California Hospital Medical Center

Community Benefit 2021 Report and 2022 Plan

Adopted November 2021

Dignity Health®
California Hospital
Medical Center

A message from

Alina Moran, president and CEO of California Hospital Medical Center and Phillip C. Hill, Chair of the Dignity Health California Hospital Medical Center Community Board.

Dignity Health's approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments that we conduct with community input, including from the local public health department. Our initiatives to deliver community benefit include financial assistance for those unable to afford medically necessary care, a range of prevention and health improvement programs conducted by the hospital and with community partners, and investing in efforts that address social determinants of health.

California Hospital Medical Center shares a commitment with others to improve the health of our community, and delivers programs and services to help achieve that goal. The Community Benefit 2021 Report and 2022 Plan describes much of this work. This report meets requirements in California state law (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. Dignity Health hospitals in Arizona and Nevada voluntary produce these reports and plans, as well. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report to our community.

In fiscal year 2021 (FY21), California Hospital Medical Center provided $130,501,534 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $19,840,912 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2021 Report and 2022 Plan at its November 4, 2021 meeting.

Thank you for taking the time to review our report and plan. We welcome any questions or ideas for collaborating that you may have, by reaching to out to 213-742-5974.

Alina Moran
President/CEO

Phillip C. Hill
Chairperson, Board of Directors

Table of Contents

At-a-Glance Summary

Community Served 	CHMC is located in a federally designated Medically Underserved Area and serves a Medically Underserved Population (MUA/P ID #04011) (Census tract 2240.10). While CHMC is located in Service Planning Area (SPA) 4 or Metro Los Angeles, its service area also includes parts of SPA 6 (South), SPA 7 (East) and SPA 8 (South Bay). CHMC serves 1,576,013 racially diverse residents with a median income of $40,705. Eight percent of adults in the hospital's service area are homeless; the service area includes Skid Row that has the largest concentration of homeless in LA County
Economic Value of Community Benefit 	$130,501,534 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $19,840,912 in unreimbursed costs of caring for patients covered by Medicare
Significant Community Health Needs Being Addressed 	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are: • 1 Housing & homelessness • 2 Access to health care • 3 Mental health • 4 Chronic diseases • 5 Economic insecurity • 6 Substance use and misuse • 7 Food insecurity • 8 Education • 9 Preventive practices • 10 Birth indicators
FY21 Programs and Services 	The hospital delivered several programs and services to help address identified significant community health needs. These included: • Programming offered through the Hope Street Margolis Family Center including Early Head Start Program (EHS), EHS-Childcare Partnership, four licensed Early Care and Education Centers, the Family Childcare Network, the Hope Street Youth Center, Youth Fitness Program, Family Literacy Program, Pico Union Family Preservation Program, Wraparound Services Program, Early Intervention Program, and CA Behavioral Health Clinic. The pandemic necessitated a food and other necessities pantry. • LA Best Babies Network's perinatal and early childhood home visitation programs including Welcome Baby, Healthy Families America, and Parents as Teachers and the LA Perinatal and Early Childhood Home Visitation Consortium. All in-person visits pivoted to virtual in late March 2020. • *Para Su Salud*, health insurance enrollment and outreach program

	• Health Ministry screening and health education programs
	  o Chronic Disease Self-Management Program
	  o Diabetes Empowerment Education Program
	  o Healthy Eating and Lifestyle Program (H.E.L.P.)
	  o Heart HELP
	  o The pandemic resulted in the temporary curtailment of in-person classes and the advent of telephonic one-on-one health education and case management; food and diapers were in the highest demand.
	• 10th Decile Project for chronically homeless frequent users of health care
	• Cultural Trauma and Mental Health Resiliency Program
	• Family Medicine Residency Program
	• CA Bridge Program in ED
	• Mental Health Support for Women with Histories of Homelessness
	• Zahn Memorial Center & Lily's Place for Homeless Families
	• Healing Domestic Abuse Victims to Create a Healthier, More Self-Sufficient Community

FY22 Planned Programs and Services	FY21 programs will continue with the following changes: • The COPE Health Scholars Program ended June 30, 2021. • CHMC's grantees for the Cultural Trauma and Mental Health Resiliency Program will change from LA Trust for Children's Health, Wellnest, and NAMI Urban LA to LA Trust for Children's Health and NAMI Urban LA on December 1, 2020. • The following program will end at the end of 2021: o Healing Domestic Abuse Victims to Create a Healthier, More Self-Sufficient Community

This document is publicly available online at https://www.dignityhealth.org/about-us/community-health/community-health-programs-and-reports/community-benefit-reports

Written comments on this report can be submitted to the CHMC's COMMUNITY HEALTH OFFICE, 1401 S. Grand Ave., Los Angeles, CA 90015 or by e-mail to m.l.yonekura@dignityhealth.org.

Our Hospital and the Community Served

About California Hospital Medical Center

California Hospital Medical Center is a member of Dignity Health, which is a part of CommonSpirit Health.

California Hospital Medical Center (CHMC), founded in 1887, is located at 1401 S. Grand Avenue, Los Angeles, CA 90015. It became a member of Dignity Health in 2004. The facility has 318 licensed beds, and will complete construction on a new patient tower in 2022. CHMC has a staff of more than 1800 and professional relationships with more than 400 local physicians. Major programs and services include: emergency and trauma services, women's health, obstetrics, neonatal intensive care, pediatrics, medical/surgical services, cardiac care, stroke care, critical care, orthopedics, and cancer care

Our Mission

As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Our Vision

A healthier future for all – inspired by faith, driven by innovation, and powered by our humanity.

Financial Assistance for Medically Necessary Care

California Hospital Medical Center is dedicated to creating healthier communities by providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay. Advocating for the poor and vulnerable is both our mission and our passion. The hospital has financial assistance available to help pay for medically necessary services provided to those patients who meet certain income requirements. The financial assistance policy, a plain language summary of the policy, and a financial assistance application are on the hospital's web site.

Description of the Community Served

California Hospital Medical Center (CHMC) is located in a federally designated Medically Underserved Area and serves a Medically Underserved Population (MUA/P ID #04011) (Census tract 2240.10). CHMC serves 28 ZIP codes in Los Angeles City Council District 14. The service area is comprised of portions of Los Angeles Service Planning Areas (SPAs) 4, 6, 7, and 8. The hospital service area was determined from the ZIP Codes that reflect a majority of patient admissions from the local geographic area. A summary description of the community is below. Additional details can be found in the CHNA report online.

- CHMC serves the most densely populated area of Los Angeles County, second only to Manhattan, containing the oldest housing stock and with only 0.95 park acres of green space/1000 persons (compared to 8.0 countywide). CHMC's service area is home to a largely Central American and Mexican immigrant population as well as a Korean immigrant population (5.6%). Spanish is spoken in the home among 55.3% of the population, English in 35.1%, an Asian language in 5.6%, and an Indo-European language in 2.6%. In CHMC's service area there are 476,121 households and 501,827 housing units. Over the last five years, households grew by 4.0%, housing units grew at a lower rate (2.3%) and vacant units decreased by 12%. Owner-occupied housing increased by 1.8% and renter-occupied units increased by 6.1%. 58.6% of owner and renter-occupied households in the service area spend 30% or more of their income on housing (compared to 48.0% countywide). Among residents in CHMC's service area, 29.9% live in households which have incomes <100% of the Federal Poverty Level. 45.4% of children in SPAs 4 and 6 and 29.9% of children in SPA 7 live below the poverty level. In SPA 4, 46.4% of adults below 200% FPL can't afford food and 25.5% utilize CalFresh. In SPA 6, 49.3% of residents below 200% FPL can't afford food and 29% utilize CalFresh. In SPA 7, 49.7% of residents below 200% FPL can't afford food and 24.6% utilize CalFresh. Among children in SPA 4, 53.6% access WIC benefits, 69.9% in SPA 6 access WIC benefits and in SPA 7 49.7% access WIC benefits. Among SPA 6 resident, 15.8% are TANF/CalWORKs recipients, 10.7% of SPA 4 residents and 11% of SPA 7 residents are TANF/CalWORKs recipients

- In CHMC's service area 8% of adults reported being homeless or not having their own place to live or sleep in the past five years (compared to the county rate of 4.8%). In SPA 4, 89.7% of the homeless are individual adults and 9.9% are families. In SPA 6, 70.1% of the homeless are single adults and 25.8% are families. In SPA 7, 85.2% of the homeless are single adults and 19.5% are families. Among the homeless population, 30.2% in SPA 4, 20.7% in SPA 6, and 18.7% in SPA 7 are chronically homeless. The rates of chronic homelessness among individuals in SPA 4 have increased from 2015 to 2018 and decreased in SPAs 6 and 7. Rates of serious mental illness among the homeless have also gone down in SPAs 6 and 7 but remain unchanged at 29.4% in SPA 4. From 2015 to 2018, there has been an increase in the homeless population with domestic violence experience in SPAs 4 and 6. Substance abuse rates among the homeless have decreased across the service area SPAs from 2015 to 2018.

- Demographic Profile of People Living in CHMC's Service Area:

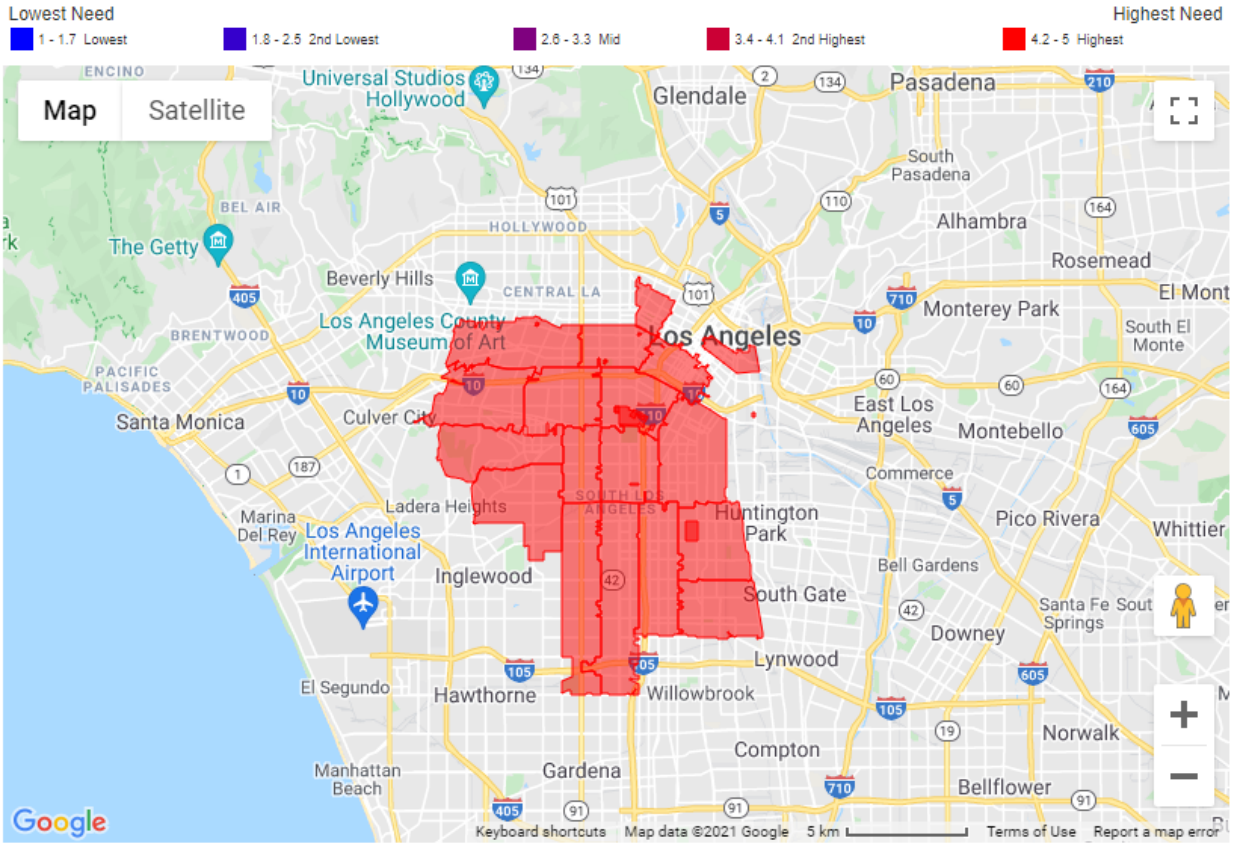
    - Total population: 959,515
    - Race
        - Hispanic/Latinx 66.1%
        - Black/African American 21.6%
        - Asian/Pacific Islander 5.9%
        - White-non-Hispanic 4.4%
        - All others 2.0%
    - % Below Poverty 21.8%
    - Unemployment 7.3%
    - No High School Diploma 37.0%
    - Medicaid (household) 14.6%
    - Uninsured (household) 6.8%

Source: Caritas Pop-Facts® 2021; SG2 Market Demographic Module

Community Need Index

One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and IBM Watson Health. The CNI analyzes data at the zip code level on five factors known to contribute or be barriers to health care access: income, culture/language, education, housing status, and insurance coverage.

Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zip code in the community. Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores.



Mean(zipcode): 4.8 / Mean(person): 4.8 CNI Score Median: 4.9 CNI Score Mode: 5

Zip Code	CNI Score	Population	City	County	State
90001	4.8	58592	Los Angeles	Los Angeles	California
90002	5	54551	Los Angeles	Los Angeles	California
90003	5	71556	Los Angeles	Los Angeles	California
90006	5	59104	Los Angeles	Los Angeles	California
90007	5	43200	Los Angeles	Los Angeles	California
90008	4.6	32203	Los Angeles	Los Angeles	California
90011	5	107184	Los Angeles	Los Angeles	California
90013	5	14508	Los Angeles	Los Angeles	California
90015	5	23862	Los Angeles	Los Angeles	California
90016	4.6	48623	Los Angeles	Los Angeles	California
90018	4.8	52489	Los Angeles	Los Angeles	California
90019	4.4	64912	Los Angeles	Los Angeles	California
90037	5	65344	Los Angeles	Los Angeles	California
90043	4.8	44699	Los Angeles	Los Angeles	California
90044	4.8	92374	Los Angeles	Los Angeles	California
90047	4.6	49349	Los Angeles	Los Angeles	California
90057	5	44565	Los Angeles	Los Angeles	California
90062	4.8	32400	Los Angeles	Los Angeles	California

Community Assessment and Significant Needs

The hospital engages in multiple activities to conduct its community health improvement planning process. These include, but are not limited, to conducting a Community Health Needs Assessment with community input at least every three years, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

Community Health Needs Assessment

The health issues that form the basis of the hospital's community benefit plan and programs were identified in the most recent CHNA report, which was adopted in April 2019.

The CHNA contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods;
- Presentation of data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at www.chmcla.org or upon request at the hospital's Community Health office.

Significant Health Needs

The most recent community health needs assessment identified the following significant community health needs:

1. **Housing and homelessness** - 8% of adults in CHMC's service area reported being homeless or not having their own place to live or sleep in the past five years (compared to the county rate of 4.8%). 58.6% of service area owner and renter-occupied households spend 30% or more of their income on housing (compared to 48% countywide). Many families who spend a high percent of their income on housing live in crowded housing conditions and poor housing and that contributes to adverse health outcomes.
2. **Access the health care** – 17.7% of adults and 2.3% of children in CHMC's service area are uninsured. In the service area, 97.7% of children and 73% of adults have a regular source of health care.
3. **Mental health** – In the hospital service area, 9.1% of SPA 4 adults, 7.2% of adults in SPA 6, and 9.3% of adults in SPA 7 had experienced serious psychological distress in the past year. Stakeholders noted that for many ethnic communities, there is stigma around needing mental health services.
4. **Chronic diseases** - Heart disease, cancer and stroke are the top three causes of death in the service area. Diabetes is the fourth leading cause of death and Chronic Lower Respiratory Disease is the fifth leading cause of death in the service area.

5. **Economic insecurity** - Among the residents in CHMC's service area, 29.9% live in households with incomes less than 100% FPL. A high poverty rate is both a cause and a consequence of poor economic conditions. Stakeholders noted there are not enough jobs, which results in increased numbers of low-income people.
6. **Substance use and misuse** - Prescription drug misuse and its related problems are among society's most pervasive health and social concerns. In SPA 4, 20% of the population had misused prescription drugs. 18% of SPA 6 and 16% of SPA 7 residents had misused prescription drugs.
7. **Food insecurity** - 38.1% of service area households with incomes equal to or less than 300% FPL are food insecure. This percent is higher than the county rate of 29.2%.
8. **Education** – 37.4% of the adult population in the service area had less than a high school education (compared to 27.4% in the county). The HS graduation rate for Los Angeles Unified School District (76.1%) is lower than the Healthy People 2020 objective of 87%.
9. **Preventive practices** – In the service area, 56.3% of children, 6 months to 17 years, and 32.3% of adults have been vaccinated for influenza. The Healthy People 2020 objective is to have 70% of the population receive a flu shot. In the service area, 80.3% of women had a mammogram in the past two years compared to the Healthy People 2020 objective of 81.1%.
10. **Birth indicators** - The service area rate of low birth weight babies is 7.9% (78.8/1000 live births) which is higher than the county rate of 7.1%. Breastfeeding rates at CHMC indicate 91.0% of new mother use some breastfeeding and 63.8% use breastfeeding exclusively.

There are additional needs identified by the CHNA that were not deemed to be significant compared to the other needs, but the hospital does have programming addressing most of them, which will be described later in this report.

Significant Needs the Hospital Does Not Intend to Address

The hospital intends to take actions to address all of the prioritized significant health needs in the CHNA report, both through its own programs and services and with community partners. Lists and descriptions of those planned actions are included in this report.

2021 Report and 2022 Plan

This section presents strategies and program activities the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It summarizes actions taken in FY21 and planned activities for FY22, with statements on anticipated impacts, planned collaboration, and patient financial assistance for medically necessary care. Program Digests provide detail on select programs' goals, measurable objectives, expenses and other information.

This report specifies planned activities consistent with the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in community assets and resources directed to those needs may merit refocusing the hospital's limited resources to best serve the community.

The anticipated impacts of the hospital's activities on significant health needs are summarized below, and for select program initiatives are stated in Program Digests. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to needed and beneficial care; and help create conditions that support good health. The hospital works to evaluate impact and sets priorities for its community health programs in triennial Community Health Needs Assessments.

Creating the Community Benefit Plan

California Hospital Medical Center is dedicated to improving community health and delivering community benefit with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

The Community Benefit Planning Workgroup comprised of key community stakeholders and *promotoras* residing in CHMC's service area uses a process that focuses on two levels of decision making to determine how identified health issues will be addressed:

- Content areas
    - Size of the problem
    - Severity of the problem
    - Economic feasibility
    - Available expertise
    - Necessary time commitment

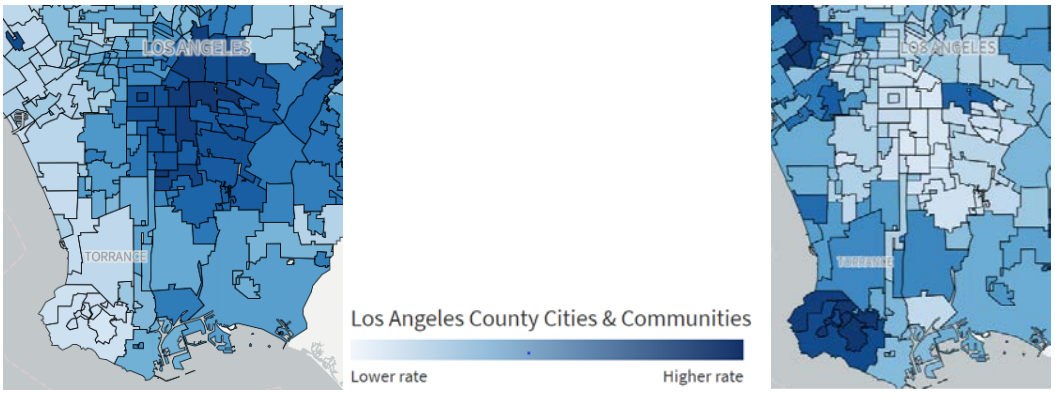
    - External salience
- Project activities
    - Target population
    - Number of people (i.e., How many people will be helped by this intervention?)
    - Estimated effectiveness/ efficiency
    - Existing efforts (i.e., who else is working on this? What is our role? How can we best complement/enhance an existing effort?)

We also considered:

- Existing programs with evidence of success/impact
- Expanding or adapting a successful program run by another health system (e.g., UniHealth Cultural Trauma and Mental Health Resiliency Project)
- Access to appropriate skills or resources
- Problems linked to high utilization rates at CHMC
- Prevention Requirements of Level II Trauma Center
- Requirements for Stroke Program
- *Hope Street Margolis Family Center's 2020 CHNA*
- *Dignity Health Community Health Strategy Blueprint 2019-2023*
- *Dignity Health Diabetes System Strategy Assessment*, June 2019
- *Plan for a Healthy Los Angeles: A Health and Wellness Element of the General Plan of Los Angeles City*, 2014
- *Homelessness Los Angeles, CA*, Urban Land Institute Advisory Services Panel Report, December 2017

Impact of the Coronavirus Pandemic

As the saying goes 'a picture is worth a thousand words.' The map below on the left shows the rate per 100,000 people of confirmed cases of COVID-19 cases in cities and communities in and near our service area as of October 14, 2021. The map on the right shows the COVID-19 vaccination rates in the same areas.



Even this late in the pandemic as cases, death rates, as hospitalizations continue to fall elsewhere in Los Angeles County, we have persistently high case rates, hospitalizations and death rates in our service area as a result of several problems: overcrowded housing, lots of essential workers, and low vaccination rates particularly among African American and Latinx populations.

A major contributor to the high case rates in our service area is overcrowding. In fact, low-income zip codes in South and Central LA are among the most crowded in the nation. 'Crowded' is defined as more than one person per room in a housing unit. 90011 is the #1 most crowded zip code in the nation at 34.6%. In order to afford housing, it's not unusual for multiple, often unrelated, families to occupy an apartment. This results in multiple generations of people crowded together; many are essential workers with high potential exposure rates. Social distancing or quarantining are simply not possible.

- The COVID-19 pandemic exacerbated the following community needs:
  - Homelessness
    - Even before the pandemic, the annual Homeless Count in January 2020 documented 66,433 homeless individuals –a 12.7% rise in LA County and a 14.2% rise in LA City. SPA 4 had 17,121 homeless individuals and 15, 795 homeless households; both represent a 4% increase over 2019. In SPA 6, there were 13,012 homeless individuals and 10,293 homeless households, representing a 36% and 28% increase over 2019, respectively. Homeless seniors (62+) increased 20%. Homeless transitional-age youth and unaccompanied minors increased 19%. There was a 45.7% increase in homeless families but fortunately, more than 75% of them are sheltered. There was a doubling of unsheltered adults 18+ who report substance use (27.0%), while the number of unsheltered reporting serious mental illness remained stable (25.0%).
    - In 2019, LA housed more people than ever, yet our housing affordability crisis drove a net rise in homelessness. LA needs 509,000 new affordable housing units to meet current demand. Systemic racism leads to a disproportionate number of black people becoming homeless in LA County, where 8% of the overall population is black but black people represent 34% of those experiencing homelessness. Wages have not kept pace with rents. Renters in LA County need to earn $41.96 per hour – 2.8 times the City of LA minimum wage – to afford the average monthly asking rent of $2,182.
    - 2/3 of unsheltered adults are on their first episode of homelessness. Reasons cited for falling into homelessness were: economic hardship (59%); weakened social network (39%); disabling health condition (24%); system discharge (11%); violence (8%); and other (4%).
    - In FY21, the LA County Homeless Initiative achieved the following outcomes:
      - 743 families and 1,264 individuals were prevented from becoming homeless
      - 16,936 individuals were newly engaged by outreach teams
      - 13,975 individuals and family members were active in the interim housing program and 2,684 were active in the interim housing program for people exiting institutions
      - 3,427 individuals and family members were placed in rapid re-housing; 1,940 individuals and family members were placed in permanent supportive housing; and 766 households were housed using landlord incentives
      - Project Roomkey has provided temporary hotel or motel stays to 8,723 people experiencing homelessness. In addition, with Project Homekey, the County purchased 10 hotels and motels to shelter about 900 people during the pandemic. Every Homekey unit will ultimately become permanent supportive housing.
  - Severely rent-burdened households
    - A majority of the households in our service area are severely rent-burdened (spending >50% of income on rent). Income losses due to decreased hours or job losses related to the pandemic are only making this worse.

        - While they are currently protected by the eviction moratoria, the concern is about what will happen once they are lifted.
    - Access to healthcare
        - During the first 4 months of the pandemic, there was decreased access to healthcare because the majority of the clinics were closed or had reduced hours. Nor was telehealth always an option for people in our service area because of lack of access to technology (computer/tablet) and Wi-Fi.
        - Families also avoided the clinics and ED/hospitals out of fear of contracting COVID-19.
        - During FY21, 53% of health care visits were virtual or telephonic. More families had access to technology because of a child attending virtual school and receiving the necessary equipment/hotspot from the school.
    - Mental Health and Substance Use
        - The pandemic and the resulting economic recession have negatively affected many people's mental health and created new barriers for people already suffering from mental illness or substance use disorders. In the KFF Tracking Poll conducted in mid-July, 53% of adults in the U.S. reported that their mental health had been negatively impacted due to worry and stress over the pandemic, significantly higher than the 32% reported in March. Manifestations included difficulty sleeping (36%) or eating (32%) increases in alcohol consumption or substance use (12%), and worsening chronic conditions (12%).
        - Job loss is associated with increased depression, anxiety, and low self-esteem and may lead to higher rates of substance use disorder and suicide.
        - The pandemic has also increased domestic violence (7%) and child abuse
        - Students depending on school services such as meal programs and physical, social, and mental health services are being negatively impacted; moreover, the mental health of children and adolescents may deteriorate due to fewer opportunities to engage with peers.
    - Chronic Diseases
        - Due to a combination of factors, i.e., sheltering in place, empty shelves in local grocery stores, limited resources, decreased access to health care, and running out of medication, chronic diseases were not well managed.
    - Economic Insecurity
        - May CHIS data revealed that regionally, LA County had high rates of job loss (15.1%) and reduced job hours/income (24.5%). Those who were uninsured were more likely to experience job reduced job hours/income (34%) compared to those who were insured (20.1%), more likely to have lost their job (26.3% vs. 11.2%), and experience financial difficulties with rent/mortgage (20.5% vs. 9.4%).
        - The pandemic is disproportionately affecting women of color and those with young children. The unemployment rate for Black and Hispanic women remains high, and women between the ages of 25 and 54 are increasingly dropping out of the workforce to care for children, since access to childcare is extremely limited and expensive. The participation gap between men and women in this age group is now widening after shrinking to the narrowest ever right before the pandemic.
    - Food Insecurity
        - In 2017 LA County had the largest population of food insecure people in the U.S. Food insecurity is highly correlated with low household income. The pandemic has exacerbated this problem because of the resulting shelter-in-place order, business closures (except for those providing essential services), reduced job hours/income

and job losses. As the months wear on, food insecurity increases as evidenced by the long line of cars waiting for donations from food banks. Unfortunately, the most food insecure in our service area don't even own cars.
        - USC Dornsife released the profile of food insecure Angelenos during this pandemic: 57% female; 55% Latino; 82% low income; 59% aged 18-40 years old; 50% of households with children.
        - A report from the Brookings Institute noted that 2 in 5 families with children under the age of 12 were food insecure by the end of April 2020. There is a concern that if this is not promptly addressed by the government it could lead to chronic negatives effects on children's health, cognition, and socioemotional development.
    - Education
        - The majority of public schools closed in mid-March 2020 and then tried to provide online services for their students (FY21). This revealed the huge digital divide that exists. The majority of children in our service area lack access to computers/tablets as well as Wi-Fi access. The schools have tried to provide devices and hotspots to as many students as possible; however, many households are not computer literate and/or lack someone to assist the students during the school day.
    - Preventive Services
        - Immunization rates of children have decreased 25-45% due to fear of taking children for well-child visits in the midst of the pandemic and the limited number of in-person appointments available, especially during the early months of the pandemic.

- In FY21, CHMC took the following actions to respond to the needs created or exacerbated by COVID-19:
    - The Hope Street Margolis Family Center:
        - Converted their in-person home visits or family visits to telephonic or virtual.
        - Set up an on-site emergency pantry in order to provide food baskets and essentials items such as diapers, formula, cleaning supplies, masks, detergent, etc. to families.
        - Converted ESL classes to virtual classes so that parents would not fall behind on their education.
        - Decided to continue their summer STEMI programming for school-age youth, with masks and social distancing.
        - Encouraged families to take children for well-child visits to keep their immunizations up-to-date
        - Offered on-site mentoring for school-age children during the "school day" so that students could have reliable internet access and devices for their school work. This also enabled some parents to work instead of having to provide childcare for their school-age children.
        - Offered on-site physical activity breaks for students.
        - The Family Childcare Network remained open throughout the year, enabling essential workers to have much needed childcare.
        - As soon as allowed, Early Care and Education sites reopened, though with reduced capacity to allow for social distancing.
    - Los Angeles Best Babies Network:
        - Converted all the in-person home visits to telephonic or virtual.
        - Hosted webinars for all home visitors to enable them to learn how to provide virtual visits as well as do various assessments virtually.
        - Deployed a donation of over a million diapers to families in need.
        - Encouraged families to keep immunizations up-to-date and to attend well-child visits

        - With help from the Board of Supervisors, laptops and Wi-Fi bundles were loaned to families so they could participate in virtual home visits.
    - Welcome Baby hospital liaisons at CHMC:
        - Developed a hybrid (mostly virtual with some in-person) protocol for doing formerly in-person visits on Couplet Care to offer free perinatal and early childhood home visitation programs to new families and to obtain the necessary consents. This served as a model for the other thirteen hospitals offering Welcome Baby.
        - Began giving out the Welcome Baby program incentives like the Welcome Baby Book, the boppy pillow, and safety kit to enrolled families since the nurses and parent coaches were no longer doing in-person visits. However, we had to stop this practice in October 2021.
    - Community Health staff:
        - Started calling community members who had participated in our in-person classes to find out how they were doing and if they had any pressing needs or questions.
            - Helped them find the local resources they needed, especially food and diapers.
            - Employees provided cash donations, food, clothing, and other necessities for families and dropped them off.
            - Provided one-on-one education on a variety of topics, including nutrition, diabetes management, cardiovascular disease management, stress management, COVID-19, etc.
            - Helped families get tested for COVID-19 and figure out how to safely quarantine.
        - Spiritual care staff and staff from a variety of other departments began referring individuals/families with questions or needing resources to us.
        - Responded to requests from community partners to provide virtual health education to either their staff or families
- In addition to continuing many of the actions identified above, CHMC plans to take the following actions in FY22 to continue helping alleviate pandemic-induced needs:
    - Focused our FY22 Community Grants Program on homelessness/housing insecurity and behavioral health since these remain major pandemic needs that are likely to worsen over the ensuing months.
    - Strongly encouraging community members to get their flu shot and educating them about the increased importance in light of the COVID-19 pandemic.
    - Continue to encourage unvaccinated community members to get their COVID-19 vaccinations and if they qualify, boosters.

Report and Plan by Health Need

The tables below present strategies and program activities the hospital has delivered or intends to deliver to help address significant health needs identified in the community health needs assessment.

They are organized by health need and include statements of strategy and program impact, and any collaboration with other organizations in our community.

Housing and Homelessness

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
10th Decile Project	• This Dignity Health Community Grant-funded project connects the top 10% highest cost, highest need chronically homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical and behavioral health care services through a collaboration of Corporation for Supportive Housing, JWCH Institute, and Housing Works. • In August 2020 Blue Shield CA became the grant-funder for the expansion of this program. Then in August 2021, Dignity Health Homeless Health Initiative became the funder.	☒	☒
HSFC's Early Head Start Program	• Homeless pregnant women and/or parenting women with child ages 0-3 yr. are a priority group for program enrollment based on HSFC's last EHS Community Needs Assessment. • EHS staff outreach to these families in shelters and work to help them access permanent affordable housing	☒	☒
HSFC's The Nest, 4th ECE Center	• Priority enrollment will be given to children 0-5 experiencing homelessness	☐	☒
Zahn Memorial Center & Lily's Place for Homeless Families	• This Dignity Health Community Grant will fund a Housing Specialist who will assist 30 families in residence at Zahn Memorial Center & Lily's Place in locating and securing permanent housing more quickly	☒	☒

Mental Health Support for Women with Histories of Homelessness	• The Downtown Women's Health Center is the only gender-specific health clinic in Skid Row and provides specialized, trauma-informed primary care, patient navigation, medical case management, behavioral health care, women's specialty health and holistic wellness services.	☒	☒
Social Workers focused on Homeless Patients seen in ED	• The Dignity Health Homeless Health Initiative provided us with 3 grant-funded social workers to assist with discharge planning of homeless patients seen in ED	☒	☒

Impact: : Increased access to permanent supportive housing for chronically homeless individuals with complex needs; increased access to permanent affordable housing for homeless families; increased access to female-centric, trauma-informed mental health services for homeless women; decreased ED utilization and hospital readmissions and improved health and wellbeing.

Collaboration: Each of these programs involves collaboration with multiple agencies serving the homeless including hospital navigators, physical and behavioral health providers, housing navigators, homeless shelters, etc.
CHMC will also collaborate with Dignity Health's Homeless Health Initiative.

Access to Health Care

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Para Su Salud	• Enrollers assist individuals and families sign up for health and dental health insurance benefits • Recertification is required every 6 mo.	☒	☒
Health Ministry Program	• Parish Nurse screens for common chronic conditions at a variety of community sites; on hold due to pandemic • Refers those with abnormal results and those without a medical home to local FQHCs • Provided one-on-one diabetes education during pandemic; however, Diabetes Empowerment Education Program (DEEP) classes resumed in FY22	☒	☒
Charity Care based on financial need	• See CHMC's financial assistance policy	☒	☒
Clinical experience for medical professional students	• CHMC provides clinical experience to: our own Family Medicine residents, UCLA Santa Monica, Charles Drew, Harbor-UCLA, and Eisenhower residents, Ross University School of Medicine	☒	☒

	students, and nursing students from a variety of schools		
COPE Health Scholars Program	• Program participants are ≥ 18 yr., accepted to, enrolled in, or graduated from an accredited college or university, pursuing a career in health care and basic CPR certified • They enroll in an 8-unit certification course through UC Riverside Extension delivered on site at CHMC; serve a minimum of 4-6 hr./wk.; accumulate ≥280 hr. in order to formally graduate from the program and receive certification of completion. During the pandemic, these classes will be offered online. • They work alongside nurses, physicians, and allied health professionals in clinical and administrative settings at CHMC • They receive training to assist in basic patient-care tasks such as bathing, changing and feeding patients as they rotate among the different departments of the hospital • The students came back at the hospital in non-patient facing roles due to the pandemic. • This program ended on June 30, 2021	☒	☐
10th Decile Project	• This grant-funded project connects the top 10% highest cost, highest need chronically homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services through a collaboration of Corporation for Supportive Housing, Housing Works, and JWCHI, Inc.	☒	☒
HSFC's Early Head Start Program	• Assists families in accessing health and dental health insurance coverage • Assists families in establishing a medical home for each family member • Encourages attendance at all prenatal and/or well-child visits	☒	☒
LA Best Babies Network's perinatal and early childhood home visitation programs	• Assists families in accessing health and dental health insurance coverage • Assists families in establishing a medical home for each family member • Encourages attendance at all prenatal and/or well-child visits	☒	☒
Navigation the Health Care System	• A four-unit health literacy curriculum designed by Nemours Children's Health System for use with high school students in classroom or community setting	☒	☒

	• It is designed to prepare students to be responsible for managing their own health care as they transition into adulthood • Usually delivered by public health interns but currently on hold due to pandemic; as soon as colleges and universities allow students to come back in person, this program will resume.		

Impact: : Gains in public or private health care coverage; increased knowledge about how to access and navigate the health care system; increased primary care "medical homes" among those reached by navigators; workforce development in a safety net hospital

Collaboration: The hospital partners with many local schools, churches and community sites to provide enrollment assistance for uninsured individuals and families and/or make referrals to FQHCs of the Southside Coalition of Community Health Centers. The hospital also collaborates with a variety of medical professional education programs to provide clinical experience for their students. HSFC has over 30 community partners. LABBN works with 14 hospitals and over 38 community partners, First 5 LA, LACDPH, LACDPSS, Work2Live, and PAC/LAC. LABBN oversees the training of all new home visitors and together with Work2Live and MCHA provides technical assistance to all home visiting agencies and maintains their common database.

Mental Health

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
HSFC Early Head Start Program	• Parents will be screened for depression/anxiety and intimate partner violence (IPV) • Parents and/or children 0-3 needing treatment will be referred to community resources	☒	☒
Pico Union Family Preservation Network	• Parents will be screened for depression/anxiety and IPV. • Children with be screened for adverse childhood experiences (ACEs) and mental health or behavioral issues • Parents and/or children needing treatment for mental health concerns will be referred to community resources • Offers support group for women who have experienced IPV • Offers anger management psychoeducational group • Offers a parenting psychoeducational group	☒	☒

Wraparound Services Program	• Parents will be screened for depression/anxiety and IPV • Wraparound Program provides community-based support and individualized planning for children, including those with severe emotional and behavioral disorders and their families • The Wraparound Team creates an intensive family preservation plan that supports keeping the child at home with their family. • Parents and/or children needing treatment for mental health issues are referred to community resources.	☒	☒
HSFC Early Care and Education Centers	• Children will be screened for mental health and behavioral issues • Those needing treatment will be referred to community resources	☒	☒
Hope Street Youth Center	• Youth needing treatment for mental health issues will be referred to community resources • Youth are encouraged to participate in Youth Fitness Program • Youth learn how to manage stress through yoga	☒	☒
CA Behavioral Health Clinic	• Children aged 0-21 with Medi-Cal receive mental health services • Women suffering from PMADs receive dyadic care with their infant/toddler	☒	☒
LABBN's perinatal and early childhood home visitation programs	• Home visitors routinely screen for PMADs and IPV and refer individuals needing treatment to community resources	☒	☒
10th Decile Project	• This grant-funded project connects the top 10% highest cost, highest need chronically homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services through a collaboration of Corporation for Supportive Housing, Housing Works, and JWCHI, Inc. • 25% of people experiencing homelessness have SMI and 27% have SUD.	☒	☒
Mental Health Support for Women with Histories of Homelessness	• The Downtown Women's Health Center is the only gender-specific health clinic in Skid Row and provides specialized, trauma-informed primary care, patient navigation, medical case management, behavioral health care, women's specialty health and holistic wellness services	☒	☒

	• This is a Dignity Health Community Grant-funded program is a collaboration of Downtown Women's Center, JWCH, Inc., and USC Chan Division of Occupational Science and Occupational Therapy during 2021. In 2022 this program will be a collaboration of Downtown Women's Center, John Wesley Community Health Institute, Inc., USC Chan Division of Occupational Science and Occupational Therapy, and West Coast University.		
UniHealth Cultural Trauma and Mental Health Resiliency Project	• Joint effort of the six Dignity Health hospitals in Southern California working in tandem to increase the capacity of local community organizations, community members and hospitals to identify mental distress and/or suicidality among at risk youth, and to respond appropriately • Improve access to prevention and early intervention mental health and SUD services, thereby decreasing health disparities, especially for those affected by poverty, racism, adverse childhood experiences, and violence. • This project is jointly funded by UniHealth Foundation, participating Dignity Health hospitals, and the Dignity Health Foundation. • Each hospital identifies and funds its own grantees who deliver Mental Health First Aid, Youth Mental Health First Aid, and Question, Persuade, and Refer to the target population in their service area.	☒	☒
Healing Domestic Abuse Victims to Create a Healthier, More Self-Sufficient Community	• Each client is assigned a treatment team comprised of a therapist and case manager • Clients receive intensive mental health services and referrals to community resources to stabilize their life domain issues and to address barriers to treatment and recovery. • This project involves collaboration between Amanecer Community Counseling Service, the Anne Douglas Center at the LA Mission, Institute of Multicultural Counseling & Education Services, and Peace Over Violence.	☒	☐

Impact: The hospital's initiatives to address mental health issues are anticipated to result in: early identification and treatment of women with depression/anxiety or PMADs thereby improving the developmental trajectory of their infants/toddlers and older children; increased access to needed mental health services for children and adults; youth and adults will learn healthy coping skills; by providing navigation services to high risk individuals with mental illness, increased likelihood of their accessing treatment services; increased ability of those interacting with vulnerable youth to identify mental distress and/or suicidality and respond appropriately; decreased mental health stigma and increased help seeking among those with clinical need.

Collaboration: Each of the programs involves collaboration with multiple community partners. CHMC is also an active member of the Immigrant Integration Task Force hosted by CCF in order to stay abreast of all the politically motivated attacks on the immigrant community striking fear, confusion, isolation, depression/anxiety, and a sense of hopelessness.

Chronic Diseases

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Health Ministry Program	• Parish Nurse screens for common chronic diseases including overweight/obesity; screening on hold due to the pandemic during FY21 but resumed in FY22 • Refers those with abnormal results to local FQHCs if they do not already have a medical home • Pre-diabetics are referred to National Diabetes Prevention Program and/or Diabetes Empowerment Education Program (DEEP) • Individuals with elevated cholesterol or hypertension are referred to Heart HELP Program • If interested in smoking cessation, refers them to DPH Smoking Cessation assistance program and/or 1-800-NO-BUTTS	☒	☒
Heart HELP Program	• Participants learn how to minimize their risk for cardiovascular disease (CVD) by healthy eating and cooking and maintaining an active lifestyle and addressing risk factors like obesity/overweight, hypertension, cholesterol, and pre-diabetes/diabetes • Early in the pandemic, one-on-one health education was provided telephonically since the majority lack computer/tablet and Wi-Fi access. With time more learned how to use Zoom platform and many gained access to computer/tablet and Wi-Fi access through equipment given to their children for home schooling. • Heart HELP classes resumed virtually in FY22	☒	☒
Diabetes Empowerment Education Program	• Participants with pre-diabetes learn how to prevent diabetes • Participants with diabetes learn how to manage their disease and improve their health in order to prevent complications	☒	☒

	• Participants learn that diabetes is a major risk factor for CVD and are encouraged to attend Heart HELP after completing DEEP • During the pandemic, one-on-one health education was provided telephonically since the majority lack computer/tablet and Wi-Fi access. With time more learned how to use Zoom platform and many gained access to computer/tablet and Wi-Fi access through equipment given to their children for home schooling. • Parish Nurse translated virtual DEEP curriculum into Spanish and resumed giving classes in FY22		
Chronic Disease Self-Management Program	• In 6 weekly workshops participants with chronic conditions learn how to manage and improve their health • Topics include: pain management, nutrition, exercise, medication use, emotions, and communicating with doctors • During the pandemic, one-on-one health education is provided telephonically since the majority lack computer/tablet and Wi-Fi access. With time more learned how to use Zoom platform and many gained access to computer/tablet and Wi-Fi access through equipment given to their children for home schooling. • This program will resume in FY22	☒	☒
Emotional Well-being Support Group	• Patient and community support group for people with chronic diseases to improve their emotional well-being through mutual support, coping strategies, and psychoeducation • During the pandemic sessions are offered via Zoom and/or telephone.	☒	☒
CHMC's Women Health Center	• Uninsured women are referred to Women's Health Center for free mammography and cervical cancer screening	☒	☒
Coordinated Care Initiative	• Patients with chronic diseases who have their medical home at FQHCs belonging to the Southside Coalition of Community Health Centers and are inpatients at CHMC are eligible for this program • Deploys HIE*Lite for patient identification and management • Patient navigators develop care plans for enrolled patients and coordinate their post-discharge care • Decreases ED revisits and 30-day readmissions	☒	☒
10th Decile Project	• This Dignity Health Community Grant-funded project connects the top 10% highest cost, highest	☒	☒

	need chronically homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services through a collaboration of Corporation for Supportive Housing, Housing Works, and JWCHI, Inc. • A majority of these patients have chronic diseases such as hypertension, diabetes, or CVD.		
Healthy Eating and Lifestyle Program	• Overweight/obese children aged 5-12 yr. are referred to this program by their primary care provider • The children and their parents learn to decrease screen time, consumption of fast food, sugar-sweetened beverages, and calorie-dense, nutrient poor food and to increase their physical activity and consumption of fresh fruits and vegetables and water • By decreasing children's overweight/obesity, the program will decrease their risk for diabetes and hypertension. • Currently this program is being offered via Zoom.	☒	☒
HSFC's Early Head Start Program	• Pregnant and parenting women with children aged 0-3 yr learn about the importance of: exclusive breastfeeding for the first 6 mo. of life with continued breastfeeding for as long as feasible; the consumption of fresh fruits and vegetable as well as water; the avoidance of fast food, sugar sweetened beverages, and calorie-dense nutrient poor foods; and maintaining an active lifestyle in order to prevent obesity/overweight • During the pandemic, all visits are telephonic or virtual.	☒	☒
HSFC Early Care and Education Centers	• Parenting women with children aged 0-3 yr learn about the importance of: exclusive breastfeeding for the first 6 mo. of life with continued breastfeeding for as long as feasible; the consumption of fresh fruits and vegetable as well as water; the avoidance of fast food, sugar sweetened beverages, and calorie-dense nutrient poor foods; and maintaining an active lifestyle in order to prevent obesity/overweight • Menus of licensed childcare centers conform with nutrition guidelines for EHS/HS • A limited number of children were welcomed back to the centers in July 2020	☒	☒
HSFC Family Childcare Network	• Pregnant and parenting women with children aged 0-3 yr. learn about the importance of: exclusive	☒	☒

	breastfeeding for the first 6 mo. of life with continued breastfeeding for as long as feasible; the consumption of fresh fruits and vegetable as well as water; the avoidance of fast food, sugar sweetened beverages, and calorie-dense nutrient poor foods; and maintaining an active lifestyle in order to prevent obesity/overweight • Menus of licensed childcare centers conform with nutrition guidelines for EHS/HS • These sites remained open throughout the pandemic.		
Hope Street Youth Center	• Children and Youth aged 7-18 yr. learn about healthy eating, healthy cooking, portion control, the importance of maintaining an active lifestyle and healthy coping strategies for life's stressors • They are encouraged to participate in the Youth Fitness Program • Some of these activities are currently on hold due to the pandemic. They will resume when the majority of the participants are fully vaccinated.	☒	☒
LABBN's Perinatal and Early Childhood Home Visitation Programs	• Pregnant and parenting women with children aged 0-5 yr. learn about the importance of: exclusive breastfeeding for the first 6 mo. of life with continued breastfeeding for as long as feasible; the consumption of fresh fruits and vegetable as well as water; the avoidance of fast food, sugar sweetened beverages, and calorie-dense nutrient poor foods; and maintaining an active lifestyle in order to prevent obesity/overweight • All services quickly pivoted from in-person to virtual in late March 2020. • The Board of Supervisors enabled staff to loan new computers and provide Wi-Fi bundles for families who lacked them so they could participate in virtual visits.	☒	☒

Impact: CHMC's initiatives related to chronic diseases are designed to: prevent early childhood overweight/obesity; prevent adolescent obesity by early identification and treatment of overweight/obesity in children aged 5-12 yr.; prevent diabetes by early identification and treatment of pre-diabetes; prevent complications of diabetes by teaching people with diabetes how to better manage their disease; prevent complications of CVD by teaching people with hypertension, high cholesterol and/or heart disease how to better manage their disease; help people cope with living with a chronic diseases

Collaboration: LA County Community Health Assessment and Action Partnership (LA Partnership) is made up of community health directors of non-profit hospitals and health systems of LA County who have agreed to collaborate on their CHNA with the support of LACDPH and engage in population health improvement strategies. It will invest in upstream prevention strategies to maximize population

impact (“making the healthy choice the easy choice”). It will promote a coordinated set of strategies in selected high need communities to achieve measurable gains. Unfortunately, this plan was abandoned during the pandemic and when the group recently reconvened virtually on October 6, 2021, it was decided to focus on some aspect of homelessness instead.
The LA County DPH-led National Diabetes Prevention Program Community Advisory Board aims to spread NDPP throughout LA County, increase access to the program through commercial and public health plans including Medicare and Medi-Cal thereby increasing access for high-risk, low income community members with pre-diabetes

Economic Insecurity

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
HSFC Family Literacy Program	• Family literacy program helps parents improve both their parenting and literacy skills while providing young children with early childhood education to support their emerging literacy skills • Parents learn ESL and the importance of child-led play • Parents also learn financial literacy • During the pandemic ESL classes continue for the parents via Zoom.	☒	☒
HSFC Early Head Start Program	• Promotes economic self-sufficiency for parents • Beginning with expectant families, healthy, loving relationships between parents and children will lead to success in school and life • EHS promotes school readiness in a variety of ways including encouraging parents to talk, read, and sing to their infants, toddlers, and young children	☒	☒
HSFC Early Care and Education Centers	• Access to full-day licensed childcare enables parents to continue their education or work • Children 0-5 learn school readiness skills at these centers that meet the rigorous EHS/HS standards • Due to the pandemic a limited number of children were welcomed back to the centers in July 2020	☒	☒
HSFC Family Childcare Network	• Access to licensed childcare during evenings, nights and week-ends enables parents to continue their education or work • Children 0-5 learn school readiness skills at these centers that meet the rigorous EHS/HS standards • These sites remained open throughout the pandemic	☒	☒

Hope Street Youth Center	• Youth aged 7-18 can access homework assistance, a computer learning lab, and the Youth Fitness Program at this afterschool program • College students provide mentoring and computer learning opportunities (on hold due to pandemic); instead, staffing was increased. • High school students and their parents participate in College Prep training and local college tours • Due to the pandemic, the Youth Center became an online school-work site where students are socially distant and wearing masks while staff circulate to provide assistance/tutoring/computer problem solving and much needed social support. • During the summer, a special STEMI Program is offer in collaboration with the Museum of Science and Industry; this continued despite the pandemic. • LAUSD and other local schools resumed in-person classes for the FY22 school year; youth ages 16 and older were mandated to be vaccinated.	☒	☒
LABBN's Perinatal and Early Childhood Home Visitation Program	• Home visitors encourage parents to talk, read, and sing to their infants, toddlers, and young children. • With the onset of the pandemic, in-person services quickly pivoted to virtual.	☒	☒
Healing Domestic Abuse Victims to Create a Healthier, More Self-Sufficient Community	• Each client is assigned a treatment team comprised of a therapist and case manager • Clients receive intensive mental health services and referrals to community resources to stabilize their life domain issues and to address barriers to treatment and recovery. • The majority will receive vocational/educational or job-readiness training either through Amanecer or through collaborative partners • This project involves collaboration between Amanecer Community Counseling Service, the Anne Douglas Center at the LA Mission, Institute of Multicultural Counseling & Education Services, and Peace Over Violence. • This Dignity Health Community Grant funded program ends December 31, 2021.	☒	☐

Impact: CHMC's initiatives to improve literacy in general and more specifically health and financial literacy are anticipated to result in: improved school readiness; improved success in elementary, middle, and high school; improved college readiness; greater likelihood of pursuing higher education; improved financial earning power as well as better health is associated with increased educational attainment. Providing high quality, all-day childcare for infants, toddlers and young children as well as family childcare during evening, nights, and week-ends enables parents to continue their education or work.

Collaboration: All of these programs involve community partnerships/collaborations

Substance Use and Misuse

Strategy or Program Name	Summary Description	Active FY20	Planned FY21
CA Bridge Program in ED	• Initiate buprenorphine for patient with Opioid Use Disorder in withdrawal • Teach family and friends of patient with OUD how to use naloxone in case of opioid overdose • Substance Use Navigator (SUN) will arrange discharge plan with local MAT provider • If patient with OUD is homeless, he/she may qualify for Bridge Housing for 90 day. The MAT provider must make that request.	☒	☒
Pico Union Family Preservation Program	• Family Preservation services are short-term, family-focused services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. • Families may be referred to this program by DCFS because of parental SUD and/or child abuse or neglect • Parent with SUD will be referred to appropriate treatment program • If child has mental health or behavioral concerns, he/she will be referred to appropriate community resource	☒	☒
Wraparound Services Program	• Wraparound Program provides community-based support and individualized planning for children, including those with severe emotional and behavioral disorders and their families • The Wraparound Team creates an intensive family preservation plan that supports keeping the child at home with his/her family • By preventing ACEs, one can decrease the likelihood that the child will become an alcoholic or drug addict in the future.	☒	☒
HSFC Early Head Start Program	• EHS is a Federal initiative providing child development and parent support services to low-income pregnant women and families with children birth-3 yr. • Children who participate have lower rates of child abuse and neglect, thereby decreasing the likelihood	☒	☒

	that they will become an alcoholic or drug addict in the future		
HSFC Early Care and Education Centers	• Parents learn the importance of responsive caregiving and keeping their children safe. • Early education and parent support services are provided to low-income families with children birth to 5 yr. • By preventing ACEs, one can decrease the likelihood that the child will become an alcoholic or drug addict in the future	☒	☒
HSFC Family Childcare Network	• Parents learn the importance of responsive caregiving and keeping their children safe. • Early education and parent support services are provided to low-income families with children birth to 5 yr. • By preventing ACEs, one can decrease the likelihood that the child will become an alcoholic or drug addict in the future	☒	☒
CA Behavioral Health Clinic	• Children aged 0-21 yr. with Medi-Cal will receive mental health services; services will primarily be virtual during the pandemic. • By diagnosing and addressing children's mental health needs, there is a decreased likelihood that they will become an alcoholic or drug addict in the future.	☒	☒
HSFC Early Intervention Program	• Families with infants or toddlers who have a developmental delay or disability or with an established risk condition likely to result in a delay are eligible for services • Specialists evaluate and assess infants and toddlers and provide EI and family support services for young children birth – 3 yr. • Families who understand the nature of their child's delay or disability are less likely to abuse the child • By preventing adverse childhood experiences (ACEs), one can decrease the likelihood that the child will become an alcoholic or drug addict in the future	☒	☒
LABBN's Perinatal and Early Childhood Home Visitation Programs	• Home visitors teach the families about milestones of child development • Families receiving family support services through home visits are significantly less likely to abuse or neglect their children • By preventing adverse childhood experiences (ACEs), one can decrease the likelihood that the	☒	☒

	child will become an alcoholic or drug addict in the future		
10th Decile Project	• This grant-funded project connects the top 10% highest cost, highest need chronically homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services through a collaboration of CSH, Housing Works, and John Wesley Community Health Institute, Inc. • According to the 2020 Homeless Count in LA County, 27% of adults experiencing homelessness have SUD (up from 14.2% the year before) and 25.1% have a serious mental illness (stable from the year before).	☒	☒
UniHealth Cultural Trauma and Mental Health Resiliency Project	• Joint effort of the six Dignity Health hospitals in Southern California working in tandem to increase the capacity of local community organizations, community members and hospitals to identify mental distress and/or suicidality among at risk youth, and to respond appropriately • Improve access to prevention and early intervention mental health and SUD services, thereby decreasing health disparities, especially for those affected by poverty, racism, adverse childhood experiences, and violence.	□	☒

Impact: CHMC's initiatives to prevent child abuse or neglect are anticipated to prevent children from suffering from ACEs which are known to impose neurobiological and psychosocial effects that often results in health risk behaviors (smoking, drinking, substance use) in adolescence which, in turn, result in long-term consequences such as alcoholism, SUD, chronic disease, mental illness, unemployment, criminal behavior, and homelessness. CHMC's initiatives to address child abuse and neglect are anticipated to ameliorate the long-term consequences of ACEs. CHMC's initiatives to address mental illness and homelessness are anticipated to increase access to SUD treatment services for those in need. CHMC's CTMHR Project will result in: increased ability of those interacting with vulnerable youth to identify mental distress and/or suicidality and respond appropriately; decreased mental health stigma and increased help seeking among those with clinical need.

Collaboration: All of these programs involve community collaborations. The CTMHR Project involves collaboration between all six Dignity Health hospitals in Southern CA and their community partners; moreover, each County (LA & SB) has its own Community Advisory Committee.

Food Insecurity

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Para Su Salud	• Health insurance enrollers are encouraged to offer enrollment in food assistance programs that the individual/families may qualify for, i.e., WIC or CalFresh. • Seniors are now eligible for CalFresh • Can now enroll in CalFresh online, instead of going into DPSS office	☒	☒
Diabetes Empowerment Education Program	• As many as 15% of individuals who are food insecure have diabetes and 27.7% are obese; therefore, it is important to screen all participants for food insecurity using a short screening tool called the Hunger Vital Sign. • Those who are food insecure should be referred to CalFresh, WIC. and other food assistance programs for which they qualify • Nutrition education should teach individuals to maximize their family budget while preparing healthy diabetic meals.	☒	☒
Heart HELP	• 27.7% of individuals who are food insecure are obese and 30% have hypertension, 29.6% have high cholesterol, and 15% have diabetes; therefore, it is important to screen all participants for food insecurity using a short screening tool called the Hunger Vital Sign. • Those who are food insecure should be referred to CalFresh, WIC. and other food assistance programs for which they qualify • Nutrition education should teach individuals to maximize their family budget while preparing heart healthy meals.	☒	☒
Chronic Disease Self-Management Program	• In 6 weekly workshops participants with chronic conditions learn how to manage and improve their health • Topics include: pain management, nutrition, exercise, medication use, emotions, and communicating with doctors • All participants should be screened for food insecurity using a short screening tool called the Hunger Vital Sign	☒	☒

	• Those who are food insecure should be referred to CalFresh, WIC. and other food assistance programs for which they qualify		
Healthy Eating and Lifestyle Program	• Overweight/obese children aged 5-12 yr. are referred to this program by their primary care provider • Parents should be screened for food insecurity using a short screening tool called the Hunger Vital Sign • Those who are food insecure should be referred to CalFresh, WIC. and other food assistance programs for which they qualify • The children and their parents learn to decrease screen time, consumption of fast food, sugar-sweetened beverages, and calorie-dense, nutrient poor food and to increase their physical activity and consumption of fresh fruits and vegetables and water • During the pandemic this program is offered via Zoom.	☒	☒
HSFC Early Head Start Program	• All families are screened for food insecurity • Those who are food insecure are referred to WIC, CalFresh, and other food assistance programs for which they qualify • The pandemic resulted in job loss, increased financial insecurity, and tremendous food insecurity. HSFC set up a food pantry and access to needed items such as diapers and wipes. HSFC also hosted a food drive and a fund raiser in order to access more food.	☒	☒
LABBN's Perinatal and Early Childhood Home Visitation Programs	• All families are screened for food insecurity • Those who are food insecure are referred to WIC, CalFresh, and other food assistance programs for which they qualify • An online resource guide for families in English/Spanish was developed soon after the onset of the pandemic. Food resources in every SPA are identified.	☒	☒
CHMC's Food Recovery Initiative	• Food produced for cafeteria consumption that is not consumed is appropriately cooled and set aside for pick-up by Food Finders • Food Finders picks up the food and immediately transports it to a local partner that can use it, i.e., a homeless shelter, a sober living home, etc.	☒	☒
Health Ministry Program	• Since the onset of the pandemic, the *promotora* has fielded many questions re how to access food. She provides resources closest to the client including	☒	☒

	food banks, drive-through giveaways, local food pantries, etc. • She also reminds undocumented clients that the new Public Charge Rule is on hold during the pandemic so clients can access CalFresh without fear of reprisals. • A Directory of Food Resources by zip code was developed by Health Ministry staff to mail to clients who were food insecure.		

Impact: CHMC's initiatives to address food insecurity are anticipated to assist individuals and families in accessing affordable, nutritious food.

Collaboration: : LA County Community Health Assessment and Action Partnership (LA Partnership) is made up of community health directors of non-profit hospitals and health systems of LA County who have agreed to collaborate on their CHNA with the support of LACDPH and engage in population health improvement strategies. It will invest in upstream prevention strategies to maximize population impact ("making the healthy choice the easy choice"). It will promote a coordinated set of strategies in selected high need communities to achieve measurable gains. One of the workgroups is focused on addressing food insecurity by:1) increasing CalFresh enrollment; and 2) increasing the participation of more hospitals in the Food Recovery Initiative. Unfortunately, this plan was abandoned during the pandemic and when the group reconvened virtually on October 6, 2021, it was decided to focus on some aspect of homelessness instead.

Education

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
HSFC Family Literacy Program	• Family literacy program helps parents improve both their parenting and literacy skills while providing young children with early childhood education to support their emerging literacy skills • Parents learn ESL and the importance of child-led play • Parents also learn financial literacy • During the pandemic, ESL classes continue for the parents via Zoom.	☒	☒
HSFC Early Head Start Program	• Beginning with expectant families, healthy, loving relationships between parents and children will lead to success in school and life • EHS promotes school readiness in a variety of ways including encouraging parents to talk, read, and sing to their infants, toddlers, and young children	☒	☒

HSFC Early Care and Education Centers	• Access to full-day licensed childcare enables parents to continue their education or work • Children 0-5 learn school readiness skills at these centers that meet the rigorous EHS/HS standards	☒	☒
HSFC Family Childcare Network	• Access to licensed childcare during evenings, nights and week-ends enables parents to continue their education or work • Children 0-5 learn school readiness skills at these centers that meet the rigorous EHS/HS standards	☒	☒
Hope Street Youth Center	• Youth aged 7-18 can access homework assistance, a computer learning lab, and the Youth Fitness Program at this afterschool program • College students provide mentoring and learning opportunities (on hold due to pandemic) • High school students and their parents participate in College Prep training and local college tours • Due to the pandemic, in FY 21 the Youth Center became an all-day online school-work site where students are social distant and wearing masks while staff circulate to provide assistance/tutoring/computer problem-solving, and much needed social support. • During the summer, a special STEMI Program is offered in collaboration with the Museum of Science and Industry • LAUSD and other local schools resumed in-person classes during Fall 2021 and all students 16 and over were mandated to be vaccinated against COVID-19.	☒	☒
LABBN's Perinatal and Early Childhood Home Visitation Programs	• Home visitors encourage parents to talk, read, and sing to their infants, toddlers, and young children.	☒	☒
UniHealth Cultural Trauma and Mental Health Resiliency Project	• Joint effort of the six Dignity Health hospitals in Southern California working in tandem to increase the capacity of local community organizations, community members and hospitals to identify mental distress and/or suicidality among at risk youth, and to respond appropriately • Improve access to prevention and early intervention mental health and SUD services, thereby decreasing health disparities, especially for those affected by poverty, racism, adverse childhood experiences, and violence • Improving the mental health of youth will result in decreased conduct problems, aggressive behavior,	☒	☒

	hyperactivity/attention problems, risky sexual behavior, substance abuse, social deviance and anxiety/depression and increased empathy, well-being, quality relationships, prosocial behavior, satisfaction with school, leadership skills, and academic achievement.		
Healing Domestic Abuse Victims to Create a Healthier, More Self-Sufficient Community	• Each client is assigned a treatment team comprised of a therapist and case manager • Clients receive intensive mental health services and referrals to community resources to stabilize their life domain issues and to address barriers to treatment and recovery. • The majority will receive vocational/educational or job-readiness training either through Amanecer or through collaborative partner • This project involves collaboration between Amanecer Community Counseling Service, the Anne Douglas Center at the LA Mission, Institute of Multicultural Counseling & Education Services, and Peace Over Violence. • This Dignity Health Community Grant-funded program will end Dec. 31, 2021.	☒	☐

Impact: CHMC's initiatives to improve literacy in general and more specifically health literacy are anticipated to result in: improved school readiness; improved success in elementary, middle, and high school; improved college readiness; greater likelihood of pursuing higher education; improved financial earning power as well as better health is associated with increased educational attainment. Although not everyone needs to go to college, everyone needs skills and knowledge for which others are willing to pay a living wage. Providing high quality, all-day childcare for infants, toddlers and young children as well as family childcare during evening, nights, and week-ends enables parents to continue their education or work.

Collaboration: All of these programs involve community collaborations. The CTMHR Project involves collaboration between all six Dignity Health hospitals in Southern CA and their community partners; moreover, each County (LA & SB) has its own Community Advisory Committee.

Preventive Services

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
HSFC Early Head Start Program	• EHS is a Federal initiative providing child development and parent support services to low-	☒	☒

	income pregnant women and families with children birth-3 yr. • All pregnant women and infants and toddlers from birth to age 3 are strongly encouraged to keep all of their scheduled appointments in order to receive all necessary preventive services. • Influenza vaccination is strongly encouraged annually for children 6 months old and above and for all adults		
LABBN's Perinatal and Early Childhood Home Visitation Programs	• All pregnant women and infants, toddlers and young children from birth to age 5 are strongly encouraged to keep all of their scheduled appointments in order to receive all necessary preventive services. • Influenza vaccination is strongly encouraged annually for children 6 months old and above and for all adults	☒	☒
CHMC's Women's Health Center	• Uninsured women are referred to Women's Health Center for free mammography and cervical cancer screening	☒	☒
HSFC Early Care and Education Centers	• Vaccine records of all participating children must be kept up to date including an annual influenza vaccine after 6 months of age.	☒	☒
HSFC Family Childcare Network	• Vaccine records of all participating children must be kept up to date including an annual influenza vaccine after 6 months of age.	☒	☒
Para Su Salud	• Enrollers assist individuals and families sign up for health insurance and dental health insurance benefits. • Recertification is required every 6 mo. • Once individuals and families have physical and dental health insurance, they can establish a medical home where they can readily access necessary preventive services.	☒	☒

Impact: CHMC's initiatives to increase compliance with recommended preventive services are anticipated to result in improved vaccination rates among participating infants, toddlers, and young children; however, busy parents who may be working multiple jobs often do not prioritize their own preventive care. Additionally, the pandemic has made many parents fearful of taking their children to clinics/offices for well-child care and vaccinations.

Collaboration: All of these programs involve community collaborations.

Birth Indicators

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
LABBN's Perinatal and Early Childhood Home Visitation Programs	• Home visiting services that start prenatally can improve birth outcomes by decreasing prematurity and low birth weight • Programs are offered by 14 hospitals and their community partners throughout LA County including at CHMC • Patients experiencing their first pregnancy are enrolled in Nurse Family Partnership which is run by LA County DPH. • LACDPH-funded, LACDPSS-funded, and CHVP-funded community partners now cover areas of LA County previously uncovered by First 5 LA-funded sites.	☒	☒
HSFC's Early Head Start Program	• Pregnant women can enroll in home-based EHS services • Home visiting services starting prenatally can improve birth outcomes by decreasing prematurity and LBW	☒	☒
African American Infant and Maternal Mortality Initiative (AAIMM)	• CHMC was invited to participate in this initiative led by LA County DPH because of our high proportion of African American births • This initiative aims to decrease black infant mortality by decreasing prematurity, LBW, and SIDS. • The director of LABBN is co-sponsor of the South LA AAIMM workgroup.	☒	☒
Cherished Futures for Black Moms & Babies	• Cherished Futures –part of Communities Lifting Communities, an initiative of the Hospital Association of Southern CA (HASC) - is a collaborative effort to reduce infant mortality and improve maternal patient experiences and safety among Black moms and babies in South LA and the Antelope Valley. • It is aligned with the comprehensive LA County African American Infant and Maternal Mortality (AAIMM) initiative and aims to support the legacy of local communities working to advance birth equity.	☒	☒

	• By December 2020, Cherished Futures implemented a proactive collaborative to explore key interventions focusing on clinical, organizational, and community level strategies to address African American birth inequities. • It increased the capacity of project partners to meet the needs of Black women and families through a series of learning opportunities on equity, root causes, and implicit bias. • Collaborative members include: Health Net (funder), LACDPH, First 5 LA, March of Dimes, Public Health Alliance of Southern CA, HASC, Centinela Medical Center, Cedars-Sinai Medical Center, Providence Little Company of Mary, Antelope Valley Medical Center, CHMC and Eisner Health.		
LA County Perinatal and Early Childhood Home Visitation Consortium	• This consortium is run by LABBN • Membership includes the majority of organizations providing home visiting services in LA County • In FY18 developed a plan to expand home visiting services to reach more new families as per the request from the LA County Board of Supervisors • In FY19 implemented plan to expand PAT and HFA in Los Angeles County. Services to be offered by certified PAT and HFA providers who will hire additional staff with funding from LACDMH. • In FY 20 funding shifted from LACDMH to LACDPH, LACDPSS, and CHVP.	☒	☒

Impact: : CHMC's initiatives to improve birth outcomes are anticipated to result in: decreased prematurity and LBW by providing intensive case management, health education, and improved access to needed resources through perinatal and early childhood home visiting programs; decreased disparities in birth outcomes among African American women compared to other racial/ethnic groups in our county and state.

Collaboration: LABBN's perinatal and early childhood home visitation programs is a collaborative involving 14 hospitals and over 38 community partners, First 5 LA, LACDPH, Work2Live, and PAC/LAC. LABBN oversees the training of all new home visitors and together with Work2Live and MCHA provides technical assistance to all home visiting agencies and maintains their common database.

LA County Perinatal and Early Childhood Home Visitation Consortium is a network of approximately 50 perinatal and early childhood home visitation programs, maternal and child health organizations, advocacy groups, and stakeholders. Together, they work to support Los Angeles County's home visitation programs by sharing training and educational resources, researching best practice standards, supporting enhanced referral systems between programs, conducting research and collecting data on home visiting outcomes, and advocating for systems and policies that recognize the tremendous value of home visitation services.

CDPH Community Birth Plan was a collaborative effort to reduce African American preterm births. The Maternal, Child and Adolescent Health Division partnered with key organizations across California to develop, pilot and implement a Community Birth Plan uniting the Black community, hospitals, perinatal healthcare providers and other statewide and community organizations. The objective was to educate the community about Black preterm birth rates and implement evidence-based health improvement activities that improve birth outcomes, ultimately resulting in a reduction in Black preterm births.

The **African American Infant and Maternal Mortality Steering Committee** guides the implementation of the LA County Department of Public Health's 5-Year Action plan to address African American and infant mortality as well as informs the development and implementation of strategies to compliment the plan. This group also comes together to advance advocacy, awareness and policy change.

Overweight and Obesity

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Health Ministry Program	• Parish Nurse will screen adults for obesity/overweight • Parish Nurse will refer obese/overweight adults to CHMC's programs that address physical activity and healthy eating • During the pandemic, no screening events in the community were conducted; however, the nurse continued to provide one-on-one nutrition counseling over the telephone, including for pre-bariatric surgery patients. Screening events resumed in FY22.	☒	☒
Diabetes Empowerment Education Program	• Pre-diabetics will learn how to prevent type 2 diabetes by addressing obesity/overweight through increasing their physical activity and healthy eating • Participants will be screened for food insecurity using a short screening tool called the Hunger Vital Sign • Those who are food insecure are referred to CalFresh, WIC. and other food assistance programs for which they qualify • During the pandemic, pre-diabetics and diabetics received telephonic one-on-one nutrition counseling by the Parish Nurse. Virtual DEEP classes resumed in FY22.	☒	☒
Healthy Eating and Lifestyle Program	• Overweight/obese children aged 5-12 yr. will be referred to this program by their pediatrician/family physician	☒	☒

	• The children and their parents will learn to decrease screen time, consumption of fast food, sugar-sweetened beverages, and calorie-dense, nutrient poor foods and to increase their physical activity and consumption of fresh fruits and vegetables and water. • Parents will be screened for food insecurity using a short screening tool called the Hunger Vital Sign • Those who are food insecure should be referred to CalFresh, WIC. and other food assistance programs for which they qualify • During the pandemic, this program is offered via Zoom.		
Hope Street Youth Center	• Children aged 7-18 yr. will learn about healthy eating, healthy cooking, portion control, the importance of maintaining an active lifestyle and healthy coping strategies for life's stressors • During the pandemic, in FY21 the Youth Center was converted to an all-day online school-work site, guaranteeing consistent Wi-Fi access as well as computer access and on-site mentoring/tutoring. • LAUSD and other local schools resumed in-person classes in Fall 2021 and mandated that all students 16 and over be vaccinated against COVID-19. Therefore, we were able to resume our after-school homework assistance program and Fitness Program.	☒	☒
LABBN's Perinatal and Early Childhood Home Visitation Programs	• Home visiting staff will learn about: the importance of, and how to support, exclusive breastfeeding for the first 6 mo. of life and as long as feasible thereafter; how to introduce solid foods to infants, portion control, the importance of fresh fruits & vegetables, drinking water and maintaining an active lifestyle; and the importance of limiting sugar-sweetened beverages, fast food, and screen time. • Home visitors will impart this information to families during home visits • Parents will be screened for food insecurity using a short screening tool called the Hunger Vital Sign • Those who are food insecure should be referred to CalFresh, WIC. and other food assistance programs for which they qualify • Since the onset of the pandemic, in-person home visits were promptly converted to telephonic and then virtual home visits.	☒	☒

CHMC's Food Recovery Initiative	• Food produced for cafeteria consumption that is not consumed is appropriately cooled and set aside for pick-up by Food Finders • Food Finders picks up the food and immediately transports it to a local partner that can use it, i.e., a homeless shelter, a sober living home, etc.	☒	☒

Impact: : The hospital's initiatives to address obesity/overweight are anticipated to result in: prevention of childhood obesity/overweight; early identification and treatment of obesity/overweight in children aged 5-12 yr.; increased knowledge about the importance of healthy eating and maintaining an active lifestyle; less food insecurity by assisting families to access WIC and CalFresh benefits and local food banks; increased healthy eating, healthy cooking, and physical activity among participating adults.

Collaboration: All of these programs involve planned collaborations.
LA County Community Health Assessment and Action Partnership (LA Partnership) is made up of community health directors of non-profit hospitals and health systems of LA County who have agreed to collaborate on their CHNA with the support of LACDPH and engage in population health improvement strategies. It will invest in upstream prevention strategies to maximize population impact ("making the healthy choice the easy choice"). It will promote a coordinated set of strategies in selected high need communities to achieve measurable gains. One of the workgroups is focused on thr prevention of overweight and obesity by addressing food insecurity by:1) increasing CalFresh enrollment; and 2) increasing the participation of more hospitals in the Food Recovery Initiative. Unfortunately, this plan was abandoned during the pandemic and when the group reconvened virtually on October 6, 2021, it was decided to focus on some aspect of homelessness instead.

Dental Care

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Para Su Salud	• Enrollers assist individuals and families sign up for health and dental health insurance benefits • Recertification is required every 6 months	☒	☒
LABBN's Perinatal and Early Childhood Home Visitation Programs	• Home visitors teach mothers how to prevent early childhood caries by: o Cleaning baby's gums with a soft toothbrush or cloth and water starting at birth. Once their first tooth erupts, use a soft toothbrush twice a day. Use a "smear" of toothpaste if child is under two years of age and a "pea-size" amount if they are between two and five years of age. o Not dipping pacifiers in any sweetened liquid.	☒	☒

	o Not putting baby to bed with bottle filled with milk, formula, juice or other sweet liquids. o Teaching child to start drinking from a cup as early as possible, preferably before they turn one year of age. By drinking from a cup, the liquid is less likely to pool around the front teeth. o Taking child to a pediatric dentist for an early evaluation by their first birthday		
HSFC Early Head Start Program	• EHS is a Federal initiative providing child development and parent support services to low-income pregnant women and families with children birth-3 yr. • Home visitors teach mothers how to prevent early childhood caries (as detailed above) and to take their children to a pediatric dentist for an annual check-up beginning at one-year of age	☒	☒
Diabetes Empowerment Education Program	• Diabetics are at increased risk for periodontal disease and tooth loss. • Diabetics participating in this educational program are referred to Eisner Health's dental clinic which has the only periodontal clinic based in an FQHC in LA County. By agreement, Eisner Health provides periodontal care to all diabetics seen by Southside Coalition of Community Clinics.	☒	☒
Impact: CHMC's initiatives to address oral health are anticipated to result in: increased access to oral health services; prevention of early childhood caries; increased access to periodontal treatment services to medication-dependent diabetics and homeless individuals.			
Collaboration: All of these programs involve planned collaborations.			

Violence and Injury Prevention

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Hope Street Youth Center	• Youth aged 7-18 can access homework assistance, a computer learning lab, and the Youth Fitness Program at this afterschool program	☒	☒

	• Youth develop relationships with caring adults and are much less likely to join a gang • During the pandemic, the Youth Center has been converted to an all-day online school-work site, guaranteeing consistent Wi-Fi access as well as computer access and on-site mentoring/tutoring and social support. • LAUSD and other local schools resumed in-person classes in Fall 2021 and mandated that all students 16 and over be vaccinated against COVID-19. Therefore, we were able to resume our after-school homework assistance program and Youth Fitness Program		
HSFC Youth Fitness Program	• Youth aged 7-18 can participate in a variety of physical activity programs • Youth learn healthy coping skills through yoga	☒	☒
CA Behavioral Health Clinic	• Children aged 0-21 yr. with Medi-Cal will receive mental health services • If children have been victims of child abuse or neglect, it is important to address their resulting mental health needs as promptly as possible in order to prevent long-term consequences of ACEs • Some children suffer from PTSD as a result of witnessing IPV involving their parents • By diagnosing and addressing children's mental health needs there is a decreased likelihood that they will join a gang	☒	☒
LABBN's Perinatal and Early Childhood Home Visitation Programs	• Home visitors teach the families about milestones of child development • Parents learn the importance of responsive caregiving and keeping their children safe • Families receiving family support services through home visits are significantly less likely to abuse or neglect their children • Participants are routinely screened for IPV and referred for counseling and support as needed • Participating families receive First 5 LA *Kit for New Parents* that discusses car seat safety and making your home safe for an infant/toddler • Home visitors also discuss these topics with families during home visits • Home visitors give all families a home safety kit • Since the onset of the pandemic, all in-person home visits were converted to telephonic and then virtual visits.	☒	☒

HSFC Early Care and Education Centers	• Families learn about milestones of child development • Parents learn the importance of responsive caregiving and keeping their children safe • Families engaged with their children's preschool are less likely to abuse or neglect their children • Participants are routinely screened for IPV and referred for counseling and support as needed	☒	☒
HSFC Early Head Start Program	• Early Head Start (EHS) is a Federal initiative providing child development and parent support services to low-income pregnant women and families with children birth to 3 years old • Parents learn the importance of responsive caregiving and keeping their children safe • Families learn about milestones of child development and the child is routinely evaluated for any developmental delays so that early interventions services can be offered • Children who participate have lower rates of child abuse and neglect • Participants are routinely screened for IPV and referred for counseling and support as needed	☒	☒
HSFC Family Childcare Network	• Parents learn the importance of responsive caregiving and keeping their children safe • Early education and parent support services are provided to low-income families with children birth to 5 yr. • Access to licensed childcare during evenings, nights and week-ends enables parents to continue their education or work • Participants are routinely screened for IPV and referred for counseling and support as needed	☒	☒
HSFC Early Intervention Program	• Families with infants or toddlers who have a developmental delay or disability or with an established risk condition likely to result in a delay are eligible for services • Specialists evaluate and assess infants and toddlers and provide EI and family support services for young children birth – 3 yr. • Families who understand the nature of their child's delay or disability are less likely to abuse the child • Participants are routinely screened for IPV and referred for counseling and support as needed	☒	☒
LA County Perinatal and Early Childhood Home Visitation Consortium	• Membership includes the majority of organizations providing home visiting services in LA County.	☒	☒

	• Families learn about milestones of child development • Families learn about the importance responsive caregiving and keeping their children safe • Participants are routinely screened for IPV and referred for counseling and support as needed • Since the onset of the pandemic, the majority of home visits have been either telephonic or virtual instead of in-person.		
UniHealth Cultural Trauma and Mental Health Resiliency Project	• Joint effort of the six Dignity Health hospitals in Southern California working in tandem to increase the capacity of local community organizations, community members and hospitals to identify mental distress and/or suicidality among at risk youth, and to respond appropriately • Improve access to prevention and early intervention mental health and SUD services, thereby decreasing health disparities, especially for those affected by poverty, racism, adverse childhood experiences, and violence • Improving the mental health of youth will result in decreased conduct problems, aggressive behavior, hyperactivity/attention problems, risky sexual behavior, substance abuse, social deviance and anxiety/depression and increased empathy, well-being, quality relationships, prosocial behavior, satisfaction with school, leadership skills, and academic achievement. • The pandemic necessitated that MFHA, YMHFA, and QPR classes switch to a virtual format. Unfortunately, MHFA and YMHFA were not available in Spanish in the virtual format in FY21; in FY22 they became available in Spanish.	☒	☒
Pico Union Family Preservation Program	• Family preservation services are short-term, family-focused services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. • The most common indication for FPS is suspected/documented child abuse or neglect • A support group for women who are victims of IPV is conducted in Spanish every week • An anger management group for men and women is conducted in Spanish every week • A parenting group for men and women is conducted in Spanish every week	☒	☒

Wraparound Services Program	• Wraparound Program provides community-based support and individualized planning for children, including those with severe emotional and behavioral disorders (SED),and their families • The Wraparound Team creates an intensive family preservation plan that supports keeping the child at home with their family. • Parents are referred to the support group for women who are victims of IPV, anger management group, and/or parenting group as needed	☒	☒
Dignity Health Human Trafficking Response Initiative	• CHMC has a Human Trafficking Response Task Force that is responsible for implementing the strategy designed by Dignity Health, now CommonSpirit Health. • The local task force is responsible for CHMC staff and provider training • The goal is to identify potential victims of sex and/or labor trafficking in our ED and other hospital units. • CHMC works closely with our community partners, LAPD Vice Squad and Coalition against Slavery and Trafficking (CAST LA). • The survivor advocate hired by CAST LA works in our ED to assist staff in identifying potential victims and convincing potential victims to accept services. Due to the pandemic these services were offered virtually in FY21. In FY 22, in-person services by two survivor advocates will resume as soon as deemed safe by CAST LA and Journey Out.	☒	☒
Health Ministry Program	• Parish Nurse refers potential victims of intimate partner violence to community partners providing needed services including shelter services • This was on hold due to the pandemic in FY21, but will resume in FY22	☒	☒
Stop the Bleed Program	• Stop the Bleed is a national awareness campaign and call-to-action. It is intended to cultivate grassroots efforts that encourage bystanders to become trained, equipped, and empowered to help a bleeding emergency before professional help arrives.	☒	☒

	• No matter how fast professional emergency responders arrive, bystanders will always be first on the scene. A person who is bleeding can die from blood loss within 5 minutes, therefore it is important to quickly stop the blood loss. Those nearest to someone with life threatening injuries are best positioned to provide first care. • Hospital staff teach Stop the Bleed to interested groups. • These classes were on hold due to the pandemic in FY21, but will resume in FY22		
Maternity Tours	• Car seat safety is discussed at Maternity Tours which are currently virtual due to the pandemic. • No infant can be released from the hospital without there being an infant car seat installed in the car • Free car seats are given to new parents delivering at CHMC	☒	☒
CA Bridge Program in ED	• Initiate buprenorphine for patient with Opioid Use Disorder in withdrawal • Teach family and friends of patient with OUD how to use naloxone in case of opioid overdose • Substance Use Navigator (SUN) will arrange discharge plan with local MAT provider • If patient with OUD is homeless, he/she may qualify for Bridge Housing for 90 day. The MAT provider must make that request.	☒	☒

Impact: CHMC's initiatives to address gang prevention are anticipated to result in: more youth participating in productive learning and fitness activities after school, surrounded by healthy, caring adults with whom they can talk and interact
CHMC's initiatives to address child car seat safety and home safety are anticipated to result in: less severe injuries if the car that the infant/child is riding in is involved in an accident; less accidental injuries involving infants/toddlers if the parents have used a home safety kit to cover plugs, keep cupboard doors shut (especially those with cleaning supplies, etc.), and put up a gate by stairs.
CHMC's initiatives to prevent child abuse and neglect are anticipated to prevent children from suffering from ACEs which are known to impose neurobiological and psychosocial effects that often results in health risk behaviors (smoking, drinking, substance use, promiscuity) in adolescence which, in turn, result in long-term consequences such as alcoholism, SUD, chronic diseases, mental illness, unemployment, criminal behavior, and homelessness. CHMC's initiatives to address child abuse and neglect are anticipated to ameliorate the long-term consequences of ACEs.
CHMC's initiatives to prevent and/or treat family violence are anticipated to result in: less long-term consequences as a result of being a witness to family violence (one of the ACEs); early intervention with mental health services for those who witnessed family violence; comprehensive services to victims of family violence; youth and children developing healthy coping and communication skills so that they don't resort to physical, verbal, or sexual abuse; parents understanding the potential long-term consequences of a child witnessing family violence.

UniHealth CTMHR Project is anticipated to improve the mental health of youth and decrease suicidality in children and youth.
The CA Bridge program is anticipated to increase access to MAT for OUD and decrease the risk of accidental opioid overdose and death.
Dignity Health's Human Trafficking Response Network is anticipated to identify more victims of sex and/or labor trafficking in our EDs and help them access comprehensive healing services in the community.
The Stop the Bleed Campaign is anticipated to teach more bystanders how to become trained, equipped, and empowered to help a bleeding emergency before professional help arrives thereby saving lives.

Collaboration: All of these programs include planned collaborations.
LA County Perinatal and Early Childhood Home Visitation Consortium membership is a network of approximately 50 perinatal and early childhood home visitation programs, maternal and child health organizations, advocacy groups, and stakeholders. Together, they work to support Los Angeles County's home visitation programs by sharing training and educational resources, researching best practice standards, supporting enhanced referral systems between programs, conducting research and collecting data on home visiting outcomes, and advocating for systems and policies that recognize the tremendous value of home visitation services.
The CTMHR Project involves collaboration between all six Dignity Health hospitals in Southern CA and their community partners; moreover, each County has its own Community Advisory Committee.
Dignity Health Human Trafficking Response Initiative is a collaborative involving all the Common Spirit Health hospitals and local partnering agencies.
CA Bridge, a program of the Public Health Institute, is an accelerated training program for healthcare providers, designed to support access to around-the-clock treatment for substance use disorders, urgently needed to confront the opioid epidemic. The CA Bridge model is a significant improvement from traditional hospital strategies that provide referrals but do not directly treat addiction like other life-threatening chronic illnesses. Funded through the Substance Abuse and Mental Health Services Administration's (SAMHSA) State Targeted Response to the Opioid Crisis Grant to the California Department of Health Care Services (DHCS), participating program sites receive allocated funding, training, and technical assistance to launch facility-wide treatment and referral for substance use disorders.

Community Grants Program

One important way the hospital helps to address community health needs is by awarding financial grants to non-profit organizations working together to improve health status and quality of life. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations.

In FY21, the hospital awarded the grants below totaling $159,000. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount

The Salvation Army California South Division	Zahn Memorial Center and Lily's Place for Homeless Families	$ 53,000
Downtown Women's Center	Mental Health Support for Women with Histories of Homelessness	$ 53,000
Amanecer Community Counseling	Healing Domestic Abuse Victims to Create a Healthier, More Self-Sufficient Community	$ 53,000

Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs. The digests include program descriptions and intervention actions, statements of which health needs are being addressed, any planned collaboration, and program goals and measurable objectives.

10th Decile Project	
Significant Health Needs Addressed	☒Significant Health Need Housing and Homelessness ☒Significant Health Need Access to Healthcare ☒Significant Health Need Mental Health ☒Significant Health Need Chronic Diseases ☒Significant Health Need Substance Use and Misuse ☒Significant Health Need Dental Care
Program Description	This grant-funded project connects the top 10% highest cost, highest need chronically homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical and behavioral health care services through a collaboration of Corporation for Supportive Housing, JWCH Institute, Inc., and Housing Works.
Community Benefit Category	A3. Health Care Support Services
FY 2021 Report	
Program Goal / Anticipated Impact	After 12 mo. in supportive housing (SH), 10th Decile individuals placed in SH show: 40% reduction in ER visits; 35% reduction in hospital readmissions 85% of individuals placed in SH during the grant period retain their housing for 12 mo. After 12 mo. in SH, of individuals placed in SH: 40% are using primary care; 35% are using Substance Use Disorder (SUD) services; 35% are using mental health services.
Measurable Objective(s) with Indicator(s)	After 12 mo., at least 40 homeless patients are using community-based health services within JWCH.

	After 12 mo., at least 20 homeless patients are connected to the Coordinated Entry System (CES) By the end of the grant period, 8 10th Decile homeless high utilizers with complex health challenges are placed in SH.
Intervention Actions for Achieving Goal	Two CHNs screen patients on-site at CHMC and identifies and refers homeless high utilizers with complex health challenges to community-based health services and to HW. HW dedicates two full-time housing navigators to CHMC patients in the 10th Decile. HW case management includes care coordination, housing navigation, housing search, and tenancy support services. Dignity Health Homeless Health Initiative will convene JWCH, CHMC, and HW to discuss progress against target activities. Corporation for Supportive Housing provides CHMC, JWCH, and HW with targeted technical assistance on funding streams in the HHP.
Collaboration	This projected involves the planned collaboration of CHMC, Corporation for Supportive Housing (CSH), JWCH (who hires and supervises the CHNs), and Housing Works (who hires and supervises the housing navigators).
Performance / Impact	CHN position was .75 FTE until August 1, 2021 when it was increased to 2 FTEs. The HW housing navigator position was part-time until August 1, 2021 when it was increased to 2 FTEs. CHNs screened 650 people experiencing homelessness in FY21 - 555 from inpatient units and 164 from the ER. They enrolled 727 in a medical home. They referred 113 patients to Housing Works for the 10th Decile Project. Housing Works provided navigation services for 32 new CHMC 10th Decile patients and successfully enrolled them in the Coordinated Entry System (CES). During the first half of FY21, five were temporarily housed; in Q3 they obtained permanent housing. During the second half of FY21, HW obtained temporary housing for 24 10th Decile patients and 2 became permanently housed. The CHNs scheduled 54 appointments at JWCH; unfortunately, patients kept only 31.5% of these appointments despite the fact that CHNs provided education re importance of being on time and transportation to and from JWCH, phone number to call, and appointment reminders Identified unmet needs include: housing resources to support individuals experiencing high medical need and SMI, including dementia and safe storage solutions for belongings and important documents of those experiencing homelessness. Workflows that can be improved include: pre- and post-discharge workflow barriers (i.e, transportation, medication, temporary housing placement information, and lack of working phone; streamlined communication between Care Coordination, JWCH, HW, and the People Concern Hospital Liaison. The project is providing a model for the role hospitals play in the fight to end homelessness in LA County. LAHSA is now elevating this model to incorporate it into the homeless system.

Hospital's Contribution / Program Expense	The hospital contributed space, a computer and office supplies for the CHNs within the SW/CC department. . Beginning August 1, 2020, Blue Shield of CA funded this project with a $500,000/yr. grant for 2 years. CHMC will provide additional office space, computer and supplies for a program manager hired by the Homeless Health Initiative. However, Blue Shield of CA ended its funding as of July 31,2021 because the program failed to provide services to enough Blue Shield Promise members. The Dignity Health Homeless Health Initiative (HHI) began funding this program August 1, 2021.
FY 2022 Plan	
Program Goal / Anticipated Impact	After 12 mo. in supportive housing (SH), 10th Decile individuals placed in SH show: 40% reduction in ER visits; 35% reduction in hospital readmissions 85% of individuals placed in SH during the grant period retain their housing for 12 mo. After 12 mo. in SH, of individuals placed in SH: 40% are using primary care; 35% are using Substance Use Disorder (SUD) services; 35% are using mental health services.
Measurable Objective(s) with Indicator(s)	600 CHMC homeless patients have better access to primary care, mental health and behavioral health care through community-based health services. 50 10th Decile patients are referred to Housing Works (HW) for the 10th Decile Project. 36 high-acuity homeless patients move into temporary supportive housing and are better able to recover from a health crisis. 10 patients are enrolled in Coordinated Entry System, obtain housing vouchers, and move into supportive housing units. HW's continued wraparound services help ensure that patients stay in SH and stabilize their chronic health conditions. CSH will report the number of individuals utilizing community-based health services within JWCH, and the number of individuals enrolled and housed through HW. By the end of the grant period, JWCH is positioned to connect patients to new or existing referral pathways for CHMC's homeless patients. CHMC is able to maximize its utilization of the Homeless Information Management System (HMIS) to better target strategies (such as patient navigators at hospitals), services, and referrals for patients.
Intervention Actions for Achieving Goal	2 full-time CHNs screen patients on-site at CHMC and identify and refer homeless high utilizers with complex health challenges to community-based health services; those that qualify for 10th Decile project will be referred to HW. HW dedicates 2 full-time housing navigators to CHMC patients in the 10th Decile. HW case management includes care coordination, housing navigation, housing search, and tenancy support services.

	Program Manager will convene CHMC, JWCH, HW, and CSH to discuss progress against target activities. CSH provides CHMC, JWCH, and HW with targeted technical assistance on funding streams in the HHP.
Planned Collaboration	This projected involves the planned collaboration of CHMC, CSH, JWCH (who hires and supervises the CHNs), and Housing Works (who hires and supervises the housing navigators).

Para Su Salud – Enrollment Assistance Program

Significant Health Needs Addressed	. ☒Significant Health Need Access to Health Care ☒Significant Health Need Food Insecurity ☒Significant Health Need Preventive Services ☒Significant Health Need Dental Care
Community Benefit Category	A3. Health Care Support Services

FY 2021 Report

Program Goal / Anticipated Impact	The program goal is to enroll uninsured individuals into the health insurance program he/she qualifies for.
Measurable Objective(s) with Indicator(s)	How many people did the enrollers outreach to? How many people did they enroll in health insurance? How many 6 mo. recertifications did they complete?
Intervention Actions for Achieving Goal	The enrollers outreach to a number of different sites in the community as well as at the hospital. They assess each individual in order to determine which health insurance, if any, he/she qualifies for. Then they enroll individuals in that health insurance and explain how it works. They remind the individual that their insurance needs to be recertified every 6 months.
Collaboration	They collaborate with a variety of community sites. However, due to pandemic they have not been able to give presentations at the clinics. They give Zoom presentations to new clients and educate them on how to use the services.
Performance / Impact	How many people did the enrollers outreach to? 4009 How many people did they enroll in health insurance? 1660 How many 6 mo. recertifications did they complete? 216 They have noted an increase in clients who are requesting assistance with Cal-Fresh and GR benefits due to the pandemic.
Hospital's Contribution / Program Expense	Total program expense = $ 446,387 Restricted grant = $297,397 Staff is all CHMC employees. CHMC contributes office space, computers, printers, and office equipment.

FY 2022 Plan	
Program Goal / Anticipated Impact	The program goal is to enroll uninsured individuals into the health insurance program he/she qualifies for. However, in light of the confusion about the new Public Charge rule which went into effect on Feb. 20, 2020 but is on hold during the pandemic, health insurance enrollers will have to debunk many of the incorrect rumors about what counts and what doesn't count when an individual plans to seek a green card. This will make their task more time consuming and fewer people may ultimately enroll out of fear.
Measurable Objective(s) with Indicator(s)	How many people did the enrollers outreach to? How many people did they enroll in health insurance? How many 6 mo. recertifications did they complete? Track trend data based on prior 3 yrs. and then moving forward.
Intervention Actions for Achieving Goal	The enrollers outreach to a number of different sites in the community as well as at the hospital. They assess each individual in order to determine which health insurance, if any, he/she qualifies for. Then they enroll individuals in that health insurance and explain how it works. They remind the individual that their insurance needs to be recertified every 6 months
Planned Collaboration	The enrollers collaborate with a variety of community sites.

HSFC Early Head Start Program

Significant Health Needs Addressed	☒Significant Health Need Housing and Homelessness ☒Significant Health Need Access to Health Care ☒Significant Health Need Mental Health ☒Significant Health Need Chronic Diseases ☒Significant Health Need Economic Insecurity ☒Significant Health Need Substance Use and Misuse ☒Significant Health Need Food Insecurity ☒Significant Health Need Education ☒Significant Health Need Preventive Practices ☒Significant Health Need Birth Indicators ☒Significant Health Need Overweight and Obesity ☒ Significant Health Need Dental Care ☒ Significant Health Need Violence and Injury Prevention
Program Description	This program is funded by a federal grant. Core services of EHS include: early childhood education (ECE); healthcare and mental health services; parenting education; childcare; adult education; and housing, legal, and financial assistance. We have

	put into place a continuum of home and center-based ECE services that responsively meet the individual and changing needs of young families. Options currently available to families include: 1) home-based services with weekly in-home ECE, along with twice per month socialization opportunities; 2) full-year, full-day center based ECE, with monthly home visits; 3) combination option services, with daily center-based family literacy services, combined with biweekly in-home ECE; and biweekly in-home ECE, concurrent with enrollment in high-quality childcare and bimonthly visits at the childcare site. Priority EHS enrollment is given to: pregnant mom with child already enrolled in EHS; homeless families; foster children; children with special needs; parents interested in ESL or high school diploma/GED studies; and families participating in other HSFC programs. Enrollment priorities reflect 2016 HSFC EHS Community Needs Assessment data that document a high incidence of developmental disabilities and homelessness within the service area; large numbers of recent immigrant, mono-lingual Spanish-speaking young families; and low adult literacy and educational levels.
Community Benefit Category	Community Health Improvement Services: A 1. Community Health Education A 2. Community-based clinical services A 3. Health care support services Community Building Activities: F3. Community Support F5. Leadership Development and Leadership Training for community members
FY 2021 Report	
Program Goal / Anticipated Impact	1. Promote children's (infant/toddler) overall development 2. Enhance the capacity of parents to nurture and care for their young children 3. Build on existing services and foster community partnerships to increase services for young children and their families 4. Expand staff knowledge, skills, and competencies in working with young children and their families
Measurable Objective(s) with Indicator(s)	Maintain full enrollment throughout the year. At least 10% of EHS children will have a disability Goal 1: Promote overall physical, cognitive, social, language, and emotional development of infants and toddlers Goal 2: Enhance the capacity of parents to nurture and care for their young children Goal 3: Build community service delivery capacity. Goal 4: Refine and expand staff knowledge, skills, and abilities.
Intervention Actions for Achieving Goal	Continue to provide EHS services for qualifying families in our service area in accordance with EHS performance standards and guidance as specified in our contract and implementation plan

Collaboration	HSFC has signed MOUs with the following organizations: Angelica Church, St.Marks Church, Crystal Stairs Pathways, Children's Learning Center, Museum of Contemporary Art, Enrichment Works, Community Counseling Services, LAUSD, Pacific Asian Consortium in Employment, UCLA, LA City College, West ED, Bresee Foundation, Chrysalis, First 5 LA, LA Conservation Corp, St. Francis Center, Eisner Health, CHMC-Eisner Health Family Practice, WIC, Pico Union Housing Corp, Esperanza Community Housing Corp, Asian Pacific American Legal Center, Lanterman Regional Center, South Central Regional Center, LA County DHS, LA County DCFS, LA Trade Technical College, Abram Friedman Vocational Education Center
Performance / Impact	Unable to maintain full enrollment during first 3 quarters of the year as we were unable to fill all vacancies left by children graduating or exiting for other reasons; recruitment efforts hampered by: a decrease in referrals from traditional community partners who were providing no or limited in-person services; decreased interest in home-based services due to pandemic concerns; and limited opportunities to outreach due to school, church, and community-center closures and restrictions. Served 256 low-income families with an average earned income of $19,803 were served; 94% of children were Latino, 4% were African American or biracial; home language of mother was Spanish 87%; 20% of children were special needs. Family characteristics: 64% had two-parent household; 92% employment in 2-parent household (pre-COVID); 35% employment in single-parent household (pre-COVID); 54% low literacy (<HS grad); 4% homeless Goal 1 Promote Overall Development • Environmental rating scores: Fall 2020=6.69; spring 2021=6.46. Classrooms open the entire year • 90% of infants/toddlers received on-time health screenings; 90% were current on the well-child care and 91% were current on immunizations. Goal 2 Enhance Capacity of Families to Nurture and Care for their Children Goal 2 Enhance the capacity of parents to nurture and care for their young children • Florida Family Assessment (FFA) is used to assess family support for children's school readiness and changes in educational practices at home. o Child development/parenting skills Post Mean Score 3.8; Gain +0 o Family education at home Post mean score 3.7; gain +.1 o School readiness Post mean score 3.7; gain +.2 o The lack of growth over 6 mo. period is perhaps a measure of the pandemic's impact on family life and relationships • Center-based childcare allowed parents to find, accept (90%), and/or keep a job with better pay (74%); 64% attended educational or training programs.

	• Parental education, employment, and citizenship goals were supported for home-based parents thru collaboration with LAUSD Adult Education Division. This year they offered morning and afternoon virtual ESL classes. Goal 3 Build Community Service Delivery Capacity • An average of 10 parents participated in monthly Policy Council meetings. Policy Council elections were held in April and there were 16 candidates nominated for eleven positions. • The Florida Family Assessment is used to assess civic engagement, leadership and community involvement. Pre- and Post-Family Assessments were compared. o Families and Communities: post mean score 3.2; gain - 0.1 o Leadership and Advocacy: post mean score 2.3; gain - 0 o Volunteering: post mean score 1.6; gain - 0 o The lack of growth correlates with the closure of schools, faith-based institutions, and community centers, and fewer opportunities for building community and civic engagement • The Desired Results for Children and Families Parent Survey in 2021 that 85% of center-based parents were very satisfied and 15% were satisfied with overall quality of the program; 88% of home-based parents were very satisfied and 12% were satisfied with overall quality of the program. Goal 4 Expand Staff Knowledge & Skills • Teacher qualifications: 3% Master's degree; 64% Bachelor's degree; 24% Associate's degree; 9% Child development coursework & CDE permit. • Enrolled in: 2 associate's program
Hospital's Contribution / Program Expense	HSFC is housed in a customized 4 story building (30,000 sq ft.) built by the hospital; it has attached play areas for young children as well as a full-sized basketball court for older youth and teens. All services are supported by grants ($11,100,005) and philanthropy.
FY 2022 Plan	
Program Goal / Anticipated Impact	1. Promote children's (infant/toddler) overall development 2. Enhance the capacity of parents to nurture and care for their young children 3. Build on existing services and foster community partnerships to increase services for young children and their families 4. Expand staff knowledge, skills, and competencies in working with young children and their families
Measurable Objective(s) with Indicator(s)	Maintain full enrollment throughout the year. At least 10% of EHS children will have a disability

	Goal 1: 100% of classrooms will provide quality environments that support optimal development; 70% of children who receive at least 6 mo. of services will demonstrate age-appropriate development. Goal 2: 80% of parents will acquire skills to support learning and language development; improved school/employment opportunities for 60% of working/studying parents; case management supports for all parents; 100% on-time health screens; 95% current well-child care and immunizations. Goal 3: 60% of parents will participate in leadership and civic engagement opportunities. Goal 4: 75% of teachers will hold a Bachelor's degree or will be progressing toward a BA; 100% of teachers without a degree will progress toward an Associate's degree; 100% of staff will demonstrate professional competency.
Intervention Actions for Achieving Goal	Continue to provide EHS services for qualifying families in our service area in accordance with EHS performance standards and guidance as specified in our contract and implementation plan
Planned Collaboration	HSFC has signed MOUs with the following organizations: Angelica Church, St.Marks Church, Crystal Stairs Pathways, Children's Learning Center, Museum of Contemporary Art, Enrichment Works, Community Counseling Services, LAUSD, Pacific Asian Consortium in Employment, UCLA, LA City College, West ED, Bresee Foundation, Chrysalis, First 5 LA, LA Conservation Corp, St. Francis Center, Eisner Health, CHMC-Eisner Health Family Practice, WIC, Pico Union Housing Corp, Esperanza Community Housing Corp, Asian Pacific American Legal Center, Lanterman Regional Center, South Central Regional Center, LA County DHS, LA County DCFS, LA Trade Technical College, Abram Friedman Vocational Education Center

LABBN's Perinatal and Early Childhood Home Visitation Programs	
Significant Health Needs Addressed	☒Significant Health Need Access to Health Care ☒Significant Health Need Mental Health ☒Significant Health Need Chronic Diseases ☒Significant Health Need Economic Insecurity ☒Significant Health Need Substance Use and Misuse ☒Significant Health Need Food Insecurity ☒Significant Health Need Education ☒Significant Health Need Preventive Practices ☒Significant Health Need Birth Indicators ☒Significant Health Need Overweight and Obesity ☒Significant Health Need Dental Care ☒Significant Health Need Violence and Injury Prevention

Program Description	LABBN is funded by First 5 LA and LACDPH. LABBN is a community benefit of CHMC where the staff is based. The staff is CHMC employees. LABBN, First 5 LA, PAC/LAC, and Maternal Child Health Access comprise the Family Strengthening Oversite Entity (FSOE). The FSOE oversees and supports the standardization of the Welcome Baby Program to ensure adherence to program fidelity by the Welcome Baby sites across the county. The Oversight Entity also provides training and technical assistance to all home visitors, supports to the Parents as Teachers and Healthy Families America providers and support efforts to maintain referral pathways between Welcome Baby and PAT and HFA providers, as well as other existing home visitation programs throughout the County. Additional responsibilities include the provision of technical assistance to providers utilizing First 5 LA's data management information system; facilitation of cross-site peer learning exchanges; and coordination and support of communication and messaging efforts
Community Benefit Category	Community Health Improvement Services: A1 Community health education A2. Community-based clinical services A3. Health care support services Community-Building Activities: F3. Community support F7. Advocacy for community health improvements & safety F8. Workforce development
FY 2021 Report	
Program Goal / Anticipated Impact	Build and strengthen the knowledge and awareness of WB and PAT and HFA staff on theory, research, and topics that will support their working with families using a strengths-based, client-centered and solution-focused approach for strengthening families Promote the development and application of skills by the WB and PAT and HFA staff that will support their work with families Provide guidance, coaching, and training to WB and PAT and HFA sites to promote implementation of the program models with fidelity Establish a seamless integration of WB into the organizational (hospital) structure Promote the establishment of a strong infrastructure within WB and PAT and HFA sites to ensure that program outcomes are achieved Promote the establishment of a strong infrastructure within WB and PAT and HFA sites to sustain these family strengthening service
Measurable Objective(s) with Indicator(s)	Measurable, observable, and attainable objectives including: □ Outcomes-changes in health/mental health status, developmental status, attitudes, behaviors, knowledge, skills, practices, or policies □ Outputs-the direct result of activities and typically expressed as the number or scope of services and/or products that are delivered or produced • # staff trained/yr.

	• #families served/yr. □ Major Deliverables-tangible products that are submitted in fulfillment of contract requirements
Intervention Actions for Achieving Goal	Coordinate and implement two sets of trainings of core topics for new WB and PAT and HFA program staff in conjunction and with participation of MCHA, Work2Live, and PAC/LAC as needed annually. Update, as needed, and distribute WB Orientation and Protocols Manuals via online links to 14 WB and all PAT and HFA programs annually Provide training and ongoing TA to WB and PAT and HFA staff as new features are developed for the Stronger Families Database Provide leadership and oversight for database development activities Convene and facilitate one, full day, peer learning workshop within each of the four regions of LA County annually to provide opportunities for cross-site learning for WB and PAT and HFA staff Convene one, full day, peer learning workshop for all WB programs annually and one for all PAT and HFA programs annually. Implement 2 Successful Leadership and Change Management Workshop for new WB and PAT and HFA staff annually Provide Reflective Practice coaching sessions monthly for WB clinical supervisors and separately for PAT and HFA supervisors Conduct annual audits of each WB and/or PAT and HFA site for model fidelity, implementation progress, and to identify any challenges and successes according to the established protocol Coordinate with F5LA staff and all external evaluators of WB and/or PAT and HFA programs Provide marketing and messaging templates to ensure consistent messaging across WB and PAT and HFA sites Convene quarterly meetings of LA County Perinatal and Early Childhood Home Visitation Consortium (LACPECHVC) Plan and convene with Consortium partners' monthly workgroup meeting- Referrals, Best Practices, Advocacy, and Data.
Collaboration	The primary partners of the FSOE are: LABBN, First 5 LA, Maternal Child Health Access (MCHA), Work2Live, and the Perinatal Advisory Council: Leadership, Advocacy & Consultation (PAC/LAC). Our hospital partners are: CHMC, Providence Holy Cross Medical Center, Northridge Hospital Medical Center, Valley Presbyterian Hospital, Emanate Health, Adventist Health White Memorial Medical Center, St. Francis Medical Center, Centinela Hospital, Miller Children's Hospital, Providence Little Company of Mary, Torrance Memorial Medical Center, St. Mary Medical Center and Martin Luther King Jr. Community Hospital. Our community partners include: Antelope Valley Partners for Health, Children's Bureau, Child and Family Guidance Center, Child Care Resource Center, Children's Center of Antelope Valley, El Nido Family Center, SPIRITT Family Services, Foothill Family Services, Human Services Association, Plaza Community Services, The Whole Child, Shields for Families, Children's Institute, South LA BioMed,

	Wellnest, Richstone Family Center, Families in Good Health, The Children's Clinic, and Pacific Asian Counseling Services.
Performance / Impact	327 new F5LA-funded HFA & PAT enrollments in FY 21 16,067 new WB hospital enrollments in FY 21 **16,394 total new families served in FY21** **Number of staff trained overall in FY 21 = 609** • WB - 230 active staff • HFA o HV - 138 o DPSS: 73 active staff o CHVP: 3 active staff • PAT o HV - 34 o DPSS: 37 active staff o CHVP: 5 active staff • MAMA's Neighborhood- 89 total active staff 406/22,729 (2%) of families were referred to DCFS in FY20/21; 283 from WB and 123 from HFA and PAT. 33% of these cases were accepted by DCFS; of those, ~27% were substantiated and being monitored, while another 5% were sustained and the children removed from the home. The home visiting field continues to grow in LA County due to additional funding. LABBN continues to serve as the oversight entity for the Welcome Baby, Healthy Families America, and Parents as Teachers programs funded by First 5 LA, LACDMH. LACDPH, LACDPSS, and California Home Visiting Programs (CHVP). Thanks to the expansion of funding sources, home visiting slots are no longer limited to certain geographic regions (aka Best Start Communities), but rather the whole county. With nearly 700 active staff across three models and four funding sources, LABBN leads the efforts for ensuring standardization of data collection and analysis, continuous quality improvement, model fidelity and technical assistance, staff training and protocol implementation, branding and communication marketing materials, and policy and advocacy. The highlight of the year was the Family Strengthening Virtual Annual Summit celebrating all home visiting staff that took place on June 17, 2021. The theme of the virtual summit was *Home Visiting Works: Honoring the Changemakers;* the presentations and speaker addresses focused on honoring the hard work of home visitors amidst the COVID-19 pandemic, recognizing the impact of home visiting on the lives and health of the families served, and motivating home visitors for continued dedication in the next FY.

Prior to the summit, the LABBN TA and Training Team created a registration form that was sent via email to all home visiting staff and funders within the Family Strengthening Network. A total of 596 participants registered for the event. Of the 237 participants who submitted evaluation forms:

- 107 indicated that their agency implements the Welcome Baby Model;
- 75 indicated that their agency implements the Healthy Families America Program Model;
- 57 indicated that their agency implements the Parents as Teachers Program Model; •
- 2 indicated that their agency implements the MAMA's Neighborhood/Visits Model;
- 1 indicated the Nurse Family Partnership Model;
- 2 indicated that they are a funder/partner/supporter of home visiting;
- 3 indicated that their agency implements 'Other' Program Model.

All registrants were sent the zoom link, agenda, and packet of speaker bios prior to the summit.

A participatory process was used to coordinate and plan the logistics and theme of the Annual Summit. The topic, content, goals, and objectives of the Summit was determined based on needs observed from previous trainings, monthly leads calls, and overall requests for technical assistance, as well as from feedback from the FY19-20 virtual summit. The agenda included 7 presentations/speaker addresses. Topics and a brief description of each agenda item are detailed below.

- *Welcome and Introductions* – icebreakers and brief welcome/thank you addresses from Dr. Sharlene Gozalians (LABBN), John Wagner (First 5 LA), Dr. Deborah Allen (DPH), and Alina Moran (CHMC).
- *Support for the Changemakers*: *How LABBN Supports HV Systems in LA County* – introduction of each LABBN department and presentation of capacity building activities conducted by LABBN over the past FY.
- *Analytics from Home* – presentation of FY20-21 home visiting data, presented by Delisa Young (LABBN) and Monica Charles (LABBN).
- *Being More than One Thing, Finding More than One Way* – keynote address, presented by Dr. Junlei Li.
- *#HomeVisitingWorks: Two Families Tell Us How* – home visiting clients shared their experience with the program, facilitated by Steve Nish (LABBN), Amie Miramontes-Franco (LABBN), Osvaldo Lopez (LABBN), and Brandon Craw (LABBN).

	• *Life Support* – spoken word piece honoring the work of home visitors presented by Avi Silver. • *Closing Message* – final thank you and call to action, presented by Dr. Sharlene Gozalians (LABBN).
Hospital's Contribution / Program Expense	FSOE is supported by a $3,699,122 annual grant from First 5 LA. LABBN is primarily supported by this grant. DPH-, DPSS-, and CHVP-funded sites reimburse LABBN for trainings on a cost-reimbursement basis. CHMC provides office space, meeting and conference space, storage space, and access to its computer learning lab. LABBN staff is CHMC employees.
FY 2022 Plan	
Program Goal / Anticipated Impact	Build and strengthen the knowledge and awareness of WB and PAT and HFA staff on theory, research, and topics that will support their working with families using a strengths-based, client-centered and solution-focused approach for strengthening families Promote the development and application of skills by the WB and PAT and HFA staff that will support their work with families Provide guidance, coaching, and training to WB and PAT and HFA sites to promote implementation of the program models with fidelity Establish a seamless integration of WB into the organizational (hospital) structure Promote the establishment of a strong infrastructure within WB and PAT and HFA sites to ensure that program outcomes are achieved Promote the establishment of a strong infrastructure within WB and PAT and HFA sites to sustain these family strengthening services
Measurable Objective(s) with Indicator(s)	Measurable, observable, and attainable objectives including: □ Outcomes-changes in health/mental health status, developmental status, attitudes, behaviors, knowledge, skills, practices, or policies □ Outputs-the direct result of activities and typically expressed as the number or scope of services and/or products that are delivered or produced • # staff trained/yr. • #families served/yr. □ Major Deliverables-tangible products that are submitted in fulfillment of contract requirements WB and PAT and HFA training, implementation, and cross-site professional development WB and SHV technical assistance Stronger Families Database efforts and coordination WB and SHV evaluation and fidelity oversight Marketing and Communication Perinatal and Early Childhood Home Visitation Consortium Regional Breastfeeding Consortium Key Partner coordination and reporting requirements

Intervention Actions for Achieving Goal	Coordinate and implement two sets of trainings of core topics for new WB and PAT and HFA program staff in conjunction and with participation of MCHA and PAC/LAC as needed annually. Update, as needed, and distribute WB Orientation and Protocols Manuals via online links to 14 WB and all PAT and HFA programs annually Provide training and ongoing TA to WB and PAT and HFA staff as new features are developed for the Stronger Families Database Provide leadership and oversight for database development activities Convene and facilitate one, full day, peer learning workshop within each of the four regions of LA County annually to provide opportunities for cross-site learning for WB and PAT and HFA staff Convene one, full day, peer learning workshop for all WB programs annually and one for all PAT and HFA programs annually. Implement 2 Successful Leadership and Change Management Workshop for new WB and PAT and HFA staff annually Provide Reflective Practice coaching sessions monthly for WB clinical supervisors and separately for PAT and HFA supervisors Conduct annual audits of each WB and/or PAT and HFA site for model fidelity, implementation progress, and to identify any challenges and successes according to the established protocol Coordinate with F5LA staff and all external evaluators of WB and/or PAT and HFA programs Provide marketing and messaging templates to ensure consistent messaging across WB and PAT and HFA sites Convene quarterly meetings of LA County Perinatal and Early Childhood Home Visitation Consortium (LACPECHVC) Plan and convene with Consortium partners' monthly workgroup meeting- Referrals, Best Practices, Advocacy, and Data.
Planned Collaboration	The primary partners of the FSOE are: LABBN, First 5 LA, Maternal Child Health Access (MCHA), Work2Live, and the Perinatal Advisory Council: Leadership, Advocacy & Consultation (PAC/LAC). Our hospital partners are: CHMC, Providence Holy Cross Medical Center, Northridge Hospital Medical Center, Valley Presbyterian Hospital, Emanate Health, Adventist Health White Memorial Medical Center, St. Francis Medical Center, Sentinels Hospital, Miller Children's Hospital, Providence Little Company of Mary, Torrance Memorial Medical Center, St. Mary Medical Center and Martin Luther King Jr. Community Hospital. Our community partners include: Antelope Valley Partners for Health, Children's Bureau, Child and Family Guidance Center, Child Care Resource Center, Children's Center of Antelope Valley, El Nido Family Center, SPIRITT Family Services, Foothill Family Services, Human Services Association, Plaza Community Services, The Whole Child, Shields for Families, Children's Institute, South LA BioMed, Wellnest, Richstone Family Center, Families in Good Health, The Children's Clinic, and Pacific Asian Counseling Services.

Health Ministry Program/Community Health	
Significant Health Needs Addressed	☒Significant Health Need -Access to health care ☒Significant Health Need - Mental Health ☒Significant Health Need - Chronic Diseases ☒Significant Health Need -Food Insecurity ☒Significant Health Need –Overweight and Obesity
Program Description	CHMC sponsors the Manager of Community Health, Parish Nurse, and community health promotora (CHW) at over 55 schools, churches, and community sites to provide health screenings, health education and information, and referral services. Each site selects their health education classes from a menu of choices offered annually. Health Ministry staff also participates in some local health fairs.
Community Benefit Category	Community Health Improvement Services: A1. Community-based health education A2. Community-based clinical services
FY 2021 Report	
Program Goal / Anticipated Impact	Eliminate health disparities in CHMC's service area by screening for common chronic conditions and referring people to medical homes for treatment and follow-up. Heart HELP: Educate participants about how to minimize their risk for cardiovascular disease (CVD) by healthy eating and maintaining an active lifestyle and addressing risk factors like obesity/overweight, hypertension, cholesterol, and diabetes. Healthy Eating Lifestyle Program: Educate focus children and their parents about how to decrease the risk of overweight/obese children aged 5-12 from becoming obese adolescents by healthy eating, maintaining an active lifestyle (at least 1 hr of physical activity/day) and reducing screen time to less than 2 hr/day. Diabetes Empowerment Education Program: Educating participants with either prediabetes or diabetes how to reduce or postpone becoming diabetic and/or to decrease their risk of complications from diabetes by maintaining their HbA1c< 7 by losing weight, eating a healthy diet, and maintaining an active lifestyle and taking medication as recommended by their health care provider. Healthy Living aka Chronic Disease Self-Management Program: Increase the ability of people with chronic conditions to manage their health and maintain active and fulfilling lives QPR is an emergency mental health intervention for suicidal persons created in 1995 by Paul Quinnett. An abbreviation for Question, Persuade and Refer, the intent is also to identify and interrupt the crisis and direct that person to the proper care

Measurable Objective(s) with Indicator(s)	**Health screens**: Number of individuals screened for obesity (BMI), hypertension (BP), prediabetes/diabetes (HbA1c), hyperlipidemia (cholesterol), and anemia (Hgb); number of health screening events; number and type of referrals made **Heart HELP**: • increase the proportion of adults with hypertension who meet guidelines for BMI; saturated fat consumption; sodium intake; physical activity; and smoking cessation • increase the proportion of adults with hypertension who take the prescribed medications to lower their blood pressure increase the proportion of adults with hypertension whose blood pressure is under control • Increase the proportion of adults aged 20 yr and older who are aware of the symptoms of and how to respond to a heart attack or stroke Healthy Eating Lifestyle Program: • Reduce weight or weight velocities; BMI < 85% for age in children • Normal lipid levels (if initial screening cholesterol > 200) • Reduce % of body fat • Improve exercise tolerance • Self-reported: o Improve food selection – more "gold and silver" selections and less "bronze and brick" selection Decrease consumption of sugar-sweetened beverages and fast food o Increased exercise frequency: goal 1 hr, at least 3 times/wk o Reduce screen time to < 2 hr/day o Improved exercise and nutrition self-efficacy **Diabetes Empowerment Education Program**: • Reduce diabetes risk factors, including obesity and hypertension • Increase knowledge of diabetes and its risk factors • Increase self-management skills • Manage psychosocial issues • Facilitate short- and long-term behavioral change **Healthy Living aka CDSMP**: • Improve health behaviors: exercise, cognitive symptom management, and communication with physicians • Improve self-efficacy • Improve health status: fatigue, shortness of breath, pain, role function, depression, and health distress • Reduce visits to ED and hospitalizations **Question, Persuade, and Refer (QPR):** • Recognize the warning signs of suicide • Know how to offer hope • Know how to get help and save a life
Intervention Actions for Achieving Goal	Normally we provide free health screens for common chronic conditions at Health Ministry sites and Hope Street Margolis Family Center (HSFC); Provide referrals to primary care clinics when screening tests

	are positive and/or if participant does not have a medical home; Participate in local health fairs as requested; Offer free workshop series in English and/or Spanish at schools, churches, and community sites, including at community clinics and HSFC, in CHMC's service area. Workshop series include: Heart HELP, H.E.L.P., DEEP, and CDSMP. Conduct health screens before and after workshop series to document impact of program participation However, due to the pandemic we were unable to offer any health screens, participate in any health fairs, or offer any in-person workshop series. Moreover, since a majority of community lacked computers, Wi-Fi access or computer literacy, it was difficult to quickly switch to Zoom classes. Due to the overwhelming stress and anxiety expressed by community members, a number of individual classes were added to help them manage their stress and recognize the warning signs of suicide.
Collaboration	We collaborate with ~50 schools, churches, clinics, and community sites in our service area that provide the venues for these screenings and health education workshops
Performance / Impact	Health screens: 0 Heart HELP: 13 workshop series in English- 17/20 completed; 14 workshop series in Spanish – 91/98 completed CVD Awareness class: 30 classes for 32 individuals DEEP workshops: 0 given because virtual curriculum not available Diabetes Awareness class: 37 classes for 37 individuals H.E.L.P workshops in English: 2 series given for 33 children; 17 completed the program. Nutrition Education: 95 classes provided for 116 individuals Stress management class: 21 classes given to 205 individuals Walking for Health class: 15 individuals Journaling & Health Benefits: 20 individuals Stress and Your Health: 21 individuals Sleep: 21 individuals Hydration and Your Body: 20 individuals Monthly Emotional Wellbeing Support Group: 11 sessions attended by 109 individuals QPR: 8 classes provided to 80 individuals COVID-19 class: 15 classes given to 204 individuals Telehealth services (included individualized resource/referral and case management calls): provided to 975 individuals during FY21
Hospital's Contribution / Program Expense	CHMC hires all staff for Health Ministry Program and provides a spacious office, office furniture, supplies, computers, printers, and testing equipment and supplies. ($340,195.26).

FY 2022 Plan

Program Goal / Anticipated Impact	Eliminate health disparities in CHMC's service area by screening for common chronic conditions and referring people to medical homes for treatment and follow-up. Heart HELP: Educate participants about how to minimize their risk for cardiovascular disease (CVD) by healthy eating and maintaining an active lifestyle and addressing risk factors like obesity/overweight, hypertension, cholesterol, and diabetes. Healthy Eating Lifestyle Program: Educate focus children and their parents about how to decrease the risk of overweight/obese children aged 5-12 from becoming obese adolescents by healthy eating, maintaining an active lifestyle (at least 1 hr of physical activity/day) and reducing screen time to less than 2 hr/day. Diabetes Empowerment Education Program: Educating participants with either prediabetes or diabetes how to reduce or postpone becoming diabetic and/or to decrease their risk of complications from diabetes by maintaining their HbA1c< 7 by losing weight, eating a healthy diet, and maintaining an active lifestyle and taking medication as recommended by their health care provider. Healthy Living aka Chronic Disease Self-Management Program: Increase the ability of people with chronic conditions to manage their health and maintain active and fulfilling lives QPR is an emergency mental health intervention for suicidal persons created in 1995 by Paul Quinnett. An abbreviation for Question, Persuade and Refer, the intent is also to identify and interrupt the crisis and direct that person to the proper care
Measurable Objective(s) with Indicator(s)	**Health screens**: Number of individuals screened for obesity (BMI), hypertension (BP), prediabetes/diabetes (HbA1c), hyperlipidemia (cholesterol), and anemia (Hgb); number of health screening events; number and type of referrals made **Heart HELP**: • increase the proportion of adults with hypertension who meet guidelines for BMI; saturated fat consumption; sodium intake; physical activity; and smoking cessation • increase the proportion of adults with hypertension who take the prescribed medications to lower their blood pressure increase the proportion of adults with hypertension whose blood pressure is under control • Increase the proportion of adults aged 20 yr and older who are aware of the symptoms of and how to respond to a heart attack or stroke Healthy Eating Lifestyle Program: • Reduce weight or weight velocities; BMI < 85% for age in children • Normal lipid levels (if initial screening cholesterol > 200) • Reduce % of body fat • Improve exercise tolerance • Self-reported: o Improve food selection – more "gold and silver" selections and less "bronze and brick" selection

	Decrease consumption of sugar-sweetened beverages and fast food o Increased exercise frequency: goal 1 hr, at least 3 times/wk o Reduce screen time to < 2 hr/day o Improved exercise and nutrition self-efficacy **Diabetes Empowerment Education Program**: • Reduce diabetes risk factors, including obesity and hypertension • Increase knowledge of diabetes and its risk factors • Increase self-management skills • Manage psychosocial issues • Facilitate short- and long-term behavioral change **Healthy Living aka CDSMP**: • Improve health behaviors: exercise, cognitive symptom management, and communication with physicians • Improve self-efficacy • Improve health status: fatigue, shortness of breath, pain, role function, depression, and health distress • Reduce visits to ED and hospitalizations **Question, Persuade, and Refer (QPR):** • Recognize the warning signs of suicide • Know how to offer hope • Know how to get help and save a life
Intervention Actions for Achieving Goal	Normally we provide free health screens for common chronic conditions at Health Ministry sites and Hope Street Margolis Family Center (HSFC); Provide referrals to primary care clinics when screening tests are positive and/or if participant does not have a medical home; Participate in local health fairs as requested; Offer free workshop series in English and/or Spanish at schools, churches, and community sites, including at community clinics and HSFC, in CHMC's service area. Workshop series include: Heart HELP, H.E.L.P., DEEP, and CDSMP. Conduct health screens before and after workshop series to document impact of program participation As community sites begin to open up for in-person events, we plan to resume offering health screens and some in-person workshops and classes. Our community has proved resilient and have embraced Zoom classes mostly on their phones and sometimes on tablets or computers. We will continue to offer stress management and QPR classes because there is still a lot of housing insecurity as well as food insecurity and unemployment in our community.
Planned Collaboration	We collaborate with ~50 schools, churches, clinics, and community sites in our service area that provide the venues for these screenings and health education workshops

Other Programs and Non-Quantifiable Benefits

The hospital delivers community programs, services and non-quantifiable benefits in addition to those described elsewhere in this report. Like those programs and initiatives, the ones below are a reflection of the hospital's mission and its commitment to improving community health and well-being.

- "*Your leadership, ingenuity, and hard work have earned **Dignity Health California Hospital** this year's **Environmental Excellence Award**. This recognizes your organization's ongoing commitment to improving its environmental performance and your efforts to build sustainability into the operations of your institution*." The Environmental Excellence Awards are the nation's premier recognition program for environmental performance in the health care sector. Launched in 2002, the awards program recognizes health care facilities and health systems for their commitment to environmental stewardship and their sustainability achievements.

- **Community Investments by Dignity Health in Southern California**
  - Abode Communities (Abode)

    In 2019 Dignity Health approved a 3-year $2,000,000 line of credit to fund acquisition and predevelopment costs related to new development projects. A partner of Dignity Health since 2010, Abode is considered a thought leader in the affordable housing industry and since 2012, has placed in service 500 affordable housing units within the County of Los Angeles, with another 900 affordable units currently under construction and expected to be placed in service over the next several years. With Dignity Health's support, Abode has built affordable housing in Long Beach, Hollywood, South and Central Los Angeles.

  - Art Share Los Angeles Inc. (Art Share)

    In 2015, Dignity Health approved a 5-year $500,000 loan to Art Share, a community arts center and affordable housing complex for low-income artists in downtown Los Angeles. Art Share used the loan to assume the mortgage on the center and refurbish the 30 low-income rental housing units located above the gallery spaces.

  - Corporation for Supportive Housing (CSH)

    In June 2016 Dignity Health approved a 7-year $3,000,000 loan to CSH to further this CDFI's work in creating supportive housing geared toward preventing and ending homelessness. CSH has been a close partner with Dignity Health hospitals particularly in Santa Cruz, Los Angeles and Las Vegas, working to reduce length of stays by frequent users (mostly homeless) of the hospitals'

Economic Value of Community Benefit

306 California Hospital Medical Center
Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2020 through 6/30/2021

	Persons	Expense	Revenue	Net Benefit	% of Expense
Benefits for Poor					
Financial Assistance	**6,750**	**15,317,326**	**0**	**15,317,326**	**2.9%**
Medicaid	**65,078**	**332,744,621**	**230,627,668**	**102,116,953**	**19.5%**
Community Services					
A - Community Health Improvement Services	46,263	25,220,324	20,632,759	4,587,565	0.9%
C - Subsidized Health Services	0	83,229	0	83,229	0.0%
E - Cash and In-Kind Contributions**	3	949,021	1,793,295	0	0.0%
G - Community Benefit Operations	1,423	550,636	0	550,636	0.1%
Totals for Community Services	**47,689**	**26,803,210**	**22,426,054**	**4,377,156**	**0.8%**
Totals for Poor	**119,517**	**374,865,157**	**253,053,722**	**121,811,435**	**23.3%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	1,630	894,997	128,173	766,824	0.1%
B - Health Professions Education	45	9,073,845	2,090,787	6,983,058	1.3%
C - Subsidized Health Services	5,535	4,794,472	4,018,695	775,777	0.1%
F - Community Building Activities	438	164,440	0	164,440	0.0%
Totals for Community Services	**7,648**	**14,927,754**	**6,237,655**	**8,690,099**	**1.7%**
Totals for Broader Community	**7,648**	**14,927,754**	**6,237,655**	**8,690,099**	**1.7%**
Totals - Community Benefit	**127,165**	**389,792,911**	**259,291,377**	**130,501,534**	**24.9%**
Medicare	**10,417**	**59,458,492**	**39,617,580**	**19,840,912**	**3.8%**
Totals with Medicare	**137,582**	**449,251,403**	**298,908,957**	**150,342,446**	**28.7%**

**Consistent with IRS instructions and CHA guidance, Cash and In-kind Contributions is reported at $0 net benefit because offsetting revenue was greater than expense in FY21. This was due to the return of a large donation in the fiscal year. Net gain for cash and in-kind contributions is still included in all "Totals" calculations, however.

The economic value of all community benefit is reported at cost. Patient financial assistance (charity care) reported here is as reported to the Office of Statewide Health Planning and Development in Hospital Annual Financial Disclosure Reports, as required by Assembly Bill 204. The community benefit of Medicaid and other means-tested programs is calculated using a cost-to-charge ratio to determine costs, minus revenue received for providing that care. Other net community benefit expenses are calculated

using a cost accounting methodology. Restricted offsetting revenue for a given activity, where applicable, is subtracted from total expenses to determine net benefit in dollars.

Hospital Board

Board Member	Title	Company/Primary Address	Phone	Email
TAMMARA ANDERSON Community Board Secretary	Associate Dean	University of Southern California Office of Experiential and Applied Learning Dornsife College of Letters, Arts and Sciences 3601 Watt Way GFS 315 Los Angeles, CA 90089-1694	(213) 740-1824 Cell: (323) 447-7201 Fax: (213) 740-1825	tanderso@usc.edu
KELLY A. BRUNO	Chief Executive Officer	National Health Foundation	(213) 538-0708	kbruno@nhfca.org
ROBERT BUENTE Quality Subcommittee Chair	President & CEO	1010 Development Corporation 1001 South Hope Street Los Angeles, CA 90015	(213) 749-0214 - Ext. 202 Cell: (626) 818-2183	bbuente@1010dev.org
MARK GONZALEZ	District Director, 53rd Assembly District Assembly Member Miguel Santiago & Chair, Communications and Conveyance Committee	320 West 4th Street, Suite 1050 Los Angeles, CA 90013	(213) 620-4646 Cell: (323) 828-7561 Fax: (213) 620-6319	mark.gonzalez@asm.ca.gov
PHILLIP C. HILL Community Board Chair & Medical Staff Relations Subcommittee Chair		California Hospital Medical Center Attention: Administration Department 1401 S. Grand Avenue Los Angeles, CA 90015	(310) 351-5342	cfihill@gmail.com

GUDATA S. HINIKA, MD	Medical Director CHMC Trauma Program	Crenshaw Medical Center 5141 Crenshaw Boulevard Los Angeles, CA 90043-1853	(323) 545-9288 Cell: (310) 704-3018	hinikamd@gmail.com
LINDA G. LOPEZ	CEO	Impact Strategies 2754 Monterey Road San Marino, CA 91108	Cell: (202) 577-6529	lindaglopez@yahoo.com
PATRICIA LOTT	Business Strategist	PALSolutions 2309 Marshallfield Lane, Unit #3 Redondo Beach, CA 90278	Cell: (310) 413-5011	pattlott@yahoo.com
RALPH MAYER, MD ***Ex-Officio - Voting Member***	Chief of Staff	California Hospital Medical Center Attention: Medical Staff Office 1401 S. Grand Avenue Los Angeles, CA 90015	(310) 613-7224	rmdoc@aol.com
ALINA MORAN ***Ex-Officio - Voting Member***	President	California Hospital Medical Center 1401 S. Grand Avenue Los Angeles, CA 90015	(213) 742-5778 Cell: (917) 806-9544	Alina.moran@dignityhealth.org
VERONICA PEREZ **Community Board Vice Chair**	President	Veronica Perez & Associates 611 Wilshire Blvd., Ste. 1107 Los Angeles, CA 90017	(213) 221-7161 Cell: (626) 644-5525 Fax: (213) 478-0539	vp@veronicaperez.com
SARAH SCHER	Chief Executive Officer	Cooperative of American Physicians 333 S. Hope Street, 8th Floor Los Angeles, CA 90071	(213) 473—8701 Fax: (213) 483-6650	sscher@capphysicians.com