2025

COMMUNITY BENEFIT REPORT/

PROGRESS ON 2023-2025 COMMUNITY HEALTH IMPROVEMENT PLAN

Providence Saint John's Health Center

Santa Monica, California

Reporting Period: January 1, 2025 - December 31, 2025

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To provide feedback on this CB report or obtain a printed copy free of charge, please email Justin Joe at justin.joe@providence.org

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EXECUTIVE SUMMARY

Providence Saint John's Health Center has been serving the Santa Monica and westside Los Angeles county communities since 1942, and since that time has earned a reputation for clinical excellence and award-winning care in a compassionate and tranquil healing environment. For community benefit planning purposes, Providence Saint John's Health Center defines its service area to include the cities and neighborhood areas surrounding the Health Center, and the addresses of patients using the hospital's services. The service area is identified as Service Planning Area (SPA) 5 which includes communities such as Santa Monica, Malibu, Pacific Palisades, Venice, Marina del Rey, Mar Vista, Playa Vista, Westwood, Brentwood, and parts of West Los Angeles.

During calendar year 2025, the economic value of community benefit provided by Providence Saint John's Health Center is calculated to be $43,150,244 (includes Charity Care, Unpaid Cost of Medi-Cal, Unpaid Costs of Other Means-tested Government Programs, and Community Benefit Services) with an additional $66,325,149 in Unpaid Costs of Medicare.

The 2025 CB Report can be located online at: FY2025 Community Benefit Reports. The most recent CHNA and CHIP can be located online at: CHNA and CHIPs | Providence under Southern California, then Santa Monica.

2023-2025 Providence Saint John's Health Center Community Health Improvement Plan Priorities

As a result of the findings of our 2022 CHNA and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, Providence Saint John's Health Center will focus on the following areas for its 2023-2025 Community Benefit efforts.

HOMELESSNESS & HOUSING INSTABILITY

Homelessness is defined as any individual or family who lacks a fixed, regular, and adequate nighttime residence; an individual or family who will imminently lose their primary nighttime residence; and any individual or family who is fleeing, or is attempting to flee, domestic violence, has no other residence, and lacks the resources or support networks to obtain other permanent housing. Health and homelessness are inextricably linked. Health problems can cause a person's homelessness as well as be exacerbated by the experience. Housing is key to addressing the health needs of people experiencing homelessness.

Housing instability encompasses several challenges such as having trouble paying rent, overcrowding, moving frequently, staying with relatives, or spending the bulk of household income on housing. Households are considered "cost burdened" if spending more than 30% of household income on housing, and "severely cost burdened" if spending more than 50% of household income on housing. Cost-burdened households have little left over each month to spend on other necessities such as food, clothing, utilities, and health care.

2025 Accomplishments

- Supported CHW Homeless Care Navigators embedded in the Emergency Department to connect patients experiencing homelessness to services and reduce avoidable ED utilization.
  - 396 unduplicated patients experiencing homelessness were served through navigator support.
  - 62 patients were connected to shelter/housing after discharge.
  - 51 patients were referred to the LAHSA Hospital Liaison (and related coordinated entry pathways).
- Deepened cross-sector coordination by participating in regional homelessness coalitions, including the Westside Coalition, LA Partnership, and the LA Recuperative Care Learning Network.
- Sustained and strengthened partnerships with community providers including Community Corporation of Santa Monica, The People Concern, Salvation Army – Santa Monica Corps, St. Joseph Center, and Venice Family Clinic.
- Invested in the continuum of homeless services through local grantmaking: $25,000 awarded by Providence Saint John’s Health Center and $525,000 awarded by the Providence Saint John’s Health Center Foundation to support recuperative care, street medicine, interim housing, and related services.

BEHAVIORAL HEALTH (MENTAL HEALTH AND SUBSTANCE MISUSE)

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

Substance use/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.

2025 Accomplishments

- Expanded access to outpatient behavioral health services through the Child and Family Development Center, providing therapy for children, youth, adults, and families, including patients served via Medi-Cal.
  - 490 patients and families were served through outpatient therapy.
  - Strengthened perinatal and infant mental health supports through the Perinatal Wellness Program (home visiting, therapy, and support groups): 42 families served; 58 children; 60 adults; and 21 families served via warm line referrals.
  - Provided school- and community-based mental health services through the Child/Youth Development Project: 38 children/youth served in group therapy; 58 served in individual/family therapy; and 3 parent training groups delivered.

- Built community capacity for prevention and early intervention by training and certifying 206 participants in Mental Health First Aid.
- Invested in community-based behavioral health services through local grantmaking: $365,215 awarded to six grantees by the PSJHC Foundation.

ACCESS TO HEALTH CARE AND PREVENTATIVE 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.

2025 Accomplishments

- Advanced community-driven colorectal cancer screening efforts through Community Health Action Teams (CHATs), including a mixed-methods study that surveyed 1,798 screening-eligible adults and convened focus groups with 65 community members.
- Completed bilingual community engagement deliverables to support preventive care uptake, including an English/Spanish photovoice exhibit and dissemination of culturally responsive research and outreach tools.
- Expanded health equity outreach focused on hypertension prevention and control, reaching 2,205 individuals through 76 outreach events and providing 808 blood pressure screenings.
- Invested in safety-net access through local grantmaking to community agencies serving underserved populations (including Federally Qualified Health Centers): $75,000 awarded by Providence Saint John's Health Center and $640,000 awarded by the PSJHC Foundation.

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

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

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

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

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

Our Commitment to Community

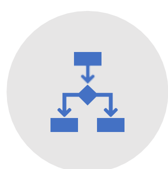
Providence health system dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. In 2025, Providence Saint John's Health Center provided $43,150,244 in Community Benefit in response to unmet needs. For more information on the resources invested to improve the health and quality of life for the communities we serve, please refer to our Annual Report to our Communities: https://www.providence.org/about/annual-report.

Health Equity

At Providence, 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.

To ensure that equity is foundational to our CHIP, we have developed an equity framework that outlines the best practices that each of our hospitals 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



Address root causes of inequities by utilizing evidence-based and leading practices

Explicitly state goal of reducing health disparities and social inequities

Reflect our values of justice and dignity

Leverage community strengths

Community Benefit Governance

Providence Saint John's Health Center demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation, and collaboration with community partners. The Director of Community Health is responsible for coordinating implementation of State and Federal 501r requirements.

The Community Ministry Board of Directors for Providence Saint John's Health Center authorized an ad hoc Community Health Needs Assessment Oversight Committee to review the ministry's Community Health Needs Assessment and prioritize the identified significant community needs. The Committee was chaired by a board member and composed of external stakeholders and Providence Saint John's leadership. The Committee met on November 4, 2022 to review key data findings and select the top three Priority Needs.

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 Saint John's Health Center has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients.

One way Providence Saint John's Health Center 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 here. In 2025, Providence Saint John's Health Center provided $3,603,767 in charity care.

Medi-Cal (Medicaid)

Providence Saint John's Health Center provides access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California. In 2025, Providence Saint John's Health Center provided $34,642,658 in unreimbursed care to patients with Medi-Cal.

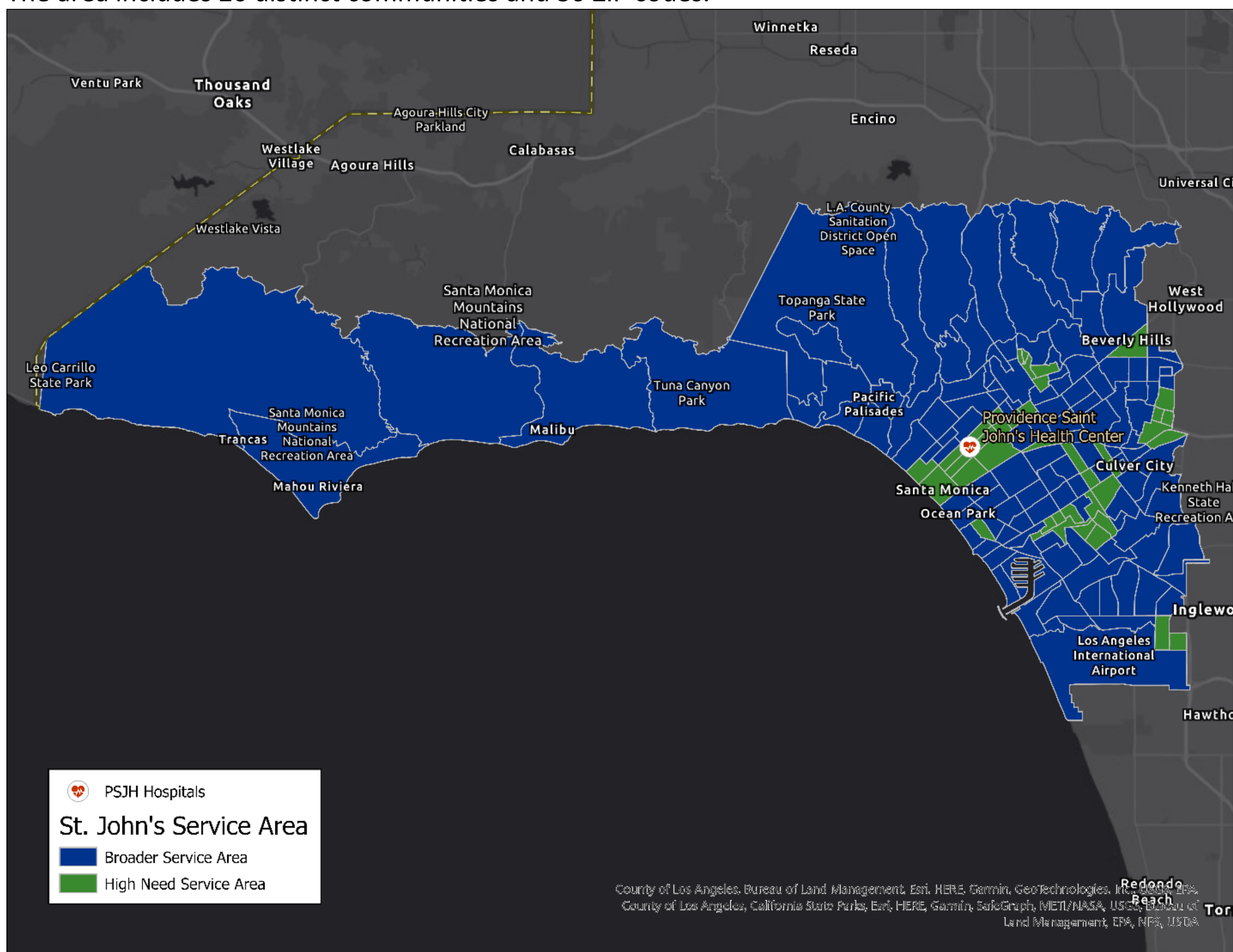
OUR COMMUNITY

Description of Community Served

For this annual update report, we have continued to use the boundaries and descriptive demographic data of the Providence Saint John's Health Center community defined in the 2022 Community Health Needs Assessment (CHNA).

Westside Community

The service area defined for the Providence Saint John's Health Center (PSJHC) CHNA includes the neighborhoods located within Service Planning Area (SPA) 5 of Los Angeles County. The planning area includes the communities located on the west side of the county (referred to as "the Westside" locally, and in this report), and represents the area where a significant portion of the patients served by the hospital resides. SPA 5 was used as the target geographic area for this CHNA because 1) it closely matched where a majority of PSJHC's patients reside, 2) using the SPA definition aligned data collection to boundaries used by the L.A. County Department of Public Health and other government agencies and 3) it aligned with service areas of other hospitals whom we collaborated with in the needs assessment process. The area includes 20 distinct communities and 30 ZIP codes.



For the 2022 CHNA we identified a high need service area within the total Westside service area, based on the social determinants of health specific to the inhabitants of the service area census tracts. Based on work done by the Public Health Alliance of Southern California and their Healthy Places Index (HPI) tool, the following variables were used to calculate a high need census tract:

- Population below 200% the Federal Poverty Level (American Community Survey, 2019)
- Percent of population with at least a high school education (American Community Survey, 2019)
- Percent of population, ages 5 Years and older in Limited English Households (American Community Survey, 2020)
- Life expectancy at birth (estimates based on CDC, 2010 – 2015 data)
- Of the over 650,000 permanent residents of the Westside, roughly 24% live in the “high need” area, defined by lower life expectancy at birth, lower high school graduation rates, and more households below 200% FPL compared to census tracts across the county. For reference, in 2020, 200% FPL represents an annual household income of $52,400 or less for a family of four. These households are more likely to regularly make spending tradeoffs regarding utilities, rent, groceries, medicine, and other basic expenses.

Community Demographics

POPULATION AND AGE DEMOGRAPHICS

The age distribution of the population in the Westside skews towards a larger proportion of younger adults (ages 20-39), most notably within the high need service area. Within the high need service area 45.4% of the population are between the ages of 20 to 39, compared to 30.8% in the broader service area. There are more children and youth in the broader service area with 20% of the population between the ages of 0-19 compared to 15.7% in the high need service area. Across the total Westside service area 51.2% of the population is female compared to 48.8% male.

POPULATION BY RACE AND ETHNICITY

The majority of residents in the service area are White (69.7%) with Asian populations being the second largest racial group (13.8%). There is a larger percentage of White (72.3%) populations in the broader service area compared to the high need service area (61.1%). The high need service area has a larger percentage of Black or African American population compared to broader service area (6.6% vs. 5.6%), Asian population (16.5% vs. 12.9%) and population that identify as another race (9.7% vs 3.0%). A larger population in the high need service area are Hispanic (28.0%) compared to only 12.3% of the broader service area.

SOCIOECONOMIC INDICATORS

Table 1. Income Indicators for Westside Service Area

Indicator	Broader Service Area	High Need Service Area	Westside Service Area	Los Angeles County
Median Income Data Source: 2019 American Community Survey, 5-year estimate	$118,295	$67,046	$98,059	$67,817
Population Below 200% of the Federal Poverty Level Data Source: 2019 American Community Survey, 5-year estimate	16.1% (73,856 persons)	34.8% (52,863 persons)	20.8% (126,719 persons)	34.9% (3,458,721 persons)
Percent of Renter Households with Severe Housing Cost Burden Data Source: 2019 American Community Survey, 5-year estimate	22.3%	28.8%	25.1%	29.04%

Full demographic and socioeconomic information for the service area can be found in the 2022 CHNA for Providence Saint John's Health Center.

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

The 2024 Community Benefit Plan Update is linked to the 2022 Community Health Needs Assessment and 2023-2025 Community Health Improvement Plan, which is posted on Providence's website at: https://www.providence.org/about/annual-report/chna-and-chip-reports

Providence Saint John's Health Center conducts a Community Health Needs Assessment (CHNA) every three years, and the results are used as the basis of our community benefit planning. The Community Health Needs Assessment process was based on the understanding that health and wellness are influenced by factors within our communities, not only within medical facilities. In gathering information on the communities served by the hospital(s), we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. Additionally, we invited key stakeholders and community members (including LA County Department of Public Health) to provide additional context to the quantitative data through qualitative data in the form of interviews and listening sessions. Providence Saint John's Health Center partnered with Cedars-Sinai Medical Center, Cedars-Sinai Marina del Rey Hospital, Ronald Reagan UCLA Medical Center, UCLA Medical Center Santa Monica, and Resnick Neuropsychiatric Hospital at UCLA, to conduct 33 stakeholder interviews with representatives from community-based organizations during October and November 2021. Additionally, Providence Saint John's Health Center conducted 3 listening sessions with 24 community members in June 2022.

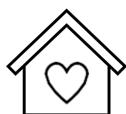
We reviewed data from the American Community Survey and local public health authorities. In addition, we included hospital utilization data to identify disparities in utilization by income and insurance, geography, and race/ethnicity when reliably collected. As often as possible, equity was at the forefront of our presentation of the data, which often have biases based on collection methodology. We recognized that there are often geographic areas where the conditions for supporting health are substantially poorer than nearby areas. Whenever possible and reliable, data was reported at the ZIP Code or census tract level. These smaller geographic areas allow us to better understand the neighborhood level needs of our communities and better address inequities within and across communities.

Eight significant community health needs were identified for a prioritization process by the Community Health Needs Assessment Oversight Committee through a review of the secondary health data collected and based on qualitative data collected from interviews and listening sessions.

- Access to Health Care and Preventive Care
- Behavioral Health (Mental Health and Substance Use/Misuse)
- Chronic Diseases
- Community Safety
- COVID-19
- Economic Insecurity
- Food Insecurity
- Homelessness and Housing Instability

Significant Community Health Needs Prioritized

Through a collaborative process, the Community Health Needs Assessment Oversight Committee identified the following priority areas:



HOMELESSNESS & HOUSING INSTABILITY

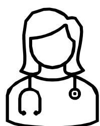
Homelessness is defined as any individual or family who lacks a fixed, regular, and adequate nighttime residence; an individual or family who will imminently lose their primary nighttime residence; and any individual or family who is fleeing, or is attempting to flee, domestic violence, has no other residence, and lacks the resources or support networks to obtain other permanent housing. Health and homelessness are inextricably linked. Health problems can cause a person's homelessness as well as be exacerbated by the experience. Housing is key to addressing the health needs of people experiencing homelessness.

Housing instability encompasses several challenges such as having trouble paying rent, overcrowding, moving frequently, staying with relatives, or spending the bulk of household income on housing. Households are considered "cost burdened" if spending more than 30% of household income on housing, and "severely cost burdened" if spending more than 50% of household income on housing. Cost-burdened households have little left over each month to spend on other necessities such as food, clothing, utilities, and health care.

BEHAVIORAL HEALTH (MENTAL HEALTH AND SUBSTANCE MISUSE)

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

Substance use/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.



ACCESS TO HEALTH CARE SERVICES

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.

Needs Beyond the Hospital's Service Program

No hospital facility can address all the health needs present in its community. We are committed to continuing our Mission through programs and grants addressing six of the eight identified health needs from the 2022 Community Health Needs Assessment.

The following community health needs identified in the ministry CHNA will not be addressed as part of the Community Health Improvement Plan and an explanation is provided below:

- COVID-19: This need ranked relatively low on the list of identified needs (7 out of 8) and many of the relevant interventions that would be implemented in addressing this need are already included within efforts to address Access to Health Care and Preventive Care.
- Community Safety: This need ranked relatively low on the list of identified needs (8 out of 8). Our hospital does not have the expertise to effectively address community safety compared to other local stakeholders who are better equipped to address this need and have dedicated resources focused on addressing it as part of their organizational purpose and mission.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

The 2023-2025 Community Health Improvement Plan (CHIP) was developed by leadership in Providence Saint John's Health Center's Community Health Investment department. The CHIP considers 1) existing evidence-based hospital programs and investments, 2) new potential opportunities for additional growth, and 3) partnerships with local organizations committed to addressing the top three needs identified in the 2022 CHNA. The CHIP was presented to and reviewed by the Executive Committee of the Community Ministry Board of Directors on April 26, 2023 and was unanimously approved and adopted by the Committee on behalf of the Community Ministry Board.

While the focus of the 2023-2025 CHIP primarily is centered around efforts to address the top three identified needs, Providence Saint John's Health Center recognizes there are numerous other programs that address other community needs that the hospital will remain committed to continuing--particularly those with a long history and reputation of positive and effective impact. Furthermore, in light of the recent COVID-19 pandemic, we recognize that the needs of the community are a dynamically evolving situation and we may need to adapt accordingly to be responsive to those needs. While our CHIP outlines our best intended efforts to meet the community's needs, we believe that it will be important to maintain a spirit of flexibility in our approach to community benefit throughout the course of this three-year period.

Addressing the Needs of the Community: 2023- 2025 Key Community Benefit Initiatives and Evaluation Plan

2025 Accomplishments

COMMUNITY NEED ADDRESSED #1: HOMELESSNESS & HOUSING INSTABILITY

Long-Term Goal(s)/ Vision

A seamless connection between health care and homeless services, ensuring that people experiencing homelessness receive timely and appropriate linkage to community-based homeless services.
Providence is a dedicated member of local coalitions to ensure coordination of homeless support services, including recuperative care, and that there are increased connections to supportive services for individuals experiencing homelessness.

Table 2. Strategies and Strategy Measures for Addressing Homelessness & Housing Instability

Strategy	Strategy Measure(s)	2023-2025 Objectives	2025 Impact
CHW Homeless Care Navigators: CHWs placed within our emergency department to specifically care for patients experiencing homelessness. They act as liaisons between homeless service providers and	Number of patients experiencing homelessness connected to shelter/housing Number of patients	350 patients approached per year 50 patients connected to shelter/housing per year	396 unduplicated patients served 62 patients connected to shelter/housing after discharge

our Medical Centers to reduce avoidable emergency department visits and link patients with permanent and interim housing.	connected to LAHSA Hospital Liaison or Coordinated Entry System	75 patients connected to LAHSA Hospital Liaison or Coordinated Entry System per year	51 patients referred to LAHSA Hospital Liaison
Partnership Building: Strengthen organizational partnerships to address homelessness and housing insecurity. Stakeholders include homeless service providers, FQHCs, affordable housing providers, and other hospitals.	Participation and engagement in local/regional coalitions on homelessness New potential partnerships identified Number of cooperative and collaborative partnerships	Increased participation and representation of Providence at two local coalitions on homelessness Networking & Coordinating: Identify additional community-based organizations for potential partnerships Collaborating: Strengthen existing partnerships to form collaborative relationships	Coalition Participation: Westside Coalition, LA Partnership, LA Recuperative Care Learning Network Continued partnerships with Community Corporation of Santa Monica, The People Concern, Salvation Army - Santa Monica Corps St. Joseph Center, and Venice Family Clinic
Grantmaking: Financial support to local partners across the continuum of homeless services, including: recuperative care, street medicine, and interim housing	Number of grants awarded Total $ value of grants awarded	2023: Identify organizations and award grants through PSJHC and PSJHC Foundation local ministry grantmaking 2024-2025: Nominate and advocate for local organizations for funding to Providence's South Division future grantmaking structure	Total of $25,000 awarded to one grantee by Providence Saint John's Health Center Total of $525,000 awarded to six grantees by Providence Saint John's Health Center Foundation

Evidence Based Sources

- [Community health workers | County Health Rankings & Roadmaps]

Resource Commitment

- Staffing for CHW Homeless Navigators
- Staff time for coalition building among hospitals, homeless service providers and FQHCs
- Grant funding for homeless service providers including recuperative care, street medicine and interim shelter

Key Community Partners

United Way: Greater Los Angeles, LAHSA, Westside Coalition, City of Santa Monica, U.S. Vets, The Landing at St. Robert's Center, Pacific Palisades Task Force on Homelessness, Safe Place for Youth, The People Concern, Venice Family Clinic, and The Salvation Army

COMMUNITY NEED ADDRESSED #2: BEHAVIORAL HEALTH (MENTAL HEALTH AND SUBSTANCE MISUSE)

Long-Term Goal(s)/ Vision

To ensure equitable access to high-quality, culturally responsive, and linguistically appropriate mental health services, especially for populations with low incomes.

An improved workforce of mental health professionals that is representative of the community served and can effectively and compassionately respond to the community's mental health and substance use needs.

Table 3. Strategies and Strategy Measures for Addressing Behavioral Health

Strategy	Strategy Measure(s)	2023-2025 Objectives	2025 Impact
Child and Family Development Center – Outpatient Therapy: Outpatient mental health services are available to children, teens, young adults and adults with developmental disabilities. Therapists offer targeted evidence-based treatment through a family focused lens that helps address problematic behaviors, thoughts and feelings with achievable goal-oriented strategies.	Number of patients who received therapy (Medi-Cal) Number of uninsured patients who received therapy	601 patients served with Medi-Cal per year 15 uninsured/indigent patients served per year	490 patients and families served
Child and Family Development Center - Perinatal Wellness Program: Bilingual perinatal and infant mental health specialist visit families weekly	Number of families served Number of children Number of adults	39 families per year 70 children per year 41 adults per year 50 families served via warm line referral	42 families served 58 children 60 adults 21 families served via warm line referral services

in their homes to provide individual, dyadic, couple, and/or family therapy. Ongoing weekly perinatal support groups are offered to reduce isolation and promote social engagement.	Number of families served via the warm line referral service	service	
Child and Family Development Center – Child/Youth Development Project: is a school and community-based mental health program serving Santa Monica schools and community sites through direct mental health services, outreach, and school/community collaboration. Priority is given to children, youth and families who have been impacted by community violence, familial discord, poverty, substance abuse and trauma.	Number of children served in group therapy services Number of children served in individual/family therapy services Number of parent training groups/workshops conducted	50 children/youth served in group therapy services per year 35 children/youth served in individual therapy services per year Continue providing two parent training groups	38 children/youth served in group therapy services 58 children/youth served in individual/family therapy 3 parent training groups provided
Mental Health First Aid: support prevention and early intervention by teaching the evidence-based MHFA curriculum. The skills-based course teaches participants how to identify, understand and respond to signs and symptoms of mental health and substance use challenges	Number of participants trained and certified in Mental Health First Aid	By 2025, average 200 participants trained and certified in MHFA per year	206 participants trained and certified in Mental Health First Aid
Grantmaking: Financial support to local non-profit mental health providers to increase access to services	Number of grants awarded Total $ value of grants awarded	2023: Identify organizations and award grants through PSJHC and PSJHC Foundation local ministry grantmaking 2024-2025: Nominate and advocate for local organizations for funding to Providence's South Division future grantmaking structure	Total of $365,215 awarded to six grantees by PSJHC Foundation

Evidence Based Sources

- Community health workers | County Health Rankings & Roadmaps
- Crisis lines | County Health Rankings & Roadmaps
- Early childhood home visiting programs | County Health Rankings & Roadmaps
- Mental health benefits legislation | County Health Rankings & Roadmaps
- Mental Health First Aid | County Health Rankings & Roadmaps
- Telemental health services | County Health Rankings & Roadmaps

Resource Commitment

- Staffing for the multiple programs operated by the Child and Family Development Center
- Staffing for preventive education classes on mental health
- Funding for agencies providing mental health and substance use treatment services

Key Community Partners

Westside Family Health Center, California WIC, DPSS, Santa Monica Public Library, Boys and Girls Clubs of Santa Monica, Venice Family Clinic, Well Baby Center, Open Paths, Mental Health First Aid from The National Council for Mental Wellbeing, Meals on Wheels West, Love Dad, Harvest Home, Los Angeles County Department of Mental Health, Santa Monica Malibu Unified School District, LAUSD

COMMUNITY NEED ADDRESSED #3: ACCESS TO HEALTHCARE SERVICES

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 the appropriate level of care at the right time.

Table 4. Strategies and Strategy Measures for Addressing Access to Healthcare Services

Strategy	Strategy Measure(s)	2023-2025 Objectives	2025 Impact
Community Health Action Teams -- Improve Access to Colorectal Cancer Screening: **deploy community health action teams (CHATs) to implement a locally designed and operated CRC screening campaign in Santa Monica (90404 zip code)**	Number of individuals engaged Number of people screened Number of people referred to primary care or continued services (financial counseling, charity care, etc)	2023-2025 Objective 1,109 residents newly screened from Santa Monica 90404 zip code (achieving an 80% screening rate within the population)	The mixed methods study surveyed 1,798 adults eligible for colorectal cancer screening and conducted focus groups with 65 people across the same communities. Providence's Health Research Accelerator partnered with Providence Saint John's Cancer Institute on the study, funded by a grant from Stand Up To Cancer. Wrapped up efforts: Photo voice exhibit in English & Spanish: Knowledge is

			Power Published biorepository toolkit: Best Practices Framework for Culturally Competent Biospecimen Research
Health Equity - Hypertension: Community Health Worker driven outreach and educational campaign to reduce hypertension in communities of color, focusing on at-risk Black and Latinx patient populations	Number of patients engaged Number of patients receiving blood pressure monitor	Baseline (2022)[1] Saint John's Physician Partners 53.6% of Black patients diagnosed with hypertension have blood pressure adequately controlled (<140/90 mmHG) 57.7% of Latinx patients diagnosed with hypertension have blood pressure adequately controlled (<140/90 mmHG) 2023-2025 Objective Saint John's Physician Partners Improve blood pressure control in Black patients by 1% annually Improve blood pressure control in Latinx patients by 1% annually	Served a total of 2,205 individuals 76 outreach events 808 BP screenings and SDOH resources 484 families received food assistance
Grantmaking: Financial support to local agencies that provide healthcare to underserved populations, including Federally Qualified Health Centers	Number of grants awarded Total $ value of grants awarded	2023: Identify organizations and award grants through PSJHC and PSJHC Foundation local ministry grantmaking 2024-2025: Nominate and advocate for local organizations for funding to Providence's South Division future grantmaking structure	Total of $75,000 awarded to two grantees by Providence Saint John's Health Center Total of $640,000 awarded to ten grantees by PSJHC Foundation

[1] Baseline metrics adjusted for accuracy compared to metrics originally reported in 2023-2025 Community Health Improvement Plan

Evidence Based Sources

- Community health workers | County Health Rankings & Roadmaps
- Federally qualified health centers (FQHCs) | County Health Rankings & Roadmaps
- Medical homes | County Health Rankings & Roadmaps

Resource Commitment

- Staffing for multiple access to care programs
- Funding for agencies providing access to care services
- In-kind lab and radiology services to local FQHCs

Key Community Partners

The Santa Monica Family YMCA, Alcott Center, Westside Coalition, Virginia Avenue Park, Saint Anne School, Wise and Healthy Aging, Westside Family Health Center, OPICA, Boys and Girls Clubs of Santa Monica, Vision to Learn, Claris Health, Cancer Support Community Los Angeles, Venice Family Clinic

Other Community Benefit Programs

Table 5. Other Community Benefit Programs in Response to Community Needs
This section includes a description of additional noteworthy programs and services provided by Providence Saint John's Health Center in 2025 that addressed identified community needs in the 2023-2025 CHIP.

Program Name	Community Need Addressed	Description	2025 Impact
Child and Family Development Center: Multidisciplinary Assessment Team	Behavioral Health	Mental health assessments for foster children	74 children in foster care were assessed and plans were created for children's court for these children in collaboration with the LA Department of Children and Family Services
Child and Family Development Center: Therapeutic Preschool	Behavioral Health	Mental Health Day Treatment for preschoolers with severe behaviors from trauma/development	13 children and their families received treatment through the Therapeutic Preschool
Child and Family Development Center: Helen Reid Parenting Program	Behavioral Health	Mental health groups for at risk very low income pregnant and postpartum women	96 group sessions at two sites. Group sizes ranges between 2-10 participants.
Health Education FEAST classes (Food, Education, Access, Support, Together)	Food Insecurity, Economic Insecurity, Chronic Disease	Twelve-week nutrition course that provides education on food topics, cooking demo with tasting, food stipend, and support social, emotional and physical wellness.	37 participants completed the class series
CalFresh Application Assistance	Food Insecurity, Economic Insecurity	One-on-one application assistance by a Community Health Worker for eligible residents to obtain CalFresh (aka SNAP) benefits	25 applications assisted for CalFresh benefits

2025 COMMUNITY BENEFIT FINANCIALS

Providence Saint John's Health Center

(January 1, 2025-December 31, 2025)

Community Benefit Financials, referred to in legislation as the economic value of Community Benefit, are reported at cost and align with the 990 Schedule H instructions and Catholic Health Association-USA's most recent guide for Community Benefit Reporting.

Patient financial assistance (traditional charity care) is reported at cost. The unpaid cost of Medicaid, other means-tested programs and Medicare are calculated using a cost-to-charge ratio to determine costs, minus revenue received for providing that care. The unpaid cost of Medicare reported here excludes Medicare reported as a part of subsidized health services and Health Professions Education (if applicable).

Financial Assistance and Means-Tested Government Program	Vulnerable Population	Broader Community	Total
Traditional Charity Care	$3,603,767	$0	**$3,603,767**
Medi-Cal	$34,642,658	$0	**$34,642,658**
Other Means-Tested Government (Indigent Care)	$86,214	$0	**$86,214**
Sum Financial Assistance and Means-Tested Government Program	**$38,332,639**	**$0**	**$38,332,639**

Other Benefits			
Community Health Improvement Services	$2,216,945	$0	**$2,216,945**
Community Benefit Operations	$418,960	$0	**$418,960**
Health Professions Education	$0	$388,027	**$388,027**
Subsidized Health Services	$1,379,660	$0	**$1,379,660**
Research	$0	$0	**$0**
Cash and in-kind Contributions for Community Benefits	$117,172	$0	**$117,172**
Other Community Benefits	$0	$0	**$0**
Total Other Benefits	**$ 4,132,737**	**$ 388,027**	**$4,520,764**

Community Benefits Spending			
Total Community Benefits	$42,465,376	$388,027	**$42,853,403**
Medicare (non-IRS)	$66,325,149	$0	**$ 66,325,149**
Total Community Benefits with Medicare	**$108,790,525**	**$ 388,027**	**$109,178,552**

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

Providence Saint John's Health Center impacts the community in meaningful ways that extend well beyond financial support. Through trusted partnerships, hands-on service and a strong community presence, Saint John's helps improve health, strengthen relationships and expand access to resources across the Westside and surrounding communities. Its work reflects a sustained commitment to listening to residents, responding to local needs and walking alongside community organizations to advance health equity.

A key part of this impact is Providence Saint John Health Center's ability to convene and collaborate. Providence leaders helped guide the Westside Coalition's response to emerging community needs, bringing together representatives from 80 member organizations to inform program development, grantmaking and strategic planning. Providence Saint John Health Center also partners directly with community-based organizations and neighborhood hubs such as Virginia Avenue Park, Wise & Healthy Aging, Vista Del Mar High School, the Westchester Family YMCA, Northgate Market, Venice Family Clinic and St. Robert's Center to bring services and support closer to where people live, learn and gather.

Saint John's also creates community impact through education, prevention and navigation support. Caregivers and community health staff provide nutrition education through FEAST, Mental Health First Aid training, CalFresh enrollment assistance, school-based health career exploration and culturally responsive outreach for seniors, teens and families. This commitment was also demonstrated through a robust lineup of outreach events and partnerships that brought preventive care, health education and wellness programming directly into the community. Providence Saint John's hosted and participated in a wide range of activities, from large-scale events such as the Palisades July 4th 5K and CicLAVia in Culver City to targeted health fairs at schools, workplaces and community organizations including the Willows School, Crossroads School and the Jonathan Club. The team also partnered with the Los Angeles Fire Department to deliver multiple on-site wellness events focused on pulmonary screenings and education on critical conditions such as heart attack and stroke. Participation in regional initiatives like the American Heart Association Heart and Stroke Walk and the YMCA Stair Climb further reinforced Saint John's leadership in promoting cardiovascular health and active living. Across these efforts, services such as blood pressure screenings, pulmonary evaluations and health education were consistently provided, helping residents access care in approachable, community-based settings.

Beyond education and outreach, Saint John's supports vulnerable community members through relationship-based services that address everyday barriers to well-being. Its homeless care navigation efforts help connect patients leaving the emergency department to shelter, follow-up appointments, transportation, food and other basic supports. Partnership with Venice Family Clinic has improved continuity of care for unhoused patients, while caregiver volunteer events at St. Robert's Center and other sites provide food, clothing, shoes and compassionate presence for neighbors experiencing hardship. These efforts show how Saint John's contributes not only resources, but also time, expertise, advocacy and human connection.

2025 CB REPORT GOVERNANCE APPROVAL

____5/22/26___

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To request a printed copy free of charge, provide comments, or view electronic copies of current and previous Community Health Improvement Plans please email CHI@providence.org.