FY25

COMMUNITY BENEFIT REPORT/ PROGRESS ON 2024-2026 COMMUNITY HEALTH IMPROVEMENT PLAN

Providence Mission Hospital

Mission Viejo, CA

Report Year: July 1, 2024-June 30, 2025

Providence Mission Hospital – Mission Viejo: HCAI ID: 106301262
Providence Mission Hospital – Laguna Beach: HCAI ID: 106301337

Annual Strength in Numbers conference with Orange County high school students. Strength in Numbers are student- led clubs supported by Providence Mission Hospital that aims to improve mental health awareness, foster inclusivity, and create a safe space for students to discuss the pressures they face.

To provide feedback on this CB Report or obtain a printed copy free of charge, please email Maria.Peralta-Sanchez@stjoe.org

Providence

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EXECUTIVE SUMMARY

Providence continues its mission of service in Orange County through Providence Mission Hospital. Mission Hospital is an acute-care hospital with 523 licensed beds, founded in 1971 and located in Mission Viejo, CA. It serves the communities of Mission Viejo, Laguna Beach, Laguna Niguel, San Juan Capistrano, San Clemente, Rancho Santa Margarita, Rancho Mission Viejo, Lake Forest, Laguna Hills, Dana Point, Ladera Ranch, Trabuco Canyon, Capistrano Beach and Aliso Viejo. The hospital's service area is in South Orange County and includes 590,000 people.

Providence Mission Hospital dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. In FY25, the hospital provided **$89,588,713** in Community Benefit in response to unmet needs. For FY25, Providence Mission Hospital had an unpaid cost of Medicare of **$176,418,088**. FY25 CB Report can be located online at: https://www.providence.org/locations/socal/mission-hospital-mission-viejo/about-us/community-benefit

2024-2026 Providence Mission Hospital Community Health Improvement Plan Priorities

As a result of the findings of our 2023 CHNA and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, Mission Hospital will focus on the following areas for its 2024-2026 Community Benefit efforts:

PRIORITY 1: ACCESS TO CARE

Access to care goes beyond medical care, and includes dental, vision, primary care, transportation, culturally appropriate care, and care coordination. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

2025 Accomplishments

- 785 community residents were enrolled for health care through the South Orange County (SOC) and Community Health Enrichment Collaborative (CHEC) Family Resource Centers.
- In FY25, both Family Resource Centers served 8,527 clients and provided 47,064 duplicated encounters.
- Reached 2,267 community residents to educate them on Medi-Cal expansion.
- The Community Nurse Navigator coordinated care for 927 patients with diabetes, hypertension, and sepsis through visits, screenings, and education. In May 2025, a Sepsis Nurse Navigator began to provide sepsis education and care for Limited English Proficiency (LEP) patients, assisting 74 patients so far. Patients were linked to primary care and educated on appropriate emergency room use.
- The Community Care Navigator program provided assistance to 259 individuals, delivering over 999 supportive contacts and comprehensive case management services. More than 70% of clients successfully transitioned from intensive case management, attributed to improve stabilization in social and health care needs as well as marked decrease in emergency department visits.

- Through partnerships with housing providers, Mission Hospital supported 177 vulnerable residents with bridge or supportive housing. Most transitioned to stable housing; others received essential social and medical services.
- South Orange County reported fewer persons experiencing homelessness compared to the 2019 Point in Time Count. The Care Navigation program and collaborations with local non-profits serving unhoused populations may have impacted this outcome.
- Community Engagement Action Committees sustained 26 community residents who participated in 25 community activities.

PRIORITY 2: BEHAVIORAL HEALTH (INCLUDING SUBSTANCE USE)

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

Substance use/misuse occurs when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and inability to meet major responsibilities at work, school, or home. Substance use/misuse includes the use of illegal drugs and the inappropriate use of legal substances, such as alcohol, prescription drugs and tobacco. Strategies to address mental health and substance use disorders have a potential to be a catalyst to further our work and mission of reducing stigma and creating a safe place for care.

2025 Accomplishments

- Our clinical team had 2,555 encounters this year: 1,796 were counseling sessions and 763 were group sessions.
- 16% of clients with a moderate to severe PHQ-9 score showed a significant decrease in depression by the end of treatment.
- 16% of clients with a moderate to severe GAD-7 score showed a notable decrease in anxiety by the end of treatment.
- Our Family Resource Centers hosted 10 graduate level Interns.
- 24,684 encounters include residents active on Each Mind Matters and Green Bench OC Social Media sites and in person, with 3,029,050 Media impressions. A total of 29 green benches painted and installed since 2021.
- Significant decreases in teens reporting alcohol and other drug use in the last 30-days in two local school districts compared to 2019 rates.
- Provided substance used prevention information to parents and teens in the area served by Mission Hospital through three large non-traditional public health campaigns including Raising Healthy Teens, Strength in Numbers and Crianza-Positiva. These social media campaigns have garnered over 1,922,004 Media impressions and provided education to 3,925 students, parents and youth-serving adults over the course of 4,577 encounters during the fiscal year.

PRIORITY 3: ECONOMIC SECURITY

An individual's income is directly connected to poverty. If a person or family's total income is less than certain federal poverty measures, then they are considered to be in poverty. People with steady employment are less likely to live in poverty and more likely to be healthy. People with disabilities, injuries, or conditions like arthritis may be especially limited in their ability to work. In addition, many people with steady work still don't earn enough to afford the things they need to stay healthy.

Employment programs, career counseling, and high-quality childcare opportunities can help more people find and keep jobs. In addition, policies to help people pay for food, housing, health care, and education can reduce poverty and improve health and well-being.

2025 Accomplishments

- A new partnership was created to provide financial literacy to South Orange County residents through our Family Resource Centers.
- A workshop was offered to educate the community on how to start their own businesses. This brings alternative ways for the community to increase their incomes.
- 190 Cope Scholars completed rotations in many hospital clinical units to provide exposure to the medical field and ultimately grow the future workforce of the hospital providers.

About Providence

For nearly 170 years, Providence has been dedicated to supporting communities across the seven states we serve. We have always believed in the power of collaboration, recognizing that strong partnerships are essential to our vision of health for a better world.

As we focus on our core operations of delivering high-quality, compassionate care, we rely on partners in local communities to help us get upstream so we can address the social factors that affect health, especially in communities experiencing high levels of health disparities.

At the heart of this collaboration is our community benefit programs. Every year, our family of organizations identifies unmet community needs and responds with strategic contributions and partnerships. Through this work, we aim to meet basic health needs, remove barriers to health, build resilient communities and find innovative ways to serve those who are most vulnerable.

Together, our 125,000 caregivers (all employees) serve in 51 hospitals, 1,014 clinics and a comprehensive range of health and social services across Alaska, California, Montana, New Mexico, Oregon, Texas and Washington.

For more information go to: https://www.providence.org/about/annual-report

INTRODUCTION

Who We Are

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

Providence Mission Hospital is an acute-care hospital founded in 1971 by a group of physicians. In1993 Mission Hospital partnered with Children's Hospital of Orange County (CHOC) to provide pediatric services. In 1994, the hospital became a member of St. Joseph Health. In 2009, Mission Hospital acquired South Coast Medical Center in Laguna Beach. In 2016 Mission Hospital joined the Providence family of 51 hospitals. Mission Hospital has two locations, one in Mission Viejo and the other in Laguna Beach, California. The hospital has 504 licensed beds, a staff of 2,700, and professional relationships with more than 700 local physicians. Major programs and services offered to the community include the following: a Level II Trauma Center, cardiac care, critical care, neuroscience, diagnostic imaging, emergency medicine, and obstetrics.

Our Commitment to Community

Providence Mission Hospital dedicates resources improving the health and quality of life for the communities we serve. During Fiscal Year 2025 (July 1, 2024 – June 30, 2025), Providence Mission Hospital provided **$89,588,713** in Community Benefit[1] in response to unmet needs and to improve the health and well-being of those we serve in South Orange County.

Health Equity

At Providence Mission Hospital, we acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. Our Vision is "Health for a Better World," and to achieve that we believe we must address not only the clinical care factors that determine a person's length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes.

[1] Per federal reporting and guidelines from the Catholic Health Association.

To ensure that equity is foundational to our Community Health Improvement Plan (CHIP), we have developed an equity framework that outlines the best practices that each of our hospital will implement when completing a CHIP. These practices include, but are not limited to the following:

Figure 1. Best Practices for Centering Equity in the CHIP

Community Benefit Governance

Providence Mission Hospital demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation and collaboration with community partners. The Manager of Community Health Department is responsible for coordinating the implementation of State and Federal 501r requirements.

A charter approved in 2007 and revised in 2020 established the formation of the Providence Mission Hospital Community Health Committee. The role of the Community Health Committee is to support the Ministry Board in overseeing community benefit issues. The Committee acts in accordance with a Board-approved charter. The Community Health Committee is charged with developing policies and programs that address identified needs in the service area particularly for underserved populations, overseeing development and implementation of the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP), and overseeing and directing the Community Benefit (CB) activities.

The Community Health Committee has a minimum of eight members including members of the Community Ministry Board. Current membership includes two members of the Community Ministry Board and seven community members. A majority of members have knowledge and experience with the populations, most likely to have disproportionate unmet health needs. The Community Health Committee meets quarterly

Roles and Responsibilities

Senior Leadership

- The Chief Executive and senior leaders, including the hospital's Chief Mission Integration Officer, are directly accountable for CB performance.

Community Health Committee (CHC)

- CHC serves as an extension of the Community Ministry Board to oversee and advise upon the commitment to serve and address our community's health needs. The committee ensures that Providence's Mission and Core Values are fulfilled and integrated through our Community Benefit programs and service in the community and that we pay special attention to poor and vulnerable populations in South Orange County. It includes diverse community stakeholders. Ministry Board members on CHC serve as 'board level champions.'
- The Committee provides recommendations to the Ministry Board regarding budget, program targeting and program continuation or revision.

Community Health (CH) Department

- Manages CB efforts and coordination between CH and Finance departments on reporting and planning.
- Manages data collection, program tracking tools and evaluation.
- Develops specific outreach strategies to access identified Disproportionate Unmet Health Needs (DUHN) populations.
- Coordinates with clinical departments to reduce inappropriate ER utilization.
- Advocates for CH to senior leadership and invests in programs to reduce health disparities.

Local Community

- Partnership to implement and sustain collaborative activities.
- Formal links with community partners.
- Provide community input to identify community health issues.
- Engagement of local government officials in strategic planning and advocacy on health-related issues on a city, county or regional level.

Planning for the Uninsured and Underinsured

Our Mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why Providence Mission Hospital has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients.

One way Providence Mission Hospital informs the public of FAP is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third party insurers are offered an opportunity to complete the Patient Financial Assistance Application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible. For information on our Financial Assistance Program click https://www.providence.org/obp/ca. In FY25, Providence Mission Hospital provided **$7,677,031** in free (charity care) and discounted care.

Medi-Cal (Medicaid)

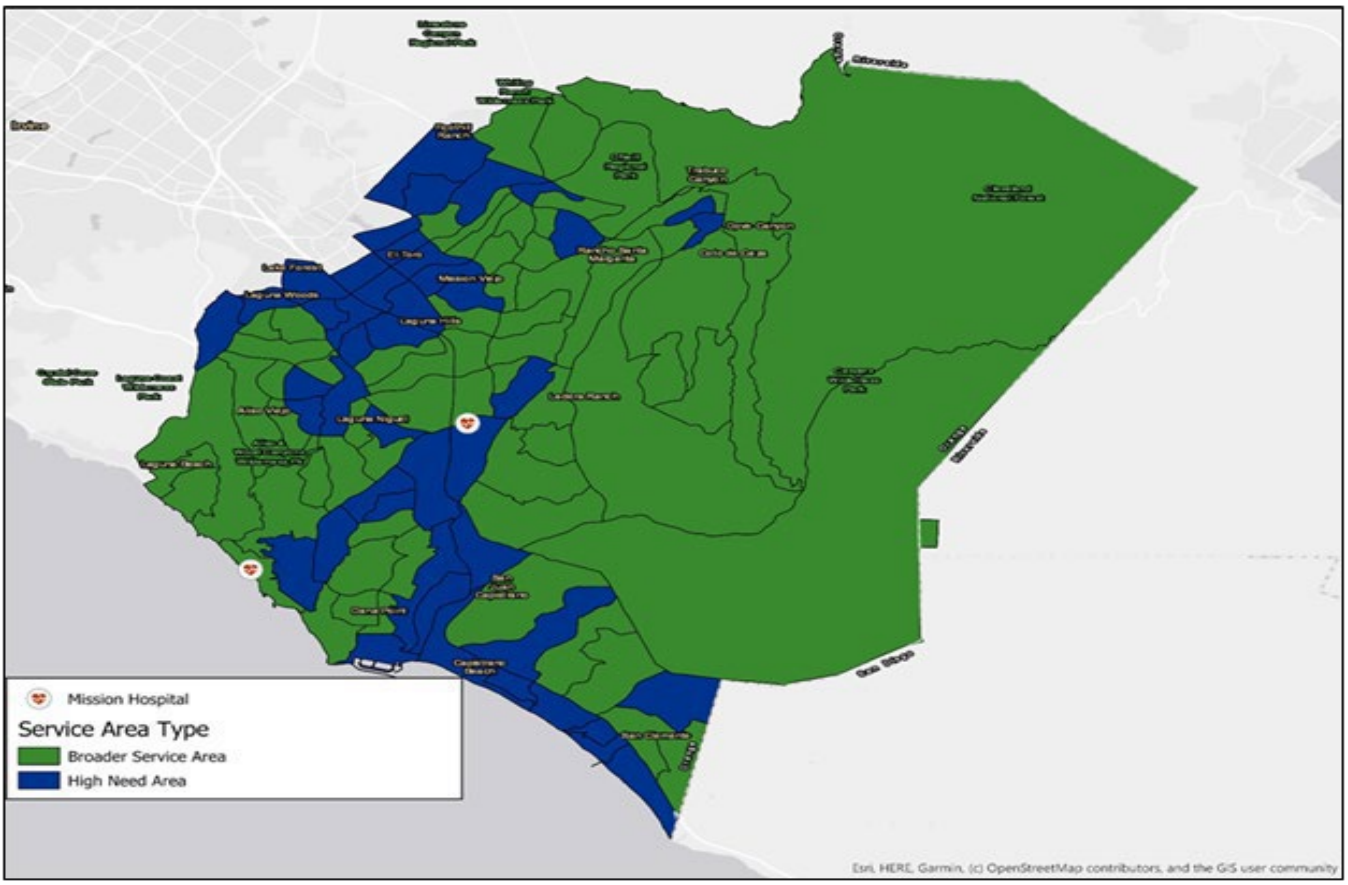
Providence Mission Hospital provides access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California. In FY25, Providence Mission Hospital provided **$76,684,464** in Medicaid shortfall.

OUR COMMUNITY

Description of Community Served

The community served by Mission Hospital is based upon geographic access and other area hospitals, as well as patient ZIP Codes. The service area for Mission Hospital was defined using census tracts inside South Orange County. In total there are 109 census tracts within the service area of Mission Hospital and includes a population of approximately 590,000 people. The population in Mission Hospital's total service area makes up 19% of Orange County.

Figure 2. Providence Mission Hospital's Total Service Area



Community Demographics

POPULATION AND AGE DEMOGRAPHICS

Of the over 581,000 permanent residents in the total service area, roughly 43% live in the high need area, defined by lower life expectancy at birth, lower high school graduation rates, and more households at or below 200% FPL compared to census tracts in the total service area. For reference, in 2021, 200% FPL is equivalent to an annual household income of $53,000 or less for a family of 4. These households are more likely to regularly make spending tradeoffs regarding utilities, rent, groceries, medicine, and other basic expenses. The population in Mission Hospital's total service area makes up 18% of Orange County.

The male-to-female distribution is roughly equal across geographies. Individuals ages 18-34 and 65 and older are more likely to live in high need census tracts.

POPULATION BY RACE AND ETHNICITY

Individuals who identify as Hispanic, Asian, Black/African American, and "other" race are overrepresented in high need census tracts compared to the Mission service area overall. People identifying as white are less likely to live in high need census tracts.

SOCIOECONOMIC INDICATORS

Table 1. Income Indicators for Orange County Service Area

Indicator	Broader Service Area	High Need Service Area	Total Service Area	Orange County
Median Income Data Source: 2021 American Community Survey, 5-year estimate	$144,199	$102,029	$126,073	$100,429

The median income for the total service area for Mission Hospital is about $25,000 higher than Orange County overall. There is over a $42,000 difference in median income between Mission Hospital's Broader Service Area and the High Need Service Area.

Full demographic and socioeconomic information for the service area can be found in the 2023 CHNA for Mission Hospital

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

Improving the health of our communities is foundational to our Mission and deeply rooted in our heritage and purpose. Our Mission calls us to be steadfast in serving all, with a special focus on our most economically poor and vulnerable neighbors. This core belief drives the programs we build, investments we make, and strategies we implement.

Knowing where to focus our resources starts with our Community Health Needs Assessment (CHNA), an opportunity in which we engage the community every three years to help us identify and prioritize the most pressing needs, assets, and opportunities.

In 2023, Mission Hospital, St. Joseph Hospital and St. Jude Medical Center collaborated to conduct an Orange County- wide assessment of community needs and strengths. Over the course of six months, seven focus groups were held with different micro-communities, a key informant survey was implemented, individual sessions were held with each hospital's executive leadership team, and hospital caregivers had an opportunity to provide input on priority areas.

Description of Community Input

To better understand the unique perspectives, opinions, experiences, and knowledge of community members and other key stakeholders, representatives from Providence Orange County in partnership with Charitable Ventures carried out three approaches for gaining community input: 1) community listening sessions, 2) a key informant survey and 3) dialogue sessions with leaders from each of the three Providence Orange County Hospitals.

Eight listening sessions were held with specific communities who have unique needs: Asian American/Native Hawaiian/Pacific Islander (AANHPI), Black/African American, Individuals with Disabilities, Older Adults, Korean speaking, Spanish speaking in South Orange County, and Vietnamese speaking. These sessions were held online as well as in person, in settings that were most accessible for participants. They were conducted in partnership with trusted messenger organizations with unique connections as well as language skills to reach community members. During these sessions, the needs, issues, barriers, visions for health, community strengths, and ideas for innovation, collaboration, and the pursuit of equity were discussed. Seven sessions were directed toward residents, with one particular to a community specific to the Mission Hospital service area (South Orange County – Spanish Speaking), and one was toward providers to AANHPI community.

The key informant survey was distributed widely to faith- and community-based organizations, school districts and educational institutions, Federally Qualified Health Centers (FQHC), medical centers, law enforcement, city representatives, government agencies, and other providers and leaders knowledgeable about community health. Finally, feedback from Providence Leadership was also obtained.

Our public health agency, the Orange County Health Care Agency, was engaged through key informant

surveys and was represented in Mission Hospital's Community Health Committee where priority areas were identified. Our Community Health Investment leaders maintained close communications with key Orange County Health Care Agency staff who were conducting a coinciding needs assessment for Orange County. The OC Health Care Agency Office of Population Health and Equity Priorities for 2023- 2028 and the 2020-2022 Orange County Health Improvement Plan were reviewed and used as a reference to ensure alignment with county public health findings and priorities.

Below is a high-level summary of the findings of these sessions and survey.

Community Listening Session Findings

The eight (8) listening sessions were completed between July 24 and August 9, 2023. Discussion centered around community needs, community strengths, and visions for a healthy community. Across the eight listening sessions, some common themes emerged.

Participants discussed their most relevant health needs, the barriers to meeting those needs, their visions for healthy communities, and community strengths. Overwhelmingly, aspects of access to health care were identified across all groups. This included affordability; lack of coverage for the immigrant population; training and support to navigate the health care system (including the transition between pediatric and adult care for those living with disabilities, particularly); timely access to care – including long waits in the emergency room or to see specialists; a need for chronic disease management; and advanced dental care needs. Cultural and linguistic competency and responsiveness, as well as transportation, were also discussed as barriers. Some participants expressed that hospitals do not always have relationships with the community, but rather it is the community-based organizations that have relationships. Thus, there is an opportunity to enhance partnerships with community-based organizations to engage the community where they are at.

Mental health care was mentioned across six of the listening sessions. Specifically, participants discussed general mental health care/access with attention to older adults living in nursing homes; guidance for parents with kids who are coming out as LGBTQIA+; and support for community members who experienced trauma, violence, and displacement. In addition, there continues to be resistance to mental health services by those in need due to stigma, which is often culturally specific. Regarding youth activities, there is an interest in engaging youth in activities, access to mental health services and providing activities in community spaces to reduce drug and alcohol access and use.

Cultural competency was noted in five listening sessions, including the need to understand the diverse communities in Orange County by race/ethnicity, language, gender, ability, and religious/spiritual beliefs and the intersectionality of these various aspects. Participants also spoke about the need to address **isolation** – particularly among older adults and older adults whose primary language is not English. There was a sense that these individuals are isolated in terms of mobility and in their ability to engage and socially interact with others.

Housing was brought up in three listening sessions. Specifically, the identification of a need for affordable and adequately sized housing to accommodate larger families, not just small nuclear families.

Transportation was noted in general, with some mentioning the long distance to health care facilities; transportation needs for older adults and especially those with limited English (noting not just a need for transportation for these individuals but also in-language supports with the driver and scheduling); and for those individuals who use a wheelchair. Lastly, **employment** was identified in two listening sessions. The need to access employment agencies and to provide work and/or training opportunities to adults who worked manual labor for their careers and are no longer able to keep this up physically was shared by respondents.

A table of the needs by micro community is below.

Table 3. Unmet Health Needs by Micro-Community

	AANHPI	Black/ African American	Individuals with Disabilities	LGBTQIA	Older Adults	Korean	Spanish-speaking OC	Vietnamese	Totals
Healthcare access	X	X	X	X	X	X	X	X	**8**
Mental Health	X		X	X		X	X	X	**6**
Cultural Competency	X	X	X	X			X		**5**
Isolation				X	X	X	X		**4**
Housing	X	X			X				**3**
Transportation					X	X		X	**3**
Employment		X					X		**2**

In discussing community strengths, participants overwhelmingly shared the resources available through **community-based programs and organizations.** These resources included churches, schools, non-profit organizations, and other organizational partners. Participants also noted that community presence and voice were strengths. An example was the growing size of the Asian American and Native Hawaiian/Pacific Islander (AANHPI) population and how this was a strength due to increased political voice and more leadership roles. Another example was how residents and community organizations came together to improve the community and to create change – in particular, aligning with other groups to show support and to help each other. Civic engagement, specifically voting, was noted as a way to change systems and to promote access.

Cultural competency and **patient/health care navigation** were also noted as community strengths. Some communities mentioned that mental health access is improving through in-language therapists and peer groups, and health care providers who speak their clients' language (specifically Vietnamese), and phone interpretation were helpful to accessing care. Lastly, two listening sessions noted that **navigator programs** have helped to increase access to services and to address language barriers.

Table 4. Strengths by Micro-Community

	AANHPI	Black/African American	Individuals with Disabilities	LGBTQIA	Older Adults	Korean	Spanish-speaking	Vietnamese	Totals
Community-based organization/ program	X	X	X	X	X	X	X	X	**8**
Community presence/ voice	X			X			X		**3**
Cultural Competency				X				X	**2**
Patient Navigation	X							X	**2**

Lastly, regarding the **vision** for a healthy community, participants unanimously shared the need for access to health care that is affordable, quality, and timely. Participants identified the following themes for a healthier community: access to medical care with health coverage; diversity, equity and inclusion practices in hospitals that cascade out to the community; better access – to mental health, registered nurses in local clinics; shorter wait times to see providers; access to specialists; and more services that are local – not only in Central Orange County.

Participants from the micro-communities shared that communities that care for each other, take care of each other, and come together, contribute to a healthy community. For them, a caring community includes one that has safe and affordable housing; access to affordable and nutritious food; and community safety. Participants spoke of safe and affordable housing for all, including seniors. They mentioned accessible fresh, nutritious, and culturally-appropriate foods that were available locally at farmers markets and grocery stores – spaces within walking distance.

Table 5. Visions for a Healthy Community by Micro-community

	AANHPI	Black/African American	Individuals with Disabilities	LGBTQIA	Older Adults	Korean	Spanish-speaking	Vietnamese	Totals
Access to health care	X	X	X	X	X	X	X	X	**8**
Cultural Competency			X	X	X	X	X		**5**
Community that cares for each other	X	X		X	X				**4**
Safety		X			X	X	X		**4**
Access to Affordable Food		X		X	X				**3**
Access to Safe and Affordable Housing		X		X	X	X			**4**
Transpor-tation		X		X		X			**3**
Patient Navigation	X		X						**2**

Priorities

Based on input from participants across the eight listening sessions, the following priorities were identified for consideration. They are generally categorized in descending order of relevance, with those recognized as needs by more micro-communities as first priorities and those recognized as needs by fewer micro-communities as later priorities.

1. Promote timely access to specialist care.
2. Provide healthcare options for immigrant, uninsured populations (access to primary care, specialists, mental health, and oral health).
3. Bolster mental health services including therapists who speak the language and understand the culture, cultural health practices, and immigration history/experiences of the community.
4. Improve cultural competency so that there are providers who understand the needs of the specific Community and speak the language(s) of the local community (e.g., understand the historical relationship of the community with the health system, have immigration history/experiences, deliver culturally Appropriate treatment, etc.).
5. Addressing isolation for populations including people identifying as LGBTQIA+, older adults, South OC Spanish speakers, and Korean older adults.

6. Promote access to safe and affordable housing, including addressing the needs of older adults and large families such as those with eight to ten family members in a household.
7. Promote affordable and accessible transportation, including language support for scheduling and communicating with the drivers.
8. Chronic disease management, particularly in the local community. 9. Establish relationships with community as well as CBOs.
9. Promote safe and clean neighborhoods.
10. Promote access to affordable, fresh, nutritious food.
11. Specific to South OC Spanish Speaking: Address long distance from language-specific healthcare facilities (e.g., resources are primarily in Central Orange County), by providing more South County resources.

Key Informant Survey Findings

Key informants were invited to participate in a survey about health assets and needs in their communities. Key informants included faith and community-based organizations, school districts and educational institutions, Federally Qualified Health Centers (FQHC), medical centers, law enforcement, city representatives, government agencies, including the Orange County Health Care Agency (our public health agency), and other providers and leaders knowledgeable about community health. The survey aimed to gather feedback to navigate and further understand the key issues explored through resident listening sessions.

Based on principles of community health and previous CHNAs, Providence identified potential unmet health needs, which were organized into five broad categories: Basic needs, Access to care, Environment and Community, Public Safety, and Education. Each category of need included sub-categories. Key informants were asked to comment on the top needs, strengths, and ways that Providence could leverage community strengths. They responded to a series of Likert-scale and open-ended questions. The Likert-scale used was 1-4 (1: Not at all a need, 2: Somewhat of a need, 3: An important need, 4: A top need). Individuals also shared the key populations they serve, and the locations of their service corresponding to all three Providence Orange County service areas.

A table indicating all service area unmet health needs is below.

Table 6. Detailed Unmet Health Needs from Key Informant Survey

Unmet Health Needs	Score (out of 4)
Basic Needs Overall Score	3.4
Affordable housing	3.7
Economic insecurity (lack of living wage jobs and unemployment)	3.5
Food insecurity	3.4
Homelessness	3.3
Access to safe, reliable, affordable transportation	3.0
Access to Care Overall Score	3.1
Behavioral health challenges and access to care (includes both mental health and substance use disorders)	3.7
Culturally and linguistically concordant services	3.3
Access to health services	3.2
Access to dental care	3.1
Aging concerns and issues (e.g., cognitive decline / dementia, mobility, etc.)	3.0
Disability inclusion	2.9
Chronic disease	2.9
Obesity	2.8
Environment and Community Overall Score	2.7
Lack of community involvement and engagement	3.0
Environment concerns (e.g., extreme heat, smoke / air quality, clean water access)	2.8
Few community-building events (e.g., arts and cultural events)	2.5
Public Safety Overall Score	2.7
Racism and discrimination	3.2
Domestic violence, child abuse / neglect	3.0
Gun violence	2.7
Community violence; lack of feeling of safety	2.7
Safe streets for all users (e.g., crosswalks, bike lanes, lighting, speed limits)	2.6
Safe and accessible parks / recreation	2.6
HIV/AIDS	2.0
Education Overall Score	1.8
Job skills training	2.1
Bullying in schools	2.0
Opportunity gap in education (e.g., funding, staffing, support systems, etc. in schools)	1.8
Affordable childcare and preschools	1.4

Additional Detail Related to Unmet Health Needs

Key informants were given multiple opportunities to share about the needs that they have identified as critical in their communities. The following are summaries of those specific additional needs.

- Mental Health Services for and related to:
- People with a substance use disorder, particularly fentanyl
- Detox and treatment beds
- LGBTQIA+ affirming and linguistically competent health and mental care for all ages
- Immigrants with undocumented status
- Young people experiencing Adverse Childhood Experiences (ACEs)
- Individuals experiencing loneliness, isolation, and disconnectedness
- Support for families with children who are diagnosed with Autism and ADHD
- Trauma care for older adults

- Housing:
- Safe and encouraging homes for people with disabilities
- Lack of affordable workforce housing for families with low incomes
- Providing a living wage to frontline workers
- Living conditions in rental housing and overcrowding in these homes
- Lack of city code enforcement on the quality of homes
- Available housing for families with low incomes

- Healthcare:
- Access to an entire system of health and behavioral health at all levels of care
- Lack of affordable health clinics
- Sexual and reproductive health care for young people
- Need for more pediatric disability service providers
- Specialty care for individuals without insurance (neurology, dental, high-risk OB patients, etc.)
- Culturally responsive health education
- Recruiting ethnically diverse healthcare workers
- Access to specialty care (i.e., neurology, ear-nose-throat, oncology) and access to dental specialists

- Community:
- Lack of social connection
- Lack of community involvement and engagement
- Need for broad community education on cultural norms and increase cultural sensitivity to diverse populations
- South County has extremes in the populations of those served, from those with very low incomes to very high incomes, which can create conflict and an unhealthy environment
- Lack of bicultural or bilingual Vietnamese speaking law enforcement officers and teachers/administrators
- Continuing drift between communities – lack of belonging for individuals.

Significant Community Health Needs Prioritized

In the priority-setting process at Mission Hospital, a special community listening, and recommendation session was held with 29 individuals representing a cross-sector of non-profits, residents, healthcare leaders and the health care agency. The community health committee met to review those recommendations
in mid-October 2023 and made final decisions based on identified criteria. The 2023 CHNA was approved by the MH Community Health Committee on November 14, 2023.

The following criteria were used in the prioritization process:

- Worsening trend over time
- Disproportionate impact on low income and/or Black/African American, Brown, Indigenous, and People of Color (BBIPOC) communities
- Providence service area/high need service area rates worse than state average and/or national benchmarks
- Opportunity to impact organizational commitment, partnership, severity, and/or scale of need
- Alignment with existing System priorities

Based upon the scoring system and discussion, MH's Community Health Committee identified the following priorities:

PRIORITY 1: ACCESS TO CARE

Access to care goes beyond medical care, and includes dental, vision, primary care, transportation, culturally appropriate care, and care coordination. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

PRIORITY 2: BEHAVIORAL HEALTH

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

Substance use/misuse occurs when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and inability to meet major responsibilities at work, school, or home. Substance use/misuse includes the use of illegal drugs and the inappropriate use of legal substances, such as alcohol, prescription drugs and tobacco. Strategies to address mental health and substance use disorders have a potential to be a catalyst to further our work and mission of reducing stigma and creating a safe place for care.

PRIORITY 3: ECONOMIC SECURITY

An individual's income is directly connected to poverty. If a person or family's total income is less than certain federal poverty measures, then they are considered to be in poverty. People with steady employment are less likely to live in poverty and more likely to be healthy. People with disabilities, injuries, or conditions like arthritis may be especially limited in their ability to work. In addition, many people with steady work still don't earn enough to afford the things they need to stay healthy.
Employment programs, career counseling, and high-quality childcare opportunities can help more people find and keep jobs. In addition, policies to help people pay for food, housing, health care, and education can reduce poverty and improve health and well-being.

Needs Beyond the Hospital's Service Program

No hospital facility can address all of the health needs present in its community. We are committed to continuing our Mission through partnering with like-minded partners with the capacity and expertise to address the needs of Orange County residents and when possible, by funding other non-profits through our internal funding program.

Furthermore, Providence Mission Hospital will endorse local non-profit partners who apply for funding through the St. Joseph Community Partnership Fund. Organizations that receive funding provide specific services and resources to meet the identified needs of underserved communities throughout the Orange County service area.

The following community health needs identified in the ministry CHNA will not be addressed due to limited funds and capacity and to ensure a focused approach to the three CHIP priorities. An explanation is provided below:

- ***Culturally and linguistically concordant services***: While this was not selected as a priority issue, Mission Hospital works to integrate culturally and linguistically concordant services in its community-based programming as well as provide interpreter services for multiple languages in its hospital-based settings.
- ***Isolation:*** Mission Hospital does not directly address issues of isolation in the community; however, it works with local organizations who address this through community building and other community-based outreach.
- ***Housing***: Mission Hospital does not directly address housing; however, we partner with several South County organizations with expertise in housing.
- ***Access to safe, reliable, affordable transportation***: Mission Hospital currently funds Age Well Senior Services to provide senior non-emergency transportation.
- ***Access to dental care***: Mission Hospital does not directly provide dental services; however, we partner with local Federally Qualified Health Centers who offer this service.
- ***Aging concerns and issues***: Compared to other priorities facing the community, this issue was not selected. Mission Hospital funds Age Well Senior Services to provide non-emergency medical transportation to those needing access to medical services in South Orange County.
- ***Food insecurity***: Mission Hospital does not directly address food insecurity; however, we partner with community organizations that help to address this issue.
- ***Domestic violence, child abuse/neglect:*** Mission Hospital does not directly address domestic violence; however, we partner with community organizations who specialize in domestic violence and child abuse/neglect through our operation of two-Family Resource Centers.

In addition, Providence Mission Hospital will collaborate with local organizations that address the above-mentioned community needs to coordinate care and referrals to address these unmet needs.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

The development of the Community Health Improvement Plan (CHIP) occurred in early 2024 and incorporated feedback from community partners, Community Health Department caregivers and leadership, and was conducted in tandem with the Orange County Health Care Agency's CHIP development process. In creating the plans, Providence Mission Hospital incorporated evidence-based practices, considered programs currently addressing prioritized needs, and reviewed internal resources to contribute toward new goals.

The CHIP was presented and approved by the Providence Mission Hospital Community Health Committee on March 26, 2024.

Addressing the Needs of the Community: 2024- 2026 Key Community Benefit Initiatives and Evaluation Plan

2025 Accomplishments

COMMUNITY NEED ADDRESSED #1: ACCESS TO CARE

Population Served

- Underserved, uninsured/underinsured communities in South Orange County.

Long-Term Goal(s)/ Vision

- To improve access to health care and preventive resources for people with low incomes and those uninsured by deploying programs to assist with navigating the health care system.
- To ease the way for people to access appropriate and culturally responsive levels of care at the right time.

Table 2. Strategies and Strategy Measures for Addressing Access to Care

Strategy	**Population Served**	**Measure**	**Baseline**	**FY25 Accomplishments**
Ensure seamless transition to Medi-Cal & Increase primary care through local FQHC partnerships	Newly Medi-Cal eligible FQHC patient population. Uninsured and underinsured residents in South OC	Newly Medi-Cal eligible FQHC patient population. Total # of unique patients Total # of visits annually FQHC patients enrolled in health insurance	FY2023: 1,163 people enrolled FY2023: 15,673 FY2023: 63,848 FY2023: 7.4% conversion rate	785 16,767 59,128 4.7%
Educate residents/patients about Financial Assistance Program (FAP)	Low-income, under-resourced residents	# people educated increase in FAP utilization at FRC and other community events	0	2,267
Support Avoidable ED Navigation Program to provide comprehensive intervention	Medi-Cal/ CalOptima patients	# of patients with AED visits supported by Community Care Navigator (CCN) # of patients supported by Community Nurse Navigator (CNN)	215 No Baseline	259 927

Strategy	Population Served	Measure	Baseline	FY25 Accomplishments
Support patients with the diagnosis of SEPSIS by facilitating care across the health care continuum	Limited English Proficiency (LEP speaking patients being treated for sepsis	# of patients supported by Sepsis Nurse Navigator (SNN)	New Service No Baseline	74 (May-June 2025)
Post-Discharge Bridge Housing Program which includes services to transition clients to housing and connecting them to social support services	Patients served through bridge housing program	# patients served	77	177
Strengthen resident empowerment through Community Building Initiatives	Low-income Family Resource Center clients	# residents engaged in community action committees # activities completed by resident groups annually	24 12	26 25
Continue South OC for All collaborative	Residents & neighborhoods identified through the collaborative	# partners engaged System/ neighborhood changes made as a result of collaborative efforts	10 2	14 3

Evidence Based Sources

Strategies for expanding health insurance coverage in vulnerable populations - Healthy People 2030 | health.gov

County Health Rankings and Roadmaps Evidence-based Strategies: What Works for Health

Resource Commitment

$2.3 million per year in operating and staffing support for all access to care initiatives in 2024- 2026.

Key Community Partners

Camino Health Center, CalOptima/CalAIM, Kaiser, CHIOC, Coalition of Community Health Centers, Laguna Beach Community Clinic, South OC for All collaborative partners, UNIDOS South OC, CHEC & SOC Family Resource Centers, St. Joseph Community Partnership Fund, Public Law Center, Friendship Shelter, OC United Way, AgeWell

2025 Accomplishments:

Ensure seamless transition to Medi-Cal: In FY 25, the two Family Resource Centers facilitated the enrollment of 785 clients through their partnerships, underscoring their role as vital community hubs. These Family Resource Centers serve as trusted points of contact where community members can access information and assistance regarding health insurance, particularly Medi- Cal. Many clients benefit from immediate assistance, including on-the-spot application assistance for Medi-Cal.

Additionally, Community Health Advocates engaged with 2,267 residents of South Orange County, providing crucial education on Medi-Cal expansion. This outreach effort highlights the ongoing commitment to community education and support, ensuring that residents are informed about healthcare options and resources available to them. These initiatives collectively strengthen community ties and enhance access to essential healthcare services.

Continue the Care Navigation program. The Care Navigation Program continued for its 7th year to create a continuum of services for patients who are homeless. In FY25, the Care Navigators spent most of their time focusing on patients who were homeless, resulting in significantly more patients being served than in prior years (in FY21, our navigators served 43 unhoused patients and in FY22, this increased to 77 patients). In FY25, Community Care Navigators engaged with 259 patients after discharged from the hospital. This includes people who are uninsured or under-insured, homeless, experiencing chronic medical problems, and demonstrate severe mental illness or substance use. 999 encounters were provided for these clients over the course of FY25. 192 clients out of the 259 clients (74%) were homeless individuals. 177 of those (92%) were referred to a hotel, recuperative care, or shelters for transitional, temporary or long-term care housing.

This provides stability and a safe place to be while bridging the clients to other options and community resources. 39 individuals were referred to Mission Hospital's Family Resource Centers for mental health, legal, health care coverage, income and or community involvement to provide stability and a sense of community. Over 90 individuals were provided transportation through CalOptima transportation or Uber services and bus passes to access services through DMV, SSA, Medical appts, and housing opportunities. This increases access to services that address basic needs, medical care services, and to obtain documentation needed for housing options. In FY25, our navigators referred 72 clients to the new Cal Aim program for

supportive services, housing navigation, and recuperative care, a nearly 160% increase over FY22. All these supportive services are provided to improve the quality of life for residents who have access to care issues while also reducing unnecessary emergency department visits and admissions. Of the 259 clients served in FY25, over 70% were successfully discharged from the program because they received services that addressed their social and health care needs and showed significant improvement in access services and reduced their ED visits. The remaining clients continue to receive services until they are socially and medically stable. In FY25, Mission Hospital had 72 patients in custodial care.

Providence Mission Hospital continued its housing mitigation program with Family Assistance Ministries (FAM) and Friendship Shelter. Our Mission Hospital Community Care Navigators (CCNs) referred a total of 89 clients to these short-term programs to support our clients who are unhoused. The FAM program took in 43 clients in FY25. These clients had a total of 693 nights at a hotel. The CCNs supported 14 clients in the partnership with Friendship Shelter, clients in that program were provided with 2,013 total nights at the shelter. In addition, Friendship Shelter assisted 32 clients with a total of 598 hotel nights. During their stay, the CCNs, with other community partners, provided supportive services that included coordinating medical care appointments, mental health services, substance use program referrals, transportation, crisis management, SSA/SSI services, and bridging clients to transitional housing options or shelters. Both the FAM and Friendship Shelter programs help to reduce avoidable emergency department visits, provide temporary shelter to residents who are unhoused in South Orange County, and connect residents to multiple social and medical services that enable them to reach a higher level of independence.

South Orange County Equity Collaborative: In 2020, Providence brought together key leaders in South Orange County to discuss how collectively we can create change that supports low- income residents. In January 2021 the South Orange County Equity Collaborative (SOCEC) was established with 11 agencies in Mission Hospital's service area, with Mission Hospital acting as the backbone agency for this effort. We renamed our collaborative to South OC For All in May 2023. The trajectory of the collaborative continued to evolve significantly during FY25.

South OC for All leverages stakeholder relationships to increase sustainable infrastructure, create funding and investment strategies supporting historically underserved neighborhoods, provide increased access to Social Services that support residents' wellness, and drive city and county-wide advocacy efforts on behalf of South County residents.

The award of the Equity in OC Health Equity grant to the collaborative in November 2022 ignited mobilization around the collaborative's first project. A CDC grant implemented through OC United Way on behalf of OC Health Care Agency, the project allowed the collaborative to collectively tackle multiple strategies corresponding to Social Determinants of Health as part of their "Housing is Health: Addressing Housing Disparities" grant project.

The Equity in OC grant project provided the template, tools and resources to extend South OC For All's long-term reach as a community centered and locally activated network. Residents continue to play a central role in directing local advocacy efforts to create community and systems change and provide ongoing insight and feedback on collaborative initiatives.

South OC for All's primary success in FY25 was to establish a cohesive collaborative engagement structure that has fulfilled complex, integrated scopes of work among diverse implementation teams. Two new

partners joined these efforts, Camino Health Clinic and CalOptima. Also, by joining the CACHI OC Network of Care, local priorities like housing stability and health were better supported. Enhanced infrastructure and data sharing now connect efforts to community needs. In February, the South OC Immigration Committee launched South OC for All's first pilot group, offering updated resources in response to changing needs from immigrant residents. Mutual trust, resident engagement and community voice are centered in each aspect of the sustained efforts we take forward beyond our first collective project, completed in May of 2024.

The collaborative's mission and vision have been implemented through increased staff participation and development, cross-collaboration and alignment of strategic partnerships across the county, and the creation of digital and data support tools. The collaborative developed a shared approach for coordinated advocacy on behalf of community members affected by persistent health inequities caused by concentrated areas of need and by geographic and logistical barriers to resources.

Camino Health Center: In FY2025 Camino Clinics provided care to 16,767 unique patients, underscoring its continued dedication to delivering accessible, high-quality healthcare. Of these patients, 60% were female and 40% were male. The ethnic composition of the patient population included 8,283 individuals identifying as Hispanic/Latino, 5,057 as non-Hispanic/Latino, and 3,427 who chose not to disclose their ethnicity. Reflecting the cultural and linguistic needs of the community, 46% of patients primarily spoke Spanish—a need that Camino effectively met through its predominantly bilingual staff.

Economic hardship remained a significant barrier for the majority of patients served. Data shows that 85% of individuals, representing 14,252 patients, were living at or below 200% of the federal poverty level. This indicates that most of those we serve face persistent financial challenges that can directly impact their access to healthcare, stability, and overall well-being.

Two key policy changes—the Medi-Cal expansion for adults age 50 and older and the full-scope Medi-Cal expansion for adults ages 26 to 49—significantly broadened access to healthcare coverage. As a direct result of these statewide initiatives, Camino saw a substantial decline in uninsured patients, with only 13% of its patient population remaining uninsured. This notable reduction highlights the positive impact of expanded healthcare policies in increasing access to care and reducing financial barriers for the community.

In total, Camino recorded 73,526 visits across its medical, dental, behavioral health, and optometry departments. The organization's strong commitment to pediatric care was also evident, with services provided to 2,403 children under the age of 18. These numbers reflect Camino's broad scope of care and dedication to meeting the diverse health needs of its community.

Our dental department remains a leader in prevention, with a particular focus on children ages 6–9 at risk for cavities. Every child is closely monitored and recalled on time to receive dental sealants on their first permanent molars, an important step in protecting their long-term oral health.

The prenatal program also continued to make a meaningful difference in the community, marked by a 16% rise in appointments. This growth reflects the increasing demand for services among pregnant women and underscores the vital role of early prenatal care in ensuring healthier pregnancies. By supporting mothers from the earliest stages, the program helps lay the foundation for positive health outcomes for both mothers and their children.

Patient well-being remained a guiding priority at Camino. Nearly all adult patients (98%) were screened for

tobacco use, underscoring the organization's emphasis on prevention. Mental health also remained a central focus, with depression remission screenings at twelve months rising 6% compared to the prior year. Recognizing the lasting effects of childhood trauma, Camino further expanded its services by introducing ACES (Adverse Childhood Experiences) screenings, ensuring a more holistic, compassionate, and trauma-informed approach to care.

The medical department also achieved measurable progress in FY2025. Preventive care efforts led to a 4% increase in breast cancer screenings, ensuring more patients received this critical service. Chronic disease management improved as well, with controlled blood pressure rates rising from 57% to 61%. These gains demonstrate Camino's dedication to helping patients live healthier lives through proactive prevention and effective management of long-term conditions.

Strengthen resident empowerment through Community Building Initiatives: In FY 25, our Community Engagement Action Committees (CEAC), formed through partnerships among multiple agencies and community members, significantly expanded their impact and participation. These committees, operating at each Family Resource Center, aim to foster collaboration and achieve positive outcomes for the populations they serve. They work together to address local issues and opportunities through shared resources, responsibilities, and joint planning efforts. During FY 25, the number of participating community action committees engaged 26 residents, indicating sustained engagement and commitment to their shared goals. These committees focused on enhancing their understanding of local community needs and developing leadership skills among members. Throughout the fiscal year, the community action committees actively participated in and led 25 events. These included 11 monthly food distributions, 2 community outreach initiatives, and 12 events hosted at our Family Resource Centers. Their involvement underscores their role in strengthening community ties, providing essential services, and promoting community leadership and engagement.

COMMUNITY NEED ADDRESSED #2: BEHAVIORAL HEALTH (INCLUDING SUBSTANCE ABUSE)

Population Served

Underserved residents living in South Orange County.

Long-Term Goal(s)/ Vision

- To ensure equitable access to high-quality, culturally responsive, and linguistically appropriate.
- Mental/behavioral health services, especially for populations who are on the margins and are low income.
- Reduce mental health stigma in the community.
- Decrease 30-day ATOD usage rates by 9th and 11th grade teens in targeted high schools.

Table 3. Strategies and Strategy Measures for Addressing Behavioral Health

Strategy	Population Served	Measure	Baseline	FY25 Accomplishments
Promote Each Mind Matters Campaign/Green Bench OC among community partners	Low-income communities with an emphasis in Latino and Vietnamese households.	# of residents active on the EMM & Green Bench OC social media sites # of new green benches installed in key/high traffic locations.	FY23: 4,005 residents 29 green benches since 2021	26,684 encounters includes residents active on social media sites and in person with 3,029,050 media impressions. A total of 29 benches painted and installed
Expand MAT Program in Emergency Department by promoting free Naloxone Program	Patients with opioid use disorder	# of patients and/or community at large who receive Naloxone prescription in the ED	FY23: 450 patients served	108 (July2024-February2025)
Provide mental health services: Including therapeutic, psychoeducational, psychiatric,	Low-income residents with an emphasis on Latino families	# unique clients served annually % of clients who complete>6 therapeutic sessions Reduction inGAD7 scores to patients completing at least 6 sessions	FY23: 641 No Baseline FY223: 72.9%	336 34% 16%

Strategy	Population Served	Measure	Baseline	FY25 Accomplishments
Or support group services served through the Family Resource Centers (FRC)		Reduction in PHQ9 scores (for patients completing at least 6 sessions)	FY2023: 79.4%	16%
Provide Free Psychiatry services	FRC clients needing psychiatry support	# of unique patients who receive psychiatric evaluation and medication management. # of encounters	100 110	41 59
Implement Youth Substance Use Prevention Program	Youth	30-day ATOD usage rates per California Healthy Kids Survey	LBUSD 2019/20: 9th - 20% 11th - 36% CUSD 2019/20: 9th - 11% 11th - 27%	LBUSD 2023/24: 9th - 11% 11th - 22% CUSD 2023/24: 9th - 7% 11th - 19%

Evidence Based Sources

Psychological therapies for women who experience intimate partner violence - Healthy People 2030 | health.gov

Tobacco Use: Community Mobilization with Additional Interventions to Restrict Minors' Access to Tobacco Products - Healthy People 2030 | health.gov

Fostering Healthy Mental, Emotional, and Behavioral Development in Children and Youth: A National Agenda (2019) - Healthy People 2030 | health.gov

Resource Commitment

$1.2 million per year in operating and staffing support for all mental health/substance use initiatives in 2024-2026.

Key Community Partners

Capistrano & Laguna Beach Unified School Districts, Saddleback College, partners working within the CHEC & South Orange County Family Resource Centers, St. Jude Medical Center, St. Joseph Hospital Orange, Westbound Communications, Limerent Communications, Boys and Girls Club-Laguna Beach, Capistrano Valley High School, Laguna Beach Unified School District Family Resource Center, Laguna Beach High School, Laguna Beach Police Department, Orange County Health Care Agency, San Clemente High School, Thurston Middle School and the Wellness and Prevention Center.

2025 Accomplishments

Mental Health Services

Mental health services continue to be a great need among the south orange county community. Mental health includes our emotional, psychological, and social well-being, and managing life stressors.

Although a full-time clinical team member was on leave, the clinical team, including MSW/MFT Interns, served 336 unique clients through all counseling modalities (individual, family, couples, and groups), and provided 1796 counseling encounters and 763 group encounters throughout the year. There were several new groups that were offered such as Women's Self Esteem, Coping through Art, Self-Expression through Art, Grief and Loss for adults and children, a Teen and Child Empowerment group, and a Mother's Support group. The ongoing groups, such as the Men's Support Group, and the Women's Crocheting Group provided a safe environment for men and women to create comradery and learn new skills.

Clients showed a significant reduction in symptoms of depression and anxiety by the end of treatment. Aside from mental health concerns, the community is also faced with the lack of basic resources such as hygiene items, food resources, utility bill assistance, and rental assistance, as well as housing. Clients in our mental health program can receive individual, child, couple, family therapy; case management; psychoeducational or support groups; and psychiatric evaluation and medication management. The Community Health Department seeks to reduce the barriers for clients to connect with mental health services. The option to have virtual sessions made it possible for more clients to access counseling sessions. The Family Resource Centers provides counseling clients with Uber services that reduce transportation barriers. In addition, psychiatry services enhance a clients' well-being, as they can cope better with the stressors of daily life, have healthy relationships, work productively, and contribute to their family and community. Psychiatry is normally not accessible to the population whom we serve. The Family Resource Centers (SOC-FRC and CHEC-FRC) provide this service free of charge to any client interested in medication management or consultation. The program delivers high quality medication management, diagnosis, and prevention of symptoms escalating, in combination with counseling treatment, 41 clients received integrated care with a total of 59 encounters. In FY25, we hosted 10 graduate-level Interns from universities across the country. In addition to counseling, interns also assisted with mental health intake screenings, case management for adults and led

several support groups for men, women, teens, and children.

In FY25, Providence Mission Hospital and Capistrano Unified School District continued a positive partnership established in FY22, to support the Alternative to Suspension Program. This program teaches skills to at risk students to improve their mental health well-being, increase positive behavior, and create healthy relationships. Two Interns led weekly workshops to support 59 students with problem solving, goal setting, communication, healthy relationships, communication, conflict mediation, and stress management.

Measurable Improvement in Mental Health

Depression and anxiety continue to be prevalent among our community. Accessible mental health support is provided through counseling, groups, psychiatry services, and case management at the Family Resource Centers. The CDC reported that depression may lead to an increased risk for physical health problems, diabetes, heart disease, and stroke. According to Mental Health America (MHA)'s 2022 California mental health statistics, one in five adults in California struggles with a mental illness. It is imperative to support the community with preventive care and interventions to reduce anxiety and depression, and to help clients manage stressors to live healthier, more fulfilling lives. 1 6 % of therapy clients with a PHQ-9 score of 10 or greater showed a significant decrease in depression by the end of treatment, PHQ-9 scores between 10-15+ points indicate moderate to severe depression. We found that 16% of the total clients improved their scores in the GAD-7, GAD-7 scores between 10-15+ indicate moderate to severe depression. 62% of therapy clients met or partially met their collaborative treatment plan goals, which increased as compared to the prior years. 34% of clients completed 6 or more sessions, which reflects an increase in client retention.

Mental Health Stigma Reduction

The Promise to Talk campaign uses communication strategies such as local outreach programs, community events, public relations and social media to reduce mental health stigma within Orange County. Each Mind Matters/Promise to Talk acquired 3M impressions across all social media and web platforms during FY25. The year ended with 24,684 residents active in social media.

A key component of the Promise to Talk campaign is the Green Bench OC movement. For the past three years, we have been working with community partners to have them paint green benches at their locations. Local organizations like the Diocese of Orange, El Sol Academy and Be Well OC, all have painted/installed benches at their locations. In total, through the Green Bench OC initiative, 29 lime green benches have been painted /installed at schools, churches, parks and mental health rehabilitation centers to encourage conversations about mental health. The Promise to Talk team attended two May Mental Health Month in-person events, Día Del Niño hosted by UNIDOS South OC, and a Cinco De Mayo celebration hosted by Bower's Museum, to foster strong connections and a positive impact with community members. The Promise to Talk booths host a green bench photo opportunity, lime green branded giveaways free and flyers with free or low-cost mental health resources and activity sheets. The in-person events drive guests to our websites and social media pages allowing our message a wider reach with our targeted audience. In addition to in-person outreach, EMM created Back-To-School Toolkit for parents to help their children navigate their emotions while integrating into a new school year. This campaign allows us to continue having important conversations with members of the community and create interest around the stigma reduction movement.

The MAT (Medication Assisted Treatment) program continues to be fully implemented in the Hospital's Emergency Department. In FY25, 108 patients received Naloxone. The MAT program is intended to serve individuals struggling with opioid addiction or substance abuse disorder. It focuses primarily on psychotherapy assisted by psychiatric prescribed medication designed to alleviate withdrawal symptoms and cravings.

Youth Substance Use Prevention Program

Background: In Orange County, drug and alcohol-related deaths have been on the rise since 2009 resulting in a sharp increase in substance-related deaths. Young adults between the ages 15-24 years old have had the largest increase in substance related deaths from 2019 to 2020 with a 165% increase.
(1) Orange County has higher hospitalization rates due to alcohol or substance use compared to 75% of California counties. (2) Additionally, the communities served by this initiative have been identified as having among the highest rate of drug and alcohol hospitalizations resulting from overdose. (3) By targeting prevention efforts during the formative years, we are improving the long-term health of our community. Ninety percent of substance use begins during adolescence underscoring the importance of supporting community stakeholders in implementing evidence-based prevention strategies.

Our approach: The 2024-2026 three-year strategic initiative has continued to build on the progress made during the previous strategic plan. The rates of substance use reported in the California Healthy Kids survey have declined year over year compared to 2019, the baseline used for this comparison.
Using the 2019/20 survey data for Past 30-day Use of Alcohol and Other Drugs, LBUSD 9th and 11th graders decreased by 45% and 39% respectively, while CUSD 9th and 11th graders decreased by 36% and 30% respectively. The strategic initiative places an emphasis on serving South Orange County communities and in particular, schools within the Capistrano Unified School District and Laguna Beach Unified School District as drug and alcohol use for these local high school districts exceeds that of neighboring public high school districts and is well above the state average of 23% (2017/19) and the county average of 14% (2022/23) for 11th graders.

Our Raising Healthy Teens and Strength In Numbers OC behavior change campaigns are the cornerstone of the youth prevention initiative.

Raising Healthy Teens has resulted in parents being better able to understand the pivotal role they play in safeguarding their children and has increased their ability to discuss substance use with their children through social media, a monthly digital newsletter, and parent guidebooks in English and Spanish. These resources have created a network of support and foster connections among parents who share similar concerns.

The Raising Healthy Teens website serves as a comprehensive resource hub, offering guidance, prevention strategies, effective communication techniques, and tips for creating a supportive environment for young people to thrive. (www.raisinghealthyteens.org)

In collaboration with the Capistrano Unified District and the Laguna Beach Unified School District, the Raising Healthy Teens Parent Resource Guide was distributed to over 1,100 middle and high school parents. The guide provides tips for helping students transition to middle and high school and how to have age-appropriate conversations about drugs and alcohol.
As of June 30, 2025 Raising Healthy Teens has:

- 3,500+ digital newsletter subscribers (an increase of 115% from prior year)
- 7,000 social media followers with over 18,000 likes, shares, comments
- 11,000 unique website visits

To support underserved monolingual households in our community, the Crianza Positiva was launched in 2024. This bilingual initiative includes a Spanish-language parent website— www.crianza-positiva.org —along with engaging social media content featuring short videos. The campaign addresses the lack of accessible resources in South Orange County, offering culturally relevant guidance on substance use prevention and mental health support for families. As of June 30, 2025 Crianza-Positiva has:

- 127,078 social media reach
- 37,000 video reach
- 1,500 social media followers
- 1,200 unique website visits

Strength In Numbers OC is specifically tailored to address the needs of teens in South Orange County, where the high pressure to excel is taking a significant toll. Student clubs provide a safe and supportive space for teens to connect, share experiences, and learn substance use prevention strategies. Established clubs at Capistrano Valley, San Clemente, and Laguna Beach High Schools empower students to make informed choices. In year-end student surveys, club members reported learning about the negative effects of drugs and alcohol, as well as healthy ways to cope with stress and anxiety.

Over 230 club members from 3 high schools participated in club activities throughout the school year gaining leadership skills and becoming advocates for change. During the school year, 39 Student-led club meetings and events were held with over 4,000 participants at the targeted schools. Over 3,000 Instagram followers receive year-round messaging that promotes substance-free living and supports teen mental health through relatable content that encourages healthy choices and coping strategies.

Campaign messaging appeared on the 3 targeted school campuses including football programs, student newspapers and high school athletic fields.

As of June 30, 2025 Strength In Numbers OC has:

- 3,094 social media followers
- 4,964 content interactions (shares, likes)
- 1,200 unique website visits www.StrengthInNumbersOC.com

Together, Raising Healthy Teens Crianza-Positiva, and Strength in Numbers provided substance use prevention education to 3,925 unique students, parents, and youth-serving adults in South Orange County through 4,577 encounters during the last fiscal year. Combined, the campaigns have garnered over 1,922,004 impressions.

COMMUNITY NEED ADDRESSED #3: ECONOMIC SECURITY

Population Served

Underserved residents living in South Orange County.

Long-Term Goal(s)/ Vision

- To ensure all people can be economically secure (i.e., afford to meet their basic needs) by providing support to services and addressing systemic barriers, with focus populations including people with preferred language other than English and young adults.

- Increase the number of people who report having access to supportive services in their preferred language related to education, employment, and income.

Table 4. Strategies and Strategy Measures for Addressing Equity & Racial Disparities

Strategy	Population Served	Measures	Baseline	FY25 Accomplishment
Increase enrollment levels in training and skill development opportunities.	Family Resource Center clients	# people completing job training and skill development programs annually through the FRCs	New Service	1,002 unduplicated 2,279 duplicated
Increase enrollment levels in financial empowerment programs for those impacted by economic disparities.	Family Resource Center clients	# people completing programs	New Service	479 unduplicated 1,090 duplicated
Implement the COPE Health Scholars Program	College students in South Orange County	# of scholars participating per year	213	190
Partner with TGR Foundation to promote health care workforce development	11th & 12th grade High school students in the Anaheim Union High School District	# of students participating in the healthcare career pathways program	125	483

Evidence Based Sources

Healthy People 2030 Evidence-Based Resources: https://health.gov/healthypeople/tools-action/browse-evidence- based-resources

Resource Commitment

$1 million per year in operating and staffing support for all economic stability initiatives in 2024-2026.

Key Community Partners

Saddleback College, South OC for All collaborative partners, Breakthrough SJC, CHEC & SOC Family Resource Center partners Boys and Girls Club-Laguna Beach, Coalition for Immigrant Rights (CHIRLA), Community Health Initiative OC (CHIOC), Congregation of the Sisters of St. Joseph, (CLUE), COPE Health Scholars Program, Family Assistance Ministries, Families Forward, Friendship Shelter, Cielo, Orange County United Way, CalOptima, Public Law Center.

2025 Accomplishments

Training and skill development/Financial empowerment: New partnerships established through the CHEC and SOC Family Resource Centers are essential for the South Orange County Community. Overall, these partnerships exemplify a coordinated approach to addressing community needs related to employment, entrepreneurship, and financial empowerment. By providing access to education, mentorship, and essential resources, these initiatives play a pivotal role in fostering economic stability and empowering individuals and families to achieve their financial goals. Here's a summary of the key partnerships and their contributions:
OC Workforce: This partnership focuses on providing essential support to the community through services like resume building, employment linkages, skills development workshops (both group and individual), and comprehensive training for employment development. These efforts are crucial for helping individuals improve their career prospects and skills.

CIELO: As a nonprofit organization, CIELO empowers aspiring entrepreneurs by offering free business workshops aimed at enhancing economic development literacy. These workshops have already been successfully implemented at SOC FRC. CIELO's small business startup program was introduced at CHEC FRC in February 2025. This initiative supports economic stability through education, helping 25 individuals transform their side projects into sustainable businesses through 116 mentorship encounters and resources.

Orange County United Way - Sparkpoint Program: This signature program provides long-term financial literacy coaching to 24 individuals and families from low-income backgrounds. Over a 12-month period and 262 encounters, participants receive support to develop personalized financial plans. This includes increasing income through career coaching and access to tax guidance and public assistance, improving credit scores through debt reduction and budgeting, and building assets via savings and asset planning for significant goals like homeownership or education expenses.

Community Action Partnership of Orange County and Children's Bureau (All for Kids): Through collaboration with these organizations, the Family Resource Centers have hosted two impactful financial literacy workshops. These workshops cover crucial topics such as savings strategies, managing IRA accounts, budgeting effectively, and more. Serving 20 individuals, these workshops have contributed significantly to enhance financial literacy within the community.

Partner with TGR Foundation to promote health care workforce development: Tiger Woods' Foundation (TGR) and Providence partnered to promote health care workforce development. In FY25, TGR hosted a Community Health Academy Day, Health Career Panel Session, Career Explorer Program with AUHSD, and a Career Explorer Presentation on CHNA. Through this partnership 483 Juniors and Seniors (high school students) from the Anaheim Union School District participated in the healthcare career pathways program. The goal of the partnership is to provide opportunities for high school students to gain real-world, tangible experiences related to their career interests.

COPE Health Scholars Program:
Providence Mission Hospital hosted 190 Health Scholars through the COPE Health Scholars program in FY24-25, resulting in 4,378 encounters. The COPE team expanded recruitment efforts locally, and several alumni were hired into roles such as patient experience, rehabilitation, endoscopy, laboratory, central supply, and float pool, demonstrating the program's success in connecting scholars with healthcare careers.

The COPE Health Solutions team took part in initiatives to reduce hospital-acquired infections at Providence Mission Hospital by enhancing hand hygiene audits. These efforts led to a significant increase in observations, greatly improving compliance across the ministry. This success was made possible by the outstanding commitment of the Health Scholar team, whose dedication also earned opportunities for micro-mentoring sessions with hospital leadership. Additionally, several Health Scholar leaders participated in group mentoring with executive staff, gaining valuable career insights and advice. Committed to providing a holistic learning experience and expanding community impact, the team actively participated in a variety of events throughout the year.

The team participated in the hospital's emergency preparedness drill, helping with patient notifications and learning about safety procedures. For the first time, COPE Health Scholars joined a community program to support a child returning to school, collecting donations and supplies. The group also attended a local health and safety fair to recruit and inspire future healthcare partners. Recognizing dedication among scholars, the program continues to expand opportunities, including new experiences in the laboratory and connecting with physician mentors. The support and collaboration of hospital caregivers and partners remain essential to the students' growth and success.

The Health Scholars have made notable progress since the program's beginning. Over the years, alumni have advanced in their careers and become community leaders, inspiring current scholars to follow their paths. Many have transitioned into nursing and healthcare administration roles, discovering new directions and seizing opportunities for professional growth. The program remains focused on supporting scholar development and opening doors to future success. FY25 has introduced several new initiatives for alumni, current, and future scholars, highlighting various opportunities available to the future health care workforce and their potential impact on communities.

Providence Government Affairs update efforts
Local- Providence continues to keep our community and elected stakeholders informed about recent changes to the local healthcare landscape. To strengthen collaboration, we hosted hospital tours and community events, providing updates on recently passed HR1 (One Big Beautiful Bill Act of 2025), state budget, and local challenges impacting our Orange County ministries. These events provide opportunities for local elected leaders, community members, and area health care partners to engage with Providence leadership and find ways to work together to strengthen Orange County's care continuum.

State- Providence collaborated with other health care organizations to advocate for the passage of legislation strengthening behavioral health treatment, ethical implementation of AI in health care, and sensible reforms to California's hospital seismic regulations. Providence also actively advocated for the passage of California's Proposition 35 to permanently extend the state's MCO tax and provide critical funding for Medi-Cal and graduate medical education.

Federal - On July 4, H.R. 1, was signed into law by President Trump. H.R. 1 includes significant policy changes affecting Medicaid, the Affordable Care Act, Medicare, and an expansion of health savings accounts. Providence and our partners advocated strongly against cuts to health care funding and harmful provisions contained in H.R. 1 but faced a challenging advocacy landscape. Providence held more than 100 meetings and events with federal lawmakers, participated in four nationwide coalitions to amplify our message, and ran our "Many Faces of Medicaid" advocacy campaign that resulted in 7,000 messages being sent to federal lawmakers from our caregivers and patients.

Other Community Benefit Programs

Table 5. Other Community Benefit Programs in Response to Community Needs

Community Need Addressed	Program Name	Description	Population Served
Access to Care/Behavioral Health/Economic Security	Family Resource Centers	Two Family Resource Centers (FRC) are managed in the community to provide access to social services for community members with limited resources. Both FRCs are part of the Families and Communities Together (FaCT) platform. FaCT is a network of 16 Family Resource Centers located throughout Orange County's highest-risk communities providing essential family support services, education and resources. Our services are aimed at addressing current community needs. Both FRCs are family-friendly, community-based sites that provide access to comprehensive services for all families. The following services are provided: Mental Health services, Skills for Life programs, Health Insurance and Social Programs Enrollment and Counseling, Parenting Support & Education, Parent/Child classes, Family Advocacy, Information & Resource Services, Personal Empowerment Programs, Community Engagement and Leadership, Legal Counseling, Adult English as a Second Language classes, Limited emergency financial assistance, Children's Programming, Support Groups, Family Bonding workshops, Food Distributions, and seasonal programs. These centers are lifelines for many people in the community and serve as a much-needed linkage to community programs. Just with our monthly food distribution we provide a highly needed service to 140-180 families every…	Low-income, vulnerable and broader community

Community Need Addressed	Program Name	Description	Population Served
		month. Partnerships continue with non-profit agencies, including newer relationships with: Children Bureau, Community Health Initiative of Orange County, Families Assistance Ministries, Human Options, Public Law Center, Olive Crest, Saddleback College, the Coalition of Community Health Centers, Orange County Social Services and we continue to seek new partnerships based on community needs. Total Encounters: 47,064 (both centers combined) SOC FRC: 34,759 CHEC FRC:12,305	
Access to Care	Trauma Education Programs	As a Level 2 trauma center, Mission Hospital provides critical education to the community on a variety of trauma-related topics. This education is often conducted in the community to support awareness, education, and ultimately protect our residents from behaviors that lead to traumatic events. Total Encounters: 1,857	Broad Community
Economic Stability	St. Joseph Worker Program	Mission Hospital is proud to partner with the Sisters of St. Joseph in implementing the St. Joseph Worker Program, a 10-month formation and service-oriented program for young women interested in exploring social services and/or the medical field. The St. Joseph Workers become an extension of the community health team to provide needed services to our under- resourced community. The following services are provided: Mental Health services, Skills for Life, Health Insurance enrollment and Social Programs Counseling, Parenting Support & Education, Parent/Child classes, Family Advocacy, Information & Resource Referral Services, Personal development. 1 St Joseph Worker with 190 service days completed	Low income, vulnerable, and broader community

FY25 COMMUNITY BENEFIT FINANCIALS

In FY25, Providence Mission Hospital provided a total of $89,588,713 in vital community benefit programs. $88,792,605 supported community benefit programs for the poor and vulnerable and $796,108 in community benefit programs for the broader community. $7,677,031 in Traditional charity care at cost was provided, $76,684,464 in unpaid cost of Medi-Cal.

Providence Mission Hospital applies a ratio of cost to charge to quantify financial assistance at cost, unreimbursed Medicaid, other means-tested government programs. The cost to charge ratio is aligned with the IRS Form 990, Schedule H Worksheet. Our community benefit program expenses are reported in alignment with the total cost incurred to run our programs, and we offset any restricted revenue received to arrive at our net community benefit expense.

FY2025 PROVIDENCE MISSION HOSPITAL (July 1, 2024 - June 30, 2025)

Financial Assistance and Means-Tested Government Program	Vulnerable Population	Broader Community	Total
Traditional Charity Care	$7,677,031	$0	**$7,677,031**
Medi-Cal	$76,684,464	$0	**$76,684,464**
Other Means-Tested Government (Indigent Care)	$589	$0	**$589**
Sum Financial Assistance and Means-Tested Government Program	**$84,362,084**	**$0**	**$84,362,084**
Other Benefits			
Community Health Improvement Services	$2,318,214	$764,108	**$3,082,322**
Community Benefit Operations	$1,089,509	$0	**$1,089,509**
Health Professions Education	$0	$30,000	**$30,000**
Subsidized Health Services	$0	$0	**$0**
Research	$0	$0	**$0**
Cash and in-kind Contributions for Community Benefits	$1,022,798	$2,000	**$1,024,798**
Other Community Benefits	$0	$0	**$0**
Total Other Benefits	**$4,430,521**	**$796,108**	**$5,226,629**
Community Benefits Spending			
Total Community Benefits	$88,792,605	$796,108	**$89,588,713**
Medicare (non-IRS)	$176,418,088	$0	**$176,418,088**
Total Community Benefits with Medicare	**$265,210,693**	**$796,108**	**$266,006,801**

Telling Our Community Benefit Story: Non-Financial Summary of Accomplishments

In addition to the financial investments made by Providence Mission Hospital, there are non-quantifiable benefits that are provided by the organization. Going out into the community and being of service to those in need is part of the tradition of our founders and is carried out by our staff and physicians every day.

Community Participation: Our leaders serve on the Boards of Directors of many non-profit organizations, including Camino Health Center, Friendship Shelter, Family Assistance Ministries, and the Boys & Girls Club of San Clemente to name a few. Caregivers support many special events with their time, including Service Days, Public Witness events, Race for the Cure and the Heart Walk. When there is a need in the community, our staff respond with their time, expertise and financial support.

Angel Program: Every year, Mission Hospital coordinates the "adoption" of families during Back to School and the holiday season. In FY25, 117 students from the community received much needed school supplies during our Back-to-School Angel Program in August, and 83 families (representing 117 adults and 175 children) were generously provided with individualized gifts for the 2024 holiday season. Over 40 hospital departments participated in this program, purchasing clothing, supplies, and gift cards for these families. We continued close partnerships with several outside organizations who adopted families in need including Cross Country Mortgage, LLC; In Spirit Center, Camino Health Center and Mission Heritage Medical Group.

St. Joseph Day Food & Clothing Drive:

As part of our celebration of St. Joseph, our Patron Saint, Mission Hospital hosts a food and clothing drive to help local non-profits who serve the vulnerable residents in South County. Our caregivers and the student volunteer program's own Sophie Anderson assisted in coordinating the food drives in March 2025 to collect donations for local pantries like Father Serra's Food Pantry and the Family Resource Centers.

2025 CB Report Governance Approval

This 2025 Community Benefit Report was adopted by the Community Health Committee of the hospital on Wednesday, August 20, 2025. The final report will be made widely available by November 20, 2025.

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Virginia Ripslinger
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11/6/2025

Virginia Ripslinger — Date

Chair, Mission Hospital Community Health Committee

Signed by:
Seth Teigen
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11/4/2025

Seth Teigen — Date

Chief Executive, Mission Hospital

Signed by:
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11/9/2025

Michael Robinson — Date

Chief Community Health Officer, South Division

Providence

Contact:

Maria G. Peralta-Sanchez, LCSW

Manager Community Services- Community Health

Providence Mission Hospital

Maria.Peralta-Sanchez@stjoe.org