
Male:	10	7%	1	5%	5	14%	3	6%	19	8%
Female:	17	7%	3	6%	6	9%	2	2%	28	6%
Very good	**86**	**21%**	**15**	**21%**	**22**	**21%**	**29**	**21%**	**152**	**21%**
Male:	31	23%	4	21%	6	17%	16	33%	57	24%
Female:	55	21%	11	22%	15	23%	13	15%	94	20%
Good	**161**	**40%**	**20**	**27%**	**41**	**39%**	**51**	**38%**	**273**	**38%**
Male:	60	44%	4	21%	17	49%	17	35%	98	41%
Female:	100	38%	16	31%	21	32%	33	39%	170	37%
Fair	**117**	**29%**	**32**	**44%**	**28**	**27%**	**49**	**36%**	**226**	**32%**
Male:	31	23%	10	53%	7	20%	12	24%	60	25%
Female:	83	32%	20	39%	20	31%	35	42%	158	34%
Poor	**10**	**2%**	**1**	**1%**	**3**	**3%**	**2**	**1%**	**16**	**2%**
Male:	4	3%	0	0%	0	0%	1	2%	5	2%
Female:	6	2%	1	2%	3	5%	1	1%	11	2%
Totals:	**401**		**73**		**105**		**136**		**715**	
Male:	136		19		35		49		239	
Female:	261		51		65		84		461	

% of total people who responded "Excellent"

% of English speaking people who responded "Excellent"

% of Spanish speaking people who responded "Excellent"

Numbers may not add up to the total because people did not answer "Male" or "Female," but rated their health "Good"

total English speaking people who responded to the question

total Spanish speaking people who responded to the question

% of English speaking people in Hawthorne who responded "Excellent"

% of Spanish speaking people in Hawthorne who responded "Excellent"

% of all people in Hawthorne who responded "Excellent"

# of total people who responded to the question

Appendix 13

St. Joseph's Community Health Coalition

Needs Assessment

In general would you say your health is:	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Excellent	**27**	**7%**	**5**	**7%**	**11**	**10%**	**5**	**4%**	**48**	**7%**
English:	13	8%	3	18%	6	19%	1	3%	23	9%
Spanish:	14	6%	2	4%	5	7%	4	4%	25	5%
Very good	**86**	**21%**	**15**	**21%**	**22**	**21%**	**29**	**21%**	**152**	**21%**
English:	44	26%	8	47%	8	26%	8	28%	68	28%
Spanish:	42	18%	7	13%	14	19%	21	20%	84	18%
Good	**161**	**40%**	**20**	**27%**	**41**	**39%**	**51**	**38%**	**273**	**38%**
English:	82	48%	5	29%	13	42%	14	48%	114	46%
Spanish:	79	34%	15	27%	28	38%	37	35%	159	34%
Fair	**117**	**29%**	**32**	**44%**	**28**	**27%**	**49**	**36%**	**226**	**32%**
English:	27	16%	1	6%	4	13%	6	21%	38	15%
Spanish:	90	39%	31	55%	24	32%	43	40%	188	40%
Poor	**10**	**2%**	**1**	**1%**	**3**	**3%**	**2**	**1%**	**16**	**2%**
English:	4	2%	0	0%	0	0%	0	0%	4	2%
Spanish:	6	3%	1	2%	3	4%	2	2%	12	3%
Totals:	**401**		**73**		**105**		**136**		**715**	
English:	170		17		31		29		247	
Spanish:	231		56		74		107		468	

In general would you say your health is:	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Excellent	**27**	**7%**	**5**	**7%**	**11**	**10%**	**5**	**4%**	**48**	**7%**
Male:	10	7%	1	5%	5	14%	3	6%	19	8%
Female:	17	7%	3	6%	6	9%	2	2%	28	6%
Very good	**86**	**21%**	**15**	**21%**	**22**	**21%**	**29**	**21%**	**152**	**21%**
Male:	31	23%	4	21%	6	17%	16	33%	57	24%
Female:	55	21%	11	22%	15	23%	13	15%	94	20%
Good	**161**	**40%**	**20**	**27%**	**41**	**39%**	**51**	**38%**	**273**	**38%**
Male:	60	44%	4	21%	17	49%	17	35%	98	41%
Female:	100	38%	16	31%	21	32%	33	39%	170	37%
Fair	**117**	**29%**	**32**	**44%**	**28**	**27%**	**49**	**36%**	**226**	**32%**
Male:	31	23%	10	53%	7	20%	12	24%	60	25%
Female:	83	32%	20	39%	20	31%	35	42%	158	34%
Poor	**10**	**2%**	**1**	**1%**	**3**	**3%**	**2**	**1%**	**16**	**2%**
Male:	4	3%	0	0%	0	0%	1	2%	5	2%
Female:	6	2%	1	2%	3	5%	1	1%	11	2%
Totals:	**401**		**73**		**105**		**136**		**715**	
Male:	136		19		35		49		239	
Female:	261		51		65		84		461	

In general would you say your health is:										
	Hawthorne/		Lawndale		Inglewood Area		Lennox		Totals	
Excellent	**27**	**7%**	**5**	**7%**	**11**	**10%**	**5**	**4%**	**48**	**7%**
18-40 years old	15	9%	2	6%	5	14%	3	5%	25	9%
41-64 years old	7	4%	3	8%	6	10%	1	2%	17	5%
65+ years old	4	10%	0	0%	0	0%	1	17%	5	10%
Very good	**86**	**21%**	**15**	**21%**	**22**	**21%**	**29**	**21%**	**152**	**21%**
18-40 years old	41	26%	7	23%	11	31%	14	23%	73	26%
41-64 years old	32	16%	7	19%	10	17%	14	22%	63	18%
65+ years old	11	28%	1	33%	0	0%	1	17%	13	25%
Good	**161**	**40%**	**20**	**27%**	**41**	**39%**	**51**	**38%**	**273**	**38%**
18-40 years old	68	43%	9	29%	12	34%	26	43%	115	40%
41-64 years old	75	39%	9	25%	24	40%	24	38%	132	37%
65+ years old	13	33%	1	33%	1	33%	1	17%	16	31%
Fair	**117**	**29%**	**32**	**44%**	**28**	**27%**	**49**	**36%**	**226**	**32%**
18-40 years old	31	20%	13	42%	7	20%	16	27%	67	24%
41-64 years old	73	38%	17	47%	17	28%	24	38%	131	37%
65+ years old	11	28%	1		2	67%	3	50%	17	33%
Poor	**10**	**2%**	**1**	**1%**	**3**	**3%**	**2**	**1%**	**16**	**2%**
18-40 years old	3	2%	0	0%	0	0%	1	2%	4	1%
41-64 years old	7	4%	0	0%	3	5%	1	2%	11	3%
65+ years old	0	0%	0	0%	0	0%	0	0%	0	0%
Totals:	**401**		**73**		**105**		**136**		**715**	
18-40 years old	158		31		35		60		284	
41-64 years old	194		36		60		64		354	
41-64 years old	39		3		3		6		51	

How long has it been since you last saw a doctor, nurse, or other health care professional for any reason	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Less than 12 months	**250**	**63%**	**49**	**69%**	**65**	**65%**	**77**	**58%**	**441**	**63%**
English:	124	73%	15	88%	25	81%	19	66%	183	74%
Spanish:	126	56%	34	63%	40	57%	58	56%	258	57%
1 year but less than 2 years	**69**	**17%**	**6**	**8%**	**18**	**18%**	**25**	**19%**	**118**	**17%**
English:	21	12%	0	0%	2	6%	1	3%	24	10%
Spanish:	48	21%	6	11%	16	23%	24	23%	94	21%
2 years but less than 5 years	**48**	**12%**	**12**	**17%**	**12**	**12%**	**19**	**14%**	**91**	**13%**
English:	11	7%	0	0%	2	6%	5	17%	18	7%
Spanish:	37	16%	12	22%	10	14%	14	14%	73	16%
5 or more years	**22**	**6%**	**3**	**4%**	**4**	**4%**	**9**	**7%**	**38**	**5%**
English:	9	5%	1	6%	2	6%	3	10%	15	6%
Spanish:	13	6%	2	4%	2	3%	6	6%	23	5%
Never	**2**	**1%**	**0**	**0%**	**1**	**1%**	**0**	**0%**	**3**	**0%**
English:	1	1%	0	0%	0	0%	0	0%	1	0%
Spanish:	1	0%	0	0%	1	1%	0	0%	2	0%
Don't know	**5**	**1%**	**1**	**1%**	**1**	**1%**	**2**	**2%**	**9**	**1%**
English:	3	2%	1	6%	0	0%	1	3%	5	2%
Spanish:	2	1%	0	0%	1	1%	1	1%	4	1%
Totals:	**396**		**71**		**101**		**132**		**700**	
English:	168		17		31		29		245	
Spanish:	226		54		69		103		452	

How long has it been since you last saw a doctor, nurse, or other heatlh care professional for any reason	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Less than 12 months	**250**	**63%**	**49**	**69%**	**65**	**65%**	**77**	**58%**	**441**	**63%**
Male:	73	43%	10	59%	17	55%	24	83%	124	50%
Female:	175	77%	37	69%	46	66%	52	50%	310	68%
1 year but less than 2 years	**69**	**17%**	**6**	**8%**	**18**	**18%**	**25**	**19%**	**118**	**17%**
Male:	30	18%	1	6%	7	23%	9	31%	47	19%
Female:	39	17%	5	9%	10	14%	14	14%	68	15%
2 years but less than 5 years	**48**	**12%**	**12**	**17%**	**12**	**12%**	**19**	**14%**	**91**	**13%**
Male:	18	11%	4	24%	7	23%	10	34%	39	16%
Female:	29	13%	7	13%	4	6%	9	9%	49	11%
5 or more years	**22**	**6%**	**3**	**4%**	**4**	**4%**	**9**	**7%**	**38**	**5%**
Male:	10	6%	2	12%	2	6%	4	14%	18	7%
Female:	11	5%	1	2%	2	3%	5	5%	19	4%
Never	**2**	**1%**	**0**	**0%**	**1**	**1%**	**0**	**0%**	**3**	**0%**
Male:	1	1%	0	0%	1	3%	0	0%	2	1%
Female:	1	0%	0	0%	0	0%	0	0%	1	0%
Don't know	**5**	**1%**	**1**	**1%**	**1**	**1%**	**2**	**2%**	**9**	**1%**
Male:	2	1%	1	6%	0	0%	2	7%	5	2%
Female:	3	1%	0	0%	0	0%	0	0%	3	1%
Totals:	**396**		**71**		**101**		**132**		**700**	
Male:	133		18		33		49		233	
Female:	257		50		62		80		449	

How long has it been since you last saw a doctor, nurse, or other heatlh care professional for any reason	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Less than 12 months	**250**	**64%**	**49**	**70%**	**65**	**65%**	**77**	**59%**	**441**	**64%**
18-40 years old	88	57%	21	72%	21	60%	28	48%	158	57%
41-64 years old	120	64%	23	66%	39	70%	43	69%	225	66%
65+ years old	36	92%	3	100%	3	100%	4	80%	46	92%
1 year but less than 2 years	**69**	**18%**	**6**	**9%**	**18**	**18%**	**25**	**19%**	**118**	**17%**
18-40 years old	26	17%	0	0%	7	20%	14	24%	47	17%
41-64 years old	39	21%	5	14%	8	14%	8	13%	60	18%
65+ years old	2	5%	0	0%	0	0%	1	20%	3	6%
2 years but less than 5 years	**48**	**12%**	**12**	**17%**	**12**	**12%**	**19**	**15%**	**91**	**13%**
18-40 years old	28	18%	5	17%	3	9%	11	19%	47	17%
41-64 years old	18	10%	7	20%	8	14%	7	11%	40	12%
65+ years old	0	0%	0	0%	0	0%	0	0%	0	0%
5 or more years	**22**	**6%**	**3**	**4%**	**4**	**4%**	**9**	**7%**	**38**	**5%**
18-40 years old	11	7%	3	10%	3	9%	5	9%	22	8%
41-64 years old	11	6%	0	0%	1	2%	4	6%	16	5%
65+ years old	0	0%	0		0	0%	0	0%	0	0%
Never	**2**	**1%**	**0**	**0%**	**1**	**1%**	**0**	**0%**	**3**	**0%**
18-40 years old	1	1%	0	0%	1	3%	0	0%	2	1%
41-64 years old	0	0%	0	0%	0	0%	0	0%	0	0%
65+ years old	1	3%	0	0%	0	0%	0	0%	1	2%
Don't know	**5**	**1%**	**1**	**1%**	**1**	**1%**	**2**	**2%**	**9**	**1%**
18-40 years old	3	2%	1	3%	0	0%	1	2%	5	2%
41-64 years old	2	1%	0	0%	0	0%	0	0%	2	1%
65+ years old	0	0%	0	0%	0	0%	1	20%	1	2%
Totals:	**396**		**71**		**101**		**132**		**700**	
18-40 years old	154		29		35		58		276	
41-64 years old	188		35		56		62		341	
41-64 years old	39		3		3		5		50	

How long has it been since you last saw a dentist or dental clinic for any reason	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Less than 12 months	**171**	**43%**	**32**	**45%**	**46**	**47%**	**47**	**37%**	**296**	**43%**
English:	81	48%	12	71%	14	45%	12	41%	119	48%
Spanish:	90	40%	20	36%	32	44%	35	33%	177	39%
1 year but less than 2 years	**83**	**21%**	**10**	**14%**	**23**	**23%**	**33**	**26%**	**149**	**22%**
English:	34	20%	1	6%	6	19%	8	28%	49	20%
Spanish:	49	22%	9	16%	17	23%	25	24%	100	22%
2 years but less than 5 years	**78**	**20%**	**17**	**24%**	**16**	**16%**	**29**	**23%**	**140**	**21%**
English:	33	20%	4	24%	6	19%	4	14%	47	19%
Spanish:	45	20%	13	24%	10	14%	25	24%	93	20%
5 or more years	**47**	**12%**	**12**	**17%**	**12**	**12%**	**17**	**13%**	**88**	**13%**
English:	15	9%	0	0%	3	10%	4	14%	22	9%
Spanish:	32	14%	12	22%	9	12%	13	12%	66	14%
Never	**10**	**3%**	**1**	**1%**	**6**	**6%**	**6**	**5%**	**23**	**3%**
English:	4	2%	0	0%	2	6%	0	0%	6	2%
Spanish:	6	3%	1	2%	4	5%	6	6%	17	4%
Don't know	**6**	**2%**	**0**	**0%**	**1**	**1%**	**2**	**2%**	**9**	**1%**
English:	2	1%	0	0%	0	0%	1	3%	3	1%
Spanish:	4	2%	0	0%	1	1%	1	1%	6	1%
Totals:	**395**		**72**		**104**		**134**		**705**	
English:	165		17		29		29		240	
Spanish:	220		54		69		99		442	

How long has it been since you last saw a dentist or dental clinic for any reason	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Less than 12 months	**171**	**43%**	**32**	**44%**	**46**	**44%**	**47**	**35%**	**296**	**42%**
Male:	53	40%	6	32%	14	40%	18	38%	91	39%
Female:	117	46%	24	48%	29	45%	29	35%	199	44%
1 year but less than 2 years	**83**	**21%**	**10**	**14%**	**23**	**22%**	**33**	**25%**	**149**	**21%**
Male:	36	27%	2	11%	9	26%	14	29%	61	26%
Female:	46	18%	8	16%	13	20%	18	22%	85	19%
2 years but less than 5 years	**78**	**20%**	**17**	**24%**	**16**	**15%**	**29**	**22%**	**140**	**20%**
Male:	25	19%	7	37%	5	14%	6	13%	43	18%
Female:	52	20%	9	18%	11	17%	21	25%	93	20%
5 or more years	**47**	**12%**	**12**	**17%**	**12**	**12%**	**17**	**13%**	**88**	**12%**
Male:	15	11%	4	21%	2	6%	6	13%	27	11%
Female:	31	12%	8	16%	10	16%	11	13%	60	13%
Never	**10**	**3%**	**1**	**1%**	**6**	**6%**	**6**	**4%**	**23**	**3%**
Male:	3	2%	0	0%	5	14%	3	6%	11	5%
Female:	7	3%	1	2%	1	2%	3	4%	12	3%
Don't know	**6**	**2%**	**0**	**0%**	**1**	**1%**	**2**	**1%**	**9**	**1%**
Male:	2	1%	0	0%	0	0%	1	2%	3	1%
Female:	4	2%	0	0%	0	0%	1	1%	5	1%
Totals:	**395**		**72**		**104**		**134**		**705**	
Male:	131		19		30		45		225	
Female:	250		49		63		80		442	

How long has it been since you last saw a dentist or dental clinic for any reason	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Less than 12 months	**171**	**43%**	**32**	**44%**	**46**	**44%**	**47**	**35%**	**296**	**42%**
18-40 years old	57	37%	12	39%	12	34%	19	32%	100	36%
41-64 years old	89	46%	16	46%	29	49%	26	41%	160	46%
65+ years old	22	56%	3	100%	1	33%	2	33%	28	55%
1 year but less than 2 years	**83**	**21%**	**10**	**14%**	**23**	**22%**	**33**	**25%**	**149**	**21%**
18-40 years old	34	22%	5	16%	10	29%	17	29%	66	23%
41-64 years old	41	21%	4	11%	12	20%	12	19%	69	20%
65+ years old	6	15%	0	0%	0	0%	1	17%	7	14%
2 years but less than 5 years	**78**	**20%**	**17**	**24%**	**16**	**15%**	**29**	**22%**	**140**	**20%**
18-40 years old	35	22%	8	26%	5	14%	13	22%	61	22%
41-64 years old	36	19%	9	26%	8	14%	13	21%	66	19%
65+ years old	5	13%	0	0%	2	67%	1	17%	8	16%
5 or more years	**47**	**12%**	**12**	**17%**	**12**	**12%**	**17**	**13%**	**88**	**12%**
18-40 years old	22	14%	5	16%	4	11%	7	12%	38	14%
41-64 years old	19	10%	6	17%	8	14%	8	13%	41	12%
65+ years old	5	13%	0	0%	0	0%	1	17%	6	12%
Never	**10**	**3%**	**1**	**1%**	**6**	**6%**	**6**	**4%**	**23**	**3%**
18-40 years old	6	4%	1	3%	4	11%	2	3%	13	5%
41-64 years old	3	2%	0	0%	2	3%	4	6%	9	3%
65+ years old	1	3%	0	0%	0	0%	0	0%	1	2%
Don't know	**6**	**2%**	**0**	**0%**	**1**	**1%**	**2**	**1%**	**9**	**1%**
18-40 years old	2	1%	0	0%	0	0%	1	2%	3	1%
41-64 years old	4	2%	0	0%	0	0%	0	0%	4	1%
65+ years old	0	0%	0	0%	0	0%	1	17%	1	2%
Totals:	**395**		**72**		**104**		**134**		**705**	
18-40 years old	154		31		35		58		278	
41-64 years old	188		35		59		63		345	
41-64 years old	39		3		3		5		50	

Where do you USUALLY go when you are sick OR need health care?	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Doctor's office or private clinic	**225**	**54%**	**34**	**48%**	**62**	**60%**	**56**	**41%**	**377**	**53%**
English:	120	68%	13	76%	24	73%	19	61%	176	68%
Spanish:	105	44%	21	38%	38	53%	37	34%	201	42%
Community clinic or County clinic	**97**	**23%**	**21**	**30%**	**22**	**21%**	**42**	**31%**	**182**	**25%**
English:	28	16%	1	6%	2	6%	6	19%	37	14%
Spanish:	69	29%	20	36%	20	28%	36	33%	145	30%
Hospital Outpatient department	**13**	**3%**	**0**	**0%**	**2**	**2%**	**2**	**1%**	**17**	**2%**
English:	8	5%	0	0%	2	6%	2	6%	12	5%
Spanish:	5	2%	0	0%	0	0%	0	0%	5	1%
Hospital Emergency Room	**32**	**8%**	**3**	**4%**	**7**	**7%**	**7**	**5%**	**50**	**7%**
English:	6	3%	1	6%	2	6%	1	3%	11	4%
Spanish:	26	11%	2	4%	5	7%	6	6%	39	8%
Some other place	**9**	**2%**	**2**	**3%**	**2**	**2%**	**4**	**3%**	**17**	**2%**
English:	4	2%	1	6%	0	0%	0	0%	5	2%
Spanish:	5	2%	1	2%	2	3%	4	4%	12	3%
No regular place of care	**39**	**9%**	**13**	**18%**	**10**	**10%**	**29**	**21%**	**91**	**13%**
English:	10	6%	1	6%	3	9%	3	10%	17	7%
Spanish:	29	12%	12	21%	7	10%	26	24%	74	16%
Totals:	**415**		**73**		**105**		**140**		**734***	
English:	176		17		33		31		258	
Spanish:	239		56		72		109		476	

***Higher total because multiple answers accepted**

Where do you USUALLY go when you are sick OR need health care?	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Doctor's office or private clinic	**227**	**55%**	**34**	**48%**	**62**	**60%**	**56**	**41%**	**377**	**53%**
Male:	73	53%	10	53%	23	66%	25	49%	131	54%
Female:	151	56%	23	45%	37	57%	31	36%	242	51%
Community clinic or County clinic	**97**	**23%**	**21**	**30%**	**22**	**21%**	**42**	**31%**	**182**	**25%**
Male:	35	25%	6	32%	4	11%	11	22%	56	23%
Female:	61	22%	15	29%	17	26%	31	36%	124	26%
Hospital Outpatient department	**13**	**3%**	**0**	**0%**	**2**	**2%**	**2**	**1%**	**17**	**2%**
Male:	7	5%	0	0%	1	3%	1	2%	9	4%
Female:	6	2%	0	0%	1	2%	1	1%	8	2%
Hospital Emergency Room	**32**	**8%**	**3**	**4%**	**7**	**7%**	**7**	**5%**	**50**	**7%**
Male:	8	6%	0	0%	3	9%	2	4%	13	5%
Female:	23	8%	2	4%	3	5%	5	6%	33	7%
Some other place	**9**	**2%**	**2**	**3%**	**2**	**2%**	**4**	**3%**	**17**	**2%**
Male:	6	4%	1	5%	0	0%	1	2%	8	3%
Female:	3	1%	1	2%	1	2%	3	3%	8	2%
No regular place of care	**39**	**9%**	**13**	**18%**	**10**	**10%**	**29**	**21%**	**91**	**13%**
Male:	10	7%	2	11%	4	11%	11	22%	27	11%
Female:	28	10%	10	20%	6	9%	16	18%	60	13%
Totals:	**417**		**73**		**105**		**140**		**734***	
Male:	139		19		35		51		244	
Female:	272		51		65		87		475	

***Higher total because multiple answers accepted**

Where do you USUALLY go when you are sick OR need health care?										
	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Doctor's office or private clinic	**227**	**55%**	**34**	**48%**	**62**	**60%**	**56**	**41%**	**377**	**72%**
18-40 years old	85	52%	13	42%	18	50%	26	41%	142	48%
41-64 years old	101	50%	17	47%	38	62%	26	41%	182	50%
65+ years old	33	92%	2	67%	2	100%	3	43%	40	75%
Community clinic or County clinic	**97**	**23%**	**21**	**30%**	**22**	**21%**	**42**	**31%**	**182**	**25%**
18-40 years old	42	26%	9	29%	10	28%	21	33%	82	28%
41-64 years old	52	26%	12	33%	12	20%	19	30%	95	26%
65+ years old	0	0%	0	0%	0	0%	2	29%	4	8%
Hospital Outpatient department	**13**	**3%**	**0**	**0%**	**2**	**2%**	**2**	**1%**	**17**	**2%**
18-40 years old	4	2%	0	0%	0	0%	1	2%	5	2%
41-64 years old	8	4%	0	0%	2	3%	1	2%	11	3%
65+ years old	0	0%	0	0%	0	0%	0	0%	1	2%
Hospital Emergency Room	**32**	**8%**	**3**	**4%**	**7**	**7%**	**7**	**5%**	**50**	**7%**
18-40 years old	9	6%	2	6%	4	11%	6	9%	21	7%
41-64 years old	18	9%	0	0%	3	5%	0	0%	21	6%
65+ years old	2	6%	1	33%	0	0%	1	14%	6	11%
Some other place	**9**	**2%**	**2**	**3%**	**2**	**2%**	**4**	**3%**	**17**	**2%**
18-40 years old	4	2%	1	3%	0	0%	2	3%	7	2%
41-64 years old	5	2%	1	3%	1	2%	1	2%	8	2%
65+ years old	0	0%	0	0%	0	0%	0	0%	0	0%
No regular place of care	**39**	**9%**	**13**	**18%**	**10**	**10%**	**29**	**21%**	**91**	**13%**
18-40 years old	19	12%	6	19%	4	11%	8	13%	37	13%
41-64 years old	17	8%	6	17%	5	8%	17	27%	45	12%
65+ years old	1	3%	0	0%	0	0%	1	14%	2	4%
Totals:	**417**		**73**		**105**		**140**		**734***	
18-40 years old	144		25		32		56		257	
41-64 years old	184		30		56		47		317	
41-64 years old	35		3		2		6		51	

***Higher total because multiple answers accepted**

Have you ever been told by a doctor or other health professional that you have...?	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Diabetes	**52**	**11%**	**4**	**5%**	**12**	**11%**	**15**	**9%**	**83**	**10%**
English:	20	10%	0	0%	1	3%	3	10%	24	8%
Spanish:	32	11%	4	6%	11	14%	12	9%	59	10%
High Blood Pressure or Hypertension	**106**	**22%**	**11**	**13%**	**16**	**14%**	**35**	**21%**	**168**	**20%**
English:	49	24%	4	21%	6	19%	5	16%	64	22%
Spanish:	57	20%	7	11%	10	13%	30	22%	104	18%
High Cholesterol	**112**	**23%**	**18**	**21%**	**29**	**26%**	**38**	**22%**	**197**	**23%**
English:	46	22%	3	16%	9	28%	3	10%	61	21%
Spanish:	66	23%	15	23%	20	25%	35	25%	136	24%
Depression	**44**	**9%**	**11**	**13%**	**9**	**8%**	**17**	**10%**	**81**	**9%**
English:	14	7%	1	5%	1	3%	1	3%	17	6%
Spanish:	30	11%	10	15%	8	10%	16	12%	64	11%
No	**176**	**36%**	**40**	**48%**	**46**	**41%**	**65**	**38%**	**328**	**38%**
English:	79	38%	11	58%	15	47%	19	61%	125	43%
Spanish:	97	34%	29	45%	31	39%	46	33%	203	36%
Totals:	**490**		**84**		**112**		**170**		**857***	
English:	208		19		32		31		291	
Spanish:	282		65		80		139		566	

***Higher total because multiple answers accepted**

Have you ever been told by a doctor or other health professional that you have...?	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Diabetes	**52**	**11%**	**4**	**5%**	**12**	**11%**	**15**	**9%**	**83**	**10%**
Male:	15	9%	1	4%	2	6%	5	8%	23	8%
Female:	36	11%	2	4%	9	13%	9	9%	56	10%
High Blood Pressure or Hypertension	**106**	**22%**	**11**	**13%**	**16**	**14%**	**35**	**21%**	**168**	**20%**
Male:	33	21%	5	22%	7	19%	10	17%	55	20%
Female:	71	22%	5	9%	9	13%	23	22%	108	19%
High Cholesterol	**112**	**23%**	**18**	**21%**	**29**	**26%**	**38**	**22%**	**197**	**23%**
Male:	36	23%	6	26%	7	19%	13	22%	62	22%
Female:	75	23%	11	20%	21	30%	24	23%	131	23%
Depression	**44**	**9%**	**11**	**13%**	**9**	**8%**	**17**	**10%**	**81**	**9%**
Male:	10	6%	3	13%	2	6%	5	8%	20	7%
Female:	34	10%	7	13%	6	8%	10	10%	57	10%
No	**176**	**36%**	**40**	**48%**	**46**	**41%**	**65**	**38%**	**328**	**38%**
Male:	64	41%	8	35%	18	50%	27	45%	117	42%
Female:	112	34%	31	55%	26	37%	38	37%	207	37%
Totals:	**490**		**84**		**112**		**170**		**857***	
Male:	158		23		36		60		277	
Female:	328		56		71		104		559	

***Higher total because multiple answers accepted**

Have you ever been told by a doctor or other health professional that you have...?	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Diabetes	**52**	**11%**	**4**	**5%**	**12**	**11%**	**15**	**9%**	**83**	**10%**
18-40 years old	11	7%	1	3%	0	0%	5	8%	17	6%
41-64 years old	32	13%	0	0%	10	15%	7	8%	49	11%
65+ years old	9	20%	2	40%	2	40%	2	22%	15	19%
High Blood Pressure or Hypertension	**106**	**22%**	**11**	**13%**	**16**	**14%**	**35**	**21%**	**168**	**20%**
18-40 years old	16	10%	5	14%	3	9%	5	8%	29	10%
41-64 years old	65	26%	5	13%	12	18%	25	28%	107	24%
65+ years old	18	39%	0	0%	1	20%	3	33%	27	33%
High Cholesterol	**112**	**23%**	**18**	**21%**	**29**	**26%**	**38**	**22%**	**197**	**23%**
18-40 years old	22	13%	4	11%	4	11%	8	12%	38	13%
41-64 years old	67	27%	12	30%	22	33%	27	30%	128	29%
65+ years old	17	37%	1	20%	2	40%	2	22%	26	32%
Depression	**44**	**9%**	**11**	**13%**	**9**	**8%**	**17**	**10%**	**81**	**9%**
18-40 years old	15	9%	4	11%	4	11%	2	3%	25	8%
41-64 years old	26	10%	5	13%	3	5%	13	15%	47	11%
65+ years old	2	4%	1	20%	0	0%	0	0%	3	4%
No	**176**	**36%**	**40**	**48%**	**46**	**41%**	**65**	**38%**	**328**	**38%**
18-40 years old	102	61%	21	60%	24	69%	45	69%	192	64%
41-64 years old	61	24%	18	45%	19	29%	17	19%	115	26%
65+ years old	0	0%	1	20%	0	0%	2	22%	10	12%
Totals:	**490**		**84**		**112**		**170**		**857***	
18-40 years old	166		35		35		65		301	
41-64 years old	251		40		66		89		446	
41-64 years old	46		5		5		9		81	

***Higher total because multiple answers accepted**

***UNABLE TO TELL IF "0" MEANS ZERO SERVINGS, OR REFUSED TO ANSWER**

How many servings of fruits and vegetables did you eat yesterday?	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
1	**99**	**29%**	**22**	**37%**	**23**	**25%**	**39**	**34%**	**183**	**30%**
English:	41	27%	5	33%	8	29%	7	28%	61	28%
Spanish:	58	30%	17	39%	15	24%	32	35%	122	31%
2	**109**	**31%**	**18**	**31%**	**28**	**31%**	**29**	**25%**	**184**	**30%**
English:	52	34%	5	33%	8	29%	7	28%	72	33%
Spanish:	57	29%	13	30%	20	32%	22	24%	112	28%
3	**73**	**21%**	**14**	**24%**	**22**	**24%**	**27**	**23%**	**136**	**22%**
English:	31	20%	4	27%	9	32%	8	32%	52	24%
Spanish:	42	22%	10	23%	13	21%	19	21%	84	21%
4	**30**	**9%**	**3**	**5%**	**9**	**10%**	**8**	**7%**	**50**	**8%**
English:	15	10%	1	7%	2	7%	1	4%	19	9%
Spanish:	15	8%	2	5%	7	11%	7	8%	31	8%
5+	**36**	**10%**	**2**	**3%**	**9**	**10%**	**13**	**11%**	**60**	**10%**
English:	13	9%	0	0%	1	4%	2	8%	16	7%
Spanish:	23	12%	2	5%	8	13%	11	12%	44	11%
Totals:	**347**		**59**		**91**		**116**		**613**	
English:	152		15		28		25		220	
Spanish:	195		44		63		91		393	

How many servings of fruits and vegetables did you eat yesterday?	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
1	**99**	**29%**	**22**	**37%**	**23**	**25%**	**39**	**34%**	**183**	**30%**
Male:	37	32%	7	44%	5	16%	15	39%	64	32%
Female:	62	27%	15	36%	16	29%	24	32%	117	29%
2	**109**	**31%**	**18**	**31%**	**28**	**31%**	**29**	**25%**	**184**	**30%**
Male:	43	37%	5	31%	14	45%	9	24%	71	35%
Female:	66	29%	13	31%	14	25%	20	27%	113	28%
3	**73**	**21%**	**14**	**24%**	**22**	**24%**	**27**	**23%**	**136**	**22%**
Male:	22	19%	2	13%	7	23%	9	24%	40	20%
Female:	50	22%	12	29%	14	25%	18	24%	94	24%
4	**30**	**9%**	**3**	**5%**	**9**	**10%**	**8**	**7%**	**50**	**8%**
Male:	5	4%	0	0%	2	6%	2	5%	9	4%
Female:	25	11%	2	5%	7	13%	5	7%	39	10%
5+	**36**	**10%**	**2**	**3%**	**9**	**10%**	**13**	**11%**	**60**	**10%**
Male:	9	8%	2	13%	3	10%	3	8%	17	8%
Female:	24	11%	0	0%	5	9%	8	11%	37	9%
Totals:	**347**		**59**		**91**		**116**		**613**	
Male:	116		16		31		38		201	
Female:	227		42		56		75		400	

How many servings of fruits and vegetables did you eat yesterday?	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
1	**99**	**29%**	**22**	**37%**	**23**	**25%**	**39**	**34%**	**183**	**30%**
18-40 years old	34	24%	10	36%	9	31%	21	40%	74	30%
41-64 years old	51	31%	10	36%	11	21%	16	30%	88	30%
65+ years old	13	37%	1	50%	0	0%	1	20%	15	33%
2	**109**	**31%**	**18**	**31%**	**28**	**31%**	**29**	**25%**	**184**	**30%**
18-40 years old	46	33%	10	36%	10	34%	10	19%	76	30%
41-64 years old	55	34%	7	25%	18	34%	17	31%	97	33%
65+ years old	6	17%	1	50%	0	0%	1	20%	8	18%
3	**73**	**21%**	**14**	**24%**	**22**	**24%**	**27**	**23%**	**136**	**22%**
18-40 years old	36	26%	6	21%	7	24%	14	26%	63	25%
41-64 years old	28	17%	8	29%	11	21%	12	22%	59	20%
65+ years old	6	17%	0	0%	3	100%	1	20%	10	22%
4	**30**	**9%**	**3**	**5%**	**9**	**10%**	**8**	**7%**	**50**	**8%**
18-40 years old	12	9%	1	4%	1	3%	4	8%	18	7%
41-64 years old	10	6%	2	7%	7	13%	4	7%	23	8%
65+ years old	6	17%	0		0	0%	0	0%	6	13%
5+	**36**	**10%**	**2**	**3%**	**9**	**10%**	**13**	**11%**	**60**	**10%**
18-40 years old	12	9%	1	4%	2	7%	4	8%	19	8%
41-64 years old	19	12%	1	4%	6	11%	5	9%	31	10%
65+ years old	4	11%	0	0%	0	0%	2	40%	6	13%
Totals:	**347**		**59**		**91**		**116**		**613**	
18-40 years old	140		28		29		53		250	
41-64 years old	163		28		53		54		298	
41-64 years old	35		2		3		5		45	

How difficult is it for you to get fresh produce (fruits and vegetables)?	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Very Difficult	**20**	**5%**	**4**	**6%**	**2**	**2%**	**15**	**11%**	**41**	**6%**
English:	2	1%	0	0%	0	0%	2	7%	4	2%
Spanish:	18	8%	4	7%	2	3%	13	12%	37	8%
Somewhat Difficult	**72**	**18%**	**10**	**14%**	**21**	**20%**	**24**	**18%**	**127**	**18%**
English:	22	13%	1	6%	2	6%	3	10%	28	11%
Spanish:	50	22%	9	16%	19	26%	21	20%	99	21%
Somewhat Easy	**102**	**26%**	**14**	**19%**	**21**	**20%**	**34**	**25%**	**171**	**24%**
English:	59	35%	2	12%	7	23%	8	28%	76	31%
Spanish:	43	19%	12	22%	14	19%	26	25%	95	21%
Very Easy	**194**	**49%**	**41**	**57%**	**59**	**57%**	**57**	**42%**	**351**	**50%**
English:	84	50%	13	76%	22	71%	14	48%	133	54%
Spanish:	110	48%	28	51%	37	51%	43	41%	218	47%
Don't Know	**8**	**2%**	**3**	**4%**	**1**	**1%**	**5**	**4%**	**17**	**2%**
English:	1	1%	1	6%	0	0%	2	7%	4	2%
Spanish:	7	3%	2	4%	1	1%	3	3%	13	3%
Totals:	**396**		**72**		**104**		**135**		**707**	
English:	168		17		31		29		245	
Spanish:	228		55		73		106		462	

How difficult is it for you to get fresh produce (fruits and vegetables)?	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Very Difficult	**20**	**5%**	**4**	**6%**	**2**	**2%**	**15**	**11%**	**41**	**6%**
Male:	4	3%	2	11%	0	0%	5	10%	11	5%
Female:	15	6%	2	4%	2	3%	10	12%	29	6%
Somewhat Difficult	**72**	**18%**	**10**	**14%**	**21**	**20%**	**24**	**18%**	**127**	**18%**
Male:	15	11%	4	21%	5	15%	6	13%	30	13%
Female:	57	22%	4	8%	14	22%	17	20%	92	20%
Somewhat Easy	**102**	**26%**	**14**	**19%**	**21**	**20%**	**34**	**25%**	**171**	**24%**
Male:	42	31%	3	16%	7	21%	9	19%	61	26%
Female:	58	23%	11	22%	14	22%	25	30%	108	24%
Very Easy	**194**	**49%**	**41**	**57%**	**59**	**57%**	**57**	**42%**	**351**	**50%**
Male:	72	53%	9	47%	22	65%	24	50%	127	54%
Female:	121	47%	31	62%	35	54%	31	37%	218	48%
Don't Know	**8**	**2%**	**3**	**4%**	**1**	**1%**	**5**	**4%**	**17**	**2%**
Male:	3	2%	1	5%	0	0%	4	8%	8	3%
Female:	5	2%	2	4%	0	0%	1	1%	8	2%
Totals:	**396**		**72**		**104**		**135**		**707**	
Male:	136		19		34		48		237	
Female:	256		50		65		84		455	

How difficult is it for you to get fresh produce (fruits and vegetables)?	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Very Difficult	**20**	**5%**	**4**	**6%**	**2**	**2%**	**15**	**11%**	**41**	**6%**
18-40 years old	5	3%	1	3%	1	3%	7	12%	14	5%
41-64 years old	10	5%	3	9%	1	2%	6	10%	20	6%
65+ years old	4	11%	0	0%	0	0%	0	0%	4	8%
Somewhat Difficult	**72**	**18%**	**10**	**14%**	**21**	**20%**	**24**	**18%**	**127**	**18%**
18-40 years old	25	16%	3	10%	6	18%	10	17%	44	16%
41-64 years old	39	20%	6	17%	13	22%	11	17%	69	20%
65+ years old	4	11%	1	33%	0	0%	1	17%	6	12%
Somewhat Easy	**102**	**26%**	**14**	**19%**	**21**	**20%**	**34**	**25%**	**171**	**24%**
18-40 years old	37	24%	5	16%	3	9%	14	23%	59	21%
41-64 years old	55	29%	8	23%	16	27%	19	30%	98	28%
65+ years old	10	26%	0	0%	0	0%	1	17%	11	22%
Very Easy	**194**	**49%**	**41**	**57%**	**59**	**57%**	**57**	**42%**	**351**	**50%**
18-40 years old	87	55%	20	65%	24	71%	26	43%	157	56%
41-64 years old	85	44%	17	49%	30	50%	26	41%	158	45%
65+ years old	18	47%	2		3	100%	3	50%	26	52%
Don't Know	**8**	**2%**	**3**	**4%**	**1**	**1%**	**5**	**4%**	**17**	**2%**
18-40 years old	3	2%	2	6%	0	0%	3	5%	8	3%
41-64 years old	3	2%	1	3%	0	0%	1	2%	5	1%
65+ years old	2	5%	0	0%	0	0%	1	17%	3	6%
Totals:	**396**		**72**		**104**		**135**		**707**	
18-40 years old	157		31		34		60		282	
41-64 years old	192		35		60		63		350	
41-64 years old	38		3		3		6		50	

Where do you receive health information/news about the Lennox, Inglewood, and Hawthorne area?	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Internet	**92**	**15%**	**18**	**16%**	**19**	**12%**	**21**	**9%**	**150**	**13%**
English:	64	23%	10	37%	5	13%	9	16%	88	22%
Spanish:	28	8%	8	9%	14	11%	12	7%	62	9%
Email	**31**	**5%**	**3**	**3%**	**7**	**4%**	**12**	**5%**	**53**	**5%**
English:	16	6%	1	4%	1	3%	4	7%	22	5%
Spanish:	15	4%	2	2%	6	5%	8	5%	31	4%
Phone	**15**	**2%**	**0**	**0%**	**5**	**3%**	**8**	**4%**	**28**	**2%**
English:	8	3%	0	0%	0	0%	1	2%	9	2%
Spanish:	7	2%	0	0%	5	4%	7	4%	19	3%
Radio	**29**	**5%**	**10**	**9%**	**6**	**4%**	**8**	**4%**	**53**	**5%**
English:	15	5%	1	4%	0	0%	2	3%	18	4%
Spanish:	14	4%	9	10%	6	5%	6	4%	35	5%
Friends	**80**	**13%**	**14**	**12%**	**22**	**14%**	**28**	**13%**	**144**	**13%**
English:	33	12%	0	0%	8	21%	11	19%	52	13%
Spanish:	47	14%	14	16%	14	11%	17	10%	92	13%
Family Members	**63**	**10%**	**4**	**3%**	**24**	**15%**	**22**	**10%**	**113**	**10%**
English:	34	12%	0	0%	9	23%	11	19%	54	13%
Spanish:	29	8%	4	5%	15	12%	11	7%	59	8%
Church bulletin	**118**	**19%**	**23**	**20%**	**27**	**17%**	**45**	**20%**	**217**	**19%**
English:	36	13%	5	19%	4	10%	2	3%	47	12%
Spanish:	82	24%	18	20%	27	22%	43	26%	170	24%
School	**28**	**4%**	**5**	**4%**	**12**	**8%**	**22**	**10%**	**68**	**6%**
English:	13	5%	3	11%	2	5%	6	10%	25	6%
Spanish:	15	4%	2	2%	10	8%	16	10%	43	6%
TV	**112**	**18%**	**26**	**23%**	**22**	**14%**	**38**	**17%**	**198**	**18%**
English:	28	10%	2	7%	4	10%	3	5%	37	9%
Spanish:	84	24%	24	27%	18	15%	35	21%	161	22%
Text messages	**4**	**1%**	**2**	**2%**	**1**	**1%**	**2**	**1%**	**9**	**1%**
English:	1	0%	0	0%	1	3%	1	2%	3	1%
Spanish:	3	1%	2	2%	0	0%	1	1%	6	1%
Local newspaper	**36**	**6%**	**8**	**7%**	**10**	**6%**	**14**	**6%**	**68**	**6%**
English:	19	7%	4	15%	3	8%	5	9%	31	8%
Spanish:	17	5%	4	5%	7	6%	9	5%	37	5%
Other	**19**	**3%**	**2**	**2%**	**4**	**3%**	**4**	**2%**	**29**	**3%**
English:	15	5%	1	4%	2	5%	3	5%	21	5%
Spanish:	4	1%	1	1%	2	2%	1	1%	8	1%
Totals:	**627**		**115**		**159**		**224**		**1130***	
English:	282		27		39		58		407	
Spanish:	345		88		124		166		723	

***Higher total because multiple answers accepted**

St. Joseph's Community Health Coalition

Needs Assessment

Where do you receive health information/news about the Lennox, Inglewood, and Hawthorne area?	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Internet	**92**	**15%**	**18**	**16%**	**19**	**12%**	**21**	**9%**	**150**	**13%**
Male:	30	15%	4	14%	8	16%	9	10%	51	14%
Female:	62	15%	14	17%	11	10%	12	9%	99	13%
Email	**31**	**5%**	**3**	**3%**	**7**	**4%**	**12**	**5%**	**53**	**5%**
Male:	11	5%	0	0%	2	4%	6	7%	19	5%
Female:	20	3%	2	1%	4	2%	4	2%	30	2%
Phone	**15**	**2%**	**0**	**0%**	**5**	**3%**	**8**	**4%**	**28**	**2%**
Male:	6	3%	0	0%	2	4%	1	1%	9	2%
Female:	8	1%	0	0%	3	1%	6	2%	17	1%
Radio	**29**	**5%**	**10**	**9%**	**6**	**4%**	**8**	**4%**	**53**	**5%**
Male:	12	6%	1	3%	2	4%	4	5%	19	5%
Female:	17	2%	9	5%	4	2%	4	2%	34	2%
Friends	**80**	**13%**	**14**	**12%**	**22**	**14%**	**28**	**13%**	**144**	**13%**
Male:	27	13%	6	21%	7	14%	8	9%	48	13%
Female:	52	6%	8	5%	15	7%	20	8%	95	6%
Family Members	**63**	**10%**	**4**	**3%**	**24**	**15%**	**22**	**10%**	**113**	**10%**
Male:	18	9%	3	10%	6	12%	9	10%	36	10%
Female:	44	6%	1	1%	17	8%	13	5%	75	5%
Church bulletin	**118**	**19%**	**23**	**20%**	**27**	**17%**	**45**	**20%**	**217**	**19%**
Male:	41	20%	3	10%	9	18%	19	22%	72	20%
Female:	77	10%	20	13%	21	11%	25	11%	143	11%
School	**28**	**4%**	**5**	**4%**	**12**	**8%**	**22**	**10%**	**68**	**6%**
Male:	11	5%	0	0%	2	4%	6	7%	19	5%
Female:	17	2%	5	3%	10	6%	16	7%	48	4%
TV	**112**	**18%**	**26**	**23%**	**22**	**14%**	**38**	**17%**	**198**	**18%**
Male:	29	14%	8	28%	8	16%	15	17%	60	16%
Female:	81	12%	17	12%	14	8%	21	11%	133	11%
Text messages	**4**	**1%**	**2**	**2%**	**1**	**1%**	**2**	**1%**	**9**	**1%**
Male:	0	0%	0	0%	0	0%	1	1%	1	0%
Female:	4	1%	2	2%	1	1%	1	1%	8	1%
Local newspaper	**36**	**6%**	**8**	**7%**	**10**	**6%**	**14**	**6%**	**68**	**6%**
Male:	13	6%	3	10%	2	4%	5	6%	23	6%
Female:	23	3%	5	4%	7	4%	9	4%	44	4%
Other	**19**	**3%**	**2**	**2%**	**4**	**3%**	**4**	**2%**	**29**	**3%**
Male:	5	2%	1	3%	1	2%	3	3%	10	3%
Female:	14	2%	1	1%	3	2%	1	0%	19	1%
Totals:	**627**		**115**		**159**		**224**		**1130***	
Male:	203		29		49		86		367	
Female:	419		84		110		132		745	

***Higher total because multiple answers accepted**

Appendix 13

Where do you receive health information/news about the Lennox, Inglewood, and Hawthorne area?	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Internet	**92**	**15%**	**18**	**16%**	**19**	**12%**	**21**	**9%**	**150**	**13%**
18-40 years old	54	20%	8	18%	8	13%	14	12%	84	17%
41-64 years old	34	11%	9	14%	10	11%	7	8%	60	11%
65+ years old	2	4%	1	33%	0	0%	0	0%	3	5%
Email	**31**	**5%**	**3**	**3%**	**7**	**4%**	**12**	**5%**	**53**	**5%**
18-40 years old	15	6%	0	0%	2	3%	7	6%	24	5%
41-64 years old	14	5%	3	5%	4	4%	4	4%	25	5%
65+ years old	1	2%	0	0%	0	0%	0	0%	1	2%
Phone	**15**	**2%**	**0**	**0%**	**5**	**3%**	**8**	**4%**	**28**	**2%**
18-40 years old	7	3%	0	0%	1	2%	3	3%	11	2%
41-64 years old	6	2%	0	0%	2	2%	3	3%	11	2%
65+ years old	1	2%	0	0%	0	0%	0	0%	1	2%
Radio	**29**	**5%**	**10**	**9%**	**6**	**4%**	**8**	**4%**	**53**	**5%**
18-40 years old	15	6%	2	5%	2	3%	5	4%	24	5%
41-64 years old	12	4%	7	11%	4	4%	3	3%	26	5%
65+ years old	1	2%	0	0%	0	0%	0	0%	1	2%
Friends	**80**	**13%**	**14**	**12%**	**22**	**14%**	**28**	**13%**	**144**	**13%**
18-40 years old	33	12%	6	14%	8	13%	11	10%	58	12%
41-64 years old	35	12%	8	13%	14	16%	14	15%	71	13%
65+ years old	9	20%	0	0%	0	0%	2	29%	11	19%
Family Members	**63**	**10%**	**4**	**3%**	**24**	**15%**	**22**	**10%**	**113**	**10%**
18-40 years old	26	10%	3	7%	8	13%	9	8%	46	9%
41-64 years old	31	10%	1	2%	14	16%	13	14%	59	11%
65+ years old	4	9%	0	0%	2	67%	0	0%	6	10%
Church bulletin	**118**	**19%**	**23**	**20%**	**27**	**17%**	**45**	**20%**	**217**	**19%**
18-40 years old	32	12%	5	11%	10	16%	24	21%	71	15%
41-64 years old	79	26%	16	25%	19	21%	19	21%	133	24%
65+ years old	5	11%	1	33%	1	33%	1	14%	8	14%
School	**28**	**4%**	**5**	**4%**	**12**	**8%**	**22**	**10%**	**68**	**6%**
18-40 years old	13	5%	3	7%	5	8%	14	12%	35	7%
41-64 years old	13	4%	2	3%	5	6%	8	9%	28	5%
65+ years old	1	2%	0	0%	0	0%	0	0%	1	2%
TV	**112**	**18%**	**26**	**23%**	**22**	**14%**	**38**	**17%**	**198**	**18%**
18-40 years old	45	17%	12	27%	12	19%	19	17%	88	18%
41-64 years old	52	17%	12	19%	10	11%	13	14%	87	16%
65+ years old	13	28%	0	0%	0	0%	2	29%	15	25%
Text messages	**4**	**1%**	**2**	**2%**	**1**	**1%**	**2**	**1%**	**9**	**1%**
18-40 years old	1	0%	0	0%	1	2%	1	1%	3	1%
41-64 years old	1	0%	2	3%	0	0%	1	1%	4	1%
65+ years old	1	2%	0	0%	0	0%	0	0%	1	2%
Local newspaper	**36**	**6%**	**8**	**7%**	**10**	**6%**	**14**	**6%**	**68**	**6%**
18-40 years old	16	6%	4	9%	4	6%	7	6%	31	6%
41-64 years old	19	6%	3	5%	5	6%	6	7%	33	6%
65+ years old	1	2%	1	33%	0	0%	1	14%	3	5%
Other	**19**	**3%**	**2**	**2%**	**4**	**3%**	**4**	**2%**	**29**	**3%**
18-40 years old	9	3%	1	2%	1	2%	1	1%	12	2%
41-64 years old	3	1%	1	2%	2	2%	1	1%	7	1%
65+ years old	7	15%	0	0%	0	0%	1	14%	8	14%
Totals:	**627**		**115**		**159**		**224**		**1130***	
18-40 years old	266		44		62		115		487	
41-64 years old	299		64		89		92		544	
41-64 years old	46		3		3		7		59	

***Higher total because multiple answers accepted**

St. Joseph's Community Health Coalition

Needs Assessment

What health-related topics would you be interested in learning more about?	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Diabetes	**133**	**11%**	**25**	**10%**	**26**	**10%**	**46**	**12%**	**230**	**11%**
English:	47	15%	2	10%	5	12%	10	19%	64	15%
Spanish:	86	19%	23	18%	21	15%	36	16%	166	18%
Nutrition	**222**	**19%**	**42**	**18%**	**57**	**22%**	**78**	**20%**	**399**	**19%**
English:	99	31%	8	38%	11	26%	17	31%	135	31%
Spanish:	123	27%	34	27%	46	34%	61	27%	264	28%
Exercise/Physical Activity	**183**	**15%**	**36**	**15%**	**50**	**20%**	**69**	**17%**	**338**	**16%**
English:	81	26%	8	38%	14	33%	15	28%	118	27%
Spanish:	102	22%	28	22%	36	26%	54	24%	220	23%
High Blood Pressure	**119**	**10%**	**18**	**8%**	**21**	**8%**	**39**	**10%**	**197**	**9%**
English:	48	15%	1	5%	6	14%	7	13%	62	14%
Spanish:	71	16%	17	14%	15	11%	32	14%	135	14%
Dental Health	**115**	**10%**	**25**	**10%**	**24**	**9%**	**50**	**13%**	**214**	**10%**
English:	41	13%	2	10%	6	14%	5	9%	54	12%
Spanish:	74	16%	23	18%	18	13%	45	20%	160	17%
Cholesterol	**126**	**11%**	**27**	**11%**	**21**	**8%**	**43**	**11%**	**217**	**10%**
English:	39	12%	4	19%	4	10%	9	17%	56	13%
Spanish:	87	19%	23	18%	17	13%	34	15%	161	17%
Mental Health	**83**	**7%**	**18**	**8%**	**14**	**5%**	**19**	**5%**	**137**	**7%**
English:	33	10%	7	33%	6	14%	4	7%	50	12%
Spanish:	50	11%	11	9%	11	8%	15	7%	87	9%
Osteoporosis	**57**	**5%**	**14**	**6%**	**10**	**4%**	**11**	**3%**	**92**	**4%**
English:	21	7%	0	0%	3	7%	2	4%	26	6%
Spanish:	36	8%	14	11%	7	5%	9	4%	66	7%
Stress Management	**142**	**12%**	**31**	**13%**	**31**	**12%**	**38**	**10%**	**243**	**12%**
English:	70	22%	8	38%	10	24%	10	19%	99	23%
Spanish:	72	16%	23	18%	21	15%	28	12%	144	15%
Other	**19**	**2%**	**3**	**1%**	**2**	**1%**	**2**	**1%**	**26**	**1%**
English:	9	3%	0	0%	1	2%	1	2%	11	3%
Spanish:	10	2%	3	2%	1	1%	1	0%	15	2%
Totals:	**1199**		**239**		**256**		**395**		**2093***	
English:	488		40		66		80		675	
Spanish:	711		199		193		315		1418	

***Higher total because multiple answers accepted**

Appendix 13

St. Joseph's Community Health Coalition

Needs Assessment

What health-related topics would you be interested in learning more about?	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Diabetes	**133**	**11%**	**25**	**10%**	**26**	**10%**	**46**	**12%**	**230**	**11%**
Male:	47	15%	8	38%	8	19%	15	28%	78	18%
Female:	85	19%	16	13%	16	12%	29	13%	146	15%
Nutrition	**222**	**19%**	**42**	**18%**	**57**	**22%**	**78**	**20%**	**399**	**19%**
Male:	70	22%	10	48%	19	45%	26	48%	125	29%
Female:	150	33%	31	25%	33	24%	50	22%	264	28%
Exercise/Physical Activity	**183**	**15%**	**36**	**15%**	**50**	**20%**	**69**	**17%**	**338**	**16%**
Male:	52	16%	7	33%	14	33%	21	39%	94	22%
Female:	131	29%	29	23%	33	24%	48	21%	241	26%
High Blood Pressure	**119**	**10%**	**18**	**8%**	**21**	**8%**	**39**	**10%**	**197**	**9%**
Male:	38	12%	8	38%	6	14%	13	24%	65	15%
Female:	80	18%	10	8%	14	10%	25	11%	129	14%
Dental Health	**115**	**10%**	**25**	**10%**	**24**	**9%**	**50**	**13%**	**214**	**10%**
Male:	36	11%	8	38%	8	19%	16	30%	68	16%
Female:	78	17%	16	13%	16	12%	33	14%	143	15%
Cholesterol	**126**	**11%**	**27**	**11%**	**21**	**8%**	**43**	**11%**	**217**	**10%**
Male:	45	14%	9	43%	9	21%	16	30%	79	18%
Female:	80	18%	17	14%	12	9%	26	11%	135	14%
Mental Health	**83**	**7%**	**18**	**8%**	**14**	**5%**	**19**	**5%**	**137**	**7%**
Male:	22	7%	3	14%	2	5%	6	11%	33	8%
Female:	61	13%	15	12%	15	11%	13	6%	104	11%
Osteoporosis	**57**	**5%**	**14**	**6%**	**10**	**4%**	**11**	**3%**	**92**	**4%**
Male:	9	3%	4	19%	3	7%	3	6%	19	4%
Female:	48	11%	9	7%	7	5%	8	4%	72	8%
Stress Management	**142**	**12%**	**31**	**13%**	**31**	**12%**	**38**	**10%**	**243**	**12%**
Male:	35	11%	8	38%	4	10%	11	20%	58	13%
Female:	105	23%	22	18%	27	20%	26	11%	180	19%
Other	**19**	**2%**	**3**	**1%**	**2**	**1%**	**2**	**1%**	**26**	**1%**
Male:	4	1%	2	10%	1	2%	1	2%	8	2%
Female:	14	3%	1	1%	0	0%	1	0%	16	2%
Totals:	**1199**		**239**		**256**		**395**		**2093***	
Male:	358		67		74		128		627	
Female:	832		166		173		259		1430	

***Higher total because multiple answers accepted**

Appendix 13

What health-related topics would you be interested in learning more about?	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Diabetes	**133**	**11%**	**25**	**10%**	**26**	**10%**	**46**	**12%**	**230**	**11%**
18-40 years old	90	17%	6	6%	6	6%	20	11%	80	9%
41-64 years old	126	19%	14	12%	17	12%	21	11%	123	12%
65+ years old	18	17%	2	33%	2	20%	3	14%	19	14%
Nutrition	**222**	**19%**	**42**	**18%**	**57**	**22%**	**78**	**20%**	**399**	**19%**
18-40 years old	107	21%	19	18%	21	23%	41	23%	188	22%
41-64 years old	97	15%	21	18%	32	22%	33	18%	183	17%
65+ years old	12	12%	0	0%	1	10%	1	5%	14	10%
Exercise/Physical Activity	**183**	**15%**	**36**	**15%**	**50**	**20%**	**69**	**17%**	**338**	**16%**
18-40 years old	76	15%	18	17%	18	19%	31	18%	143	17%
41-64 years old	88	13%	15	13%	28	19%	31	17%	162	15%
65+ years old	15	15%	1	17%	2	20%	5	24%	23	17%
High Blood Pressure	**119**	**10%**	**18**	**8%**	**21**	**8%**	**39**	**10%**	**197**	**9%**
18-40 years old	33	6%	7	7%	8	9%	10	6%	58	7%
41-64 years old	71	11%	9	8%	12	8%	26	14%	118	11%
65+ years old	12	12%	0	0%	1	10%	3	14%	16	12%
Dental Health	**115**	**10%**	**25**	**10%**	**24**	**9%**	**50**	**13%**	**214**	**10%**
18-40 years old	49	9%	12	12%	9	10%	23	13%	93	11%
41-64 years old	57	9%	13	11%	14	10%	23	12%	107	10%
65+ years old	7	7%	0	0%	1	10%	2	10%	10	7%
Cholesterol	**126**	**11%**	**27**	**11%**	**21**	**8%**	**43**	**11%**	**217**	**10%**
18-40 years old	37	7%	11	11%	4	4%	17	10%	69	8%
41-64 years old	71	11%	14	12%	16	11%	24	13%	125	12%
65+ years old	15	15%	1	17%	1	10%	1	5%	18	13%
Mental Health	**83**	**7%**	**18**	**8%**	**14**	**5%**	**19**	**5%**	**137**	**7%**
18-40 years old	42	8%	12	12%	8	9%	12	7%	74	9%
41-64 years old	34	5%	4	3%	8	5%	5	3%	51	5%
65+ years old	7	7%	0	0%	0	0%	2	10%	9	7%
Osteoporosis	**57**	**5%**	**14**	**6%**	**10**	**4%**	**11**	**3%**	**92**	**4%**
18-40 years old	13	3%	5	5%	4	4%	5	3%	27	3%
41-64 years old	36	5%	7	6%	4	3%	5	3%	52	5%
65+ years old	8	8%	1	17%	2	20%	1	5%	12	9%
Stress Management	**142**	**12%**	**31**	**13%**	**31**	**12%**	**38**	**10%**	**243**	**12%**
18-40 years old	65	13%	13	13%	15	16%	18	10%	111	13%
41-64 years old	66	10%	16	14%	14	10%	18	10%	114	11%
65+ years old	8	8%	1	17%	0	0%	2	10%	11	8%
Other	**19**	**2%**	**3**	**1%**	**2**	**1%**	**2**	**1%**	**26**	**1%**
18-40 years old	7	1%	1	1%	0	0%	0	0%	8	1%
41-64 years old	11	2%	2	2%	1	1%	1	1%	15	1%
65+ years old	1	1%	0	0%	0	0%	1	5%	2	1%
Totals:	**1199**		**239**		**256**		**395**		**2093***	
18-40 years old	519		104		93		177		851	
41-64 years old	657		115		146		187		1050	
41-64 years old	103		6		10		21		134	

***Higher total because multiple answers accepted**

What is the best day of week for you to attend health and wellness classes offered at St. Joseph's?	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Monday	**72**	**13%**	**13**	**13%**	**14**	**10%**	**23**	**12%**	**122**	**12%**
English:	24	9%	2	9%	4	11%	8	15%	39	10%
Spanish:	48	16%	11	14%	10	10%	15	10%	84	14%
Tuesday	**51**	**9%**	**12**	**12%**	**17**	**13%**	**26**	**13%**	**106**	**11%**
English:	25	9%	3	13%	3	8%	6	11%	37	10%
Spanish:	26	9%	9	12%	14	14%	20	14%	69	11%
Wednesday	**68**	**12%**	**14**	**14%**	**15**	**11%**	**32**	**16%**	**129**	**13%**
English:	34	13%	3	13%	5	13%	7	13%	49	13%
Spanish:	34	11%	11	14%	10	10%	25	17%	80	13%
Thursday	**51**	**9%**	**9**	**9%**	**13**	**10%**	**18**	**9%**	**91**	**9%**
English:	26	10%	0	0%	3	8%	6	11%	35	9%
Spanish:	25	8%	9	12%	10	10%	12	8%	56	9%
Friday	**77**	**14%**	**14**	**14%**	**17**	**13%**	**19**	**10%**	**127**	**13%**
English:	40	15%	3	13%	4	11%	7	13%	54	14%
Spanish:	37	12%	11	14%	13	13%	12	8%	73	12%
Saturday	**154**	**27%**	**26**	**26%**	**35**	**26%**	**46**	**23%**	**261**	**26%**
English:	69	26%	5	22%	12	32%	11	20%	97	25%
Spanish:	85	28%	21	27%	23	24%	35	24%	164	26%
Sunday	**96**	**17%**	**12**	**12%**	**24**	**18%**	**36**	**18%**	**168**	**17%**
English:	52	19%	7	30%	7	18%	9	17%	75	19%
Spanish:	44	15%	5	6%	17	18%	27	18%	93	15%
Totals:	**569**		**100**		**135**		**200**		**1004***	
English:	270		23		38		54		386	
Spanish:	299		77		97		146		619	

***Higher total because multiple answers accepted**

What is the best day of week for you to attend health and wellness classes offered at St. Joseph's?	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Monday	**72**	**13%**	**13**	**13%**	**14**	**10%**	**23**	**12%**	**123**	**12%**
Male:	19	9%	5	18%	6	15%	4	6%	34	10%
Female:	50	14%	8	12%	6	7%	17	13%	81	13%
Tuesday	**51**	**9%**	**12**	**12%**	**17**	**13%**	**26**	**13%**	**106**	**11%**
Male:	18	9%	4	14%	4	10%	9	14%	35	11%
Female:	33	9%	8	12%	12	14%	16	13%	69	11%
Wednesday	**68**	**12%**	**14**	**14%**	**15**	**11%**	**32**	**16%**	**129**	**13%**
Male:	21	10%	5	18%	4	10%	10	16%	40	12%
Female:	47	13%	7	10%	9	10%	21	16%	84	13%
Thursday	**51**	**9%**	**9**	**9%**	**13**	**10%**	**18**	**9%**	**91**	**9%**
Male:	20	10%	2	7%	2	5%	6	9%	30	9%
Female:	31	9%	7	10%	10	12%	11	9%	59	9%
Friday	**77**	**14%**	**14**	**14%**	**17**	**13%**	**19**	**10%**	**127**	**13%**
Male:	22	11%	2	7%	4	10%	4	6%	32	10%
Female:	55	15%	11	16%	12	14%	14	11%	92	14%
Saturday	**154**	**27%**	**26**	**26%**	**35**	**26%**	**46**	**23%**	**261**	**26%**
Male:	57	28%	7	25%	8	21%	14	22%	86	26%
Female:	96	27%	19	28%	25	29%	31	24%	171	27%
Sunday	**96**	**17%**	**12**	**12%**	**24**	**18%**	**36**	**18%**	**168**	**17%**
Male:	44	22%	3	11%	11	28%	17	27%	75	23%
Female:	50	14%	9	13%	12	14%	18	14%	89	14%
Totals:	**569**		**100**		**135**		**200**		**1005***	
Male	201		28		39		64		332	
Female:	362		69		86		128		645	

***Higher total because multiple answers accepted**

Appendix 13

What is the best day of week for you to attend health and wellness classes offered at St. Joseph's?	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Monday	**72**	**13%**	**13**	**13%**	**14**	**10%**	**23**	**12%**	**123**	**12%**
18-40 years old	42	16%	6	14%	5	11%	9	11%	53	13%
41-64 years old	25	10%	5	11%	7	9%	11	12%	56	12%
65+ years old	4	9%	1	20%	0	0%	2	15%	9	13%
Tuesday	**51**	**9%**	**12**	**12%**	**17**	**13%**	**26**	**13%**	**106**	**11%**
18-40 years old	23	9%	3	7%	5	11%	11	13%	42	10%
41-64 years old	19	8%	6	13%	10	13%	13	14%	48	10%
65+ years old	8	17%	1	20%	1	25%	2	15%	12	17%
Wednesday	**68**	**12%**	**14**	**14%**	**15**	**11%**	**32**	**16%**	**129**	**13%**
18-40 years old	35	13%	2	5%	3	7%	10	12%	50	12%
41-64 years old	26	10%	8	18%	10	13%	18	19%	62	13%
65+ years old	6	13%	3	60%	1	25%	2	15%	12	17%
Thursday	**51**	**9%**	**9**	**9%**	**13**	**10%**	**18**	**9%**	**91**	**9%**
18-40 years old	23	9%	3	7%	5	11%	10	12%	41	10%
41-64 years old	21	8%	4	9%	6	8%	7	7%	38	8%
65+ years old	7	15%	0	0%	1	25%	1	8%	9	13%
Friday	**77**	**14%**	**14**	**14%**	**17**	**13%**	**19**	**10%**	**127**	**13%**
18-40 years old	35	13%	7	17%	8	18%	8	9%	58	14%
41-64 years old	37	15%	6	13%	8	11%	10	11%	61	13%
65+ years old	3	7%	0	0%	0	0%	1	8%	4	6%
Saturday	**154**	**27%**	**26**	**26%**	**35**	**26%**	**46**	**23%**	**261**	**26%**
18-40 years old	58	22%	12	29%	9	20%	16	19%	95	23%
41-64 years old	83	33%	13	29%	22	29%	22	23%	140	29%
65+ years old	9	20%	0	0%	1	25%	4	31%	14	20%
Sunday	**96**	**17%**	**12**	**12%**	**24**	**18%**	**36**	**18%**	**168**	**17%**
18-40 years old	44	17%	9	21%	9	20%	21	25%	83	20%
41-64 years old	41	16%	3	7%	13	17%	13	14%	70	15%
65+ years old	9	20%	0	0%	0	0%	1	8%	10	14%
Totals:	**569**		**100**		**135**		**200**		**1005***	
18-40 years old	260		42		44		85		422	
41-64 years old	252		45		76		94		475	
41-64 years old	46		5		4		13		70	

***Higher total because multiple answers accepted**

What time of the day would you be able to attend health and wellness classes offered at St. Joseph's?	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Early morning	**73**	**15%**	**7**	**9%**	**29**	**24%**	**25**	**16%**	**134**	**16%**
English:	25	12%	3	18%	8	22%	7	16%	44	15%
Spanish:	48	18%	4	7%	21	24%	18	15%	91	17%
Late morning	**94**	**20%**	**9**	**12%**	**23**	**19%**	**28**	**17%**	**154**	**19%**
English:	39	19%	2	12%	6	17%	5	11%	52	17%
Spanish:	55	21%	7	11%	17	20%	23	20%	102	19%
Early afternoon	**50**	**11%**	**8**	**10%**	**8**	**7%**	**16**	**10%**	**82**	**10%**
English:	26	13%	2	12%	1	3%	7	16%	36	12%
Spanish:	24	9%	6	10%	7	8%	9	8%	46	9%
Late afternoon	**55**	**12%**	**13**	**17%**	**11**	**9%**	**20**	**12%**	**99**	**12%**
English:	27	13%	3	18%	3	8%	7	16%	40	13%
Spanish:	28	10%	10	16%	8	9%	13	11%	59	11%
Early evening	**71**	**15%**	**13**	**17%**	**15**	**12%**	**25**	**16%**	**124**	**15%**
English:	31	15%	3	18%	9	25%	6	14%	49	16%
Spanish:	40	15%	10	16%	6	7%	19	16%	75	14%
Evening	**128**	**27%**	**28**	**36%**	**36**	**30%**	**47**	**29%**	**239**	**29%**
English:	56	27%	4	24%	9	25%	12	27%	81	27%
Spanish:	72	27%	24	39%	27	31%	35	30%	158	30%
Totals:	**471**		**78**		**122**		**161**		**832***	
English:	204		17		36		44		302	
Spanish:	267		61		86		117		531	

***Higher total because multiple answers accepted**

What time of the day would you be able to attend health and wellness classes offered at St. Joseph's?	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Early morning	**73**	**15%**	**7**	**9%**	**29**	**24%**	**25**	**16%**	**135**	**16%**
Male:	30	20%	1	5%	9	23%	6	11%	46	17%
Female:	43	14%	6	11%	19	24%	18	18%	86	16%
Late morning	**94**	**20%**	**9**	**12%**	**23**	**19%**	**28**	**17%**	**154**	**19%**
Male:	22	14%	2	10%	7	18%	6	11%	37	14%
Female:	71	23%	7	13%	15	19%	22	22%	115	21%
Early afternoon	**50**	**11%**	**8**	**10%**	**8**	**7%**	**16**	**10%**	**82**	**10%**
Male:	14	9%	1	5%	5	13%	9	16%	29	11%
Female:	35	11%	6	11%	3	4%	6	6%	50	9%
Late afternoon	**55**	**12%**	**13**	**17%**	**11**	**9%**	**20**	**12%**	**99**	**12%**
Male:	16	10%	3	14%	4	10%	6	11%	29	11%
Female:	38	12%	10	18%	6	8%	14	14%	68	12%
Early evening	**71**	**15%**	**13**	**17%**	**15**	**12%**	**25**	**16%**	**124**	**15%**
Male:	23	15%	6	29%	3	8%	7	12%	39	14%
Female:	48	15%	6	11%	12	15%	18	18%	84	15%
Evening	**128**	**27%**	**28**	**36%**	**36**	**30%**	**47**	**29%**	**239**	**29%**
Male:	48	31%	8	38%	11	28%	23	40%	90	33%
Female:	80	25%	20	36%	24	30%	23	23%	147	27%
Totals:	**471**		**78**		**122**		**161**		**833***	
Male	153		21		39		57		270	
Female:	315		55		79		101		550	

***Higher total because multiple answers accepted**

What time of the day would you be able to attend health and wellness classes offered at St. Joseph's?	Hawthorne/ Gardena (90247, 90249, 90250)		Lawndale (90260)		Inglewood Area (90301, 90302, 90303)		Lennox (90304)		Totals	
Early morning	**73**	**15%**	**7**	**9%**	**29**	**24%**	**25**	**16%**	**135**	**16%**
18-40 years old	18	10%	3	9%	9	20%	9	13%	52	15%
41-64 years old	29	13%	3	8%	17	25%	11	15%	68	16%
65+ years old	2	6%	0	0%	0	0%	2	18%	6	11%
Late morning	**94**	**20%**	**9**	**12%**	**23**	**19%**	**28**	**17%**	**154**	**19%**
18-40 years old	37	21%	2	6%	7	16%	11	15%	57	17%
41-64 years old	45	20%	6	15%	15	22%	15	21%	81	20%
65+ years old	11	32%	1	33%	1	33%	2	18%	15	28%
Early afternoon	**50**	**11%**	**8**	**10%**	**8**	**7%**	**16**	**10%**	**82**	**10%**
18-40 years old	18	10%	2	6%	4	9%	10	14%	34	10%
41-64 years old	26	12%	4	10%	3	4%	5	7%	38	9%
65+ years old	6	18%	2	67%	0	0%	1	9%	9	17%
Late afternoon	**55**	**12%**	**13**	**17%**	**11**	**9%**	**20**	**12%**	**99**	**12%**
18-40 years old	20	11%	6	18%	4	9%	9	13%	39	12%
41-64 years old	27	12%	5	13%	7	10%	8	11%	47	11%
65+ years old	7	21%	0	0%	0	0%	2	18%	9	17%
Early evening	**71**	**15%**	**13**	**17%**	**15**	**12%**	**25**	**16%**	**124**	**15%**
18-40 years old	34	19%	7	21%	5	11%	9	13%	55	16%
41-64 years old	31	14%	6	15%	8	12%	13	18%	58	14%
65+ years old	3	9%	0	0%	1	33%	2	18%	6	11%
Evening	**128**	**27%**	**28**	**36%**	**36**	**30%**	**47**	**29%**	**239**	**29%**
18-40 years old	51	29%	13	39%	15	34%	23	32%	102	30%
41-64 years old	68	30%	15	38%	19	28%	20	28%	122	29%
65+ years old	5	15%	0	0%	1	33%	2	18%	8	15%
Totals:	**471**		**78**		**122**		**161**		**833***	
18-40 years old	178		33		44		71		339	
41-64 years old	226		39		69		72		414	
41-64 years old	34		3		3		11		53	

***Higher total because multiple answers accepted**

General Breakdown			
		Totals	%
Language		714	
	English:	247	35%
	Spanish:	467	65%
Gender		700	
	Male:	239	34%
	Female:	461	66%
Area		715	
	Hawthorne/Gardena (90247, 90249, 90250)	401	56%
	Lawndale (90260)	73	10%
	Inglewood Area (90301, 90302, 90303)	105	15%
	Lennox (90304)	136	19%
Age Group		689	
	18-40 years old	284	41%
	41-64 years old	354	51%
	65+ years old	51	7%

Providence Little Company of Mary Medical Center, San Pedro
Providence Little Company of Mary Medical Center, Torrance
Board Committee on Community Benefits
November 14, 2013
11:30 AM – 1:30 PM

Meeting Leaders: Mike Beaupre, Jim Tehan, & Justin Joe

Meeting Organizers: Justin Joe, Eric Aguillar, & Monica Kline

Meeting Participants: Tahia Hayslet, Dolores Bonilla Clay, Steve Tabor, Betsy Hamilton, Fr. Greg King, Michael Beaupre, Jan Brandmeyer, Elizabeth Zuanich, Paul Makarewicz, Sr. Nancy Jurecki, Carmel Nicholls, RN, David Munoz, MD, Paul Simon MD, MPH,(absent), Richard Espinosa (absent).

1. Welcome
Mr. Beaupre conducted the introduction by having everyone introduce themselves and their background, and elaborated on the purpose of the meeting – to discuss the critical findings of the community needs assessment, and what to focus on/let go during the next 3 years.

2. Video Reflection
Mr. Tehan described the video reflection as an opportunity to consider the evolution of a PLCM program which has a long history or evolution and accomplishments, contrasted with the list of identified health needs which are not currently being addressed by the Medical Centers' Community Benefit program.

3. Introduction (Mike Beaupre)
Mr. Beaupre reviewed the highlights from the August meeting of the BCCB and elaborated on the scope of today's discussion :how the community needs assessment was conducted, the findings, and the Committee's role to balance these competing interests and make recommendations to the Community Ministry Board about our priorities for the next three years.

4. Meeting Recap:
Mr. Tehan first summarized the points of consensus that were reached during the August 27 meeting:

- The Committee agreed that we should consistent with the Mission to pay special attention to the poor and vulnerable, we need to continue to direct our talents and resources to the benefit of the most economically disadvantaged communities across the South Bay region.

- Capacity Building, or the process of supporting or facilitating some type of infrastructure improvement for a community partner is a useful way to further strengthen the safety net of services for low income communities and families.

- Collaboration that brings together multiple community partners to achieve an agreed upon objective together further strengthens communities and should be an important part of our Community Benefit program.

Mr. Joe presented a number of demographic disparities that were assembled during the needs assessment process that clearly illustrate, within the Service Area, disparities related to income, educational attainment, ethnicity, age and household owners v. renters. These differences were clearly evident when the demographics were arranged according to know demographics, namely the underserved northern communities (Hawthorne, Lawndale and Gardena) the underserved Southern

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communities (Wilmington, Harbor City and San Pedro 90731) and the remaining communities across the region that were designated as the Coastal communities. In each instance, the difference between low/high need communities stark: For example, median Household Income in the Coastal Communities is nearly twice as much as the underserved North & South. The same pattern holds true in all of the demographics presented and reinforces the consensus of the BCCB .

5. Community Needs Assessment Timeline

Mr. Tehan gave an overview of the components of the data collection process– primary data, secondary data, public health input, and input from the community. He spoke to the improving quality of primary data sources, compared to prior needs assessments, with use of stronger methods of data collection (ie. Random telephone survey of end users) and collaboration (ie. St. Joseph Church needs assessment survey) as well as better outreach and use of electronic on line surveys for community partners to give feedback. He noted that secondary data came primarily from State and County data sources and included information about morbidity, mortality, health behaviors, and access to care. Our public health input included both related to chronic disease and prevention, maternal and child health, and immunization programs but also interviews with multiple organizational units within the Los Angeles County Public Health Department that centered around the potential for collaboration and capacity building. Finally, community input was received from staff and students at schools, FQHCs, CBOs, Faith Based Organizations, and the health deputies for the two County Supervisors that represetnat the South Bay region of Los Angeles County .

6. Findings

Mr. Joe presented a variety of data from secondary data sources and grouped these findings into three broad areas: access to care, wellness education, and connecting people to services. The data was presented in multiple formats: Countywide, by the Health Districts that make up Service Planning Area (SPA) 8 (excluding Long Beach) and, as available, local data from the end user survey. Mr. Joe also noted the limitation of the SPA level data because it is collected along political boundaries which means that quite often, high and low need communities are arbitrarily placed within SPA or Health District profiles, which has the effect of masking the true need that exists within a Health District or SPA. Until these data points can be grouped according to high need/low need zip codes, primary data sources are the best mechanism to estimate the true need, by community and the data from the end user survey was presented as a further contrast to the County and Health District data.

Access to care data looked at disparities related to self-rating of health (a strong predictor of health status), access and affordability of health and dental care, the presence of severe mental health, the prevalence of chronic conditions (ie. diabetes, cholesterol and hypertension) and mortality data.

Wellness education data included date related to depression and anxiety, obesity (children and adults), the need for parenting education and the lack of understanding, across all communities, about how to navigate the health care system, whether insured or uninsured.

In the area of connecting people to services, a variety of data topics were presented, including the prevalence of homelessness, uninsured adults, linguistic isolation, and seniors living alone. There was extensive discussion about the homeless statistics and the comment from one of the Committee members that changes in the methodology have lead many to suspect that the homeless count for the South Bay region is inaccurate, based on actual experience of safety net providers. Linguistic Isolation was also discussed and the data findings document that the underserved areas have twice as many people that don't speak English, which affects access and comfort levels in accessing care.

Key Informant Interviews

Mr. Tehan gave an overview of the 19 interviews (and 24 participants) conducted of leaders in the community that represent the following community sectors: Public Health, education, community based organizations, federally qualified health centers, faith based organizations, private foundations and elected representatives. The County Public Health Department has a dual focus on communicable diseases (which it has a mandate to monitor, track and enforce public health standards) and prevention of chronic disease. In the area of prevention they focus on communities with the greatest needs; in other words they have insufficient resources to reach everyone so they target communities with high need and seek out community partners to support their efforts in other areas. Our community surveys describe the population within these geographic boundaries and open our eyes to gaps for each area and potential solutions. Mr. Tehan highlighted the areas of focus of the organizations/sectors interviewed, the gaps identified by the person(s) being interviewed and their assessment of how their organizations could be involved in potential solutions for the identified gaps.

7. Setting Priorities Worksheet and Group Discussion.

Mr. Tehan advised the group that further discussion would be appropriate to help set PLCM community outreach priorities through 2016. He directed the Committee's attention to the Health Needs Priorities Worksheet in the packet and indicated we would use that tool as a way to set specific priorities. The worksheet identified 15 specific health needs that were identified by the 46 community organizations who participated in the organizational assessment of health needs. These needs were confirmed by secondary data sources across eight different data sources identified on the worksheet. In addition, identified health needs that are currently being addressed through a PCLM community outreach program were identified as strengths. Nine specific identified needs not currently addressed by PLCM were identified as a weakness in the safety net infrastructure in the South Bay. In advance of discussion among the Committee, all 15 areas of specific need identified by the organizational survey were given a yes/no rating based upon key informant interviews and whether any of the representatives interviewed reported an interest in collaboration or capacity building on the specific topic or need. A lengthy discussion followed which was summarized by student interns, by topic, as follows:

Expand senior services seniors living at alone.

- We should encourage seniors to volunteer/perhaps in hospitals, expand educational opportunities for seniors, provide more resources for aging to promote staying active at home.
- The Center for Aging Program in San Pedro may be useful resource for seniors living at home. Too often senior who move to assisted living facilities become increasingly inactive.
- The Promotora /community health worker model that involves someone to visit the elderly and provide services like instant recess.
- 1 on 1 time with a Providence community based volunteer to promote staying active.
- It may be more efficient to find a community room with facilities such as apartment complexes and churches where the elderly can interact in a group setting and take part in activities.

Addressing the need for dental care

- Providence does not have the expertise in this area; we should talk with community partners that have that purpose, and consider a mobile dental van.
- Considering forging a partnership with USC → Providence provides old PFHK van, USC provides dentist, and in return we build USC's capacity
- Contact Tzu Chi (volunteer health clinic in Wilmington), they do lots of work in dental area.
- Mobile dental clinic would be utilized! Needs ongoing resources to be sustainable.

Improve access to insurance.

- How do we use CHIP to increase the number of people currently insured thanks to CHIP?
- If we enroll 1,000 people every year, how do we get to 5,000? CHIP addresses the "TRIAD" discussed in the reflection video.
- Address the need for primary care for special populations or chronic health conditions
- The undocumented will continue to lack health insurance since the ACA excludes the undocumented.
- The emergency room needs to include/expand dental care and mental health services. There is a need for funding of such resources.

Services to the homeless.

- We should convene health care stakeholders to improve access to health. The difficulties of being homeless (finding a place to stay, eating, etc) tend to consume the homeless person's focus, and they forgo any other needed services that might be able to take advantage of.
- Education is not always enough when dealing with survival issues like housing.

Importance of prevention programs to changing health behaviors.

- COPA should also target parents so parents can incorporate COPA at home
- Partner with School Wellness Committees to educate teachers and extend what they learn in COPA to educate parents on physical activity, nutrition and wellness practices at home.
- Targeting children probably has the most bang for the buck but we should not forget adults and ways to help sedentary adults, particularly seniors, become more active.

Pilot wellness programs for adults

- Churches are a setting for people to learn about and practice physical activity, better nutrition and wellness practices. Educating seniors in this setting could be very beneficial because they already come to church to learn about their spiritual health – now they would be provided with physical health skills.
- Help with providing "coping abilities" especially for Spanish speaking residents.
- Providence currently provides Zumba and Yoga instructors to St. Joseph Church as part of its diabetes prevention programs and it has been very well received by parishioners

Vasek Polak Health Clinic

- It is well established in the community, so we could expand/add new services.
- Vasek Polak could incorporate mental health into primary care. It currently lacks any mental health services and could provide crisis education or counseling as part of the scope of primary care.
- FQHC's are seeing an increased need for LCSW's in the primary care practice although physical space is always an issue as these services grow.

Resource Directory.

- There is a need to create a concise, local, up to date directory of services that can be offered to residents in places like churches.
- Build up capacity results in trickle down (and up) health

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8. Setting Priorities: Reaching Consensus
Mr. Tehan thanked the group for their input and discussion. He first asked the group to discuss which of the identified health needs they were wiling to "let go of", meaning that it would not be a priority to address in the Community Benefit Plan over the next three years. The Committee reached consensus on three areas:

Identified Health Needs to "Let Go"
Affordable housing
Cultural and language barriers
Providers accepting MediCal has to stop

Mr. Tehan then directed the group's attention to the existing programs provided by the two Providence Little Company of Mary Medical Centers and the group reached a consensus that they should be continued but that in two instances consideration should be given to modifying the scope of services to incorporate newly identified priorities in the wellness education area (nutrition education and parent education)

Continue Existing Programs that Address Identified Needs

Identified Need	PLCMMC programs that address identified need
Primary care medical services	Vasek Polak Health Clinic (adults) and Partners for Healthy Kids (children)
Screening for acute/chronic conditions	Partners for Healthy Kids
Self care education for chronic conditions	Get Out and Live (diabetes)
Physical activity/physical fitness	Creating Opportunities for Physical Activity (COPA)
Nutrition skills education	Incorporate into COPA
Parenting Education	Welcome Baby
Outreach and enrollment into health insurance	Community Health Insurance Project (CHIP)

Of the remaining three identified needs, the Committee consensus was to explore collaboration and program development and ranked those three needs. The Committee cautioned that resource constraints would make it unlikely that all 3 could be addressed and that at least a new pilot program in any of the three areas would constitute an improvement in the existing safety net infrastructure:

New Areas to Explore
1. Services to allow seniors to live at home
2. Mental Health Education/Coping skills
3. Education about navigating the health care system

9. Wrap-Up
Mr. Beaupre thanked everyone for their input, thoughts, ideas, strategy recommendations, and suggested any further thoughts or questions could be directed to Mr. Tehan. He indicated that the recommendations of the Committee would be given strong weight by the Community Ministry Board, when the needs assessment and implementation strategy come up for adoption.

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PROVIDENCE
Health & Services
Southern California

Policies & Procedures
Southern California Region

Subject:	**Charity Care and Discount Payment Policy**
Effective Date: 01/01/14 **Supersedes:** 01/01/13	**Category:** Finance **Number:** CA-FIN-5001
***Southern California Leadership Council* Approval** **Date:** 02/28/14	**Responsibility for review and maintenance of this policy is assigned to:**
***Head of Regional Division* Submission Date:** 02/06/14 **Approval Signature:** **Title:** *Chief Financial Officer*	**Author and/or Designee:** *Regional Director, Regulatory and Quality Assurance*
	Policy Applies to: Patients

POLICY

In keeping with the mission and values of Providence Health & Services, it is the policy of Providence Health System – Southern California (PHS-SC), to provide services to all persons, regardless of age, sex, race, religion, origin, or ability to pay. Upon verifying an inability to pay, PHS-SC entities and hospitals (Providence Tarzana Medical Center, Providence Holy Cross Medical Center, Providence Saint Joseph Medical Center, Providence Little Company of Mary Medical Center Torrance and Providence Little Company of Mary Medical Center San Pedro) will provide financial assistance to qualifying patients to relieve them of their financial obligation in whole or in part for qualifying medically necessary healthcare services provided by PHS-SC. An inability to pay may be identified at any time. Further, financial assistance for qualifying patients is also available from emergency room physicians treating patients at PHS-SC acute care hospitals.

PURPOSE

To describe the process PHS-SC hospitals will follow in providing financial assistance to qualifying patients. Accordingly, this written policy:

- Describes eligibility criteria for financial assistance – free and discounted (partial charity) care
- Describes the basis for calculating amounts charged to patients eligible for financial assistance under this policy
- Describes the method by which patients may apply for financial assistance
- Describes how PHS-SC hospitals will widely publicize the policy within the community served
- Limits the amount each PHS-SC hospital will charge for emergency or other medically necessary care provided to individuals eligible for partial charity to an amount generally received by the applicable hospital for Medicare patients

This Policy is to be interpreted and implemented so as to be in full compliance with California Assembly Bill 774, codified at Health and Safety Code Section 127400 *et. seq.*, effective

January 1, 2007, as revised by California State Senate Bill 350, effective January 1, 2008 and revised by Assembly Bill 1503 effective January 1, 2011. All collection agencies working on behalf of PHS-SC shall also comply with the provisions of AB 774 and SB 350 and applicable PHS-SC policies regarding collection agencies. See related Regional Business Office Policy, GOV-107, Debt Collection Standards and Practices Policy.

DEFINITIONS

1) **"Charity care"** refers to full financial assistance to qualifying patients, to relieve them of their financial obligation in whole for medically necessary or eligible elective health care services (full charity).

2) **"Discount payment"** refers to partial financial assistance to qualifying patients, to relieve them of their financial obligation in part for medically necessary or eligible elective health care services (partial charity).

3) **Gross charges** are the total charges at the facility's full established rates for the provision of patient care services before deductions from revenue are applied. Gross charges are never billed to patients who qualify for partial charity or Private Pay Discounts.

4) **Private Pay Discount** is a discount provided to patients who do not qualify for financial assistance and who do not have a third party payer or whose insurance does not cover the service provided or who have exhausted their benefits. See Private Pay Discounting Policy, CA-FIN-5003

5) **Emergency physician** means a physician and surgeon licensed pursuant to Chapter 2 (commencing with Section 2000) of the Business and Professions Code who is credentialed by a hospital and either employed or contracted by the hospital to provide emergency medical services in the emergency department of the hospital, except that an "emergency physician" shall not include a physician specialist who is called into the emergency department of a hospital or who is on staff or has privileges at the hospital outside of the emergency department. Emergency room physicians who provide emergency medical services to patients at PHS-SC hospitals are required by California law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level.

6) **Services Eligible Under the Policy**: The charity care and discount payment policy applies to all services provided to eligible patients receiving medically necessary care or eligible elective care, including self pay patients and co-payment liabilities required by third party payers, including Medicare and Medi-Cal cost-sharing amounts, in which it is determined that the patient is financially unable to pay. Medically necessary health care includes:

   a) Emergency services in the emergency department.

   b) Services for a condition that, if not promptly treated, would lead to an adverse change in the patient's health status.

   c) Non-elective services provided in response to life-threatening circumstances outside of the emergency department (direct admissions).

   d) Medically necessary services provided to Medicaid beneficiaries that are non-covered services.

e) Any other medically necessary services determined on a case-by-case basis by PHS-SC.

7) **Eligible Elective Health Care** includes:

a) Patients and their physicians may seek charitable services for elective, deferrable care. Elective care becomes eligible for charitable and discount services only when all of the following requirements are met:

i) A member of the medical staff of a PHS-SC facility must submit the charitable services request;

ii) The patient is ALREADY a patient of the requesting physician and the care is needed for good continuity of care; aesthetic procedures are not eligible for charitable services;

iii) The physician will provide services at the same discount rate as determined by the hospital per charity guidelines of this policy, up to and including free care;

iv) The patient lives within our service area (as determined by PHS-SC); and

v) The patient completes a Financial Assistance Application and receives approval in writing from PHS-SC prior to receiving the elective care.

b) Certain elective care, such as aesthetic (cosmetic) procedures, acute rehabilitation unit, sub-acute (vent/trach) unit, skilled nursing facility, chemical dependency unit, and bariatric procedures are generally not eligible for charity care and discount services.

8) **Eligibility for Charity** shall be determined by an inability to pay defined in this policy based on one or more of the following criteria:

a) Presumptive Charity- Individual assessment determines that Financial Assistance Application is not required because:

i) Patient is without a residence address (e.g., homeless);

ii) Services deemed eligible under this policy but not covered by a third party payor were rendered to a patient who is enrolled in some form of Medicaid (Medi-Cal for California residents) or State Indigency Program (e.g., receiving services outside of Restricted Medi-Cal coverage) or services were denied Medi-Cal treatment authorization, as financial qualification for these programs includes having no more than marginal assets and a Medi-Cal defined share of cost as the maximum ability to pay; and/or

iii) Patient's inability to pay is identified via an outside collection agency income/asset search. Should the agency determine that a lawsuit will not be pursued, the account will be placed in an inactive status, where a monthly PHS-SC review will determine further action, including possible charity acceptance and cancellation from the agency and removal of credit reporting.

iv) Patient's inability to pay is identified by Regional Business Office staff through an income/asset search using a third party entity.

b) Charity- Individual Assessment of inability to pay requires:

i) Completion of a Financial Assistance Application for the Mary Potter Program for Human Dignity for all facilities in the Providence Health & Services, Southern California Region;

ii) Validation that a patient's gross income is less than two and one-half times (250%) the Federal Poverty Guidelines (FPG) applicable at the time the patient has applied for financial assistance. A patient with this income level will be deemed eligible for 100% charity care; and/or

iii) Validation that a patient's gross income exceeds 250% of the FPG applicable at the time the patient has applied for financial assistance and that their individual financial situation (medical debt load, etc.) makes them eligible for possible discount payment (partial charity care) or 100% charity care. However, patients with gross income less than 350% of FPG will owe no more than 100% of the applicable Medicare allowable amount. This amount shall be recalculated at least annually to remain current with Medicare reimbursement rates and will be based on Medicare rates that specifically apply to the applicable hospital. A patient with a gross income exceeding 350% of FPG will owe no more than the applicable private pay inpatient or outpatient discounted reimbursement rate, or stated co-pay amount, whichever is the lesser. In addition, as required by applicable California law, a patient with a gross income less than 350% of FPG who incurs total medical expenses in excess of ten percent (10%) of gross annual income will receive 100% charity benefit. Further, certain assets (retirement plan vested benefits, IRA's, 401k or 403b assets) may not be considered in determining an ability to pay and the first $10,000 of other monetary assets and 50% of the remaining monetary assets must not be used in the evaluation for financial assistance.

iv) Gross charges never apply to patients who qualify for partial charity or private pay discounts. Once gross charges are adjusted to the appropriate Medicare or private pay rate, the patient liability will not change even if eventually referred to a collection agency.

9) **Charity Care is not**:

a) Bad debt: A bad debt results from a patient's unwillingness to pay or from a failure to qualify for financial assistance that would otherwise prove an inability to pay;

b) Contractual adjustment: The difference between the retail charges for services and the amount allowed by a governmental or contracted managed care payer for covered services that is written off; or

c) Other adjustments:

i) Service recovery adjustments when the patient identified a less than optimal patient care experience;

ii) Risk management adjustments, where a potential risk liability situation is identified and Providence Risk Management has elected to absorb the cost of care and not have the patient billed;

iii) Payer denials where the facility was unable to obtain payment due to untimely billing per contractual terms; or retroactive denial of service by a managed care payer where appeal is not successful.

PROCEDURE/GENERAL INSTRUCTIONS

1) Communication and Notification of the availability of financial assistance within the community of each hospital shall be in accordance with AB 774 and SB 350 and the federal PPACA (Patient Protection and Affordable Care Act).

   a) Signage about the availability of financial assistance will be posted in registration areas of hospitals including emergency rooms and in the Regional Business Office.

   b) A Notice of Collection Practices shall be provided to all patients during registration and included in the final billing statement.

   c) This policy will be posted on each facility's internet page and will otherwise be made available upon request.

   d) Financial Assistance Applications will be available in the registration areas.

   e) PHS-SC employees including admitting/registration and financial counseling staffs as well as on site consultants such as Health Advocates will comprehensively screen patients for possible third party coverage and assist patients in applying for coverage when appropriate. Verification that a patient does not qualify for third party coverage or is ineligible for a government program is required before finalizing a charity decision.

2) PATIENT ELIGIBILITY WITH NO APPLICATION. Instances where a Financial Assistance Application is not required per charity definitions:

   a) Treatment Authorization Request (TAR) denials, Medi-Cal non-covered services, and untimely Medi-Cal billing write-offs will be recorded with their respective adjustment transaction codes. Medi-Medi accounts are written off to a unique transaction code to facilitate Medicare Bad Debt reimbursement.

   i) Finance will identify the amounts posted to those codes and transfer those amounts from contractual to charity in the general ledger.

   ii) For Medi-Medi adjustments, that portion not claimed as Medicare bad debt reimbursement will be reclassified as charity in the general ledger.

   b) Services denied due to restricted Medi-Cal coverage will be written off to charity when the denial is received on a Medi-Cal remittance advice.

   c) A patient may be verified as homeless at any time during the revenue cycle. The preferred method is at registration, where a lack of address documentation is indicated and coding to "Homeless" status is completed. This will generate the charity write-off at the time of billing.

   d) PHS-SC facilities will not engage in extraordinary collection efforts including referral to outside collection agencies before making a reasonable effort to determine whether the patient qualifies for financial assistance. Upon referral, outside collection agencies, in their collection activities, including when performing income and asset searches in preparation for lawsuit authorizations, can verify an inability to

pay and can submit the account for charity approval under the following circumstances:

i) Self pay patients with gross incomes at or below 250% of Federal Poverty Guidelines. The entire balance will be deemed charity.

ii) Self pay patients with gross incomes in excess of 250% of FPG, and limited assets, can still qualify for partial or full charity, if medical debt load is significant enough to create an inability to pay. The liability, if gross income is between 250% and 350% of FPG will be no more than Medicare allowable. For gross income in excess of 350% of FPG, the patient's liability will be no more than the self-pay discount rate.

iii) Equity in a principal residence can be considered in asset determination only when income is in excess of 350% of Federal Poverty Guidelines, and a lien against that equity can be approved, but in no instance will foreclosure proceedings be initiated. PHS-SC and its collection agencies will wait until the principal residence is sold or re-financed to collect its debt. California law places restrictions on monetary assets that can be considered in making an ability to pay determination. Consistent with California laws, monetary assets shall not include: (1) assets held under a qualified retirement plan; (2) the first ten thousand dollars ($10,000) of a patient's monetary assets; or (3) fifty percent (50%) of a patient's monetary assets in excess of $10,000.

3) PATIENT ELIGIBILITY AS ESTABLISHED BY FINANCIAL NEED PER FINANCIAL ASSISTANCE APPLICATION.

a) All PHS-SC employees including registration staff, financial counselors, patient access representatives, patient account representatives, clinical social workers, nurses, case managers, chaplains as well as mission directors and medical staff physicians during their normal course of duties, can identify potential inability to pay situations and refer patients for financial assistance. Clinical social workers identifying potential charitable services cases should liaison with financial counselors/patient access representatives in evaluating charity potential and presenting financial assistance options to the patient/family. In these instances, a Financial Assistance Application can be offered to the patient/family and the account is accordingly documented to help guide future collection efforts.

b) The Financial Assistance Application must be accompanied by proof of income, including copies of recent paychecks, W-2 statements, income tax returns, and/or bank statements showing payroll deposits. If none of these documents can be provided, one of the following is required:

i) If the patient/responsible party is paid in cash, a letter from the employer providing the rate of pay;

ii) If the patient/responsible party is provided services, such as room and board, etc., in lieu of pay for work performed, the person granting the services must provide a letter delineating the services provided and the value of those services; or

iii) If there is no employer/employee arrangement, other written documentation of in-kind income can be considered, on a case-by-case basis.

c) Patients may request a Financial Assistance Application by calling the Regional Business Office (RBO), writing to the mailing address on their patient billing statement. or downloading the form from the PHS-SC websites:

d) Patients completing Financial Assistance Applications are responsible for making reasonable effort to supply the information needed to make a determination. Failure to provide that information may result in a denial of the Financial Assistance Application.

4) FINANCIAL ASSISTANCE APPLICATION REVIEW/APPROVAL PROCESS:

a) For restricted services charity write-offs, or homeless patient charity write-offs, the write-off transaction can be initiated by any RBO employee. Standard transaction approval levels will apply.

b) A Financial Assistance Application must be reviewed by a RBO financial counselor. If gross income is at or below 250% of FPG, the counselor may approve the charity application, based on the information submitted with the application (proof of income required). If the gross income exceeds 250% FPG, an assessment for qualification of partial or full charity based on income, assets, and medical debt load will be made by the financial counselor with write-offs subject to standard approval levels.

c) Financial Assistance applications shall be reviewed and approved, denied or returned to the patient with a request for additional information within three business days of receipt.

d) Collection agency requests for charity or Financial Assistance Applications received from a collection agency shall be reviewed by a RBO financial counselor. The counselor shall follow the review process described in b) above in determining inability to pay and approving partial, total or no charity. Standard transaction approval levels will apply.

e) An approved charity determination is applicable to all services referenced in the application AND services provided up to six months after the date of the approved application, provided there is no change in the applicant's financial status that would warrant a reevaluation.

f) If charity is approved at 100%, any patient deposits paid toward accounts approved for charity must be refunded to the account guarantor. This does NOT apply to any third-party payments, including casualty insurance payments or settlements paid from attorney trust accounts. Those payments will be retained and charity will be granted for the difference between gross charges and the sum of those excluded payments. Refunds under this provision will include interest at the rate prescribed in Section 685.010 of the Code of Civil Procedure.

5) Notification of charity determination:

a) In those instances where Medi-Cal restricted services are written off to charity, the notice of charity approval will be sent to the patient.

b) For homeless charity write-offs, no notification is necessary.

c) In all instances where a Financial Assistance Application was submitted, the person approving the Application shall submit a written determination of no charity, partial charity or full charity to the person who submitted the Application on behalf of the patient within ten days of final determination of the completed Application.

d) In the event partial or no charity is approved, the notification letter will advise that the patient may appeal the determination. Appeals should be in writing to:

Regional Director, Regulatory and Quality Assurance
Providence Health & Services, Southern California
4180 190th Street
Torrance CA 90504

The Regional Director, or designee, shall respond to charity denial appeals. Should the patient's appeal be denied, and the original denial upheld, collection activities will be re-started to afford the patient ample opportunity to make payment, per the provisions of applicable California law.

e) If partial charity is approved, the remaining patient balance may be paid in interest-free installments as mutually agreed between patient and facility. Payment will not be considered delinquent, nor will further collection activity occur, as long as any payments made pursuant to a payment plan are not more than 90 days delinquent under the terms of that plan. If an outside collection agency is utilized to collect the unpaid debt, that agency agrees to abide by the requirements of this policy and of AB 774 and SB 350, including not garnishing wages or placing a lien on a principal residents.

6) Processing of charity write-off:

a) If a self-pay discount has been issued, that discount must be reversed to restore full charges. This step permits Finance to apply a ratio of cost to charges against the amount of charity write-off to accurately determine the cost of charity care for external reporting purposes.

b) The 100% charity discount percentage is then applied to the account, using existing adjustment mnemonic/transaction codes.

c) A patient who paid a deposit at the time of service and is entitled to 100% charity, or a patient who paid a deposit and is entitled to partial charity and whose deposit exceeded the final liability per the charity policy, is entitled to both a refund of the excess or full deposit plus interest at the rate prescribed in Section 685.010 of the Code of Civil Procedure. Should a partial charity account need to be referred to an outside agency for collection, the account will be flagged as a partial charity recipient so that the agency can assure that:

i) It will not initiate a lawsuit for purposes of garnishing wages or attaching a lien on a principal residence; and

ii) It will not report the delinquency to a credit-reporting agency until 150 days after the date of service, or 150 days after the patient received partial charity approval.

AUDIT/CONTROL/RECORDS RETENTION:

All Financial Assistance Applications will be retained for a period of seven years from date of completion.

The charity determinations shall be subject to outside review to determine consistency in judgment and to provide further education/training; however, a charity determination shall not be reversed at any time.

Write-off approvals are subject to internal and external audit. Standard transaction approval levels are:

Less than	$ 5,000	Manager Level
Greater than	$5,000 to $10,000	Regional Director,
Greater than	$10,000	Regional Director, Revenue Cycle Management

REFERENCE(S)/RELATED POLICIES

American Hospital Association Charity Guidelines
California Hospital Association Charity Guidelines
California Alliance of Catholic Healthcare Charitable Services Guidelines
Providence Health & Services Commitment to the Uninsured Guidelines
Patient Protection and Affordable Care Act of 2010 (Federal Exemption Standards)
Private Pay Discounting Policy CA-FIN-5003
Regional Business Office Debt Collection Standards and Practices Policy, RBO-GOV-107

COLLABORATION

This policy was developed in collaboration with the following Departments:

PHS-SC Finance Division
Providence Health & Services Department of Legal Affairs

ATTACHMENT A

2014 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in family/household	**Poverty guideline**
For families/households with more than 8 persons, add $4,060 for each additional person.	
1	$11,670
2	15,730
3	19,790
4	23,850
5	27,910
6	31,970
7	36,030
8	40,090

ATTACHMENT B

NOTICE OF COLLECTION PRACTICES

NOTICE

PATIENT RIGHTS WITH RESPECT TO COLLECTION OF DEBTS FOR HOSPITAL SERVICES

State and Federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (382-4357) or on-line at www.ftc.gov.

If you have coverage through group or private insurance, or other third party payer program, and you wish us to bill that organization, you must supply us with your enrollment information. This requirement is met by presenting your insurance card or other suitable document that provides policy information, (and dependent coverage, if applicable). If you require assistance in paying this debt, you may be eligible for the Medicare, Medi-Cal, Healthy Families, California Children's' Services, liability California Victims of Violent Crimes, automobile medical insurance, or other third-party programs, including charity care. Ask a hospital admissions or business office representative if you would like to pursue these options. Hospital charity and self-pay discount policies may be obtained by either asking an admissions or business office representative for assistance, or by visiting the hospital's web site for a downloadable form.

Non-profit credit counseling services may also be of assistance. Please consult a telephone directory for a listing of these programs.

The patient or responsible person will be required to sign the Conditions of Hospital Admission or Outpatient Treatment. That document will include an acknowledgment of financial responsibility for payment for services provided by the hospital. The hospital will bill any third party payer for which you provide enrollment information. You will be asked to pay co-payments, as prescribed by those payers. You may be responsible for services those programs do not cover. You will be billed following the conclusion of your service, although deposits may be requested prior to services being rendered. Should the debt remain unpaid, the account may be referred to an outside collection agency under contract with the hospital. The collection agency will abide by the above debt collection principles. Should the debt remain unpaid, the collection agency, on behalf of the hospital, will list the unpaid debt with credit-reporting agencies and may initiate legal proceedings, which may result in wage garnishment or a lien placed against an asset of the patient or responsible party. The Providence Health and Services charity policy provides that persons with household gross income below 250% of Federal Poverty Guidelines (FPG) are eligible for full assistance upon submission of a Financial Assistance Application. Persons with gross income above 250% may also be eligible for partial or full assistance, depending upon the information provided on the application.

If you have any questions about this notice, please ask any admissions or business office representative or by calling 800 (insert phone number for appropriate hospital).

ATTACHMENT C

FINANCIAL ASSISTANCE APPLICATION

(Available in English and Spanish)

Date: _____

Dear, _____

The Mary Potter Program is designed to provide financial assistance for those who have medical care needs, but have limited means to pay. Our policy has specific guidelines for qualification. I have enclosed an application for this program to assist you with your hospital bill.

Please complete the enclosed application and return the form to the address below. All information will be kept confidential.

Please attach the following items:

1. Paycheck stubs for 3 months (i.e. disability, unemployment, state aid, or employment)
2. Most recent tax return or W-2
3. Last 3 months of Checking and Savings Account Statements
4. Proof of income for all household members.

If you have any questions, please do not hesitate to contact our customer service office at 800-750-7703.

Return application to:

Regional Business Office

PROVIDENCE HEALTH & SERVICES
SOUTHERN CALIFORNIA REGION
PATIENT FINANCIAL ASSISTANCE APPLICATION

Date of Request: _____

Patient Name: _____ *Account No.* _____

Address: _____ *Date of Service:* _____

City/State: _____ *Zip Code:* _____

SS #: _____ *Telephone #:* _____

Date of Birth: _____

SECTION 1: RESPONSIBLE PARTY (Complete if different from above)

Name: _____

Address: _____

City/State: _____ *Zip Code:* _____

SS #: _____ *Telephone #:* _____

Occupation:

_____

Employer:

_____

Employer Address:

_____

Employer Telephone #: _____

SECTION 2: EVALUATION REQUIRED BY STATE OF CALIFORNIA

Ethnic Origin: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other *Specify)*_____

City/State of Birth: _____ *Country of Origin:* _____

Are you a U.S. Citizen or Legal Resident? ☐ Yes ☐ No

Do you have documentation of your status? ☐ Yes ☐ No

Mother's Maiden Name: _____

_____

SECTION 3: FINANCIAL EVALUATION

Family Members Living in Household: *Include all persons living in household.*
Include all INCOME (i.e. wages, public assistance, social security, unemployment, alimony, and child support)

Name	Age	Relationship	Annual Income

Monthly Expenses:

Mortgage or Rent Payments: _____

Car Payments: _____

Utilities: _____

Other: (briefly describe)

_____ _____

List all Debts (greater than $500.00):

Description	Amount

List all Assets:

Do you own your home? ☐ Yes ☐ No Market Value _____

Do you own any cars/trucks? ☐ Yes ☐ No

Other assets: _____

SECTION 4: ADDITIONAL INFORMATION

Please make additional comments about your household's financial circumstances that affect your ability to pay the hospital bill:

SECTION 5: CERTIFICATION

I, _____, (person responsible for paying hospital bill) hereby certify that the information contained in the above financial questionnaire is correct and complete to the best of my knowledge. I further understand that intentional misrepresentation or falsification of any information contained in the questionnaire is punishable by law. According to the Fair Debt and Practice Act, the hospital has the right as a creditor to check your credit status with credit agencies. Your signature below will signify that you have been notified of such:

Signature:

_____ *Date:*

Patient or Responsible Party

FOR BUSINESS OFFICE USE ONLY

Approved Assistance: ☐ Full ☐ Partial ☐ Not Approved

Payment Arrangement: ☐ Yes ☐ No Amount per Month: _____

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5/18/2014
Providence Little Company of Mary Service Area
Program Detail Full
For period from 1/1/2013 through 12/31/2013

Adopt a Family

Description:	Departments across both Hospitals adopt families at Christmas. The amount of employee time spent on this project during work is tracked for this annual Hospital sponsored project
Category:	E3
Gender:	Both Males and Females
Department Contact:	
Staff:	0.00
Volunteer:	0.00
Persons:	10
Expenses:	2,400
Revenues:	0
Benefit:	2,400

Baby Friendly Journey

Description:	This 1st 5 funded project is designed to achieve Baby Friendly designation at our San Pedro location by Baby Friendly USA by increasing our exclusive breastfeeding rate and encouraging skin to skin contact between mother and infant.
Category:	A1
Gender:	Females
Department:	1000001 (LCMH & SPH)
Department Contact:	Jim Tehan (310-257-3586)
Staff:	0.00
Volunteer:	0.00
Persons:	72
Expenses:	193,255
Revenues:	0
Benefit:	193,255

Bereavement & Gathering Place

Description:	Bereavement services are free ongoing educational services and support to any community member including family members who have lost a loved one to a terminal illness. Gathering Place is a community education resource which includes support groups to help children and adults cope with loss.
Category:	A1
Gender:	Both Males and Females
Department:	9573198 (Trinity Care Hospice)
Department Contact:	Terri Warren (310-257-3592)
Staff:	0.00
Volunteer:	0.00
Persons:	325
Expenses:	659,364
Revenues:	0
Benefit:	659,364

Case Management of Uninsured patients

Description: For patients without insurance and personal physician, individual physicians are compensated for functioning as a primary care physician and managing the patients condition while in the hospital. Specialty physicians who agree to take call to see uninsured patients are compensated for taking call
Category: A3
Gender: Both Males and Females
Department: 762 (Little Company of Mary Hospital)
Department Contact: Liz Dunne
Staff: 0.00
Volunteer: 0.00
Persons: 7,280
Expenses: 1,984,956
Revenues: 0
Benefit: 1,984,956

Children's Health Insurance Program

Description: Enroll and retain eligible children in government subsidized Health Insurance programs Medi-Cal and Healthy Families).
Category: A3
Gender: Females
Department: 171803 (Community Health)
Department Contact: Justin Joe (310-514-4362)
Staff: 0.00
Volunteer: 0.00
Persons: 1,883
Expenses: 381,285
Revenues: 200,000
Benefit: 181,285

Clinical Pastoral Education (CPE)

Description: Education and practice in hospital ministry / chaplaincy for theology students, ministers, chaplains, and lay people. Each CPE unit (class) consists of 100 hours of education and 300 hours of supervised ministry. Students learn and practice spiritual care skills, preparing them for ministry in
health-care, churches, synagouges, and other organizations.
Category: B3
Gender: Both Males and Females
Department: 86850 (Clinical Pastoral Education Dept.)
Department Contact: Dan Hudson/Sr. Nancy Jurecki (310-303-6122/310-5144364)
Staff: 0.00
Volunteer: 0.00
Persons: 13
Expenses: 98,178
Revenues: 0
Benefit: 98,178

Community Outreach

Description:	Outreach coordinator, vasek polak health clinic promotoras, and Community Health administration
Category:	A1
Gender:	Both Males and Females
Department:	171803 (Community Health)
Department Contact:	Jim Tehan (310-257-3586)
Staff:	0.00
Volunteer:	0.00
Persons:	3,168
Expenses:	544,160
Revenues:	0
Benefit:	544,160

Cost of Fundraising for Community Programs

Description:	Salary expenses for Foundation staff coordinating fund raisers, where the purpose of the special event was specifically designated for community benefit programs.
Category:	E4
Gender:	Both Males and Females
Department:	90 (LCM Comm Health Foundation)
Department Contact:	Joe Zanetta (310-303-5351)
Staff:	0.00
Volunteer:	0.00
Persons:	Unknown
Expenses:	227,153
Revenues:	0
Benefit:	227,153

Creating Opportunities for Physical ACtivity (COPA)

Description:	This physical activity initiative program uses a three prong strategy to increase physical activity in children through: 1)a peer coach training model for teachers (and their studnets), 2) a direct service after school physical activity program and 3)family nights and special events that promote children and adults (parents and teachers)involved together in physical activity. COPA currently operates at elementary schools in four underserved communities served by the Hawthorne, Lawndale, Los Angeles and Torrance Unified School Districts.
Category:	A1
Gender:	Both Males and Females
Department:	71800 (COPA)
Department Contact:	Jesus Mejia (310-514-5483)
Staff:	0.00
Volunteer:	0.00
Persons:	5,287
Expenses:	795,350
Revenues:	64,716

Benefit: 730,634

Donation of Radiological Equipment

Description: Donation of a Computed Radiology Unit and an X-Ray laser printer to the South Bay Family Healthcare Center.
Category: E3
Gender: Females
Department: 100001 (Cash and In Kind Donations)
Department Contact: Jim Tehan (310-303-5086)
Staff: 0.00
Volunteer: 0.00
Persons: Unknown
Expenses: 50,000
Revenues: 0
Benefit: 50,000

Donations

Description: Cash and InKind donations to non profit community organizations promoting healthy living or outreach to vulnerable populations by both Medical Centers.
Category: E2
Gender: Both Males and Females
Department: 100001 (Cash and In Kind Donations)
Department Contact: Various
Staff: 0.00
Volunteer: 0.00
Persons: Unknown
Expenses: 23,530
Revenues: 0
Benefit: 23,530

Free Space--Use of Hospital Conference Centers

Description: Provide free meeting space to non profit community groups that promote health education, offer support groups or hold business meetings
Category: E3
Gender: Both Males and Females
Department: 100002 (Community Services Free Space)
Department Contact: Jim Tehan (310-257-3586)
Staff: 0.00
Volunteer: 0.00
Persons: 914
Expenses: 91,400
Revenues: 0
Benefit: 91,400

Get Out and Live (G.O.A.L.) (Diabetes/CCF)

Description:	Two-year project support to provide prevention education, diabetes screenings, and medical follow-up services to diabetics/pre-diabetics to improve disease self-management in Inglewood, Hawthorne and Lawndale.
Category:	A1
Gender:	Females
Department:	75271806 (Diabetes Education)
Department Contact:	Juan Mendez (310-257-3525)
Staff:	0.00
Volunteer:	0.00
Persons:	459
Expenses:	394,495
Revenues:	0
Benefit:	394,495

Health Resource Center

Description:	Link patients to community services, including registration of comunity members in free community lectures
Category:	A1
Gender:	Both Males and Females
Department:	75287700 (Community Services)
Department Contact:	Traci Smith (310-303-6091)
Staff:	0.00
Volunteer:	0.00
Persons:	1,024
Expenses:	80,445
Revenues:	0
Benefit:	80,445

Linkage to Community Services (Poor and Vulnerable)

Description:	Diabetes classes, support groups and self-care workshops provided at Vasek Polak Health Clinic and Carson Care Station
Category:	A1
Gender:	Both Males and Females
Department:	171803 (Community Health)
Department Contact:	Juan Mendez (310-257-3525)
Staff:	0.00
Volunteer:	0.00
Persons:	2,435
Expenses:	294,438
Revenues:	0
Benefit:	294,438

Medical Library

Description: provide information and research services to physicians,students and other health professionals in training, as well as a resource library for the general public
Category: B3
Gender: Both Males and Females
Department: 186900 (Medical Library)
Department Contact: Mary Osborne (310-303-6792)
Staff: 0.00
Volunteer: 0.00
Persons: 450
Expenses: 21,000
Revenues: 0
Benefit: 21,000

Mission Immersion Trip (Mexico)

Description: As part of the Ministry Leadership Formation Program, leaders from across the Service Area travel to Mexico to provide assistance in building houses for the poor in Mexico, in collaboration with a local organization, Esperanza
Category: A4
Gender: Both Males and Females
Department: 30 (Mission Services)
Department Contact: Sr. Colleen Settles (818.847.3350)
Staff: 0.00
Volunteer: 0.00
Persons: 3
Expenses: 5,040
Revenues: 0
Benefit: 5,040

Mother Joseph Fund

Description: 5% of the above budget variance in operating income at the San Pedro and Torrance Hospitals is set aside to fund projects that benefit the poor and vulnerable in local communities,
Category: E1
Gender: Both Males and Females
Department: 1000001 (LCMH & SPH)
Department Contact:
Staff: 0.00
Volunteer: 0.00
Persons: Unknown
Expenses: 204,961
Revenues: 0
Benefit: 204,961

Palliative Care

Description: Provide hospital based consultation to patients and physicians related to pain and symptom management for adults with life threatening illnesses

Category: C9
Gender: Both Males and Females
Department: 79273110 (Palliative Care)
Department Contact: Terri Warren (310-257-3520)
Staff: 0.00
Volunteer: 0.00
Persons: 286
Expenses: 2,020,038
Revenues: 0
Benefit: 2,020,038

Paramedic radio station

Description: The paramedic base station coordinates emergency calls from the paramedic transport team for hospitals in the South Bay area.
Category: C1
Gender: Both Males and Females
Department: 91111 (Emergency)
Department Contact: Kristina Crews (310-303-5684)
Staff: 0.00
Volunteer: 0.00
Persons: 9,116
Expenses: 846,086
Revenues: 0
Benefit: 846,086

Partners for Healthy Kids Mobile Clinic

Description: Mobile pediatric clinic provides free acute and preventive medical services to uninsured children (0-18) at 10 under served school sites every week, during the school year; during summer months, the clinic provides immunizations at community events sports physicals for high school athletes. The mobile clinic is a partnership with the Lawndale and Los Angeles Unified School Districts
Category: A2
Gender: Both Males and Females
Department: 171815 (Partners for Healthy Kids)
Department Contact: Jim Tehan (310-257-3586)
Staff: 0.00
Volunteer: 0.00
Persons: 2,027
Expenses: 897,105
Revenues: 0
Benefit: 897,105

Post Discharge Expense for Medically Indigent

Description: Follow up care given to psychiatric or homeless persons, usually at College Hospital.
Category: A3

Gender: Females
Department: 171803 (Community Health)
Department Contact: Gloria S. Noell (310-303-6481)
Staff: 0.00
Volunteer: 0.00
Persons: 198
Expenses: 368,734
Revenues: 0
Benefit: 368,734

Post Discharge Pharmacy Medications

Description: Medications/pharmacy supplies given to those individuals who qualify at low or no cost by both Medical Centers.
Category: A3
Gender: Females
Department: 171803 (Community Health)
Department Contact: Muno Bholat/Hiro Nishi (310-303-5722/310-514-5268)
Staff: 0.00
Volunteer: 0.00
Persons: 1,680
Expenses: 169,784
Revenues: 0
Benefit: 169,784

Preceptorships

Description: Across both hospitals, 12 different departments have formal agreement to preceptor student from local colleges/universities related to 9 different health professions: pharmacy, respiratory therapy, nursing, radiation technology, hospice, social work, psychology, physical therapy and occupational therapy. The amount of time spent by Hospital employees preceptoring students is included as a community benefit contribution. Multiple universities enter into formal agreements with both Hospitals related to the oversight and preceptoring of their students. Examples include UCLA, CSULB, El Camino College, Harbor College, Mount St. Mary's etc. Also include Summer Urban Scholars Project
Category: B3
Gender: Both Males and Females
Department: 171803 (Community Health)
Department Contact: Jim Tehan (310-257-3586)
Staff: 0.00
Volunteer: 0.00
Persons: 600
Expenses: 2,028,380
Revenues: 0
Benefit: 2,028,380

Sexual Assault Response Team

Description: Hospital based domestic violence screening/advocate response and outreach to under served communities; forensic nurse exam for victims of sexual assault for the purpose of continuity of patient care and assistance with prosecution
Category: A1
Gender: Both Males and Females
Department: 87713 (Domestic Violence/Sexual Assault Team)
Department Contact: Alicia Hernandez (310.241.4317)
Staff: 0.00
Volunteer: 0.00
Persons: 184
Expenses: 206,007
Revenues: 122,910
Benefit: 83,097

Support Groups

Description: Provide ongoing support and linkage to community resources for individuals with chronic health issues.
Category: A1
Gender: Both Males and Females
Department Contact: Kathryn Sprague (310-793-8166)
Staff: 0.00
Volunteer: 0.00
Persons: 345
Expenses: 25,300
Revenues: 0
Benefit: 25,300

Transportation/Taxi Vouchers for Medically Indigent

Description: Transportation for those individuals that would not otherwise have a way to get "home" safely.
Category: A3
Gender: Females
Department: 171803 (Community Health)
Department Contact: Karen Papadakis-Hill (310-514-5474)
Staff: 0.00
Volunteer: 0.00
Persons: 4,490
Expenses: 116,791
Revenues: 0
Benefit: 116,791

Trinity Kids Care

Description: Unreimbursed cost of delivering services in the home for children with a terminal illness; includes outreach and education to physicians, parents and providers about Hospice care for children, including how and when to access care.
Category: C9

Gender: Both Males and Females
Department: 9573198 (Trinity Care Hospice)
Department Contact: Terri Warren (310-257-3566)
Staff: 0.00
Volunteer: 0.00
Persons: 1,720
Expenses: 4,226,078
Revenues: 1,669,808
Benefit: 2,556,270

Vasek Polak Health Clinic

Description: Vasek Polak Health Clinic provides low cost primary care to uninsured adults using a fixed price payment model. Community Health provides clinic outreach assistance with linkage to health services beyond the scope of clinic services. In collaboration with Clinic staff, community Health also operates a diabetes education program using a self-care model developed at Stanford
Category: C3
Gender: Both Males and Females
Department: 78071832 (Vasek POlak Health Clinic)
Department Contact: Jim Tehan (310.257.3586)
Staff: 0.00
Volunteer: 0.00
Persons: 3,562
Expenses: 1,124,182
Revenues: 343,552
Benefit: 780,630

Welcome Baby Program

Description: A voluntary, universal home visitation program available to all pregnant women who deliver at Providence Little Company of Mary Medical Center San Pedro. Through one-on-one visits visits from nurses and parent coaches, Welcome Baby aims to enhance the health and wellbeing of mothers and their families. Provides new parents with information and resources, prenatally through the child's first nine months of life, that will support them to help their child reach developmental milestones.
Category: A1
Gender: Females
Department: 772 (San Pedro Hospital)
Department Contact: Nancy Carlson
Staff: 0.00
Volunteer: 0.00
Persons: 77
Expenses: 455,708
Revenues: 0
Benefit: 455,708

Women's and Children's Clinic

Description:	Provides pediatric care to uninsured children and comprehensive prenatal care to low income pregnant mothers eligible for Medi-Cal; provides social and educational services in Spanish to target population.
Category:	C5
Gender:	Females
Department:	9371861 (Women's Clinic)
Department Contact:	(310-784-5800)
Staff:	0.00
Volunteer:	0.00
Persons:	Unknown
Expenses:	5,403
Revenues:	0
Benefit:	5,403

Totals:

Number of Programs:	**31**
Staff:	**0.00**
Volunteer:	**0.00**
Persons:	**47,608**
Expenses:	**18,541,006**
Revenues:	**2,400,986**
Benefit:	**16,140,020**

5/18/2014

Providence Little Company of Mary Service Area

Selected Categories - Detail

For period from 1/1/2013 through 12/31/2013

Category / Title / Department	Monetary Inputs			Outputs
	Expenses	Offsets	Benefit	Persons
Community Health Improvement Services (A)				
Community Health Education (A1)				
Baby Friendly Journey				
LCMH & SPH (1000001)	193,255	0	193,255	72
Bereavement & Gathering Place				
Trinity Care Hospice (9573198)	659,364	0	659,364	325
Community Outreach				
Community Health (171803)	544,160	0	544,160	3,168
Creating Opportunities for Physical ACtivity (COPA)				
COPA (71800)	795,350	64,716	730,634	5,287
Get Out and Live (G.O.A.L.) (Diabetes/CCF)				
Diabetes Education (75271806)	394,495	0	394,495	459
Health Resource Center				
Community Services (75287700)	80,445	0	80,445	1,024
Linkage to Community Services (Poor and Vulnerable)				
Community Health (171803)	294,438	0	294,438	2,435
Sexual Assault Response Team				
Domestic Violence/Sexual Assault Team (87713)	206,007	122,910	83,097	184
Support Groups				
Unknown (0)	25,300	0	25,300	345
Welcome Baby Program				
San Pedro Hospital (772)	455,708	0	455,708	77
***** Community Health Education**	**3,648,522**	**187,626**	**3,460,896**	**13,376**
Community Based Clinical Services (A2)				
Partners for Healthy Kids Mobile Clinic				
Partners for Healthy Kids (171815)	897,105	0	897,105	2,027
***** Community Based Clinical Services**	**897,105**	**0**	**897,105**	**2,027**
Health Care Support Services (A3)				
Case Management of Uninsured patients				
Little Company of Mary Hospital (762)	1,984,956	0	1,984,956	7,280
Children's Health Insurance Program				
Community Health (171803)	381,285	200,000	181,285	1,883
Post Discharge Expense for Medically Indigent				
Community Health (171803)	368,734	0	368,734	198
Post Discharge Pharmacy Medications				
Community Health (171803)	169,784	0	169,784	1,680
Transportation/Taxi Vouchers for Medically Indigent				
Community Health (171803)	116,791	0	116,791	4,490
***** Health Care Support Services**	**3,021,550**	**200,000**	**2,821,550**	**15,531**
Other (A4)				
Mission Immersion Trip (Mexico)				
Mission Services (30)	5,040	0	5,040	3
***** Other**	**5,040**	**0**	**5,040**	**3**
****** Community Health Improvement Services**	**7,572,217**	**387,626**	**7,184,591**	**30,937**

Health Professions Education (B)

5/18/2014
Providence Little Company of Mary Service Area
Selected Categories - Detail
For period from 1/1/2013 through 12/31/2013

Category / Title / Department	Monetary Inputs			Outputs
	Expenses	Offsets	Benefit	Persons
Other Health Professional Education (B3)				
Clinical Pastoral Education (CPE)				
Clinical Pastoral Education Dept. (86850)	98,178	0	98,178	13
Medical Library				
Medical Library (186900)	21,000	0	21,000	450
Preceptorships				
Community Health (171803)	2,028,380	0	2,028,380	600
***** Other Health Professional Education**	**2,147,558**	**0**	**2,147,558**	**1,063**
****** Health Professions Education**	**2,147,558**	**0**	**2,147,558**	**1,063**
Subsidized Health Services (C)				
Emergency and Trauma Services (C1)				
Paramedic radio station				
Emergency (91111)	846,086	0	846,086	9,116
***** Emergency and Trauma Services**	**846,086**	**0**	**846,086**	**9,116**
Hospital Outpatient Services (C3)				
Vasek Polak Health Clinic				
Vasek POlak Health Clinic (78071832)	1,124,182	343,552	780,630	3,562
***** Hospital Outpatient Services**	**1,124,182**	**343,552**	**780,630**	**3,562**
Women's and Children's Services (C5)				
Women's and Children's Clinic				
Women's Clinic (9371861)	5,403	0	5,403	Unknown
***** Women's and Children's Services**	**5,403**	**0**	**5,403**	**0**
Palliative Care (C9)				
Palliative Care				
Palliative Care (79273110)	2,020,038	0	2,020,038	286
Trinity Kids Care				
Trinity Care Hospice (9573198)	4,226,078	1,669,808	2,556,270	1,720
***** Palliative Care**	**6,246,116**	**1,669,808**	**4,576,308**	**2,006**
****** Subsidized Health Services**	**8,221,787**	**2,013,360**	**6,208,427**	**14,684**
Financial and In-Kind Contributions (E)				
Cash Donations (E1)				
Mother Joseph Fund				
LCMH & SPH (1000001)	204,961	0	204,961	Unknown
***** Cash Donations**	**204,961**	**0**	**204,961**	**0**
Grants (E2)				
Donations				
Cash and In Kind Donations (100001)	23,530	0	23,530	Unknown
***** Grants**	**23,530**	**0**	**23,530**	**0**
In-kind Donations (E3)				

5/18/2014
Providence Little Company of Mary Service Area
Selected Categories - Detail
For period from 1/1/2013 through 12/31/2013

Category / Title / Department	Monetary Inputs			Outputs
	Expenses	Offsets	Benefit	Persons
Adopt a Family				
Unknown (0)	2,400	0	2,400	10
Donation of Radiological Equipment				
Cash and In Kind Donations (100001)	50,000	0	50,000	Unknown
Free Space--Use of Hospital Conference Centers				
Community Services Free Space (100002)	91,400	0	91,400	914
***** In-kind Donations**	**143,800**	**0**	**143,800**	**924**
Cost of Fundraising for Community Programs (E4)				
Cost of Fundraising for Community Programs				
LCM Comm Health Foundation (90)	227,153	0	227,153	Unknown
***** Cost of Fundraising for Community Programs**	**227,153**	**0**	**227,153**	**0**
****** Financial and In-Kind Contributions**	**599,444**	**0**	**599,444**	**924**
Number of Programs 31 Grand Totals	**18,541,006**	**2,400,986**	**16,140,020**	**47,608**