Dignity Health
St. Mary Medical Center
A member of CommonSpirit

2025 Community Health Implementation Strategy and Plan

Adopted September 2025

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At-a-Glance Summary

Community Served	Dignity Health St. Mary Medical Center serves the greater Long Beach area including the cities of Compton, Long Beach, Paramount and Wilmington in Los Angeles County.The population of the service area is 681,24 The hospital service area is located in Service Planning Areas (SPAs) 6 and 8 in Los Angeles County.
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 the hospital intends to address with strategies and programs are: • Access to Care • Chronic Disease • Housing and Homelessness • Mental Health • Prevention
Strategies and Programs to Address Needs	The hospital intends to take several actions and to dedicate resources to these needs, including: ***Access to Care*** CARE Program Community Health Improvement Grants program Families in Good Health Financial assistance for medically necessary care Low Vision Center ***Chronic Disease*** Bazzeni Wellness Center CARE Program Community Health Improvement Grants program Every Woman Counts Families in Good Health Food Systems Advisory Committee Mobile Care Unit ***Housing and Homelessness*** Community Health Improvement Grants program ***Mental Health*** CARE Program Community Health Improvement Grants program

Prevention
Bazzeni Wellness Center
CARE Program
Community Health Improvement Grants program
Every Woman Counts
Families in Good Health
Food Systems Advisory Committee
Mobile Care Unit

Planned resources and collaborators to help address these needs, as well as anticipated impacts of the strategies and programs, are described in the "Strategies and Program Activities by Health Need" section of the document.

This document is publicly available online on the hospital's website. Written comments on this strategy and plan can be submitted to the St. Mary Medical Center Community Health Office, 1050 Linden Avenue, Long Beach, CA 90813 or by email to Kit Katz, Director, Community Health at Kit.Katz@Commonspirit.org.

Our Hospital and the Community Served

About the Hospital

St. Mary Medical Center is a part of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 2,200 care sites in 24 states coast to coast, serving patients in big cities and small towns across America.

- The hospital is located at 1050 Linden Avenue, Long Beach, California, 90813.
- St. Mary Medical Center was founded in August 1923 by the Sisters of Charity of the Incarnate Word.
- The hospital facility is licensed for 398 beds.
- St. Mary Medical Center is a designated Baby-Friendly® hospital. It is a Certified Advanced Primary Stroke Center and a Los Angeles County-designated STEMI Receiving Center.

Our Mission

The hospital's dedication to assessing significant community health needs and helping to address them in conjunction with the community is in keeping with its 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.

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.

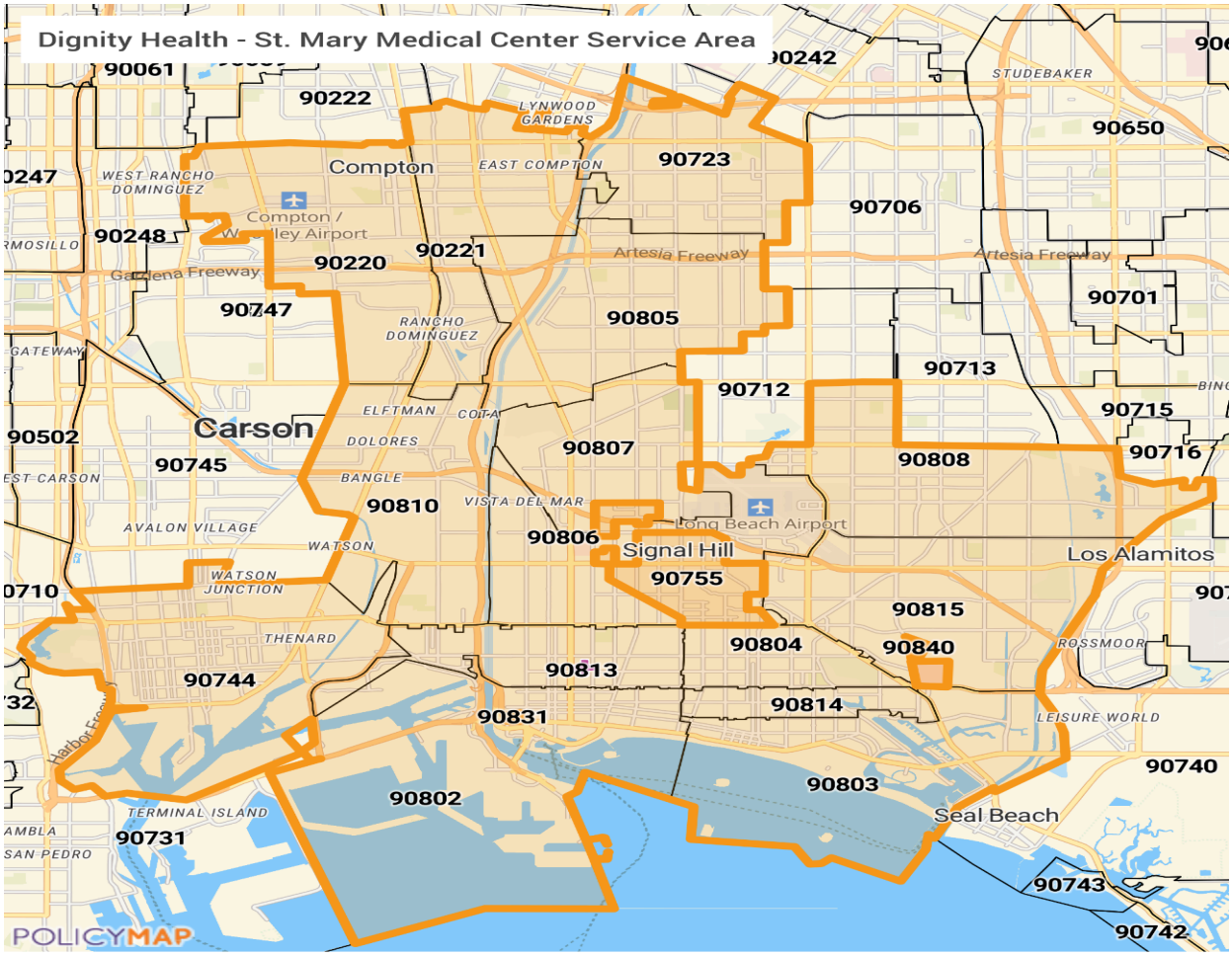
Description of the Community Served

The hospital defines its primary service area as including 15 ZIP Codes in Los Angeles County, 11 of

which are in the City of Long Beach. Los Angeles County is subdivided into eight Service Planning Areas (SPAs). The hospital service area comprises portions of SPA 6 and SPA 8.

St. Mary Medical Center Primary Service Area

Place	ZIP Code	Service Planning Area
Compton	90220, 90221	SPA 6
Long Beach	90802, 90803, 90804, 90805, 90806, 90807, 90808, 90810, 90813, 90814, 90815	SPA 8
Paramount	90723	SPA 6
Wilmington	90744	SPA 8



The population of the service area is 681,242. Children and youth, ages 0-17, make up 22.9% of the population, 65.4% are adults, ages 18-64, and 11.7% of the population are seniors, ages 65

and older. The largest portion of the population in the service area are Hispanic or Latino residents (55%), 19.5% are White or Caucasian residents, 12.3% are Black or African American residents, 11.9% are Asian residents, and 2.7% of the population are non-Latino multiracial residents, 0.5% are Native Hawaiian or Pacific Islander residents, and 0.2% are American Indian or Alaskan Native residents. In the service area, 47% of the population, 5 years and older, speak only English in the home. Among the area population, 44.3% speak Spanish, 6.7% speak an Asian or Pacific Islander language, and 1.5% speak an Indo-European language in the home.

Among the residents in the service area, 15.7% are at or below 100% of the federal poverty level (FPL) and 36.2% are at 200% of FPL or below. The median household income in the service area is $77,432 and the unemployment rate is 6.7%. Educational attainment is a key driver of health. In the hospital service area, 24.1% of adults, ages 25 and older, lack a high school diploma, which is higher than the state rate (15.6%). 26.9% of area adults have a bachelor's or higher degree.

In the service area, 47% of owner and renter occupied households spend 30% or more of their income on housing. Among renters-only, the rates are higher, with 56.4% of service area renter households being cost burdened, as opposed to 34.7% for owner households. Furthermore, 8.1% of households live in overcrowded conditions, and an additional 5% live in severely overcrowded conditions, for a total of 13.1% of all households being overcrowded.

In the service area, 89.6% of the civilian, non-institutionalized population have health insurance, and 95.3% of children, ages 18 and younger, have health insurance coverage. Among SPA 6 residents, 40% have Medi-Cal coverage and 23.3% of SPA 8 residents have Medi-Cal coverage.

The U.S. Health Services Administration (HRSA) designates medically underserved areas/populations (MUA) as areas or populations having too few primary care providers, high infant mortality, high poverty, or a high elderly population. North Long Beach, Long Beach/West Central, Long Beach Port and Compton are designated as MUAs for primary care.

There are three categories of Health Professions Shortage Area (HPSA) designations: 1) primary medical, 2) dental health, and 3) mental health. The primary factor used to determine a HPSA designation is the number of health professionals relative to the population with consideration of high need. The following regions in the service area are designated as a HPSA for primary care for high needs or low-income populations: Long Beach/West Central, Paramount N/Willowbrook, Compton East and the Long Beach Port. The following regions in the service area are designated as a HPSA for dental health: Long Beach Central and Bixby Knolls/Long Beach Central. The following regions in the service area are designated as a HPSA for mental health: Compton East/North Long Beach, Long Beach West Central and Lynwood South/Paramount N.

Community Assessment and Significant Needs

The health issues that form the basis of the hospital's community health implementation strategy and plan were identified in the most recent CHNA report, which was adopted in May 2025. The CHNA report includes:

- description of the community assessed consistent with the hospital's service area;
- description of the assessment process and methods;
- data, information and findings, including significant community health needs;
- community resources potentially available to help address identified needs; and
- impacts of actions taken by the hospital since the preceding CHNA.

Additional details about the needs assessment can be found in the CHNA report, which is publicly available on the hospital's website or upon request from the hospital, using the contact information in the At-A-Glance Summary.

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 or health care services, and also health-related social and community needs that have an impact on health and well-being.

Significant Health Need	Description	Intend to Address?
Access to Care	Access to health care refers to the availability of primary care, specialty care, vision care and dental 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.	●
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.	
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.	●
Economic Insecurity	Economic insecurity is correlated with poor health outcomes. People with low incomes are more likely to have difficulty accessing health	

Significant Health Need	Description	Intend to Address?
	care, have poor-quality health care, and seek health care less often.	
Environmental Pollution	Polluted air, contaminated water, and extreme heat are environmental conditions that can negatively impact community health.	
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.	
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.	●
Mental Health	Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act.	●
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 for chronic diseases. Overweight and obesity are linked to a lack of physical activity and unhealthy eating habits.	
Prevention	Preventive practices refer to health maintenance activities that help to prevent disease. For example, preventive care includes vaccines, routine health screenings (mammogram, colonoscopy, Pap smear) and injury prevention strategies.	●
Racism and Discrimination	Racism and discrimination in health care are systemic issues that negatively impact patient care and health outcomes, particularly for people of color. These issues manifest as disparities in access, treatment, and quality of care.	
Substance Use	Substance use is the use of tobacco products, illegal drugs, prescription drugs, 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.	
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.	

Significant Needs the Hospital Does Not Intend to Address

Taking existing hospital and community resources into consideration, St. Mary Medical Center will not directly address the remaining significant health needs identified in the CHNA, which include birth indicators, economic insecurity, environmental pollution, food insecurity, overweight and obesity, racism and discrimination, substance use and violence and injury.

Knowing there are not sufficient resources to address all the community health needs, St. Mary Medical Center 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 the identified needs and, in some cases, the needs are being addressed by others in the community.

2025 Implementation Strategy and Plan

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years, including resources for and anticipated impacts of these activities.

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 Implementation Strategy

The hospital is dedicated to improving community health and delivering community benefit with the engagement of its staff, clinicians and board, and in collaboration with community partners.

St. Mary Medical Center engaged the Community Health Advisory Committee and the Leadership Team to examine the significant health needs. The CHNA served as the resource document for the review of the significant health needs as it provided statistical data on the severity of issues and included community input. Also, the community prioritization of the significant health needs was taken into consideration.

The programs and initiatives described here were selected based on:

- 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 Core Strategies

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources. CommonSpirit Health has established three core strategies for community health improvement activities. These strategies help to ensure that program activities overall address strategic aims while meeting locally identified needs.

- Core Strategy 1: Extend the care continuum by aligning and integrating clinical and community-based interventions.
- Core Strategy 2: Implement and sustain evidence-informed health improvement strategies and programs.
- Core Strategy 3: Strengthen community capacity to achieve equitable health and well-being.

Vital Conditions and the Well-Being Portfolio

Community health initiatives at CommonSpirit Health use the Vital Conditions framework and the Well-Being Portfolio[1] to help plan and communicate about strategies and programs. Investments of time, resources, expertise and collaboration to improve health and well-being can take different approaches. And usually, no single approach can fully improve or resolve a given need on its own.

One way to think about any approach is that it may strengthen "vital conditions" or provide "urgent services," both of which are valuable to support thriving people and communities. A set of program activities may seek to do one or both. Taken together, vital conditions and urgent services compose a well-being portfolio.

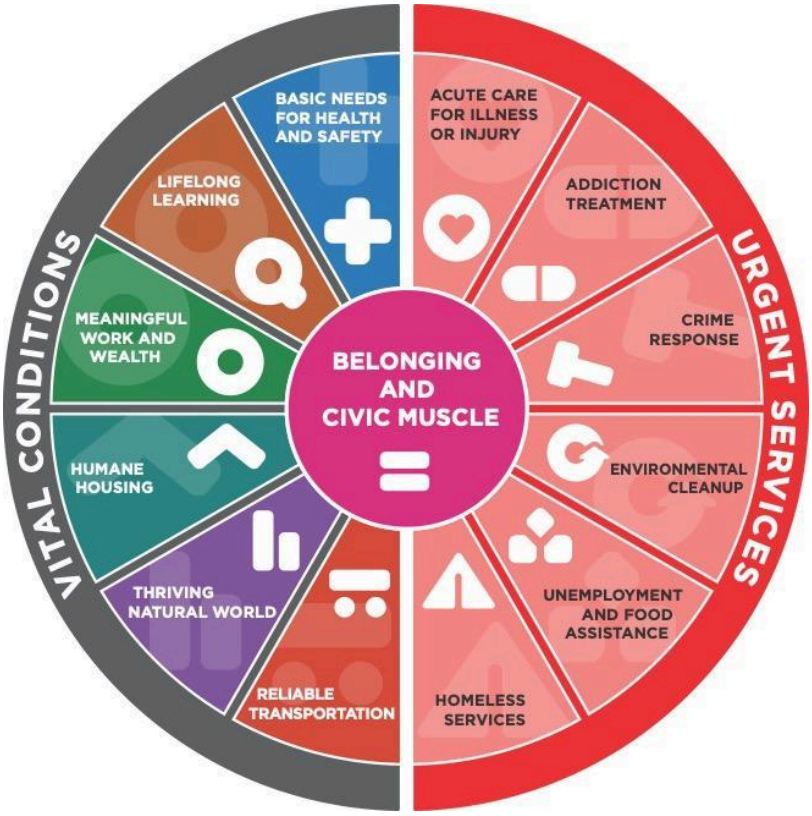
What are Vital Conditions?
These are characteristics of places and institutions that all people need all the time to be healthy and well. The vital conditions are related to social determinants or drivers of health, and they are inclusive of health care, multi-sector partnerships and the conditions of communities. They help create a community environment that supports health.

What are Urgent Services?
These are services that anyone under adversity may need temporarily to regain or restore health and well-being. Urgent services address the immediate needs of individuals and communities, say, during illness.

What is Belonging and Civic Muscle?
This is a sense of belonging and power to help shape the world. Belonging is feeling part of a community and valued for what you bring. Civic muscle is the power of people in a society to work across differences for a thriving future.

Well-Being Portfolio in this Strategy and Plan

The hospital's planned strategies and program activities that follow are each identified as aligning with one of the vital conditions or urgent services in this figure.



This helps to identify the range of approaches taken to address community needs, and also acknowledges that the hospital is one community resource and stakeholder among many that are dedicated to and equipped for helping to address these needs and improve health.

[1] The Vital Conditions Framework and the Well-Being Portfolio were created by the Rippel Foundation, and are being used with permission. Visit https://rippel.org/vital-conditions/ to learn more.

Strategies and Program Activities by Health Need

Health Need	**Access to Care**				
Population(s) of Focus	Individuals who experience barriers to accessing health care. Uninsured and underinsured people.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
CARE Program	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.	●	●	●	Acute care for illness or injury
Community Health Improvement Grants	Offer grants to nonprofit community organizations that provide health care access programs and services.	●		●	Acute care for illness or injury
Families in Good Health	Families in Good Health is a multilingual, multicultural health and social education program for Southeast Asian residents, Latino residents and other communities in Long Beach. Its mission is to help the community make informed choices and gain access to needed health and social resources.	●	●	●	Lifelong learning
Financial Assistance	Provide financial assistance to those who have	●	●	●	Acute care for

Health Need	**Access to Care**				
program	health care needs and are uninsured, underinsured, ineligible for a government program or otherwise unable to pay.				illness or injury
Low Vision Center	Provide no cost vision screening, optical aids, education and referrals for people with limited vision.	•	•	•	Basic needs for health and safety
Planned Resources:	Health care providers, dental care providers, vision care providers, enrollment counselors, community health educators, case managers, philanthropic cash grants, outreach communications, and program management support for these initiatives				
Planned Collaborators:	Community clinics, the Welcome Baby Program, community-based organizations, the LGBTQ Center, schools and school districts, faith groups, public health and city agencies				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increase access to health care for the medically underserved and reduce barriers to care.	Reduce to 5.9% the proportion of people who can't get medical care when needed.	Healthy People 2030

Health Need	**Chronic Disease and Prevention**				
Population(s) of Focus	Individuals with chronic diseases and their families, people at risk of developing chronic diseases. Individuals who experience barriers to accessing preventive care services.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Bazzeni Wellness Center	Provide health education, health screenings and chronic disease prevention services.	●	●		Lifelong learning
CARE Program	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 received 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.	●	●		Acute care for illness or injury
Community Health Improvement gGrants program	Offer grants to nonprofit community organizations that provide chronic disease-and preventive care focused programs and services.	●	●	●	Lifelong learning
Every Woman Counts	Provide mammogram services to underserved women older than age 40. Cervical screenings are offered for women ages 21 and older.	●	●		Acute care for illness or injury
Families in Good Health	Families in Good Health is a multilingual, multicultural health and social education program for Southeast Asian residents, Latino residents and other communities in Long Beach.	●	●	●	Lifelong learning

Health Need	**Chronic Disease and Prevention**				
	Its mission is to help the community make informed choices and gain access to needed health and social resources. FiGH also offers disease management programs.				
Food Systems Advisory Committee	Participate in CommonSpirit systemwide committee to address food insecurity issues in the community, including reducing barriers to accessing healthy food.	●	●	●	Unemployment and food assistance
Mobile Care Unit	Provide health care screenings, education and outreach to communities at high-risk of negative health outcomes.	●	●		Acute care for illness or injury
Planned Resources	The hospital will provide care coordinators, health care providers, community health educators, philanthropic cash grants and outreach communications.				
Planned Collaborators	Community-based organizations, public health, faith community, senior service agencies, youth organizations, community clinics, schools and school districts				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increased compliance with chronic disease management recommendations.	55.2% of people with diabetes get formal diabetes education. Reduce asthma attacks to 35.1% of people who have asthma.	Healthy People 2030
Increase the percentage of women who get screened for breast cancer.	80.3% of females, ages 50-74, receive breast	Healthy People 2030

	cancer screening.	

Health Need	**Housing and Homelessness**				
Population(s) of Focus	Individuals and families at risk of or experiencing homelessness.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Community Health Improvement gGrants program	Offer grants to nonprofit community organizations that provide housing and homelessness programs and services.	●			Homeless services
Planned Resources	Philanthropic cash grants and outreach communications				
Planned Collaborators	Housing developers, city agencies, funders, faith community, community clinics, community-based organizations, and housing agencies				

Anticipated Impacts (overall long-term goals)	Measure	Data Source

Health Need	Mental Health				
Population(s) of Focus	Individuals and families at-risk for and/or experiencing mental health distress.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
CARE Program	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 received 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.		●	●	Acute care for injury or illness
Community Health Improvement gGrants program	Offer grants to nonprofit community organizations that provide mental health programs and services.		●	●	Lifelong learning
Planned Resources	Mental health care providers, care managers, social workers, philanthropic cash grants, outreach communications, and program management				
Planned Collaborators	Schools and school districts, community-based organizations, law enforcement, and regional collaboratives that seek to support mental health and case management needs				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increase prevention, screening, assessment, and treatment of mental health disorders.	65.6% of adults, ages 18 and older with	Healthy People 2030

	depression, receive treatment.	