Dignity Health California Hospital Medical Center

Community Benefit 2023 Report and 2024 Plan

Adopted October 2023

Dignity Health
California Hospital
Medical Center

A message from

Alina Moran, President, and Robert Buente, 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 2023 Report and 2024 Plan describes much of this work. This report meets requirements in California (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. Dignity Health hospitals in Arizona and Nevada voluntarily 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 2023 (FY23), California Hospital Medical Center provided $159,263,432 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $9,472,553 in unreimbursed costs of caring for patients covered by Medicare fee-for-service.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2023 Report and 2024 Plan at its October 26, 2023 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 out to Barbara Gonzalez, Interim Director of Community Health Outreach.

Alina Moran
President

Robert Buente
Chairperson, Board of Directors

Table of Contents

At-a-Glance Summary

Community Served	Dignity Health California Hospital Medical Center (CHMC) primarily serves downtown and South Los Angeles. The hospital service area is located in Los Angeles County Service Planning Area (SPA) 4 (Metro Los Angeles) and also includes parts of SPA 6 (South), SPA 7 (East), and SPA 8 (South Bay). CHMC serves 1,942,854 racially diverse residents. The service area includes Skid Row which has the largest concentration of unhoused individuals in Los Angeles County. Approximately 50% of persons experiencing homelessness in LA County live in our service area.
Economic Value of Community Benefit	$159,263,432 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $9,472,553 in unreimbursed costs of caring for patients covered by Medicare fee-for-service
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. Access to health care 2. Behavioral health (mental health and substance use) 3. Birth indicators 4. Chronic diseases (includes overweight/obesity and food insecurity) 5. Housing Insecurity & Homelessness 6. Violence Prevention
FY23 Programs and Services	The hospital delivered several programs and services to help address identified significant community health needs. These included: *Access to health care* Financial assistance Para Su Salud Coordinated Care Initiative 10th Decile Project/FUSE Program (Homeless Health Initiative) Hope Street Family Center (HSFC) Early Head Start, Home Visitation Program Health Ministry/Community Health Program *Behavioral Health (Mental Health and Substance Use)* CA Bridge Program CA Behavioral Health Clinic Family Preservation Program HSFC Early Head Start, Early Childhood Education Center and Youth Center Wraparound Services Program Welcome Baby 10th Decile Project/FUSE Program (Homeless Health Initiative) UniHealth Cultural Trauma and Mental Health Resiliency Project Centinela Valley Mental Health Project

	Birth Indicators Welcome Baby LA Best Babies Network Los Angeles County Perinatal & Early Childhood Home Visiting Consortium HSFC Early Head Start Maternal Health Equity *Chronic Diseases (including Overweight & Obesity, Food Insecurity)* Heart HELP Program Emotional Support Groups HFSC Early Head Start, Early Childhood Education Center, Family Childcare Network & Youth Center Diabetes Education Empowerment Program (DEEP) Health Ministry Program Women's Center Welcome Baby *Housing Insecurity and Homelessness* 10th Decile Project /FUSE Program (Homeless Health Initiative Program) Samaritan Project HSFC Early Head Start and Early Childhood Education Center LA Partnership *Violence and Injury Prevention* CA Behavioral Clinic Family Preservation Program Wraparound Services Program Human Trafficking Response Task Force Stop the Bleed Trainings UniHealth Cultural Trauma & Mental Health Resiliency Project HSFC Early Head Start, Early Childhood Education Center, Family Childcare Network, Home Visting Program Welcome Baby
FY23 Planned Programs and Services	FY24 programs and services will continue with the exception of the following: CommonSpirit Health Community Health Improvement Grant recipients will change on January 1, 2024, when the new funding cycle begins.

This document is publicly available online at https://www.dignityhealth.org/socal/locations/californiahospital/about-us/community-programs/community-health-needs-assessment-plan.

Written comments on this report can be submitted to the CHMC Community Health Office, 1401 S. Grand Ave., Los Angeles, CA 90015 or by e-mail to barbara.gonzalez@commonspirit.org.

Our Hospital and the Community Served

About Dignity Health California Hospital Medical Center

California Hospital Medical Center (CHMC) is a member of Dignity Health, which is a part of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 1,000 care sites in 21 states coast to coast, serving 20 million patients in big cities and small towns across America. CHMC is located at 1401 S. Grand Ave., Los Angeles, California 90015. It has served the greater Los Angeles community for over 130 years. The hospital facility is licensed for 318 beds and provides a full-continuum of acute care services, including a Level II Trauma Center, Level III Neonatal Intensive Care Unit (NICU), seven operating suites, and a free-standing Los Angeles Center for Women's Health. CHMC has the busiest private Trauma Center in Los Angeles County and the 13th largest center for births in California.

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

It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay. This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.

Description of the Community Served

Dignity Health California Hospital Medical Center (CHMC) is located at 1401 S. Grand Ave., Los Angeles, CA 90015. The hospital tracks zip codes of origin for all patient admissions and includes all who received care without regard to insurance coverage or eligibility for financial assistance. The hospital defines its primary service area that includes 36 zip codes in 10 cities within Los Angeles County, 17 of which are located in the City of Los Angeles, and ten that are in South LA, and comprises of portions of Los Angeles County Service Planning Areas (SPAs) 4, 6, 7, and 8. Five zip codes are located in SPAs 7 and 8, and are not examined in the current CHNA. A summary description of the community is below. Additional details can be found in the CHNA report online.

Demographic Profile of People Living in CHMC Service Area

Total Population	**1,399,676**
Race	
Asian/Pacific Islander	9.2%
Black/African American – Non-Hispanic	13.8%
Hispanic or Latino	65.3%
White Non-Hispanic	8.6%
All others	3.1%
% Below Poverty	16.3%
Unemployed	6.3%
No High School Diploma	33.1%
Medicaid	41.6%
Uninsured	7.9%

Source: Claritas Pop-Facts® 2023; SG2 Market Demographic Module

The population of the CHMC service area is 1,399,676. Children and youth ages, ages 0-17, make up 25.2% of the population, 65.1% are adults, ages 18-64, and 9.8% of the population is seniors, ages 65 and older. The largest portion of the population in the service area identifies as Hispanic/Latino (65.3%), 13.8% of the population identifies as Black/African American, 9.2% as Asian, 8.6% as White. Approximately 1.3% of the population identifies as multiracial (two or more races), 0.2% are American Indian/Alaskan Native and 0.2% are Native Hawaiian/Pacific Islander. Those who are of race/ethnicity not listed represent an additional 0.3% of the service area population. In the service area, 29.1% of the population, 5 years and older, speak only English in the home. Among the service area population, 63% speak Spanish, 5.7% speak an Asian/Pacific Islander language, and 1.2% speak an Indo-European language in the home.

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 2022.

This document also reports on programs delivered during fiscal year 2023 that were responsive to needs prioritized in the hospital's previous CHNA report.

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 https://www.dignityhealth.org/socal/locations/californiahospital/about-us/community-programs/community-health-needs-assessment-plan or upon request at the hospital's Community Health office.

Significant Health Needs

The CHNA identified the significant needs in the table below, which also indicates which needs the hospital intends to address. Identified needs may include specific health conditions, behaviors and health care services, and also health-related social needs that have an impact on health and well-being.

Significant Health Need	Description	Intend to Address?
Access to health care	Access to health care refers to the availability of primary care and specialty care services. Health insurance coverage is considered a key component to ensure access to health care. Barriers to care can include lack of transportation, language and cultural issues.	X
Birth indicators	Poor pregnancy and birth outcomes include low birthweight, preterm births, and infant mortality. These are associated with late or no prenatal care, unplanned pregnancy, cigarette smoking, alcohol and other drug use, being HIV positive, obesity, maternal age, and poor nutrition.	X
Chronic diseases	A chronic disease or condition usually lasts for three months or longer and may get worse over time. Chronic diseases can usually be controlled but not always cured. The most common types of chronic diseases are cancer, heart disease, stroke, diabetes, and arthritis.	X

Significant Health Need	Description	Intend to Address?
COVID-19	The coronavirus disease (COVID-19) is an infectious disease caused by the SARS-CoV-2 virus. In the U.S., over one million persons have died as a result of contracting COVID-19.	
Economic insecurity	Economic insecurity is correlated with poor health outcomes. Persons with low incomes are more likely to have difficulty accessing health care, have poor quality health care, and seek health care less often.	
Education	Educational attainment is a key driver of health. Low educational attainment is associated with self-reported poor health, shorter life expectancy, and higher rates of death, disease and disability.	
Food insecurity*	The USDA defines food insecurity as limited or uncertain availability of nutritionally adequate foods or an uncertain ability to acquire foods in socially acceptable ways.	X
Housing and homelessness	Homelessness is known as a state of being unhoused or unsheltered and is the condition of lacking stable, safe and adequate housing.	X
Mental health+	Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act.	X
Overweight and obesity*	Overweight and obesity are common conditions that are defined as the increase in size and amount of fat cells in the body. Obesity is a chronic health condition that raises the risk of heart disease and is linked to many other health problems, including Type 2 diabetes and cancer.	X
Preventive practices	Preventive practices refer to health maintenance activities that help to prevent disease. For example, vaccines, routine health screenings (mammogram, colonoscopy, Pap smear) are preventive practices.	
Substance use+	Substance use is the use of tobacco products, illegal drugs, prescription or over-the-counter drugs, or alcohol. Excessive use of these substances, or use for purposes other than those for which they are meant to be used, can lead to physical, social or emotional harm.	X
Violence and injury	Violent crimes include homicide, rape, robbery and assault. Property crimes include burglary, larceny and motor vehicle theft. Injuries are caused by accidents, falls, hits, and weapons, among other causes.	X

**These significant needs will be addressed within the scope of the chronic disease need.*
+Mental health and substance use are combined and addressed as Behavioral Health.

Significant Needs the Hospital Does Not Intend to Address

Taking existing hospital and community resources into consideration, CHMC will not directly address COVID-19, economic insecurity, education and preventive practices as priority health needs. Knowing that there are not sufficient resources to address all the community health needs, CHMC chose to concentrate on those health needs that can most effectively be addressed given the organization's areas of focus and expertise. The hospital has insufficient resources to effectively address all of the identified needs and, in some cases, the needs are currently addressed by others in the community.

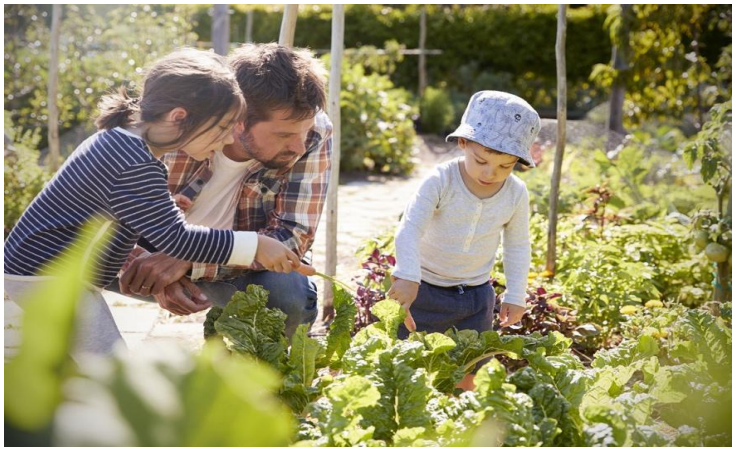
2023 Report and 2024 Plan

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

FY23 and planned activities for FY24, with statements on impacts and community collaboration. Program Highlights provide additional detail on select programs.

Planned activities are consistent with current significant needs and the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.

Creating the Community Benefit Plan



The hospital 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.

CHMC's community health programs involve departments beyond Community Health and Mission in their planning and operation. Hospital and health system participants included CHMC Senior Leadership Team, leadership of Hope Street Margolis Family Center (HSFC) and all of its programs and services, leadership of LA Best Babies Network, leadership of Emergency and Trauma Services, leadership of Business Development and Strategic Planning, leadership of Obstetric and NICU services, leadership of CommonSpirit Health's Homeless Health Initiative, leadership of CommonSpirit Health Violence/Human Trafficking Response and of United Against Violence Initiative, and leadership of Southside Coalition of Community Health Center.

Community input or contributions to this community benefit plan included input during the CHNA process from leaders and representatives of medically underserved, low-income, and minority populations, or local health or other departments or agencies that have "current data or other information relevant to the health needs of the community served by the hospital facility."

The programs and initiatives described here were selected on the basis of the following criteria:

- Existing Infrastructure: There are programs, systems, staff and support resources in place to address the issue.
- Established Relationships: There are established relationships with community partners to address the issue.
- Ongoing Investment: Existing resources are committed to the issue. Staff time and financial resources for this issue are counted as part of our community benefit effort.
- Focus Area: the hospital has acknowledged competencies and expertise to address the issue and the issue fits with the organizational mission.

Community Health Strategic Objectives

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources and engagement of participants both inside and outside of the health care delivery system.

CommonSpirit Health has established four core strategic objectives for community health improvement activities. These objectives help to ensure that our program activities overall address strategic aims while meeting locally-identified needs.

Create robust alignment with multiple departments and programmatic integration with relevant strategic initiatives to optimize system resources for advancing community health.

Scale initiatives that complement conventional care to be proactive and community-centered, and strengthen the connection between clinical care and social health.

Work with community members and agency partners to strengthen the capacity and resiliency of local ecosystems of health, public health, and social services.

Partner, invest in and catalyze the expansion of evidence-based programs and innovative solutions that improve community health and well-being.

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 1: Access to Health Care

Strategy or Program	Summary Description	Active FY23	Planned FY24
Financial Assistance	• CHMC provides financial assistance to those who have health care needs and are uninsured, underinsured, ineligible for government programs or otherwise unable to pay.	☒	☒
Para Su Salud	• Enrollment assistance to individuals and families to sign up for health and dental health insurance benefits.	☒	☒
Coordinated Care Initiative	• Provides navigation services to patients who receive primary care from clinics associated with the Southside Coalition of Community Health Centers. • The goal of the project is to ensure patients follow up with their primary care doctor following a hospitalization or a visit to the ER. Overall objective is to reduce admissions among patients with hypertension, diabetes and/or congestive heart failure while providing more intensive outpatient care and ensuring patients are connected back to their medical home.	☒	☒
10th Decile Project / FUSE Program	• A Homeless Health Initiative 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 with Corporation for Supportive Housing, Housing Works, and JWCH, Inc.	☒	☒
HSFC Early Head Start Program & Home Visitation Program	• Assists families in accessing health and dental health insurance coverage. • Assists families in establishing a medical home for each family member.	☒	☒

Health Ministry Program/Community Health Program	• Parish nurse refers those without a medical home to federally qualified health centers (FQHCs) • Navigating the Health Care System: a four-unit health literacy curriculum designed by Nemours Children's Health System for high school students. This curriculum prepares students to manage their own health care as they transition to adulthood.	☐	☒

Goal and Impact: The hospital's initiatives to address access to care are anticipated to result in increased access to health care for the medically underserved, reduced barriers to care, and increased availability and access to primary and specialty care services.

Collaborators: Key partners include community clinics, FQHCs, community-based organizations, faith groups, public health, city agencies and homeless services organizations. The hospital will provide health care providers, parish nurse, enrollment counselors, community health educators, case managers, philanthropic cash grants, outreach communications, and program management support for these initiatives.

Health Need 2: Behavioral Health

Strategy or Program	Summary Description	Active FY23	Planned FY24
CA Bridge Program	• Supports the emergency department as a primary access point for the treatment of substance use disorders and co-occurring mental health conditions. • Utilizes trained navigator to identify patients who would benefit from initiating medication for addiction treatment (MAT) or mental health services.	☒	☒
CA Behavioral Health Clinic	• Supports the emotional and psychological well-being of children and their families by providing individual, family, and group psychotherapy, psychiatric and case management services.	☒	☒
Family Preservation Program	• Screens parents for depression/anxiety and IPV. Screens children for adverse childhood experiences (ACEs) and mental health or behavioral issues. • Refers parents and/or children needing treatment for mental health concerns. • Offers support group for women who have experienced IPV, anger management psychoeducation group, and parenting psychoeducational group.	☒	☒
HSFC Early Head Start Program, Early Childhood Education Center and Youth Center	• Screens parents for depression, anxiety and IPV. • Screens children and youth for mental health and behavioral issues. • Refers parents and children who need treatment to community resources.	☒	☒
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.	☒	☒

Welcome Baby	• Home visitors screen for perinatal mood and anxiety disorders (PMADs), Intimate Partner Violence (IPV) and substance use disorders, and refers individuals needing treatment to community resources.	☒	☒
10th Decile Project / FUSE Program	• This Homeless Health Initiative grant-funded project connects the top 10% of the 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 with Housing Works, and JWCH, Inc.	☒	☒
UniHealth Cultural Trauma and Mental Health Resiliency Project	• Joint effort of the six Dignity Health hospitals in Southern California working in partnership 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.	☒	☒
Centinela Valley Mental Health Project	• CHMC working in partnership with Providence Health will increase the capacity of local community organizations, community members, youth organizations and schools in the Centinela Valley to identify mental health distress and/or suicidality, and to respond appropriately. • Community Health Promoters will deliver Mental Health First Aid training and Mind Matters workshops primarily to organizations and community members of the Centinela Valley.	☒	☒

Goal and Impact: The hospital's initiatives to address behavioral health are anticipated to result in increased access to mental health and substance use services in the community, and improved screening and identification of mental health substance use needs.

Collaborators: Key partners include schools and school districts, community-based organizations, UniHealth Foundation, Dignity Health Southern California Hospitals, Providence Health and LA County agencies. The hospital will provide mental health care providers, case managers, health educators, social workers, philanthropic cash grants, outreach communications, and program management support for these initiatives.

Health Need 3: Birth Indicators

Strategy or Program	Summary Description	Active FY23	Planned FY24
Welcome Baby	• Welcome Baby provides pregnant women and new moms with information, support, and a trusted partner to help them through the journey of pregnancy and early parenthood. This program is grant-funded by First 5 LA in partnership with Maternal & Child Health Access.	☒	☒
LA Best Babies Network	• Offers programs run by 14 hospitals and 22 community partners throughout LA County.	☒	☒

	• Provides training and technical assistance related to perinatal health and home visitation services to over 60 organizations in LA County. • Oversees the Family Strengthening Network database.		
Los Angeles County Perinatal & Early Childhood Home Visiting Consortium	• A consortium led by LABBN. Membership includes the majority of organizations providing home visiting services in LA County. • Members work to support LA 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 and support the tremendous value of home visitation services.	☒	☒
HSFC Early Head Start Program	• Provides prenatal home visiting services to improve birth outcomes. • Provides postpartum and early childhood home visiting services to improve maternal and child outcomes. • Provides case management services to address social determinants of health.	☒	☒
Maternal Health Equity Workgroup	• CHMC Workgroup to address health care disparities particularly in decreasing maternal hemorrhage rates.	☒	☒

Goal and Impact: The hospital's initiatives to address birth indicators are anticipated to result in: improved birth outcomes, reduced barriers to care, and increased availability and access to prenatal and perinatal services.

Collaborators: Key partners include community clinics, community-based organizations focused on maternal-infant health, Maternal Child Health Access, First 5 LA, LA County Department of Public Health. The hospital will provide health care providers, community health educators, case managers, philanthropic cash grants, outreach communications and program management support for these initiatives.

Health Need 4: Chronic Diseases (including Overweight and Obesity, and Food Insecurity)

Strategy or Program	Summary Description	Active FY23	Planned FY24
Heart HELP Program	• Five-week curriculum to help minimize risk for cardiovascular disease through healthy eating and cooking, maintaining an active lifestyle, and addressing risk factors such as overweight/obesity, hypertension, and cholesterol. • Refers participants who are food insecure to CalFresh, WIC and other food assistance programs as appropriate.	☒	☒
Emotional Support Group	• Supports persons with chronic diseases to improve their emotional well-being through	☒	☒

	mutual support, coping strategies, and psychoeducation.		
HSFC Early Head Start Program, Early Childhood Education Center, Family Childcare Network & Youth Center	• Pregnant and parenting women with children ages 0-5, learn about the importance of breastfeeding, healthy eating, and maintaining an active lifestyle in order to prevent overweight/obesity. • Children and youth, ages 7-18, learn about healthy eating and cooking, portion control, and the importance of maintaining an active lifestyle and healthy coping strategies. • Refers those who are food insecure to CalFresh, WIC and other food assistance programs as needed.	☒	☒
Diabetes Education Empowerment Program (DEEP)	• Participants with diabetes learn to manage diabetes and improve health. Participants with pre-diabetes learn tools and techniques to help prevent diabetes. • Refers participants who are food insecure to CalFresh, WIC, and other food assistance programs as needed.	☒	☒
Health Ministry/ Community Health Program	• Parish nurse provides free health screenings including cholesterol, glucose, A1c, blood pressure, and BMI. • Provides health education on health screening results and refers to community clinics if they do not have a medical home.	☐	☒
Women's Center	• Uninsured women are referred to CHMC's Women's Health Center for free mammography and cervical cancer screenings.	☒	☒
Welcome Baby	• Pregnant and parenting women with children, ages 0-5, learn about the importance of breastfeeding, consumption of fruits, vegetables, and water, and maintaining an active lifestyle in order to prevent overweight/obesity. • Refers those who are food insecure to CalFresh, WIC and other food assistance programs as needed.	☒	☒

Goal and Impact: The hospital's initiatives to address chronic diseases are anticipated to result in: increased identification and treatment of chronic diseases, increased compliance with disease prevention recommendations (screenings, and lifestyle and behavior changes), and improved healthy eating and active living.

Collaborators: Key partners include: FQHCs, Southside Coalition of Community Health Centers, LA County Department of Public Health, youth organizations, faith-based groups, senior centers, and community-based organizations. The hospital will provide health care providers, parish nurse, community health promoters, patient navigators, philanthropic cash grants, outreach communications, and program management support for these initiatives.

Health Need 5: Housing Insecurity and Homelessness

Strategy or Program	Summary Description	Active FY22	Planned FY23
10th Decile Project / FUSE Program (Homeless Health Initiative Program)	• This Homeless Health Initiative grant-funded project connects the top 10% of 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 with Housing Works and JWCH, Inc.	☒	☒
Samaritan Project	• Samaritan is a support platform that empowers people to meet needs & take action on their path to stable housing. • Street outreach and case management team give out Samaritan Memberships and Members get a smart wallet and develop action steps and needs with a care giver • Members earn bonuses for taking action steps towards their goals in their case plans and receive financial/in-kind support from the community to meet needs along the way. • Funds are spent flexibly through care partners to meet survival and strategic needs, enabling Members to reach outcomes sooner.	☒	☒
HSFC Early Head Start and Early Childhood Education Center	• Enrolls unhoused pregnant women and/or parenting women with children, ages 0-3. • Outreach to families in shelters to help them access affordable permanent housing. • At the Nest, priority enrollment will be given to children, ages 0-5, experiencing homelessness.	☒	☒
LA Partnership	• The LA Partnership is comprised of community health directors of nonprofit hospitals and health systems in LA County who have agreed to collaborate on housing insecurity and homelessness in their overlapping service areas. HASC's Communities Lifting Communities provides the backbone infrastructure for the LA Partnership.	☒	☒

Goal and Impact: The hospital's initiatives to address housing insecurity and homelessness are anticipated to result in: improved health care delivery to persons experiencing homelessness and increased access to community-based services and supports for persons experiencing homelessness.

Collaborators: Key partners include Housing Works, JWCH, Inc., LA Partnership, Samaritan, city and county agencies, faith community, community clinics, community-based organizations, other nonprofit hospitals and homeless service providers. The hospital will provide social workers, health care providers, case managers, philanthropic cash grants, outreach communications, and program management for these initiatives.

Health Need 6: Violence Prevention

Strategy or Program	Summary Description	Active FY22	Planned FY23
CA Behavioral Clinic	● Children ages 0-21, with Medi-Cal receive mental health services. ● Parents may receive dyadic care with their child.	☒	☒
Family Preservation Program	● Family preservation services are short-term, family-focused services to assist families in crisis by improving parenting and family functioning while keeping children safe. ● A support group for women who are victims of IPV, and anger management group for men and women, and a parenting group for men and women are conducted in Spanish every week.	☒	☒
Wraparound Services Program	● Provides community-based support and individualized planning for children, including those with severe emotional and behavioral disorders and their families. ● The Wraparound Team implements an intensive family preservation plan that supports keeping the child at home with his/her family.	☒	☒
Human Trafficking Response Task Force	● The Human Trafficking Response Task Force provides training to identify potential victims of sex and/or labor trafficking in the ED and other hospital units. ● The survivor advocates from Cast and Journey Out work in the ED to assist staff in identifying potential victims and encourage potential victims to accept services.	☒	☒
Stop the Bleed Trainings	● Stop the Bleed is a national awareness campaign and call-to-action. ● Trains, equips and empowers the pubic to help in a bleeding emergency before professional help arrives.	☒	☒
UniHealth Cultural Trauma & Mental Health Resiliency Project	● Joint effort of the six Dignity Health hospitals of Southern California working in partnership 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.	☒	☒
HSFC Early Head Start Program, ECE, Family Childcare Network, and Youth Center	● Screens parents for depression/anxiety and intimate partner violence (IPV). Screens children for mental health and behavioral issues. Refers parents and children who need treatment to community resources	☒	☒
Welcome Baby	● Home visitors teach families about milestones of child development. ● Parents learn the importance of responsive caregiving and keeping their children safe. ● 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 safety for infants and toddlers.	☒	☒

Goal and Impact: The hospital's initiative to address violence and injury prevention are anticipated to result in: increased access to programs in the community that focus on reduced violence and injury prevention.

Collaborators: Key partners include Cast, Journey Out, Safe Haven Medical Clinic, the other four Dignity Health hospitals in LA County, faith community, community-based organizations, public safety agencies, city agencies, schools and school districts, community health centers, Providence Health, UniHealth Foundation, and youth organizations. The hospital will provide case managers, health care providers, health educators, social workers, philanthropic cash grants and outreach communications in support of this initiative.

Community Health Improvement 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 related to CHNA priorities.

In FY23, the hospital awarded the grants below totaling $241,000. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Cancer Support Community Los Angeles	Healing Equitable through Action, Resiliency, and Teamwork (HEART) Initiative	$75,000
Coalition to Abolish Slavery & Trafficking	Housing assistance and support services to survivors of human trafficking in Los Angeles County	$83,000
The Salvation Army	Zahn Memorial Center	$83,000
TOTAL		$241,000

Program Highlights

The following pages describe a sampling of programs and initiatives listed above in additional detail, illustrating the work undertaken to help address significant community health needs.

	***Para Su Salud* – Enrollment Assistance Program**
Significant Health Needs Addressed	• Need 1 Access to Health Care • Need 4 Chronic Diseases – Food Insecurity
Program Description	*Para Su Salud* helps navigate the application process for Medi-Cal, Covered California and other health access and public benefit programs. Community Health Specialists assess each individual to determine eligibility for health insurance and other public benefit programs and assist with enrollment. They also assist with annual redetermination renewals. This is a grant-funded program.
Population Served	Persons who need assistance with health insurance coverage and annual renewals.
Program Goal / Anticipated Impact	Overall program goal is to enroll uninsured individuals into health insurance program s/he qualifies for. Specific outcomes include: • Number of persons reached through outreach. • Number of persons enrolled in health insurance. • Number of six-month re-certifications completed.
	FY 2023 Report
Activities Summary	As more meetings and events opened up and were held in-person, the Community Health Specialists were able to participate in community outreach events and do presentations with community partners in person. They were also able to meet with and assist participants in person.
Performance / Impact	From July 2022 to June 2023, *Para Su Salud* assisted a total of 4,288 persons: • Outreached to 2,349 persons • Enrolled 754 persons in health insurance • Provided assistance and troubleshooting to 1,748 persons • Assisted 294 individuals with their recertification and renewals
Hospital's Contribution / Program Expense	Total program expense is $368,963, with a restricted grant of $283,170. The program is staffed by CHMC employees comprised of a Project Supervisor, Community Health Specialists, Utilization/Determination Specialist and Administrative Assistant. CHMC also contributes office space, computers, printers and office equipment.
	FY 2024 Plan
Program Goal / Anticipated Impact	The program goal is to provide enrollment assistance and redetermination assistance. Para Su Salud staff will continue to track the number of person they outreach to, number enrolled, number of re-certifications completed.
Planned Activities	No planned changes in program activities.

	CA Bridge Program

Significant Health Needs Addressed	● Need 1 Access to Care ● Need 2 Behavioral Health – Substance Use
Program Description	CHMC is committed to helping decrease the harms linked with drug use of its patients. The CA Bridge program at CHMC provides help for substance use disorders (SUD) and co-occurring behavioral health conditions. The CA Bridge program supports clinicians to make medication for addiction treatment (MAT) accessible as the standard of care. The CA Bridge model includes three core elements: rapid access to low-barrier treatment, navigation to on-going care, and a culture of harm reduction.
Population Served	Patients with substance use disorders
Program Goal / Anticipated Impact	The program goals of the CA Bridge Program at CHMC are to connect patients to addiction treatment and address social and behavioral health needs with the support of the Substance Use Navigator. Specific outcomes for this program includes: ● Number of referrals received through the ED and inpatient units ● Number of ED/hospital encounters where a patient was seen by the navigator for any reason ● Number of ED/hospital encounters where a patient was discharged with a follow up appointment with a SUD provider ● Number of ED/hospital encounters where a patient was treated with buprenorphine ● Number of ED/hospital encounters where a patient was diagnosed with overdose and seen by the Navigator ● Number of naloxone distributed
FY 2023 Report	
Activities Summary	Patients in the ED or inpatient units who have issues with opioids, alcohol, methamphetamines or any licit or illicit drugs or who ask for help with substance use is referred to the Substance Use Navigator. Depending on the situation, a clinician may provide a dose of Buprenorphine. Buprenorphine is a safe drug that can help relieve withdrawal symptoms. CHMC's Substance Use Navigator will help patients link to services or treatment programs outside of the hospital setting.
Performance / Impact	From July 2022 to June 2023, the CA Bridge Program at CHMC had the following outcomes: ● Total number of referrals: 912 ● Number of referrals from the Emergency Department: 309 ● Number of ED/hospital encounters where a patient was seen by the Navigator for any reason: 771 ● Number of ED/hospital encounters where a patient was diagnosed with opioid use disorder: 252 ● Number of ED/hospital encounters where a patient was discharged with a follow up appointment with a substance use disorder (SUD) provider: 203 ● Number of ED/hospital encounters where the Navigator facilitates patient referral to follow up mental health treatment: 19 ● Number of ED/hospital encounters where a patient was diagnosed with overdose and seen by the Navigator: 57 ● Number of naloxone distributed: 112
Hospital's Contribution / Program Expense	Total program expense is $207,912 with grant funding of $140,482. CHMC contributes office space, computers, printers and office equipment.
FY 2024 Plan	

Program Goal / Anticipated Impact	The program goal and anticipated impacts for FY2024 remains the same as the previous year - to connect patients to addiction treatment and address social and behavioral health needs with the support of the Substance Use Navigator.
Planned Activities	No planned changes in program activities.

	Welcome Baby
Significant Health Needs Addressed	• Need 1 Access to Care • Need 3 Birth Indicators • Need 4 Chronic Disease including Overweigh/Obesity and Food Insecurity • Need 6 Violence Prevention
Program Description	Welcome Baby provides pregnant women and new moms with information, support, and a trusted partner to help them through the journey of pregnancy and early parenthood. This program is grant-funded by First 5 LA in partnership with Maternal & Child Health Access.
Population Served	Pregnant women and new moms in the Metro LA community.
Program Goal / Anticipated Impact	The goals of the Welcome Baby program at CHMC are: • Support pregnant women to receive needed mental health, dental services and other needed services • Achieve as safe and healthy of a home environment as possible • Increase breastfeeding initiation, exclusivity and duration rates • Provide education and support services for families at postpartum visits • Promote healthy physical and emotional development • Create or enhance existing linkages with social services, educational and health care agencies to obtain needed services
FY 2023 Report	
Activities Summary	This free and voluntary program at CHMC offered the following during pregnancy and throughout the baby's first nine months: • An in-hospital visit where they receive assistance with breastfeeding and information about bonding and attachment, taking care of your baby, and resources their family may need • A personal Parent Coach who meets with the mother and their family in the comfort and convenience of their home • Information and support on breastfeeding, home safety and other topics • An in-home appointment with a nurse within the first few days after delivering at the hospital • Referrals to additional resources to help the mother and baby • Baby- and mom-friendly items such as thermometers, nursing pillows, toys and baby-proofing supplies for the home
Performance / Impact	From July 2022 to June 2023, the Welcome Baby program served 1,839 women and 1,832 newborns. Below are some of the impacts of the program: Goal 1: Support pregnant women to receive needed mental health, dental services and other needed services. • 89% (July-Dec) and 88% (Jan-Jun) of enrolled prenatal women received at least one referral during their pregnancy • 100% of enrolled women were screened for depression at intake through the Patient Health Questionnaire Goal 2: Achieve as safe and healthy of a home environment as possible. • 93% (July-Dec) and 96% (Jan-Jun) of program participants received home safety and security information by the 2-month or the 9-month visit, depending on their program enrollment

	● 95% (July-Dec) and 92% (Jan-Jun) of program participants received at least one home safety item or conducted at least one improvement by the 2-month or 9-month visit, depending on their program enrollment Goal 3: Increase breastfeeding initiation, exclusivity and duration rates. ● 51% (July-Dec) and 59% (Jan-Jun) of women enrolled prenatally initiated exclusive breastfeeding or feeding only breastmilk at time of hospital visit ● 91% (July-Dec) and 94% (Jan-Jun) of program participants were breastfeeding or feeding some breastmilk at the time of the 72-hour nurse home visit ● 74% (July-Dec) and 75% (Jan-Jun) of program participants who initiated any breastfeeding at time of hospital visit are still breastfeeding or feeding some breastmilk at the 9-month visit Goal 4: Provide education and support services for families at postpartum engagement points. ● 99% of program participants were informed of food resources and WIC coupons during the 2-4 week postpartum visit Goal 5: Promote healthy physical and emotional development in 100% of infants visited ● 92% of Medi-Cal eligible infants have health insurance by the 2-month visit ● 97% of babies were up to date with their immunizations at the 9-month visit ● 97% of babies have a medical provider at the 9-month visit Goals 6: Create or enhance existing linkages with social services, educational and healthcare agencies to obtain needed services. ● 96% of postpartum women received at least one referral at or before the 2-month visit or the 9-month visit, depending on their program enrollment
Hospital's Contribution / Program Expense	This is grant-funded program with funding from First 5 LA and offered in partnership with Maternal and Child Health Access. The hospital liaisons that conduct the in-hospital visits are CHMC employees. CHMC provides office space, computers, printers and office support for this program.
FY 2024 Plan	
Program Goal / Anticipated Impact	The goals of the Welcome Baby program for FY 2024 remain the same: ● Support pregnant women to receive needed mental health, dental services and other needed services ● Achieve as safe and healthy of a home environment as possible ● Increase breastfeeding initiation, exclusivity and duration rates ● Provide education and support services for families at postpartum visits ● Promote healthy physical and emotional development in 100% of infants visited ● Create or enhance existing linkages with social services, educational and health care agencies to obtain needed services
Planned Activities	No planned changes in program activities in FY 2024.

	Health Ministry/Community Health Programs: Heart HELP and CVD Awareness Classes
Significant Health Needs Addressed	● Need 4 Chronic Diseases
Program Description	The Community Health Program at CHMC offers a variety of health education classes and activities to promote healthy and active lifestyles and to help prevent chronic conditions. All programs are offered free to community partners and to community members. The Heart

	H.E.L.P. and CVD Awareness workshops are a series of weekly workshops for adults suffering from or at risk for cardiovascular diseases such as hypertension, hypercholesterolemia, myocardial infarction, stroke, or congestive heart failure. Participants learn about reducing risk factors which includes good nutrition, physical activity and weight management.
Population Served	Adults living in service area of CHMC, parents whose children attend schools in the service area, parents of children served by HSFC.
Program Goal / Anticipated Impact	The overall goal of the Heart HELP and CVD Awareness workshops is for participants to: ● Meet the recommended guidelines for BMI ● Decrease saturated fat consumption and sodium intake ● Increase physical activity ● Increase the number of participants whose blood pressure is under control ● Increase medication compliance among those with prescribed medication ● Increase the proportion of adults who are aware of the symptoms and know to respond to a heart attack or stroke
FY 2023 Report	
Activities Summary	A CHMC Community Health Promoter taught the Heart HELP classes and CVD Awareness workshops at 24 different locations in Los Angeles. They were taught virtually, at elementary, middle and high schools, churches and community partner sites.
Performance / Impact	A total of 30 Heart HELP series were offered – seven in English and 23 in Spanish. A total of 245 individuals enrolled in the Heart HELP series of which 213 individuals completed the whole series. Twelve CVD Awareness classes were offered with a total of 67 participants. Participants shared impact of these classes and the lifestyle changes they have implemented including decreased soda consumption, making exercise a priority, cooking more often at home, eating less fast food, and increasing fiber intake. A participant shared that although they have been living with diabetes for over ten years, it was never explained to them what A1c meant and now they understand it due to this class. Many participants learned how to read nutrition facts labels (food labels) and this has helped them to avoid foods with added sugar. Due to a staffing vacancy for the Community Health RN position during FY23, the health screenings that are part of the Heart HELP and CVD Awareness classes to track the health outcomes and impact of the program were not conducted. CHMC is actively recruiting for this position and health screenings will be resumed as soon as this position is filled.
Hospital's Contribution / Program Expense	The overall program expense for the CHMC's Parish Ministry/Community Health Program is $444,874. CHMC hires all staff for the program which includes a Director Community Health Outreach, Manager of Community Health, Community Health Promoter and Community Health RN (currently vacant). CHMC also provides a spacious office, office furniture, supplies, computers and printers.
FY 2024 Plan	
Program Goal / Anticipated Impact	The overall goals of the Heart HELP and CVD Awareness workshops are: ● Meet the recommended guidelines for BMI ● Decrease saturated fat consumption and sodium intake ● Increase physical activity ● Increase the number of participants whose blood pressure is under control ● Increase medication compliance among those with prescribed medication

	• Increase the proportion of adults who are aware of the symptoms and know to respond to a heart attack or stroke.
Planned Activities	Resume health screenings as soon as a Community Health RN is hired along with the same planned activities as FY 203.

	**10th Decile Project (FUSE Program)**
Significant Health Needs Addressed	• Need 1 Access to Health Care • Need 2 Behavioral Health • Need 5 Housing Insecurity and Homelessness
Program Description	The Frequent Users System Engagement (FUSE) Program is a CommonSpirit Homeless Health Initiative that connects the top 10% of highest cost and highest need, chronically homeless individuals seen at CHMC Emergency Department to intensive case management, permanent supportive housing, and appropriate physical and behavioral health care services. This is a collaborative effort in partnership with JWCH Institute, Inc., and Housing Works.
Population Served	Individuals who are experiencing chronic homelessness and are seen in CHMC's Emergency Department or inpatient units.
Program Goal / Anticipated Impact	The overall goal of this program is to improve the health of patients who are experiencing chronic homelessness who meet the criteria as belonging in the 10th decile, increase their housing stability, and reduce avoidable ED visits. Project outcomes include reducing avoidable ED visits/hospitalizations; improve health and housing stability among 30% or more of patients enrolled in FUSE. Additional project outcomes include: • Number of patients screened • Number of patients referred to Housing Works for permanent supportive housing • Number of patients enrolled in the 10th Decile Track • Number of patients scheduled for appointments with JWCH • Number of patients attended appointment with JWCH
FY 2023 Report	
Activities Summary	CHMC Care Coordination staff identifies patients experiencing homelessness in the ED or inpatient departments and refers them to the in-house JWCH Community Health Navigator (CHN). The CHNS are onsite at CHMC and will screen referred patients using the 10th Decile Screening Form. The screening factors in past ED visits, chronic conditions, and behavioral health history. For low acuity patients, CHNs will refer them, as appropriate, to behavioral and/or medical health services, medical home or primary facility, connect them to the Coordinated Entry System, and other services as needed. For high acuity patients who meet the FUSE program requirements, the CHNs will refer the patients to the Housing Works Navigator. The Housing Works Navigator will transition unhoused patients from the hospital and provide warm handoff to interim housing, and provide support and coordination for comprehensive health services and other resources while working toward permanent housing solutions.

Performance / Impact	From July 2022 through June 2023: ● 957 patients were screened by the onsite Community Health Navigators ● 96 patients were referred to Housing Works ● 16 patients were enrolled in the 10th Decile Track ● 129 patients were scheduled for appointments with JWCH ● 32 patients attended their appointment with JWCH ● 15 patients have been moved to permanent supportive housing, with seven move-ins occurring in the last quarter of FY23. Since 2020, 2,583 patients have been screened, 35 patients have been matched to housing and 33 patients have been housed.
Hospital's Contribution / Program Expense	The FUSE program is a Homeless Health Initiative funded project of CommonSpirit Health. CHMC contributed space, computers and office supplies for the Community Health Navigators within the Social Work/Care Coordination department.
FY 2024 Plan	
Program Goal / Anticipated Impact	The overall goal of this program is to improve the health of patients who are experiencing chronic homelessness who meet the criteria as belonging in the 10th decile, increase their housing stability, and reduce avoidable ED visits. Project outcomes include reducing avoidable ED visits/hospitalizations; improve health and housing stability among 30% or more of patients enrolled in FUSE
Planned Activities	No change in program activities from last year.

Hope Street Margolis Family Center	
Significant Health Needs Addressed	● Need 1 Access to Health Care ● Need 2 Behavioral Health ● Need 3 Birth Indicators ● Need 4 Chronic Disease ● Need 5 Housing Insecurity & Homelessness ● Need 6 Violence Prevention
Program Description	Hope Street Margolis Family Center (Hope Street) was established in 1992 as a collaboration between UCLA and CHMC. Its mission is to educate children, strengthen families, and transform the community. HSFC empowers and strengthens families by addressing the social determinants of health through a continuum of care that includes health screenings, mental health, literacy, early childhood education, early intervention, child welfare, youth and social services. Programs and services include Early Head Start (EHS), Child Development Centers, Family Childcare Network, Family Literacy, School Readiness, Youth Center, Family Preservation, Wraparound Services, California Behavioral Clinic, and Home Visitation.
Population Served	HSFC focuses its efforts on the some of the poorest and most densely populated areas in Los Angeles County. HSFC programs serve children, youth, parents and families.
Program Goal / Anticipated Impact	The goals of HSFC's continuum of whole child and family programs are: ● Enhance the capacity of parents and families to nurture and care for their children ● Promote children's overall health, mental health, development, school readiness, and academic achievement ● Strengthen existing service delivery networks and foster community partnerships ● Develop services that are accessible and responsive to our local community
FY 2023 Report	
Activities Summary	● Early Head Start (EHS) offered comprehensive child development and family support services for children 0-3 years old. ● Early Childhood Education Centers: four licensed child development centers served children from 0-5 years old through four licensed centers. ● Family Childcare Network offered developmentally enriched childcare for infants, toddlers, and preschool aged children through a network of licensed family childcare providers. ● Family Literacy provided parents with literacy training, English as a Second Language, GED and other adult education as well as parenting education. ● School Readiness prepared children and their families' successful transition to kindergarten through full day education and case management. ● The Youth Center provided academic support, health and wellness activities, sports and recreation, and arts programming for elementary, middle and high school students. Summer of Science program is offered every year and aims to inspire students to explore STEAM subjects and careers. College prep and career development activities are also offered. ● Family Preservation provided weekly home-based counseling and case management, care coordination, parenting classes, support groups and multi-disciplinary care to families whose children are at risk of abuse, neglect, and exploitation.

	● Wraparound Services provided home-based permanency support to meet the complex needs of children with mental health and behavioral concerns who are involved in the child welfare system. ● California Behavioral Clinic provided individual, family and group psychotherapy, psychiatric and case management services to support the emotional and psychological well-being of children and their families. ● Home Visitation program provided support, education and resources for mothers through an in-home prenatal and early childhood nurse visits.
Performance / Impact	Below are the number of children and families served by HSFC by program by quarter in FY 2023:

Program	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Early Head Start	1,328	1,278	1,216	1,503
Family Child Care	176	176	176	198
Youth Center	320	320	320	472
Family Preservation	302	279	293	270
Behavioral Health	1,238	1,103	1,215	1,080
Center-Based	648	736	640	766

Hospital's Contribution / Program Expense	HSFC is housed in a customized 4-story building (30,000 sq. ft.) built by CHMC. 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 and philanthropy, total program expense of $16,705,685. All HSFC staff are CHMC employees.
FY 2024 Plan	
Program Goal / Anticipated Impact	● The goals of HSFC's continuum of whole child and family programs are: ● Enhance the capacity of parents and families to nurture and care for their children ● Promote children's overall health, mental health, development, school readiness, and academic achievement ● Strengthen existing service delivery networks and foster community partnerships ● Develop services that are accessible and responsive to our local community
Planned Activities	No change in program activities from last year.

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.

- CHMC has been named to the annual **Consumer Loyalty Best in Class** list, the only loyalty-based hospital rankings, recognizing the top US healthcare facilities. The 100 top-scoring organizations are included in the ranking, but only the top 10 of those receive the Best in Class Designation.

- Healthgrades named CHMC a **Five-Star Recipient** in the areas of Heart Failure, Hip Fracture Treatment, Pneumonia, and Sepsis Treatment. A Five-Star rating indicates that the hospital's clinical outcomes are statistically significantly better than expected when treating the condition or performing the procedure being evaluated.

- CHMC was awarded the American Heart Association/American Stroke Association's Get with the Guidelines® - **Stroke Gold Plus Quality Achievement Award** in 2023. This award highlights the hospital's commitment to ensuring stroke patients receive the most appropriate treatment, according to nationally recognized, research-based guidelines, and the latest scientific evidence. CHMC also received the **Stroke Elite Honor Roll** and **Type 2 Diabetes Honor Roll Award**.

- CHMC was recognized for the **2023 Opioid Care Honor Roll** and achieved *Superior Performance* for its work in addressing the opioid epidemic having implemented advanced, innovative opioid stewardship strategies across multiple service lines, consistently achieving the highest level of performance. In addition, CHMC actively measured and monitored performance for the purpose of continuous quality improvement.

- Protecting our planet remains a top priority for CHMC. Our green efforts were recognized with a **Practice Greenhealth Environmental Excellence** in 2023 for setting the standard in eliminating mercury, reducing and recycling waste, and embracing sustainability as a core part of our culture. CHMC was also honored for demonstrating a strong commitment to sustainability and showing leadership in our local community and in the health care sector.

- Through our continued efforts to boost health care equality for all, CHMC has been recognized as an **Equality Leader by the 2022 Human Rights Campaign**'s Healthcare Equality Index. This rigorous national benchmarking tool evaluates health care facilities' policies, practices related to the equity and inclusion of LGBTQ+ patients, visitors and employees.

- Dignity Health Community Investment Program: Active Loans Near CHMC

    - **Abode Communities (Abode):** In 2019 CommonSpirit 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. The line of credit was renewed in 2022 and will provide 431 units of housing in Coachella Valley / Indian Wells, Berkeley (Workforce Housing), and Los Angeles.

- **Art Share Los Angeles Inc. (Art Share):** In 2015, CommonSpirit 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. CommonSpirit in September 2022 approved an extension of Art Share's remaining balance of $114,603 for 5 years.

- **Everytable, PBC:** Everytable, PBC, is a for-profit "public benefit corporation" founded in 2015 with the purpose of making healthy food affordable, convenient, and accessible for all. The company has opened nine stores throughout Los Angeles in Baldwin Hills, Century City, Downtown LA, Santa Monica, Compton, Brentwood, Watts, and Cal State Dominguez Hills. In 2019 alone, the corporation sold over 700,000 meals in these locations. In April 2020 CommonSpirit Health approved a 7-year $500,000 loan to the company to build the infrastructure for an Everytable franchise program focused on entrepreneurs from low- to medium-income communities and the build-out and launch of new stores.

- **Genesis LA Economic Growth Corporation:** Founded in 1998, Genesis LA Economic Growth Corporation (Genesis) is a Community Development Financial Institution (CDFI) with over $42 million in total assets, making it the fourth largest CDFI headquartered in Los Angeles (LA) County. In September, 2018, Dignity Health approved a 7-year $1,000,000 loan to Genesis for lending capital in Genesis' GCIF that focuses on investments in community development projects, affordable housing, and microloans to residents living in the underserved, economically distressed communities of LA County.

- **Local Initiatives Support Corporation (LISC):** The Local Initiatives Support Corporation (LISC) together with Abode Communities, Mercy Housing and LA Family Housing, jointly with Factory OS, formed the Streamlining Solutions Collaborative (the "Collaborative") to explore innovations in modular construction for permanent supportive housing. CommonSpirit Health approved a $1.2 million loan on 11/29/2021 to support fund deposits of five modular permanent supportive housing projects, creating 398 units of affordable housing for very low-income and homeless individuals in Los Angeles, California.

- **Los Angeles Community Health Centers (LACHC):** In 2017 Dignity Health approved a 7-year $5,000,000 participation loan with Nonprofit Finance Fund to help LACHC construct a new FQHC in the Skid Row neighborhood of downtown Los Angeles. Ninety-nine percent of LACHC's patients are at or below 150% of the federal poverty level because of the large homeless population being served. With the new center, LACHC hopes to increase the number of patients served at the "Joshua House" from 3,300 at its existing facility to 7,000 individuals per year at the new center.

- **United Way of Greater Los Angeles:** United Way of Greater Los Angeles is a Los Angeles, California, nonprofit organization whose mission is to permanently break the cycle of poverty for the most vulnerable individuals, supporting low-income families, students, veterans, and people experiencing homelessness. The organization administers an annual fundraising campaign in Los Angeles County, California, and uses those funds to support a variety of human services. UWGLA is focused on providing long-term solutions in three interconnected areas that the organization believes are the root causes of poverty, which include low-income individuals having a home, quality education and career, and access to economic resources and

opportunities to thrive. Loan proceeds approved in 2023 will be used to support UWGLA's new Affordable Housing Initiative Fund that was started in 2020 to finance the creation and preservation of up to 2000 affordable homes through 60 developments (Predominantly minority owned or BIPOC developers), with a focus in the Greater Los Angeles area.

Economic Value of Community Benefit

306 California Hospital Medical Center					
Complete Summary - Classified (Programs) Including Non Community Benefit (Medicare and Bad Debt)					
For period from 07/01/2022 through 06/30/2023					
	Persons	**Expense**	**Offsetting Revenue**	**Net Benefit**	**% of Expenses**
Benefits for Poor					
Financial Assistance	**13,914**	**$20,361,129**	**$0**	**$20,361,129**	**3.5%**
Medicaid	**73,968**	**$427,868,125**	**$302,850,815**	**$125,017,310**	**21.7%**
Community Services					
A - Community Health Improvement Services	55,688	$25,083,105	$21,376,175	$3,706,930	**0.6%**
C - Subsidized Health Services	Unknown	$49,231	$0	$49,231	**0.0%**
E - Cash and In-Kind Contributions	2	$1,470,319	$0	$1,470,319	**0.3%**
G - Community Benefit Operations	Unknown	$658,413	$0	$658,413	**0.1%**
Totals for Community Services	**55,690**	**$27,261,068**	**$21,376,175**	**$5,884,893**	**1.0%**
Totals for Benefits for Poor	**143,572**	**$475,490,322**	**$324,226,990**	**$151,263,332**	**26.2%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	3,762	$637,924	$141,202	$496,722	**0.1%**
B - Health Professions Education	92	$8,995,286	$2,667,945	$6,327,341	**1.1%**
C - Subsidized Health Services	4,193	$5,228,990	$4,086,869	$1,142,121	**0.2%**
E - Cash and In-Kind Contributions	Unknown	$33,916	$0	$33,916	**0.0%**
Totals for Community Services	**8,047**	**$14,896,116**	**$6,896,016**	**$8,000,100**	**1.4%**
Totals for Broader Community	**8,047**	**$14,896,116**	**$6,896,016**	**$8,000,100**	**1.4%**
Totals - Community Benefit	**151,619**	**$490,386,438**	**$331,123,006**	**$159,263,432**	**27.6%**
Medicare	**4,511**	**$20,368,341**	**$10,895,788**	**$9,472,553**	**1.6%**
Totals Including Medicare	**156,130**	**$510,754,779**	**$342,018,794**	**$168,735,985**	**29.2%**

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 and Committee Rosters

ROBERT BUENTE, Community Board Chair
President & CEO
1010 Development Corporation

MARK GONZALEZ
District Director
53rd Assembly District – Assembly Member Miguel Santiago

GUDATA S. HINIKA, MD
Trauma Program Medical Director
California Hospital Medical Center

SARAH E. SCHER
Chief Executive Officer
Cooperative of American Physicians

RUSSANA ROWLES
Board Member
California Hospital Medical Center
Community Board

PATRICIA A. LOTT
Business Strategist
PALSolutions

MAYER MAYER, MD
Chief of Staff
California Hospital Medical Center

ALINA MORAN, MPA, FACHE, FAB
President
California Hospital Medical Center

DR. MARCOS BRIANO
Professor
University of Southern California

NORMA WILLIAMS
Attorney
Williams & Associates