St. Mary Medical Center

Community Benefit 2021 Report and 2022 Plan

Adopted October 2021

Dignity Health®
St. Mary Medical Center

A message from

Carolyn Caldwell, president and CEO of St. Mary Medical Center, and Christopher Pook, Chair of the Dignity Health St. Mary 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.

St. Mary 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), St. Mary Medical Center provided $35,551,389 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $32,194,443 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 October 28, 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 the Community Health Department at 562-491-4840.

Carolyn Caldwell, FACHE
President/CEO

Christopher Pook
Chairperson, Board of Directors

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At-a-Glance Summary

Community Served	St. Mary Medical Center, Long Beach is located in Los Angeles County and encompasses 14 zip codes with a current population of slightly over 1 million people. St. Mary Medical Center is in Service Planning Area 8 which is shared with the City of Long Beach Department of Health and Human Services, Long Beach Memorial Medical Center, Millers Children's and Women's Hospital, The Children's Clinic "Serving Children and Their Families" dba TCC Family Health and Kaiser Permanente of South Bay.
Economic Value of Community Benefit	$35,551,389 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $32,194,443 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: • Access to health services • Food insecurities • Housing and homelessness • Mental health • Preventive practices
FY21 Programs and Services	The hospital delivered several programs and services to help address identified significant community health needs. These include: • Bazzeni Wellness Center – Provides health education, chronic disease management, health screenings and resources to the community. • CARE Program – HIV medical and psychosocial service program. • CARE Dental program – dental care to HIV patients. • Every Woman Counts- Mammogram services to underserved women over the age of 40. • Families in Good Health – SNAP, Cover California Enrollment, Patient Navigation, Social Service Programs. • Family Clinic of Long Beach – Provides primary care. • Low Vision Center – Free vision screenings for children and older adults. • Mary Hilton Family Clinic – Offers OB, perinatal and pediatric services.

	• Welcome Baby – Hospital and home based intervention for pregnant and post-partum women, including home visits. • Financial Assistance – Provides financial assistance through free and discounted care for health care services, consistent with the hospitals financial policy. • Community Grants Program – Dignity Health provides community grants to St. Mary Medical Center community organizations to help address needs addressed in the Community Health Needs Assessment.
FY22 Planned Programs and Services	The above mentioned programs will continue through FY'21. The approach of service delivery for some programs and services may change as more virtual programs are being developed and implemented.

This document is publicly available online at:
https://www.dignityhealth.org/socal/locations/stmarymedical/about-us/community-benefits

Written comments on this report can be submitted to the St. Mary Medical Center Community Health Office, located at 1050 Linden Avenue, Long Beach, CA, or by email to Kit.Katz@Commonspirit.org

Our Hospital and the Community Served

About St. Mary Medical Center

St. Mary Medical Center is a member of Dignity Health, which is a part of CommonSpirit Health. Located at 1050 Linden Avenue, Long Beach, CA 90813, St. Mary Medical Center was founded in 1923 by the Sisters of Charity of the Incarnate Word. The facility has 389 licensed beds. Major programs and services include: cardiac care, prenatal and childbirth services, bariatric surgery, stroke recovery, critical care, a 39-bed intensive care unit, a level IIIB NICU with 25 beds and a Disaster Resource Center. The hospital's Emergency Department is a level II trauma center and the Paramedic Base Station for the area.

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

St. Mary 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

St. Mary Medical Center is located in Long Beach, California and is a city within Los Angeles County. Long Beach is the 39th largest city in the nation, the seventh largest city in California and is the second largest city within the greater Los Angeles area. It is home to approximately 500,000 people and one of the most ethnically diverse communities in the United States with a strong sense of community and unique neighborhoods. Long Beach is known for large Cambodian, Hispanic/Latino and Black/African America communities and a growing population of adults 65 and older.

While a few of the communities enjoy a higher standard of living, the majority of the communities served have greater needs. To determine the service area, St. Mary Medical Center takes into account zip codes of inpatients from the hospital, the most recent Community Health Needs Assessment and long standing community programs and partnerships.

A summary description of the community is below. Additional details can be found in the CHNA report online.

Total Population	544,460
Race:	
White- Non-Hispanic	19.0%
Black/African American – Non-Hispanic	12.0%
Hispanic or Latino	54.2%
Asian/Pacific Islander	11.8%
All Others	3.1%
% Below Poverty	13.7%
Unemployment	6.4%
No High School Diploma	25.2%
Medicaid (household)	11.9%

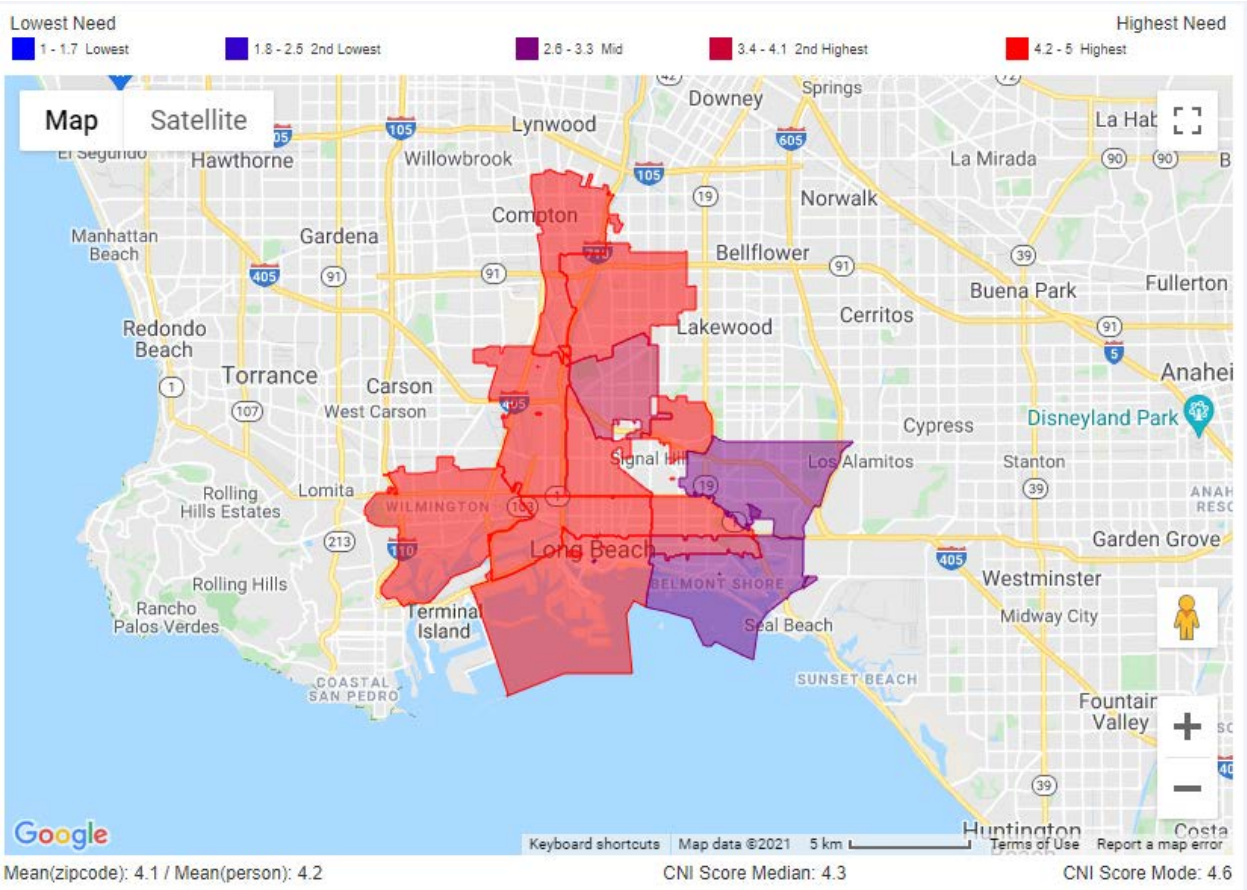
Uninsured (household)	5.5%

Source: Claritas 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): 4.1 / Mean(person): 4.2 CNI Score Median: 4.3 CNI Score Mode: 4.6

Community Assessment and Significant Needs

St. Mary Medical Center 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 (CHNA)

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 May 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 athttps://www.dignityhealth.org/socal/locations/stmarymedical/about-us/community-benefits 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 in the City of Long Beach:

- Access to Health Care
- Chronic Diseases
- Economic Insecurity
- Environment
- Exercise, Nutrition and Weight
- Food Insecurity
- Housing and Homelessness
- Mental Health
- Oral Health/Dental Care
- Pregnancy and Birth Outcomes
- Preventive Practices
- Public Safety
- Sexually Transmitted Infections
- Substance Use and Misuse

After a thorough process was applied using the criteria below, the Community Health Department under the guidance of Mission Integration and St. Mary Medical Center Senior Leadership identified the following significant health needs to be addressed:

- Access to health services
- Food insecurities
- Housing and homelessness
- Mental health
- Preventive practices

Significant Needs the Hospital Does Not Intend to Address

St. Mary Medical Center will not directly address the following needs identified in the CHNA: chronic diseases, economic insecurity, environment, exercise/nutrition/weight, oral health, pregnancy and birth outcomes, public safety, sexually transmitted infections and substance use and misuse. Taking existing community resources into consideration, St. Mary has selected to concentrate on those health needs that we can most effectively address given our areas of focus. St Mary has insufficient resources to effectively address all the identified needs and in some cases, the needs are currently addressed by others in the community.

The following four criteria were used to prioritize the significant health needs:

- **Severity:** The health need has serious consequences (morbidity, mortality, and/or economic burden) for those affected.
- **Disparities:** The health need disproportionately impacts certain groups of people more than others (e.g. by geography, age, gender, race/ethnicity).
- **Prevention:** Effective and feasible prevention is possible. There is an opportunity to intervene at the prevention level and impact overall health outcomes. Prevention efforts include those that target individuals, communities, and policy efforts.
- **Leverage:** The solution could impact multiple problems. Addressing this issue would impact multiple health issues.

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

St. Mary 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 hospital engages in multiple activities to conduct its community benefit and 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; using five core principles to guide planning and program decisions; measuring and tracking program indicators and impact; and engaging the Community Benefit Advisory Committee and other stakeholders in the development of an annual Community Benefit Plan and triennial Implementation Strategy.

Community focus groups are held to determine health needs. A focus group consists of residents of the St. Mary service area as well as other community stakeholders who may provide programs and/or services.

Once the areas of significant health needs were identified, the Community Benefits Advisory Committee met to discuss and make a recommendation to the St. Mary Senior Leadership of which health needs should be addressed.

The Community Health Department, Mission Integration and Senior Leadership met to review the recommendations and make any changes based on hospital resources and the impact of programs and services being offered.

Impact of the Coronavirus Pandemic

During the second year of the pandemic, St. Mary Medical Center followed all updated mandates from the CDC and the California Department of Health Services and made adjustments accordingly. The

hospital's Community Health Department staff were trained to provide programs virtually. Programs were also recorded on Vimeo, which is similar to a podcast format and stored on the hospital's website. The community can listen to the podcast to get health information and health lectures at anytime and anywhere. This helped with digital divide among community members that do not have access to Wifi/internet.

The below needs were identified as having increased from last year and what actions the hospital took in response to those needs:

- Support the community to have access to the Covid-19 vaccines.

1. Dignity Health Southern California Vaccine Clinic at the Dignity Health Sports Park: In February 2021 Dignity Health, The LA Galaxy, AEG and the City of Carson joined efforts to accelerate the process of vaccinating vulnerable populations in Los Angeles that don't normally have consistent access to the health care. Together with the help of 1,000 staff and volunteers, Dignity Health Southern California successfully vaccinated over 20,000 people who were able to participate in this drive through clinic.
2. St. Mary Medical Center Mobile Unit provided vaccines to underserved communities at parks and churches.

- Increase in food insecurities.

St. Mary was able to work with our community partner, The Salvation Army to provide food boxes to low income families three times during the year: Summer, Fall and for the Christmas Holiday. St. Mary also worked very closely with Food Finders to ensure their food bank was full and with Project Angel Food to ensure meal delivery service was not interrupted.

- Increase in mental health problems, especially depression due to being socially isolated.

St. Mary Community Health department under a grant from the UniHealth Foundation was able to train staff and community members in identifying signs of mental stress and trauma through the Adult Mental Health First Aide and Youth First Aide Programs.

- Staff burn out

During the months of February and March the Mission Integration and Spiritual Care Department provided spiritual and emotional healing opportunities:

1. Relaxation/reflection room – a special room for quiet contemplation
2. Employee Assistance Program representative on site
3. Kindness Tree – a place where someone could write kind motivational words or blessings to one another and hang them on the tree
4. Memorial stones and tea lights for remembering loved ones and lighting a candle for prayer, protection and guidance

Going forward into next year, the hospital will continue to work with our partners to keep our community as safe as possible and to address new or exacerbated community needs.

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.

Health Need: Significant Community Health Need #1- Access to Health Services

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Bazzeni Wellness Center	• No cost health education and health screenings.	x	x
CARE Program	• HIV medical and dental services • Psychosocial services	☒	☒
Every Woman Counts	• Mammography services and breast care for low income women.	x	x
Family Clinic of Long Beach	• Primary care services to low income	☒	☒
Families in Good Health	• Cover California • Welcome Baby Program • Public benefit navigation	☒	☒
Financial assistance	• No cost and discounted health care services consistent with the hospitals financial policy	x	x
Low Vision Center	• No cost vision screening	x	x
Mary Hilton Family Clinic	• OB and perinatal to low income women.	x	x

Impact: Proving primary care services and referrals to public benefits will help to minimize some of the barriers to accessing health services

Collaboration: In addition to direct hospital services including the GME program, the hospital will partner with the local LGTBQ center, the Long Beach Department of Health and Human Services and community partners.

Health Need: Significant Community Health Need #2 – Food Insecurities

Strategy or Program Name	Summary Description	Active FY20	Planned FY21
Food Finders	Collects food from grocery stores, restaurants and hospital cafeterias and redistributes to local nonprofit agencies and food banks. In 2021, St. Mary purchased a refrigeration container that was needed for one of their food hubs in North Long Beach.	☒	☒
Project Angel Food	Provides medically tailored home delivered meals to HIV and cancer patients. St. Mary funds the delivery of 30 meals to our CARE/HIV clients that are home bound.	☒	☒
The Salvation Army	Local food back for homeless and low income families. TSA provides food boxes for low income families obtaining services from St. Mary.	☒	☒

Impact: Providing food/meals to homeless and low income families helps promote better physical health and mental health.

Collaboration: The hospital will partner with food banks and meal service providers.

Health Need: : Significant Community Health Need #3 - Housing and Homelessness

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
LINC Housing	Affordable housing for low income families, seniors, special needs populations and youth transition from fosters homes to independent living. St. Mary has funded their youth transitional program. The hospital also partners with LINC Housing to provide health education to their residents.	☒	☒
Century Villages at Cabrillo	Property serves formerly homeless transitional to permanent housing focusing on veterans. St. Mary has funded CVC's "Pathway's to Health Project" which	☒	☒

	allowed the residents to learn about healthy eating and help them obtain healthy life styles.		

Impact: Affordable housing and homelessness are major concerns in Long Beach. Without a home or continually wondering about whether or not someone is able to pay their rent for the month increases the chance of health related issues occurring or relapsing.

Collaboration: Identify other partners to help with referral of low income housing resources and shelters. Attend City run community meetings around this issue.

Health Need: Significant health need #4 - Mental Health

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Mental Health America of Los Angeles	Provides comprehensive mental health services using a one-stop integrated model. St. Mary funds an LCSW who is assigned to the ED to provide social services to low income and homeless individuals who are frequent users of the ED.	☒	☒
NAMI Long Beach	Provides advocacy, education, support and public awareness for individuals and families affected by mental illness. St. Mary funds Mental Health First Aid trainings for the community that are facilitated through NAMI.	☒	☒

Impact. Each agency represents a different age group and different geographic area of Long Beach affecting the homeless, schools age children and those involved in any type of trauma.

Health Need: Significant Health Need #5- Preventative Practices

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
CARE Program	• HIV medical and dental services • Psychosocial services	☒	☒
Every Woman Counts	• Mammography services and breast care for low income women	x	x
Family Clinic of Long Beach	• Primary care services	☒	☒
Mary Hilton Family Clinic	• OB and prenatal care for low income women	☒	☒

Impact: Preventative care is essential for early detection of disease.

Collaboration: These are direct hospital services. The hospital also partners with a local FQHC for prevention practices and care.

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 $132,932. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Food Finders	The Community Market Place	$ 66,466
Project Angel Food	Home Delivered Medically Tailored Meals and Nutritional Counseling Support to Chronically Ill Older Adults	$ 66,466

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.

Every Woman Counts

Significant Health Needs Addressed	☑ Access to health services ☐ Food insecurity ☐ Housing and homelessness ☐ Mental health ☑ Preventive practices
Program Description	In partnership with community healthcare providers, we were able to offer mammography screening services to women age 40+ and diagnostic mammography services to men and women of any age through the Every Woman Counts Program for those who qualify. In

	addition to diagnostic services, assistance was offered to patients with positive cancer findings by enrollment into the Breast and Cervical Cancer Treatment Program and coordination of care by our staff RN.
Community Benefit Category	A2. Community-based clinical services
FY 2021 Report	
Program Goal / Anticipated Impact	Increase preventative screenings for breast and cervical cancer.
Measurable Objective(s) with Indicator(s)	Screened 4928 women for breast cancer through the EWC program. Electronic Medical Records system will assisted in tracking.
Intervention Actions for Achieving Goal	Provide outreach and health education through social media and community healthcare providers to encourage healthy behaviors and promote early detection of cancer through screenings
Collaboration	Susan G. Komen Foundation Cancer Detection Program: Every Woman Counts Healthcare providers in the Long Beach and surrounding communities
Performance / Impact	Our goal for FY 2021 was to increase awareness of the importance of breast health care. Educating women on the importance of routine screenings as a preventative measure as well as advising the Long Beach and surrounding communities of the program available to them at no cost.
Hospital's Contribution / Program Expense	St. Mary Medical Center provides for the coordination of care for this program. A registered nurse offers continuum of care throughout the patient's entire case.
FY 2022 Plan	
Program Goal / Anticipated Impact	Increase awareness regarding the importance of preventative screenings for breast cancer.
Measurable Objective(s) with Indicator(s)	Screen 3,000+ women for breast cancer through the EWC program. EMR system will assist in tracking.
Intervention Actions for Achieving Goal	Provide outreach and health education through social media and community healthcare providers to encourage healthy behaviors and promote early detection of cancer through screenings
Planned Collaboration	Susan G. Komen Foundation Cancer Detection Program: Every Woman Counts Healthcare providers in the Long Beach and surrounding communities

CARE Center	
Significant Health Needs Addressed	❑ Access to health services-- HIV testing, HIV treatment, STD testing and treatment, HCV testing and treatment ❑ Food insecurities—CARE Food Pantry, homeless emergency food and personal necessities program ❑ Behavioral health—Counseling provided by LCSWs specializing in LGBTQ and HIV-related issues ❑ Preventive practices—HIV testing, HIV Biomedical Prevention (PrEP and PEP)
Program Description	The CARE program is a multidisciplinary HIV care and support project, based on the campus of St. Mary Medical Center. Clients of the CARE program receive integrated high quality medical, dental, health, and psychosocial services to a heavily impacted population of low-income men, women, and children living with HIV and for those at high risk for acquiring HIV.
Community Benefit Category	A2 – Community based clinical services
FY 2021 Report	
Program Goal / Anticipated Impact	The program's goal was to continue emphasis on supporting clients' 1. Retention in HIV care and PrEP care 2. Achieving and maintaining ongoing viral suppression for those who are infected with HIV. 3. Testing of those who are at high risk for HIV and other STDs. 4. Starting high risk individuals on PEP and PrEP. 5. CARE will also provide behavioral health therapy to those in need 6. Provide nutritional support to clients with food insecurity.
Measurable Objective(s) with Indicator(s)	• 90% of CARE patients will be 'retained in care' for FY21. This is defined based on the standard of at least one HIV medical care visit in each 6 month period of a 12 month measurement period. • 95% of CARE patients will achieve and maintain complete HIV viral suppression. • Increase the number of total PrEP and PEP patient visits to 1200 in FY21. • Perform 9,000 HIV tests in ED and 1,000 HIV tests at CARE walk-in sexual health clinic. • Perform 3,000 STD tests (syphilis, gonorrhea and chlamydia) at CARE walk-in sexual health clinic. • Provide 1,500 behavioral health visits through telehealth. • Distribute 2,800 allotments of food through CARE food pantry.
Intervention Actions for Achieving Goal	• Provide a comprehensive, one-stop program of HIV medical and support services that support retention in care by allowing clients to access all needed medical support services in a single location,

	including medical case management, dental services, nutritional counseling, and behavioral health services. • Clinical staff will monitor and report viral load levels, provide intensive follow-up for patients who missed appointments, or who did not attend medical appointments over a 6-month period. Full-time Patient Retention Specialists provides specialized follow-up for clients who miss appointments and/or who appear to be lost to care. • Provide opt-out HIV testing to high risk ED patients. • Provide free, walk-in STD testing at CARE Clinic. • Provide partner notification services at CARE Clinic. • Offer PEP on demand in ED and in CARE Clinic to all patients with a high risk exposure to HIV in the past 72 hours. • Offer ongoing PrEP to all HIV negative patients at high risk for HIV infection. • Offer behavioral health therapy and referrals to those in need. • Offer nutritional assistance to those with food insecurity.
Collaboration	City of Long Beach Department of Health and Human Services, Los Angeles County Department of Public Health-Division of HIV and STD Programs, The Long Beach Gay and Lesbian Center, APLA Health, Bienestar, Long Beach VA and California State University Long Beach
Performance / Impact	• 86% of CARE patients were 'retained in care' in FY21. This is defined based on the standard of at least one HIV medical care visit in each 6 month period of a 12 month measurement period. This indicator remained stable, with a 1% decrease compared to FY20. • 92% of CARE patients maintained complete HIV viral suppression in FY21. This indicator remained stable, matching a 92% viral suppression rate in FY20. • There were a total of 1,182 biomedical prevention (PrEP/PEP) patient visits in FY21. This represents a 20% increase compared to FY20. • In FY21, there were a total of 3,617 HIV screening tests performed in the ED. This represents a 54% decrease compared to FY20. • In FY21, there were a total of 1,656 behavioral health visits provided. This represents a 37% increase compared to FY20. • In FY21, 1830 food allotments were distributed to food pantry clients. This represents a 25% increase compared to FY20. • In FY21, there were approximately 600 emergency food bags distributed to the community. This represents a 15% decrease compared to FY20.
Hospital's Contribution / Program Expense	CARE committed a total of approximately 9 FTEs to ED testing, Biomedical Prevention Services, retention & linkage to care, nutritional services, and mental health series, with grant funding to cover approximately 6.5 FTEs.

FY 2022 Plan	
Program Goal / Anticipated Impact	The program's goal is to continue emphasis on supporting clients' 1. Retention in HIV care and PrEP care 2. Achieving and maintaining ongoing viral suppression for those who are infected with HIV. 3. Testing of those who are at high risk for HIV and other STDs. 4. Starting high risk individuals on PEP and PrEP. 5. CARE will also provide mental health therapy to those in need 6. Provide nutritional support to clients with food insecurity
Measurable Objective(s) with Indicator(s)	• 90% of CARE patients will be 'retained in care' for FY22. This is defined based on the standard of at least one HIV medical care visit in each 6 month period of a 12 month measurement period. • 95% of CARE patients will achieve and maintain complete HIV viral suppression. • Increase the total number of biomedical prevention (PrEP and PEP) visits to 1300 in FY21. • Perform 5,000 HIV tests in ED and an additional 500 HIV tests at CARE walk-in sexual health clinic. • Provide 1,500 behavioral health visits both in-person and via telemedicine. • Distribute 2,100 allotments of food through CARE food pantry.
Intervention Actions for Achieving Goal	• Provide a comprehensive, one-stop program of HIV medical and support services that support retention in care by allowing clients to access all needed medical support services in a single location, including medical case management, dental services, nutritional counseling, and behavioral health services. • Clinical staff will monitor and report viral load levels, provide intensive follow-up for patients who missed appointments, or who did not attend medical appointments over a 6-month period. Full-time Patient Retention Specialists provides specialized follow-up for clients who miss appointments and/or who appear to be lost to care. • Provide opt-out HIV testing to high risk ED patients. • Provide free, walk-in HIV and STD testing at CARE Clinic. • Provide partner notification services at CARE Clinic. • Offer PEP on demand in ED and in CARE Clinic to all patients with a high risk exposure to HIV in the past 72 hours. • Offer ongoing PrEP to all HIV negative patients at high risk for HIV infection. • Offer behavioral health therapy and referrals to those in need. • Offer nutritional assistance to those with food insecurity. Continue to engage in community outreach activities and collaborate with community partners; continue leadership role in Long Beach HIV PrEP Working Group.

Planned Collaboration	We will continue to collaborate with City of Long Beach Department of Health and Human Services on STD screening and partner notification. Collaborations will continue with the Los Angeles County Department of Public Health-Division of HIV and STD Programs, The Long Beach Gay and Lesbian Center, APLA Health, Bienestar, Long Beach VA and California State University Long Beach.

Family Clinic of Long Beach

Significant Health Needs Addressed	❑ Access to health services ❑ Chronic Disease ❑ Obesity and Diabetes ❑ Preventive Care
Program Description	The Family Clinic of Long Beach has been providing primary care to the Long Beach community for over 25 years. Developed as part of the St. Mary Residency Program, the Family Clinic continues to support the Residency and over 30 medical students and pharmacy students each year. The Family Clinic serves as the hub of medical services for our group of clinics, serving as the medical home for adult patients seeking primary care services or referrals to specialists in our clinic network. The clinic focuses on internal medicine with additional services such as Travel Clinic, Coumadin Clinic, Diabetes Education Program and Specialty Medicine.
Community Benefit Category	1204 (a) Community-based clinic

FY 2021 Report

Program Goal / Anticipated Impact	To retain current patients and ensure proper screening on patients.
Measurable Objective(s) with Indicator(s)	Continue to screen patients for Diabetes and Cervical Cancer. Improve management of Hypertension through a coordinated approach
Intervention Actions for Achieving Goal	Continuous efforts in monitoring screening of diabetes and cervical cancer measures.
Collaboration	Would like to collaborate with health plans, CARE Clinic and Emergency Department in order to capture patients who do not have a Primary Care Physician.
Performance / Impact	Our goals are to continue to screening patients for Diabetes and Cervical Cancer as well as improve management of hypertension in our patients.
Hospital's Contribution / Program Expense	Family Clinic was developed as part of the SMMC Residency Program. This clinic continues to support the Residency Program.

FY 2022 Plan	
Program Goal / Anticipated Impact	Goals include retaining our current patients. Increase access to primary health care for our medically underserved population. Stabilize patients with diabetes and decrease disease through prevention services. Implement a new initiative in collaboration with the port of LB through a Propeller Health platform to monitor patients with COPD and asthma.
Measurable Objective(s) with Indicator(s)	Provide 50 patients with diabetes and medication therapy management. Increase access for additional 100 patients annually to obtain care at the clinic. Designate and enroll some patients who meet criteria on new propeller health initiative.
Intervention Actions for Achieving Goal	1. Provide patients with diabetes medication therapy management. 2. Screen patients with diabetes and cervical cancer. 3. Manage patient's respiratory diagnosis
Planned Collaboration	Ongoing collaboration with Propeller Health, the CARE Clinic, the Emergency Department and the Health Plans in order to improve patients' quality of life.

Mary Hilton Family Health Center	
Significant Health Needs Addressed	☑ Access to health services ☑ Preventive practices
Program Description	The Mary Hilton Family Health Center has OB, Uro-Gyn, perinatal, and pediatric services: The clinics provide comprehensive services to serve mothers and children from pregnancy through Adulthood. Services include: • Comprehensive Prenatal Services Program (CPSP) • High risk care • Vaccines • Care for diabetic expectant mothers • Nutrition, education and psychosocial services • Uro-gynecology services • Urodynamic Studies
Community Benefit Category	A1. Community Health Education A2. Community-Based Clinical Services A3. Health Care Support Services
FY 2021 Report	

Program Goal / Anticipated Impact	To support access to care. To support increased access to in-home and post-partum services through the Welcome Baby Program. To provide prenatal care and education
Measurable Objective(s) with Indicator(s)	Increase and provide prenatal care and education to women by 15%. Increase access to in home and post-partum and pediatric services through our partnership with the Welcome Baby Program.
Intervention Actions for Achieving Goal	• Ensure that all patients delivering at SMMC are offered Welcome Baby information.
Collaboration	Child Birth Prep Classes are offered every Tuesday during the last trimester of pregnancy. Topics include: • Breathing and relaxation techniques • Counting contractions • Stages of labor • Breast-feeding classes The Welcome Baby Program has been incorporated into the maternity tours
Performance / Impact	The Program begins early in pregnancy, continues during pregnancy, and extends through the postpartum period. The earlier the pregnancy is diagnosed and the woman seeks care, the sooner efforts can be undertaken to assess risk factors, establish an ongoing management
Hospital's Contribution / Program Expense	The hospital supports this program through the coordination of care and education using social workers and health educators.
FY 2022 Plan	
Program Goal / Anticipated Impact	To support access to care To increase access to in-home support and post-partum services through the Welcome Baby Program. To improve pregnancy outcomes through enhanced prenatal care
Measurable Objective(s) with Indicator(s)	Provide initial assessments on every new patient initiating prenatal care seen by Obstetrician and supplement care by nutrition, education and Psychosocial services in order to improve pregnancy outcomes.
Intervention Actions for Achieving Goal	Ensure that all prenatal patients are offered Welcome Baby information. Referral/appointments made for patients to have initial Assessment completed by CPHW (Perinatal Health worker)
Planned Collaboration	Collaboration with Community Education at SMMC Patients referred to Tours of Labor and Delivery Suites and Birthing Classes during the last trimester of pregnancy. Flyer with dates and times provided printed by Dignity Health. Welcome baby Program information has also been incorporated into the maternity tours.

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.

- Annual Helping Hands Children's Christmas Event – contactless drive thru event

- Dignity Health Southern California vaccination event at the Dignity Health Sports Park

- 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.

Economic Value of Community Benefit

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.

332 St. Mary Medical Center (Long Beach)
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	**8,117**	**8,062,581**	**0**	**8,062,581**	**2.0%**
Medicaid	**55,426**	**193,112,908**	**185,744,902**	**7,368,006**	**1.8%**
Community Services					
A - Community Health Improvement Services	17,025	8,378,770	4,979,713	3,399,057	0.8%
C - Subsidized Health Services	10,551	12,754,378	5,511,113	7,243,265	1.8%
E - Cash and In-Kind Contributions**	2	623,147	1,555,410	0	0.0%
Totals for Community Services	**27,578**	**21,756,295**	**12,046,236**	**9,710,059**	**2.4%**
Totals for Poor	**91,121**	**222,931,784**	**197,791,138**	**25,140,646**	**6.2%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	291	7,232	0	7,232	0.0%
B - Health Professions Education	33	11,144,336	1,302,796	9,841,540	2.4%
F - Community Building Activities	0	949,962	387,991	561,971	0.1%
Totals for Community Services	**324**	**12,101,530**	**1,690,787**	**10,410,743**	**2.6%**
Totals for Broader Community	**324**	**12,101,530**	**1,690,787**	**10,410,743**	**2.6%**
Totals - Community Benefit	**91,445**	**235,033,314**	**199,481,925**	**35,551,389**	**8.8%**
Medicare	**14,345**	**108,700,102**	**76,505,659**	**32,194,443**	**8.0%**
Totals with Medicare	**105,790**	**343,733,416**	**275,987,584**	**67,745,832**	**16.8%**

**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.

Hospital Board and Committee Rosters

St. Mary Medical Center Community Board 2021 Roster

Carolyn Caldwell, St. Mary Medical Center President/CEO

Christopher Pook, Community Leader – Hospital Board Chair

Gregory Vanley, M.D. – Hospital Chief of Staff

Minnie Douglas, Ed.D., RN – Board Secretary

Bertram Sohl, M.D., physician

Chester Choi, M.D., physician/Resident Program

Erin Simon, Ed.D., Assistant Superintendent LBUSD

Felton Williams, Ph.D. – LBUSD School Board President

Gloria Cordero, Community Leader

Chief Robert Luna, Long Beach Police Department

Sandy Cajas, President, Regional Hispanic Chamber of Commerce

Terry Geiling, Retired

Vattana Peong, Cambodian Community Leader