Dignity Health California Hospital Medical Center

Community Benefit 2022 Report and 2023 Plan

Adopted October 2022

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.

Dignity 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 2022 Report and 2023 Plan describes much of this work. This report meets requirements in California state law (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. Dignity Health hospitals in Arizona and Nevada 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 2022 (FY22), Dignity Health California Hospital Medical Center provided $188,505,692 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $8,432,221 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2022 Report and 2023 Plan at its October 27, 2022 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 Margaret Lynn Yonekura, M.D.

Alina Moran
President and CEO

Robert Buente
Chairperson, Board of Directors

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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 that has the largest concentration of homeless in LA County. ~50% of the people experiencing homelessness in LA County live in our service area.
Economic Value of Community Benefit	$188,505,692 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $8,432,221 in unreimbursed costs of caring for patients covered by Medicare
Significant Community Health Needs Being Addressed	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are: • 1 Access to health care • 2 Behavioral health • 3 Birth indicators • 4 Chronic diseases • 5 Housing insecurity & homelessness • 6 Violence prevention
FY22 Programs and Services	The hospital delivered several programs and services to help address identified significant community health needs. These included: *Housing insecurity and homelessness* 10th Decile Project (Homeless Health Initiative Program) HSFC's Early Head Start Program & The Nest (ECE Program) Dignity Health Community Grants Program Social Workers focused on Homeless Patients seen in ED (Homeless Health Initiative Program) *Access to Health Care* Financial assistance *Para Su Salud* – enrollment assistance program Health Ministry Program (negatively impacted by COVID-19 pandemic) HSFC Early Head Start Program and LA Best Babies Network's (LABBN) perinatal and early childhood home visitation programs Navigating the Health Care System 10th Decile Project Clinical experience for medical professional students

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CA Behavioral Health Clinic
LABBN's Network of Perinatal & Early Childhood Home Visiting Programs
10th Decile Project
UniHealth Cultural Trauma and Mental Health Resiliency Project
Dignity Health Community Grant Program

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LABBN's Network of Perinatal & Early Childhood Home Visiting Programs

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LABBN's Network of Perinatal & Early Childhood Home Visiting Programs
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H.E.L.P.
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Dental Care
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	LABBN's Network of Perinatal & Early Childhood Home Visiting Programs HSFC's Early Head Start Program DEEP (negatively impacted by COVID-19 pandemic) *Violence & Injury Prevention* HSFC's Early Head Start Program, ECEs, Family Childcare Network, Early Intervention Program, & Youth Center CA Behavioral Health Clinic LABBN's Network of Perinatal & Early Childhood Home Visiting Programs LA County Perinatal & Early Childhood Home Visiting Consortium UniHealth Cultural Trauma & Mental Health Resiliency Project Family Preservation Programs Wraparound Services Program Dignity Health Human Trafficking Response Task Force Health Ministry Program (negatively impacted by COVID-19 pandemic) Stop the Bleed Maternity Tours CA Bridge Program in ED
FY23 Planned Programs and Services	FY22 programs and services will continue, with the exception of the following:: Social Workers focused on People Experiencing Homelessness in ED – grant funding from Homeless Health Initiative ended June 30, 2022 Cherished Futures for Black Moms and Babies UniHealth CTMHR Project ends Nov. 30, 2022 Dignity Health Community Grant recipients change on Jan. 1st when the new funding cycle beginnings each year.

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

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

Our Hospital and the Community Served

About Dignity Health California Hospital Medical Center

Dignity Health California Hospital Medical Center 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 Avenue, 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, state-of-the-art Cardiac Catheterization Lab, Keith P. Russell Women's Birthing 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 (California Hospital) is located at 1401 S. Grand Avenue, Los Angeles, California 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 10 that are in South LA, and comprises 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.

- The population of the California Hospital service area is 1,942,854. Children and youth, ages 0-17, make up 25.2% of the population, 65.1% are adults, ages 18-64, and 9.8% of the population are seniors, ages 65 and older. The largest portion of the population in the service area identifies as Hispanic/Latino (67.8%), 17.3% of the population identifies as Black/African American, 6.8% are Asian, 6.2% are White. 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 a 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 area population, 63% speak Spanish, 5.7% speak an Asian/Pacific Islander language, and 1.2% speak an Indo-European language in the home. In the service area, 39.1% of the population is foreign-born, which is higher than the county (34.0%) and state (26.8%) rates. Of the foreign-born, 64.6% are not citizens. It is important to note that not being a U.S. citizen does not indicate an illegal resident status within the U.S.

- Among the residents in the service area, 24% are at or below 100% of the federal poverty level (FPL) and 52% are at 200% of FPL or below. Those who spend more than 30% of their income on housing are said to be “cost burdened.” In the service area, 56.2% of owner and renter occupied households spend 30% or more of their income on housing. This is higher than county (47.3%) and state (41.7%) rates. Educational attainment is a key driver of health. In the hospital service area, 36.2% of adults, ages 25 and older, lack a high school diploma, which is higher than the county (20.9%) and state (16.7%) rates. 17.9% of area adults have a Bachelor’s degree or higher degree.

- According to the 2022 Point-in-Time Count, CHMC has 46.9% of LA County’s homeless population in its service area, 25.8% in SPA 4 and 21.1% in SPA 6. (LA County is home to 21.2% of the U.S. PEH) 1 out of 3 people experiencing homelessness has a serious mental illness compared to 1 in 25 people in the general population. A third of people experiencing homelessness have a problem with alcohol, marijuana and/or illicit drugs. Drug overdose has

been the leading cause of death among PEH since 2017 in LA County. For the combined years of 2017-2019, PEH were 36 times more likely to die of a drug overdose than people in the general population. In SPA 4, 92% of PEH are individuals and 3% are families. In SPA 6, 61% of PEH are individuals and 39% are families. Among individuals experiencing homelessness in SPA 4, only 26.8% are sheltered; on the other hand, 85% of families experiencing homelessness are sheltered. Similarly in SPA 6, only 29% of individuals experiencing homelessness are sheltered whereas, 96% of families experiencing homelessness are sheltered. Among the homeless population, 50% in SPA 4 and 34% in SPA 6 are chronically homeless. With respect to race/ethnicity, in SPA 4, 27% are Hispanic, 1% AI/AN, 36% Black/African American, and 32% White; in SPA 6, 48% are Hispanic, 1% Asian, 28% Black/African American, 21% White, and 3% mixed races. With respect to gender, in SPA 4, 68% are male, 27% female, 5% non-binary, and 3% transgender; in SPA 6, 58% are male, 42% female, and 1% transgender. With respect to age, in SPA 4, 6% are < 18, 10% 18-24, 70% 25-54, 3% 55-61, and 9% are 62+; in SPA 6, 23% are < 18, 6% 18-24, 57% 25-54, 6% 55-61, and 7% are 62+.

- Demographic profile of people living in CHMC's service area:

Total Population	934,653
Race	
Asian/Pacific Islander	6.1%
Black/African American - Non-Hispanic	20.7%
Hispanic or Latino	63.9%
White Non-Hispanic	6.0%
All Others	3.4%
Total Hispanic & Race	
% Below Poverty	19.2%
Unemployment	6.7%
No High School Diploma	36.6%
Medicaid	35.2%
Uninsured	9.1%
Source: Claritas Pop-Facts® 2022; *SG2 Market Demographic Module*	

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 May 2022.

This document also reports on programs delivered during fiscal year 2022 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
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.	
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 for 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) and injury prevention are preventive practices.	
Substance use	Substance use is the use of tobacco products, illegal drugs or 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

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 the identified needs and, in some cases, the needs are currently addressed by others in the community.

2022 Report and 2023 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 FY22 and planned activities for FY23, 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.

Hospital and health system participants included CHMC Senior Leadership Team, leadership of the 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 the Southside Coalition of Community Health Centers.

Community input or contributions to this implementation strategy 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 FY22	Planned FY23
Financial assistance for the uninsured or underinsured	• CHMC provides financial assistance to those who have health care needs and are uninsured, underinsured, ineligible for a government program or otherwise unable to pay.	☒	☒
Para Su Salud – enrollment assistance program	• Provides assistance to individuals and families to sign up for health and dental health insurance benefits.	☒	☒
Health Ministry Program	• Parish Nurse refers those without a medical home to local FQHCs.	☒	☒
HSFC Early Head Start Program and LA Best Babies Network's (LABBN) perinatal and early childhood home visitation programs	• Assists families in accessing health and dental health insurance coverage. • Assists families in establishing a medical home for each family member	☒	☒
Navigating the Health Care System	• A four-unit health literacy curriculum designed by Nemours Children's Health System for use with high school students in classroom or community settings. The program prepares	☒	☒

	students to be responsible for managing their own health care as they transition into adulthood. • Presented to students of local high schools by Public Health and MPH interns from CHMC Community Health Dept. under supervision of Manager of Community Health		
10th Decile Project	• This grant-funded project connects the top 10% highest cost, highest need chronically homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services through a collaboration of Corporation for Supportive Housing, Housing Works, and JWCHI, Inc. • Community Health Navigators from JWCHI, Inc. based at CHMC identify and enroll patients experiencing chronic homelessness meeting the criteria for enrollment in 10th Decile Project and provide a warm hand-off to housing navigator from Housing Works • Housing navigator from Housing Works initiates intensive case management and places patient in transitional housing as quickly as possible following hospital discharge and refers patient to appropriate physical, mental, and behavioral health care services • Eventually the housing navigator places the patient in permanent supportive housing that best meets the patient's individual needs	☒	☒
Clinical experience for medical professional students	• Family Medicine interns and residents provide both in-patient and out-patient services for patients from vulnerable populations under the supervision of faculty. • 3rd year students of Ross School of Medicine provide in-patient services for patients from vulnerable populations under the supervision of faculty. • Students of a variety of professions such as nursing, physical therapy, etc. provide in-patient services for CHMC patients under the	☒	☒

	supervision of faculty and staff.		

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, Early Head Start, LA Best Babies Network, faith groups, public health, city agencies and homeless services agencies. 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 (Mental Health and Substance Use)

Strategy or Program	Summary Description	Active FY22	Planned FY23
Behavioral Health Navigator Program (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 navigators to identify patients who would benefit from initiating medication for addiction treatment (MAT) or mental health services.	☒	☒
HSFC Early Head Start Program, Early Care and Education Centers, Wraparound Services Program, Youth Center, Early Intervention Program	• Screens parents for depression/anxiety and intimate partner violence (IPV). • Screens children and youth for mental health and behavioral issues. • Refers parents and children who need treatment to community resources. • Wraparound Program provides community-based support and individualized planning for children, including those with severe emotional and behavioral disorders and their families	☒	☒
Pico Union and South LA Family Preservation Programs	• 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. • Offers anger management psychoeducational group • Offers a parenting psychoeducational group.	☒	☒

Strategy or Program	Summary Description	Active FY22	Planned FY23
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. • Improved access to prevention and early intervention mental health and SUD (substance use disorder) services, • Decreased stigma and discrimination encountered by those who need behavioral health services through increased community-wide awareness • Identifies and funds grantees who deliver Mental Health First Aid, Youth Mental Health First Aid, and Question, Persuade, and Refer (a suicide prevention curriculum) to the target population in the service area	☒	☒
Mental Health Awareness Project	• CHMC working in partnership with Providence Health will increase the capacity of local community organizations, community members, and youth organizations and schools in the Centinela Valley to identify mental distress and/or suicidality among at risk youth and adults, and to respond appropriately • Improved access to prevention and early intervention mental health and SUD (substance use disorder) services, • Decreased stigma and discrimination encountered by those who need behavioral health services through increased community-wide awareness • *Promotoras* will deliver Mental Health First Aid, Youth Mental Health First Aid, and Question, Persuade, and Refer (a suicide prevention curriculum) to the target population living in the Centinela Valley	☐	☒
10th Decile Project	• 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 of Housing Works and	☒	☒

	JWCHI, Inc. Typically a third of these patients have serious mental illness and a third have SUD, with many having both.		
CA Behavioral Health Clinic	• Children and youth, ages 0-21, with Medi-Cal receive mental health care services.	☒	☒
LABBN's Perinatal & Early Childhood Home Visiting Programs	• Home visitors screen for perinatal mood and anxiety disorders (PMADs), intimate partner violence (IPV) and substance use disorder and refers individuals needing treatment to community resources	☒	☒
Community grants program	• Offers grants to nonprofit community organizations that provide mental health and substance use programs and services	☒	☐

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 and substance use needs.

Collaborators: Key partners include: schools and school districts, community-based organizations, the UniHealth Foundation, Dignity Health Southern California Hospitals, other non-profit hospitals 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 FY22	Planned FY23
African American Infant and Maternal Mortality Initiative (AAIMM)	• Reduces Black maternal and infant mortality by decreasing risk factors for maternal mortality (advanced maternal age and obesity, IPV, PMADs), prematurity, low-birth weight, and SIDS (sudden infant death syndrome). • Improves access to doula services	☒	☒
HSFC Early Head Start Program	• Provides prenatal home visiting services to improve birth outcomes. • Provides postpartum & early childhood home visiting services to improve maternal and child outcomes • Provides case management services to address social determinants of health	☒	☒

Cherished Futures for Black Moms & Babies	• A collaborative effort to reduce infant mortality and improve maternal patient experiences and safety among Black moms and babies in South LA and the Antelope Valley. • Aligns with the comprehensive LA County African American Infant and Maternal Mortality (AAIMM) initiative and aims to support the legacy of local communities working to advance birth equity. • The collaborative explores key interventions focusing on clinical, organizational, and community level strategies to address African American birth inequities. • Increases the capacity of project partners to meet the needs of Black women and families through a series of learning opportunities on equity, root causes, and implicit bias.	☒	☐
LA County Perinatal and Early Childhood Home Visitation Consortium	• A consortium run by LABBN. Membership includes the majority of organizations providing home visiting services in LA County. • Together, members work to support Los Angeles County's home visitation programs by sharing training and educational resources, researching best practice standards, supporting enhanced referral systems between programs, conducting research and collecting data on home visiting outcomes, and advocating for systems and policies that recognize the tremendous value of home visitation services.	☒	☒
LABBN's Perinatal and Early Childhood Home Visiting Programs	• Offers programs run by 14 hospitals and 22 community partners throughout LA County including CHMC. • 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 • Provides marketing and patient education materials and resources for the Network • Prenatal services improve birth outcomes for both mother and baby • Postnatal and early childhood services improve maternal and child outcomes	☒	☒
Community grants program	• Offers grants to nonprofit community organizations that provide access to prenatal and perinatal programs and services	☐	☒

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, faith groups, Los Angeles County Department of Public Health and other non-profit hospitals. 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 Disease (including Overweight and Obesity and Food Insecurity)

Strategy or Program	Summary Description	Active FY22	Planned FY23
Health Ministry Program	• Parish Nurse screens community members for common chronic diseases including overweight/obesity and food insecurity • Refers those with abnormal results to local FQHCs if they do not already have a medical home. • Provides health education re the abnormal test and related condition(s)	☒	☒
Heart HELP Program	• Minimizes risk for cardiovascular disease by healthy eating and cooking, maintaining an active lifestyle and addressing risk factors such as obesity/overweight, hypertension, cholesterol, and pre-diabetes/diabetes. • Refers those who are food insecure to CalFresh, WIC, and other food assistance programs for which they qualify.	☒	☒
Diabetes Empowerment Education Program (DEEP)	• Prevents diabetes among persons with pre-diabetes. • • • Participants with diabetes learn to manage their disease and improve their health in order to prevent complications. • Refers those who are food insecure to CalFresh, WIC, and other food assistance programs for which they qualify.	☒	☒

Chronic Disease Self-Management Program	• In six weekly workshops, participants with chronic conditions learn to manage and improve their health.	☒	☒
Healthy Eating Lifestyle Program	• Overweight/obese children, ages 5-12, and their parents learn to decrease screen time, consumption of fast food, sugar sweetened beverages, and calorie-dense, nutrient poor food and to increase their physical activity and consumption of fresh fruits, vegetables and water. • Food insecure families are referred to CalFresh, WIC, and other food assistance programs for which they qualify	☒	☒
Women's Health Center	• Uninsured women are referred to the CHMC's Women's Health Center for free mammography and cervical cancer screenings.	☒	☒
HSFC's EHS, ECE Centers, 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 obesity/overweight. • Children and youth, ages 7-18, learn about healthy eating, healthy cooking, portion control, the importance of maintaining an active lifestyle and healthy coping strategies for life's stressors. They are encouraged to participate in the Youth Fitness Program. • Refers those who are food insecure to CalFresh, WIC, and other food assistance programs for which they qualify.	☒	☒
LABBN's Perinatal & Early Childhood Home Visiting Programs	• Pregnant and parenting women with children, ages 0-5, learn about the importance of breastfeeding, the consumption of fresh fruits, vegetables and water, and maintaining an active lifestyle in order to prevent obesity/overweight. • Refers those who are food insecure to CalFresh, WIC, and other food assistance programs for which they qualify.	☒	☒
10th Decile Project	• This grant-funded project connects the top 10% highest cost, highest need chronically homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services through a collaboration of	☒	☒

	Corporation for Supportive Housing, Housing Works, and JWCHI, Inc.		
Support groups	• Assists persons with chronic diseases to improve their emotional well-being through mutual support, coping strategies, and psychoeducation	☒	☒
Food Recovery Initiative	• Participates in CommonSpirit system wide initiative to address food insecurity issues in the community, including reducing barriers to accessing healthy food, by sharing uneaten prepared food from the cafeteria with local non-profit feeding programs	☒	☒
Community grants program	• Offers grants to nonprofit community organizations that provide chronic disease-focused programs and services.	☐	☒

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 life style and behavior changes) and improved healthy eating and active living.

Collaborators: Key partners include: FQHCs, Food Finders, Southside Coalition of Community Health Centers, LA County Department of Public Health, youth organizations, faith community, senior centers, community-based organizations and other non-profit hospitals. The hospital will provide health care providers, parish nurse, patient navigators, health educators, 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
Dignity Health Homeless Health Initiative	• Provides three social workers to assist with discharge planning for patients experiencing homelessness seen in the ED.	☒	☐
10th Decile Project	• 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 of Housing Works and JWCHI, Inc.		
HSFC's Early Head Start Program, The Nest (ECE Center)	• Enrolls homeless pregnant women and/or parenting women with children, ages 0-3. • Outreaches to families in shelters to help them access permanent affordable 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 Partnership	☒	☒
Community grants program	• Offers grants to nonprofit community organizations that provide housing and homelessness programs and services.	☒	☐

Goal and Impact: The hospital's initiative 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: Corporation for Supportive Housing, Housing Works, JWCHI, Inc., city and county agencies, funders, faith community, community clinics, community-based organizations, other non-profit hospitals and homeless services providers. The hospital will provide social workers, health care providers, case managers, philanthropic cash grants, outreach communications, and program management for this initiative.

Health Need: 6 Violence and Injury Prevention

Strategy or Program	Summary Description	Active FY22	Planned FY23
HSFC Early Head Start Program, Early Care and Education	• 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	☒	☒

Centers, Family Childcare Network			
HSFC Youth Center	• Youth, ages 7-18, access homework assistance, a computer learning lab, and the Youth Fitness Program at this afterschool program. Youth develop relationships with caring adults and learn healthy coping skills through yoga.	☒	☒
HSFC Early Intervention Program	• Serves families with infants or toddlers who have a developmental delay or disability or with an established risk condition likely to result in a delay. • Specialists evaluate and assess infants and toddlers and provide EIP and family support services for young children, ages birth to 3 years. • Parents are routinely screened for IPV and referred for counseling and support as needed.	☒	☒
CA Behavioral Health Clinic	• Children, ages 0-21, with Medi-Cal receive mental health services • Parents may receive dyadic care with their child	☒	☒
LABBN's Perinatal and Early Childhood Home Visiting Programs	• 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/toddlers.	☒	☒
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. • Improved access to prevention and early intervention mental health and SUD services, • Identifies and funds grantees who deliver Mental Health First Aid, Youth Mental Health First Aid, and Question, Persuade, and Refer to the target population in the service area.	☒	☒
Mental Health Awareness Project	• CHMC working in partnership with Providence Health will increase the capacity of local community organizations, community	☐	☒

	members, and youth organizations and schools in the Centinela Valley to identify mental distress and/or suicidality among at risk youth and adults, and to respond appropriately • Improved access to prevention and early intervention mental health and SUD (substance use disorder) services, • Decreased stigma and discrimination encountered by those who need behavioral health services through increased community-wide awareness • *Promotoras* will deliver Mental Health First Aid, Youth Mental Health First Aid, and Question, Persuade, and Refer (a suicide prevention curriculum) to the target population living in the Centinela Valley		
Stop the Bleed Program	• Stop the Bleed is a national awareness campaign and call-to-action. • Trains, equips, and empowers the public to help a bleeding emergency before professional help arrives.	☒	☒
Dignity Health Human Trafficking Response Initiative	• The CHMC 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 LA and Journey Out work in the ED to assist staff in identifying potential victims and encourage potential victims to accept services.	☒	☒
Pico Union and South LA Family Preservation Programs	• 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, an anger management group for men and women, and a parenting group for men and women is 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.	☒	☒

Community grants program	• Offers grants to nonprofit community organizations that provide violence and injury prevention programs and services	☐	☒

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: community-based organizations, CAST LA, Journey Out, Safe Haven Medical Clinic, the other 3 Dignity Health hospitals in LA County, faith community, 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 FY22, the hospital awarded the grants below totaling $173,308. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Downtown Women's Center	Mental & Physical Health Support for Women with Histories of Homelessness	$86,654.
The Salvation Army CA South Division	Zahn Memorial Center & Lily's Place for Homeless Families	$86,654.

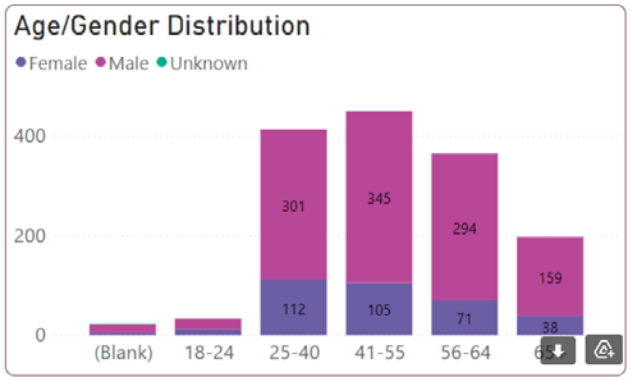
Program Highlights

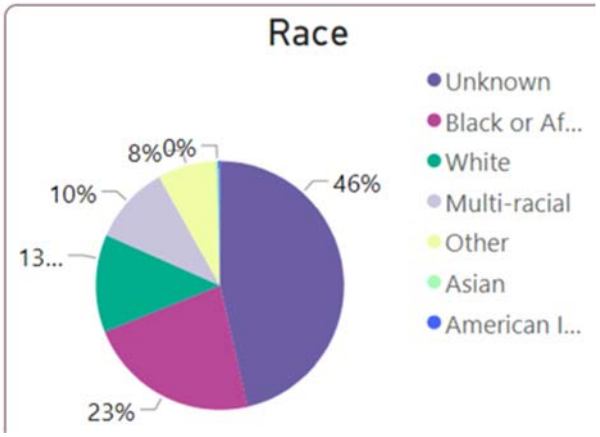
The following pages describe a sampling of programs and initiatives listed above in additional detail, illustrating the work undertaken to help address significant community health needs.

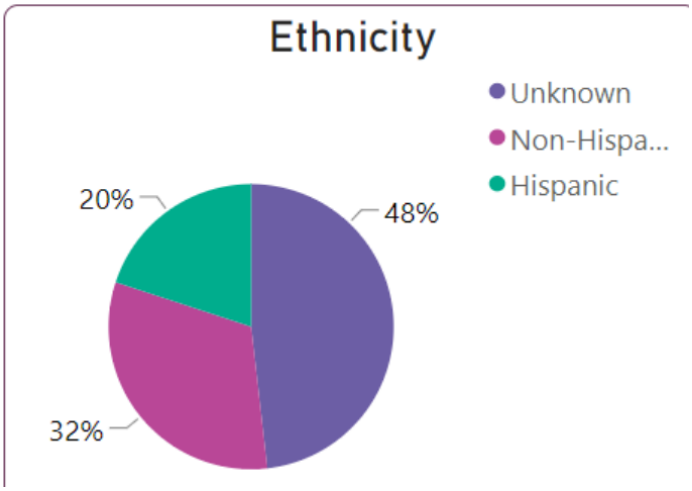
10th Decile Project	
Significant Health Needs Addressed	• Need 1 Access to Health Care • Need 2 Behavioral Health • Need 4 Chronic Disease • Need 5 Housing Insecurity and Homelessness
Program Description	• This grant-funded project connects the top 10% highest cost, highest need, chronically homeless individuals seen at CHMC to intensive case management, permanent supportive housing, and appropriate physical and behavioral health care services through a collaboration of Corporation for Supportive Housing, JWCH Institute, Inc. (JWCHI), and Housing Works (HW).
Population Served	Individuals who are experiencing chronic homelessness and are seen in CHMC's ED or inpatient units
Program Goal / Anticipated Impact	After 12 mo. in supportive housing (SH), 10th Decile individuals placed in SH show: 40% reduction in ER visits; 35% reduction in hospital readmissions 85% of individuals placed in SH during the grant period retain their housing for 12 mo. After 12 mo. in SH, of individuals placed in SH: 40% are using primary care; 35% are using Substance Use Disorder (SUD) services; 35% are using mental health services. 600 CHMC homeless patients have better access to primary care, mental health and behavioral health care through community-based health services. 50 10th Decile patients are referred to Housing Works (HW) for the 10th Decile Project. 36 high-acuity homeless patients move into temporary supportive housing and are better able to recover from a health crisis. 10 patients are enrolled in Coordinated Entry System, obtain housing vouchers, and move into supportive housing units. HW's continued wraparound services help ensure that patients stay in SH and stabilize their chronic health conditions.
FY 2022 Report	

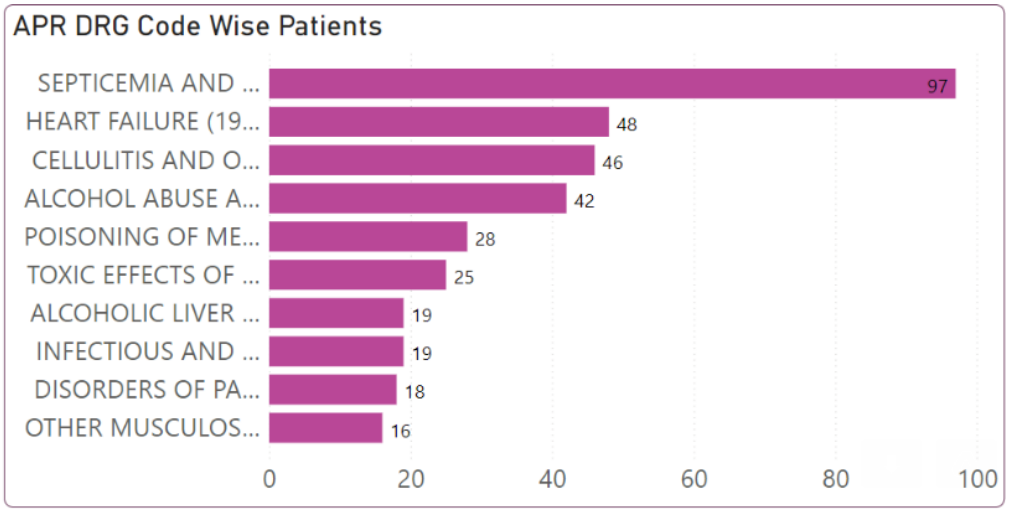
Activities Summary	Two CHNs from JWCHI screen patients on-site at CHMC and identify and refer homeless high utilizers with complex health challenges to community-based health services including behavioral health and mental health services and to HW. HW dedicates two full-time housing navigators to CHMC patients in the 10th Decile. HW case management includes care coordination, housing navigation, housing search, and tenancy support services. Dignity Health Homeless Health Initiative program manager convenes JWCHI, CHMC, and HW quarterly to discuss progress against target activities.
Performance / Impact	CC/SW referred 915 PEH to the CHNs. CHNs screened 915 people experiencing homelessness in FY22 - 706 from inpatient units and 209 from the ER. They referred 76 patients to Housing Works for the 10th Decile Project. Housing Works enrolled new 26 patients in the 10th Decile track and provided navigation services to them and successfully enrolled them in the Coordinated Entry System (CES). During FY22, HW obtained temporary housing for 21 10th Decile patients and 11 became permanently housed. The CHNs scheduled 52 appointments at JWCH; unfortunately, patients kept only 36.5% of these appointments despite the fact that CHNs provided education re importance of being on time and transportation to and from JWCH, phone number to call, and appointment reminders
Hospital's Contribution / Program Expense	The hospital contributed space, computers and office supplies for the CHNs within the SW/CC department. CC/SW staff identify PEH in ED and inpatient units and refer them to the CHNs. Although the hospital also provided space, a computer, and office supplies for the HHI program manager, she chose to continue working remotely and only coming into hospital for in-person meetings with CHNs, CC/SW leadership and staff, and/or quarterly meetings of all project partners. The HHI program manager meets monthly with Director, Community Health to provide a progress report, to discuss current challenges, and brainstorm solutions. This program is supported by a grant from Dignity Health Homeless Health Initiative.
FY 2023 Plan	
Program Goal / Anticipated Impact	After 12 mo. in supportive housing (SH), 10th Decile individuals placed in SH show: 40% reduction in ER visits; 35% reduction in hospital readmissions 85% of individuals placed in SH during the grant period retain their housing for 12 mo.

	After 12 mo. in SH, of individuals placed in SH: 40% are using primary care; 35% are using Substance Use Disorder (SUD) services; 35% are using mental health services. 600 CHMC homeless patients have better access to primary care, mental health and behavioral health care through community-based health services. 50 10th Decile patients are referred to Housing Works (HW) for the 10th Decile Project. 36 high-acuity homeless patients move into temporary supportive housing and are better able to recover from a health crisis. 10 patients are enrolled in Coordinated Entry System, obtain housing vouchers, and move into supportive housing units. HW's continued wraparound services help ensure that patients stay in SH and stabilize their chronic health conditions.
Planned Activities	No change in program activities from last year.






Ethnicity
Unknown
Non-Hispa...
Hispanic
20%
48%
32%


APR DRG Code Wise Patients
SEPTICEMIA AND ...
HEART FAILURE (19...
CELLULITIS AND O...
ALCOHOL ABUSE A...
POISONING OF ME...
TOXIC EFFECTS OF ...
ALCOHOLIC LIVER ...
INFECTIOUS AND ...
DISORDERS OF PA...
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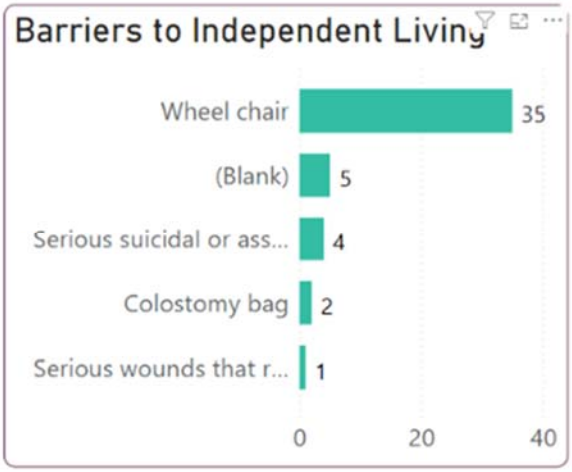
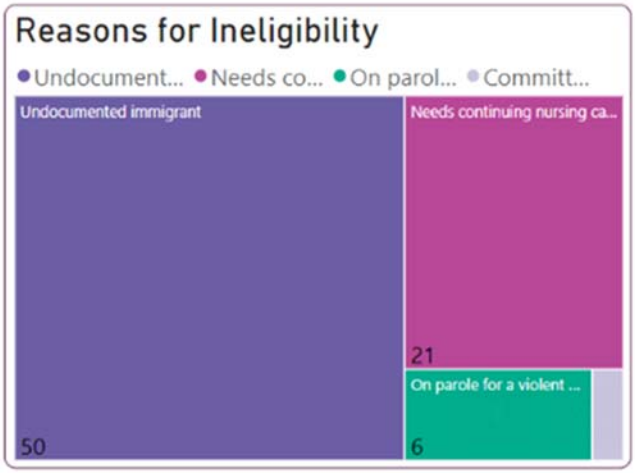
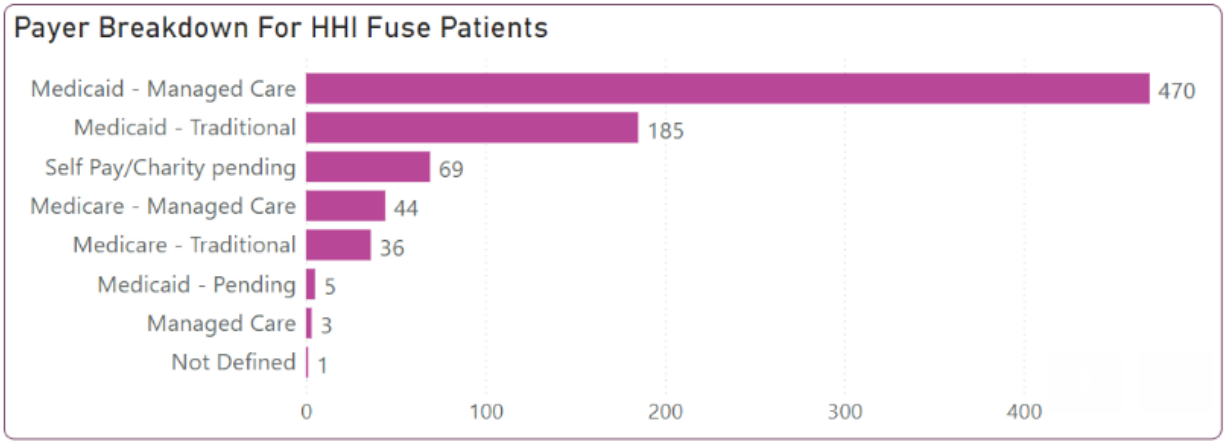
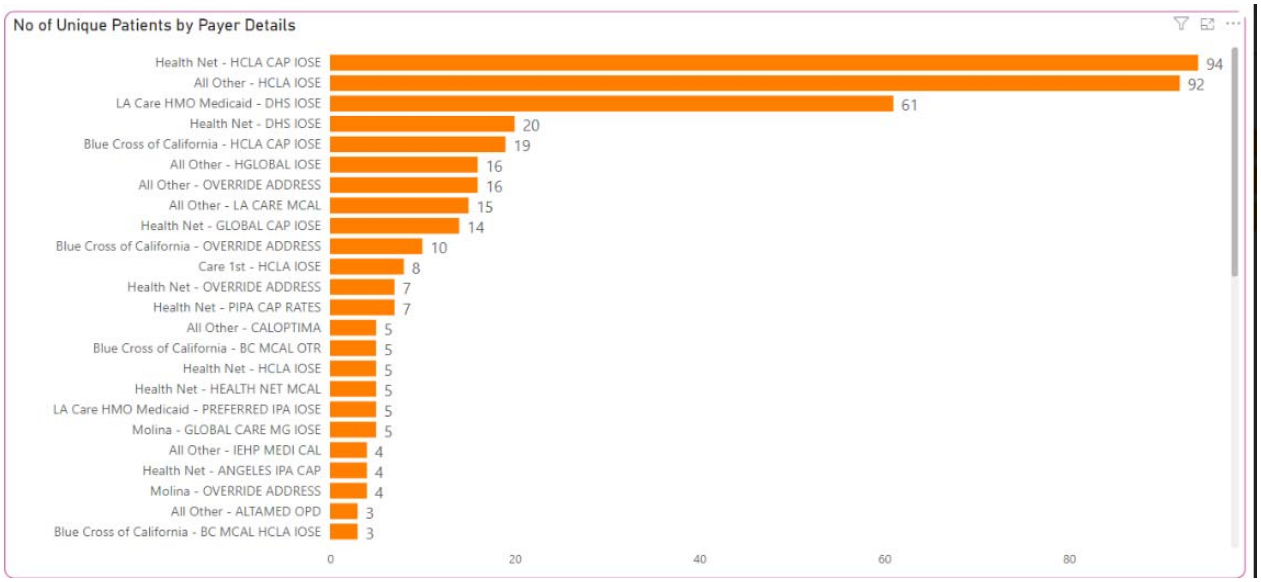
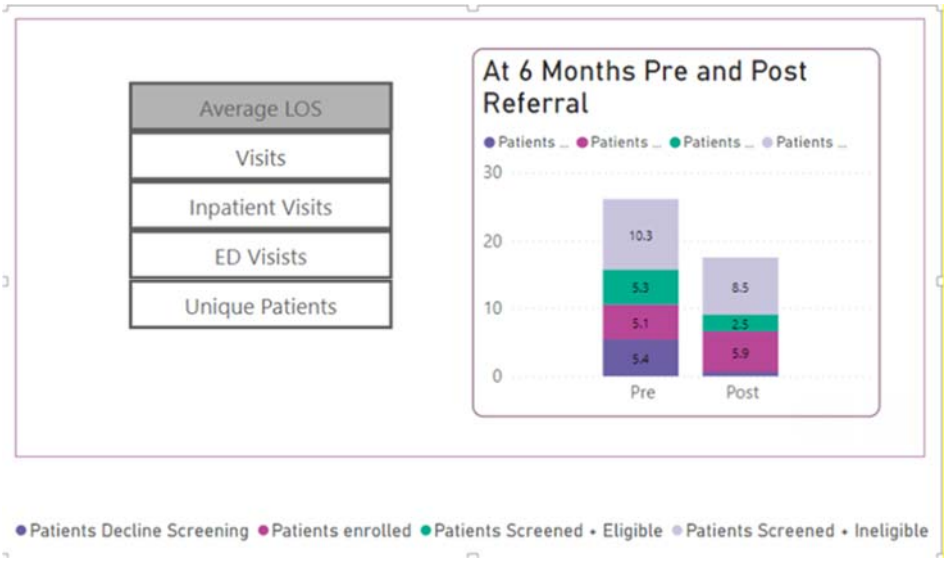
16
0
20
40
60
80
100


Barriers to Independent Living
Wheel chair
(Blank)
Serious suicidal or ass...
Colostomy bag
Serious wounds that r...
35
5
4
2
1
0
20
40


Reasons for Ineligibility
Undocument...
Needs co...
On parol...
Committ...
Undocumented immigrant
Needs continuing nursing ca...
On parole for a violent ...
50
21
6


Payer Breakdown For HHI Fuse Patients
Medicaid - Managed Care
470
Medicaid - Traditional
185
Self Pay/Charity pending
69
Medicare - Managed Care
44
Medicare - Traditional
36
Medicaid - Pending
5
Managed Care
3
Not Defined
1
0
100
200
300
400


No of Unique Patients by Payer Details
Health Net - HCLA CAP IOSE 94
All Other - HCLA IOSE 92
LA Care HMO Medicaid - DHS IOSE 61
Health Net - DHS IOSE 20
Blue Cross of California - HCLA CAP IOSE 19
All Other - HGLOBAL IOSE 16
All Other - OVERRIDE ADDRESS 16
All Other - LA CARE MCAL 15
Health Net - GLOBAL CAP IOSE 14
Blue Cross of California - OVERRIDE ADDRESS 10
Care 1st - HCLA IOSE 8
Health Net - OVERRIDE ADDRESS 7
Health Net - PIPA CAP RATES 7
All Other - CALOPTIMA 5
Blue Cross of California - BC MCAL OTR 5
Health Net - HCLA IOSE 5
Health Net - HEALTH NET MCAL 5
LA Care HMO Medicaid - PREFERRED IPA IOSE 5
Molina - GLOBAL CARE MG IOSE 5
All Other - IEHP MEDI CAL 4
Health Net - ANGELES IPA CAP 4
Molina - OVERRIDE ADDRESS 4
All Other - ALTAMED OPD 3
Blue Cross of California - BC MCAL HCLA IOSE 3
0
20
40
60
80


Average LOS
Visits
Inpatient Visits
ED Visists
Unique Patients
At 6 Months Pre and Post Referral
Patients ...
Patients ...
Patients ...
Patients ...
30
20
10
0
10.3
5.3
5.1
5.4
8.5
2.5
5.9
Pre
Post
Patients Decline Screening
Patients enrolled
Patients Screened • Eligible
Patients Screened • Ineligible

Para Su Salud – Enrollment Assistance Program	
Significant Health Needs Addressed	• Need 2 Access to Health Care • Need 7 Food Insecurity • Need 9 Preventive Services
Program Description	This is a grant-funded program. The enrollers who are employees of CHMC outreach to a number of sites in the community as well as at the hospital. They assess each individual in order to determine which health insurance, if any, he/she qualifies for. Then they enroll the individual and explain how it works. They remind the individual that their insurance needs to be recertified every 6 months.
Population Served	People who do not have health insurance
Program Goal / Anticipated Impact	The program goal is to enroll uninsured individuals into the health insurance program he/she qualifies for. How many people did the enrollers outreach to? How many people did they enroll in health insurance? How many 6 mo. recertifications did they complete?
FY 2022 Report	
Activities Summary	During the pandemic, the enrollers were unable to give presentations at the various clinics. Instead they gave Zoom presentations to new clients in their office and educated them on how to use their health insurance. This limitation impacted their ability to do outreach activities. As the COVID -19 infection rate in the community began to fall, they were able to start going to some community sites.
Performance / Impact	**See table** following this template for performance: How many people did the enrollers outreach to? How many people did they enroll in health insurance? How many 6 mo. recertifications did they complete?
Hospital's Contribution / Program Expense	Total program expense =$316,000 Restricted grant =$405,713 Staff is all CHMC employees-0 .7 FTE project supervisor, 3 FTEs community health access specialists, 0 .95 FTE utilization/redetermination specialist, and 1 FTE administrative assistant. CHMC contributes office space, computers, printers, and office equipment.
FY 2023 Plan	
Program Goal / Anticipated Impact	The program goal is to enroll uninsured individuals into the health insurance program he/she qualifies for. How many people did the enrollers outreach to? How many people did they enroll in health insurance?

	How many 6 mo. recertifications did they complete
Planned Activities	No planned change in program activities

Measurable Objectives	Implementation Activities		AB 74 Annual Target Numbers	YTD %	YTD #
Outreach	Obj. 1.1	Conduct outreach (events, calls, walk-ins)	3,006	52%	1,559
Enrollment	Obj. 2.2	Conduct enrollment using PH approved intake form	1,245	50%	626
	Obj. 2.2	Conduct enrollment verification	100%	100%	701
	Obj. 2.3	Document enrollment f/u	75%	92%	647
Troubleshooting	Obj. 3.1	Conduct troubleshooting/ Problem solving for clients	2,136	42%	944
	Obj. 3.2	Conduct utilization assistance	70%	100%	718
Retention	Obj. 4.1	Conduct redetermination assistance at 11-12 mo. for clients assisted by contractor	65%	100%	857
	Obj. 4.2	Conduct redetermination assistance for those who submitted original application elsewhere	162	174%	282

HSFC Early Head Start Program

Significant Health Needs Addressed	• **Need 1** Housing & Homelessness • **Need 2** Access to Health Care • **Need 3** Mental Health • **Need 4** Chronic Diseases • **Need 5** Economic insecurity • **Need 6** Substance Use and Misuse • **Need 7** Food Insecurity • **Need 8** Education • **Need 9** Preventive Services • **Need 10** Birth Indicators
Program Description	This program is funded by a federal grant. Core services of EHS include: early childhood education (ECE); healthcare and mental health services; parenting education; childcare; adult education; and housing, legal, and financial assistance. We have put into place a continuum of home and center-based ECE services that responsively meet the individual and changing needs of young families

Population Served	Pregnant and parenting women with children aged 0-3 yr. who live in 5 mile radius of HSFC
Program Goal / Anticipated Impact	Program goals: 1. Promote children's (infant/toddler) overall development 2. Enhance the capacity of parents to nurture and care for their young children 3. Build on existing services and foster community partnerships to increase services for young children and their families 4. Expand staff knowledge, skills, and competencies in working with young children and their families Measurable objectives: Maintain full enrollment throughout the year. At least 10% of EHS children will have a disability. Goal 1: 100% of classrooms will provide quality environments that support optimal development; 70% of children who receive at least 6 mo. of services will demonstrate age-appropriate development. Goal 2: 80% of parents will acquire skills to support learning and language development; improved school/employment opportunities for 60% of working/studying parents; case management supports for all parents; 100% on-time health screens; 95% current well-child care and immunizations. Goal 3: 60% of parents will participate in leadership and civic engagement opportunities. Goal 4: 75% of teachers will hold a Bachelor's degree or will be progressing toward a BA; 100% of teachers without a degree will progress toward an Associate's degree; 100% of staff will demonstrate professional competency.
FY 2022 Report	
Activities Summary	Options currently available to families include: 1) home-based services with weekly in-home ECE, along with twice per month socialization opportunities; 2) full-year, full-day center based ECE, with monthly home visits; 3) combination option services, with daily center-based family literacy services, combined with biweekly in-home ECE; and biweekly in-home ECE, concurrent with enrollment in high-quality childcare and bimonthly visits at the childcare site. Priority EHS enrollment is given to: pregnant mom with child already enrolled in EHS; homeless families; foster children; children with special needs; parents interested in ESL or high school diploma/GED studies; and families participating in other HSFC programs. Enrollment priorities reflect 2016 HSFC EHS Community Needs Assessment data that document a high incidence of developmental disabilities and homelessness within the service area; large numbers of recent immigrant, mono-lingual Spanish-speaking young families; and low adult literacy and educational levels.
Performance / Impact	During this funding period we enrolled 100 children and 19 pregnant women. 100 children and 3 pregnant women exited the program. Exiting

reasons included the child's graduation from EHS (54%); parent unable to meet program requirements or lack of interest (19%); family relocated outside of the EHS service area (13%); family withdrew from program for various reasons, including obtaining childcare with another agency or parent securing employment or full-time studies that prevented participation (12%); and family transitioned to EHS Family Childcare Partnership (3%).
Full enrollment was not achieved during the period and multiple factors were in play: 1) licensure for our newest center, THE NEST, was not obtained until late March, delaying initial enrollment at this site until May; 2) the current county-wide teacher shortage has impeded center-based enrollment as we have not had sufficient staffing to fully enroll classrooms while maintaining required ratios; 3) worsening economic conditions have impeded home-based enrollment as fewer parents are able to participate in home visits, with both parents needing to find employment; and 4) the pandemic's sustained impact on traditional outreach methods, i.e. community gatherings/resource fairs and word-of-mouth referrals, has limited recruitment. Many community agencies that were previously referral sources - such as WIC centers, schools, and faith communities - continue to limit in-person services or are providing services virtually. Former and current parents – who have traditionally been our best referral sources – are now more socially isolated and their community connections are less frequent. Parents are less likely to be out-and- about on busses, and there is less socializing in parks and other community spaces where word-of-mouth referrals originate.

ECE centers were fully operational throughout the year and home-based services were provided in-person, unless a family member was ill. In these instances, services were provided remotely. Visits were supported by a comprehensive literacy curriculum that included books, educational toys, and "activity boxes" stocked with a variety of learning materials (colored paper, scissors, glue, crayons, markers, chalk, chalk board,, play dough, paint). Home visitors worked closely with parents to build early communication and literacy and model book-reading as more than just reading printed words. Locally designed option services (Family Literacy) were primarily remote, with weekly parent-child interactive literacy activities provided in-person at our local park. Our 4th ECE facility, THE NEST, opened this year; it's licensed for 32 children, ages 18-36 mo. and is fully ADA compliant.
We served 286 low-income, high-need families (336 children) with an average earned income of $16,361. This income is significantly lower than the average for last year ($19,803) and lower stil lthan the average for the first year of the pandemic ($16,957). 98% of enrolled children were Latino and Spanish was the primary home language in 86% of households. Maternal education varied from less than 2 yr to college completion. 35% of mothers had had 9 yr of schooling or less; 49% had not completed high school. 30% of mothers had had some college coursework and 7% had completed a bachelor's degree. EHS

participation continue to reflect community demographics, with program services reaching a very low-income population of children and families.
Goal 1 Promote Overall Development of infants and toddlers
Obj.1 70% of infants/toddlers who receive 6 mo. or more of ECE will demonstrate age-appropriate developmental skills.

Table 1 Developmental Growth: % of Students Achieving Benchmark

Infants (15-18 months) Target = Exploring Early	Approach to Learning-Regulation	Social-Emotional	Language & Literacy	Cognitive
Winter 2021 (n= 24)	66%	83%	83%	88%
Spring 2022 (n=17)	100%	94%	94%	88%
Summer 2022 (n= 26)	80%	82%	57%	65%
Toddlers (20-24 months) Target= Exploring Later				
Winter 2021 (n= 38)	43%	40%	14%	29%
Spring 2022 (n=32)	64%	51%	32%	39%
Summer 2022 (n= 32)	49%	39%	46%	33%
Older Toddlers (32- 36 months) Target= Exploring Later				
Winter 2021 (n= 34)	100%	88%	88%	94%
Spring 2022 (n=41)	100%	95%	87%	95%
Summer 2022 (n= 45)	85%	87%	78%	88%

Table 2 Development of EHS Children Over 3

Early Pre-school (37-40 months) Target= Building Early	Approach to Learning-Regulation	Social-Emotional	Language & Literacy	Cognitive	Physical	English Language Development
Winter 2021 (n=28)	70%	85%	58%	54%	60%	Exploring English 68%
Spring 2022 (n= 19)	34%	78%	57%	49%	69%	Exploring English 67%
Summer 2022 (n=22)	57%	52%	54%	42%	100%	Exploring English 60%

Obj. 2 100% of infant/toddler classrooms will provide quality environments and comprehensive ECE services that support optimal development.

Table 3 Environmental Rating Scale Mean Scores

	Space & Furnishings	Personal Care Routines	Language & Literacy	Activities	Interactions	Program Structure	Overall Rating
Spring 2021 (n=11)	6.63	6.61	6.45	5.75	6.68	6.45	6.46
Fall 2021 (n= 10)	4.45	6.43	6.27	4.92	6.33	4.64	5.51
Spring 2022 (n=11)	6.26	6.82	6.55	6.07	6.69	6.39	6.46

Overall classroom ratings for spring 2021 and spring 2022 reflect “high quality” environments. Lower fall 2021 ratings (5.51) were largely due to the impact of COVID restrictions on physical environments,

instructional practices, and routines. Higher spring 2022 scores reflect subsequent adaptations and quality improvement activities
Obj. 3 Comprehensive and continuous health, mental health, and developmental surveillance as demonstrated by 100% initial health and developmental screenings completed within 45 and 90-day requirements. 95% of ongoing well-child care and immunization requirements met. 100% of children received comprehensive hearing, vision, and sensory screenings within 45 days of enrollment; 99% of newly enrolled children had a comprehensive physical examination within 90 days of enrollment (PIR data). At the end of the program year or at their exit date, 95% of children were up-to-day with respect to age-appropriate preventative and primary health care; 95% had up-to-date immunizations.
This year we successfully served children with a variety of health concerns including prematurity, cardiac conditions, kidney disease, plagiocephaly, hydrocephaly, failure-to- thrive, VACTERL syndrome, anemia, elevated lead levels, and vision and hearing impairments
We significantly exceeded the 10% disabilities mandate, with 24% of enrolled children having either an Individual Family Services Plan (IFSP) or Individual Education Plan (IEP). Although a majority of children with special needs (60%) were diagnosed with speech and language concerns, we also served children with a range of other special needs, including children with autism and genetic and medically involved diagnosis. 71% of children with special needs were initially identified by our staff, as a result of our comprehensive monitoring and screening practices.
Goal 2 Enchance capacity of parents to nurture and care for their young children.
Obj 1 80% of parents will have acquired skills & competencies to promote their children's learning & development

Table 4 Parent Survey Question #4 - Have you received information from the program about the following:

	YES	
	Center-based Responses n=62	Home-Based Responses n=88
How children develop at different ages	100%	98%
How your child is growing and developing	100%	99%
What you can do to help your child learn and develop	100%	100%
How to find services in the community (eg parenting classes, health care,)	97%	98%
Parenting Skills	95%	100%

Obj 2 60% of center-based and 30% of home-based parents will report that program participation facilitated employment, job promotion, or increased skills acquisition.

Table 6 Parent Survey Question #6: Has the program made it easier for you to:

	2022 (Yes)	
	Center-based Responses n=62	Home-Based Responses n= 88
Accept a job	83%	31%
Keep a job	93%	32%
Accept a better job	78%	30%
Attend educational or training programs	77%	48%

Obj 3 100% of families in need of social service support and resources will receive case management referral, linkage, and advocacy support
Individualized supportive case management services were provided for all families based on family needs and identified goals. The Florida Family Assessment (FFA) was used to evaluate the impact of case management services. Family functioning was assessed within 60 days of enrollment and every six months thereafter, using a rating scale of 1 to 5, with a score of 1 indicating "crisis"; 3 indicating "stable"; and 5 indicating "thriving". Initial assessments were completed for 298 families (86% of those enrolled); assessments were completed six months later for 214 of these families (72%). Employment and financial security were identified on initial assessments as areas of greatest need, and after six months these were the areas with the greatest gains.

Table 7 2019 Pre-Post Family Assessment Scores n=214

	Post Mean Scores	Change
Employment	3.2	+.3
Financial Security	3.4	+.2
Transportation	3.9	+.1
Health	3.8	+.1
Mental Health	3.7	0
Housing	3.9	+.2
Food and Clothing	3.9	+.1

Obj 4 100% of pregnant women receive comprehensive prenatal and postpartum care, including depression screening
21 pregnant women were served during the current program year. All received prenatal care. 43% of pregnancies were considered clinically high-risk due to conditions such as thrombocytopenia (1), hypertension (1), diabetes (3), and lupus (1). 62% of women experienced pregnancy complications from conditions that included cholestasis (1), asthma (1), seizures (1), bleeding (1), anemia (1), and urinary tract infection (1). In addition, 7 women had a COVID-19 infection during pregnancy; 2 women were unsheltered. Prenatal home visits were conducted in-person throughout this funding period and included depression and mental health screenings (Edinburg Prenatal Depression Scale – EPDS and General Anxiety Disorder - GAD-7). Post-partum home visits with new mothers and infants were conducted within 10 days of delivery or according to parental preference. Visits included repeat depression and mental health screenings, newborn assessment, and support for newborn follow-up and post-partum care.
Goal 3 Build community service delivery capacity
Obj 1 40% of parents will participate in leadership and civic engagement opportunities

179 parents participated in at least one Parent Committee or Policy Council meeting. In comparison to 2021, the number of parents attending at least one Parent Committee meeting increased by nearly 50%. In addition, parents attended more often, with 55% of parents attending more than one meeting and 39% attending three or more meetings. This year's Parent Committee meetings were conducted via Zoom, and this undoubtedly helped increase participation by reducing transportation, childcare, and other barriers to in-person attendance.

Participation in program governance also was strong this year, with Policy Council attendance averaging 11 parents each meeting. Parents also participated in numerous site visits and helped conduct interviews with prospective employees. Earlier this month parents participated in a panel discussion regarding downtown transportation needs. COVID increased parent and family isolation and limited opportunities for civic engagement.

Obj 2 80% of parents express satisfaction with management and service delivery

Table 9 Parent Survey Question #2 – How satisfied are you with the overall quality of this program?

Survey Responses - 2021	Very Satisfied	Satisfied	Not Satisfied
Center-based Parents (n= 54)	85%	15%	-
Home-based Parents (n =93)	88%	12%	-
Survey Responses - 2022			
Center-based Parents (n= 62)	92%	8%	-
Home-based Parents (n =88)	88%	12%	-

Goal 4 Refine and expand staff knowledge, skills, and abilities

Obj 1 100% of teachers without a degree will demonstrate progress toward achieving an AA degree; 75% of teachers will hold a BA degree or demonstrate progress toward achieving a BA

Table 11 Teacher Qualifications

	2018 (n=38)	2019 (n=38)	2020 (n=37)	2021 (n=33)	2022 (n=36)
Master's Degree & California Department of Education Permit	1 (3%)	2 (5%)	2 (5%)	1 (3%)	2 (5%)
Bachelor's Degree & California Department of Education Permit	22 (58%)	23 (62%)	22 (60%)	21 (64%)	21 (58%)
Associate Degree & California Department of Education Permit	11 (29%)	9 (24%)	9 (24%)	8 (24%)	12 (33%)
Child Development Coursework & California Department of Education Permit	4 (11%)	4 (11%)	4 (11%)	3 (9%)	1 (2%)

Obj 2 100% of staff will participate in professional development and will demonstrate competencies in the provision of ECE, family engagement, case management services and service delivery processes.

Classroom teachers and home visiting staff participated in professional development workshops and trainings, completing a minimum of 15 hours of professional development. Monthly two-hour on-site training opportunities were offered for teachers and bi-monthly two-hour on-site training was provided for home visitors. First Aid, CPR, and Fire Safety training was provided for newly hired staff and for staff needing certification renewals. Training workshops for classroom teachers included Creative Curriculum Implementation (2-day training); Individual Differences and Positive Behavioral Supports; Family

	Violence and Support for Families; Understanding Regulation in Infants and Toddlers; and Environmental Rating Scales and High Quality Environments. Workshops for home visiting staff included Pediatric Health; Breastfeeding; Supporting Parents of Pre-term Infants: The NICU Experience; Mental Health First Aid; Phonologic Awareness; Autism; and Creative Curriculum Implementation within a Home Setting. Home visiting practices were supported by two-day Home Visit Rating Scale (HOVRS) training in June.
Hospital's Contribution / Program Expense	HSFC is housed in a customized 4 story building (30,000 sq ft.) built by the hospital; it has attached play areas for young children as well as a full-sized basketball court for older youth and teens. All services are supported by grants ($11,100,005) and philanthropy All employees are staff of CHMC. EHS grant for FY22 was $4,895,096. The EHS Child Care partnership grant was $366,200.
FY 2023 Plan	
Program Goal / Anticipated Impact	Program goals: 1. Promote children's (infant/toddler) overall development 2. Enhance the capacity of parents to nurture and care for their young children 3. Build on existing services and foster community partnerships to increase services for young children and their families 4. Expand staff knowledge, skills, and competencies in working with young children and their families Measurable objectives: Maintain full enrollment throughout the year. At least 10% of EHS children will have a disability. Goal 1: 100% of classrooms will provide quality environments that support optimal development; 70% of children who receive at least 6 mo. of services will demonstrate age-appropriate development. Goal 2: 80% of parents will acquire skills to support learning and language development; improved school/employment opportunities for 60% of working/studying parents; case management supports for all parents; 100% on-time health screens; 95% current well-child care and immunizations. Goal 3: 60% of parents will participate in leadership and civic engagement opportunities. Goal 4: 75% of teachers will hold a Bachelor's degree or will be progressing toward a BA; 100% of teachers without a degree will progress toward an Associate's degree; 100% of staff will demonstrate professional competency.
Planned Activities	No planned changes from previous year

LABBN's Perinatal and Early Childhood Home Visitation Programs	
Significant Health Needs Addressed	• **Need 2** Access to Health Care • **Need 3** Mental Health • **Need 4** Chronic Diseases • **Need 5** Economic Insecurity • **Need 6** Substance Use and Misuse • **Need 7** Food Insecurity • **Need 8** Education • **Need 9** Preventive Practices • **Need 10** Birth Indicators
Program Description	Los Angeles Best Babies Network (LABBN) is funded by First 5 LA and LACDPH. LABBN is a community benefit of CHMC where the staff is based. The staff is CHMC employees. LABBN, First 5 LA, PAC/LAC, MCH Access, and Work2Live comprise the Family Strengthening Oversite Entity (FSOE). The FSOE oversees and supports the standardization of the Welcome Baby Program to ensure adherence to program fidelity by the Welcome Baby sites across the County. The Oversight Entity also provides training and technical assistance to all home visitors, supports to the Parents as Teachers and Healthy Families America providers and support efforts to maintain referral pathways between Welcome Baby and PAT and HFA providers, as well as other existing home visitation programs throughout the County. Additional responsibilities include the provision of technical assistance to providers utilizing First 5 LA's data management information system; facilitation of cross-site peer learning exchanges; and coordination and support of communication and messaging efforts
Population Served	Pregnant and parenting women with children 0-5 who give birth at one of the 14 hospitals in LA County offering the Welcome Baby Program (WB) and living in Best Start neighborhoods.
Program Goal / Anticipated Impact	Build and strengthen the knowledge and awareness of WB and PAT and HFA staff on theory, research, and topics that will support their working with families using a strengths-based, client-centered and solution-focused approach for strengthening families Promote the development and application of skills by the WB and PAT and HFA staff that will support their work with families Provide guidance, coaching, and training to WB and PAT and HFA sites to promote implementation of the program models with fidelity. Establish a seamless integration of WB into the organizational (hospital) structure. Promote the establishment of a strong infrastructure within WB and PAT and HFA sites to ensure that program outcomes are achieved. Promote the establishment of a strong infrastructure within WB and PAT and HFA sites to sustain these family strengthening service Measurable, observable, and attainable objectives including: □ Outcomes-changes in health/mental health status, developmental

	status, attitudes, behaviors, knowledge, skills, practices, or policies Outputs-the direct result of activities and typically expressed as the number or scope of services and/or products that are delivered or produced • # staff trained/yr. • #families served/yr. Major Deliverables-tangible products that are submitted in fulfillment of contract requirements WB and PAT and HFA training, implementation, and cross-site professional development. WB and SHV technical assistance. Stronger Families Database efforts and coordination. WB and SHV evaluation and fidelity oversight. Marketing and Communication Perinatal and Early Childhood Home Visitation Consortium Regional Breastfeeding Consortium Key Partner coordination and reporting requirements
FY 2022 Report	
Activities Summary	Coordinate and implement two sets of trainings of core topics for new WB and PAT and HFA program staff in conjunction and with participation of MCHA and PAC/LAC as needed annually. Update, as needed, and distribute WB Orientation and Protocols Manuals via online links to 14 WB and all PAT and HFA programs annually. Provide training and ongoing TA to WB and PAT and HFA staff as new features are developed for the Stronger Families Database Provide leadership and oversight for database development activities Convene and facilitate one, full day, peer learning workshop within each of the four regions of LA County annually to provide opportunities for cross-site learning for WB and PAT and HFA staff. Convene one, full day, peer learning workshop for all WB programs annually and one for all PAT and HFA programs annually. Implement 2 Successful Leadership and Change Management Workshop for new WB and PAT and HFA staff annually. Provide Reflective Practice coaching sessions monthly for WB clinical supervisors and separately for PAT and HFA supervisors. Conduct annual audits of each WB and/or PAT and HFA site for model fidelity, implementation progress, and to identify any challenges and successes according to the established protocol. Coordinate with F5LA staff and all external evaluators of WB and/or PAT and HFA programs. Provide marketing and messaging templates to ensure consistent messaging across WB and PAT and HFA sites. Convene quarterly meetings of LA County Perinatal and Early Childhood Home Visitation Consortium (LACPECHVC) Plan and convene with Consortium partners' monthly workgroup meetings- Referrals, Best Practices, Advocacy, and Data, African American Home Visiting Engagement, and Father Engagement.
Performance / Impact	292 new F5LA-funded HFA & PAT enrollments in FY22 14,668 new WB hsopital enrollments in FY22 **14,960 total new families served in FY22** **Total staff trained in FY22: 500**

	WB staff: 220 HFA staff: 146 HV: 80 DPSS: 66 CHVP: 0 PAT staff: 134 HV: 55 DPSS: 56 CHVP: 23 Over 90% of clients are screened for depression within 3 mo. of child's birth for WB and HV Over 80% of WB and HV clients report receiving a HEDIS 6 wk postpartum visit, compared to 75% of Medicaid HMO receipients. 15,467 of community referrals were successfully accessed by clients; these referrals were based on client need. LABBN staff made 5 presentations at 3 national meetings including annual meeting of PAT and of HFA. Consortium members made 8 presentations at outside meetings in FY22.
Hospital's Contribution / Program Expense	FSOE is supported by a **$3,839,431** annual grant from First 5 LA. LABBN is primarily supported by this grant. LACDPH-, LACDPSS-, and CHVP-funded sites reimburse LABBN for trainings on a cost-reimbursement basis. CHMC provides office space, meeting and conference space, storage space, and access to its computer learning lab. LABBN staff is CHMC employees.
FY 2023 Plan	
Program Goal / Anticipated Impact	Build and strengthen the knowledge and awareness of WB and PAT and HFA staff on theory, research, and topics that will support their working with families using a strengths-based, client-centered and solution-focused approach for strengthening families Promote the development and application of skills by the WB and PAT and HFA staff that will support their work with families Provide guidance, coaching, and training to WB and PAT and HFA sites to promote implementation of the program models with fidelity. Establish a seamless integration of WB into the organizational (hospital) structure. Promote the establishment of a strong infrastructure within WB and PAT and HFA sites to ensure that program outcomes are achieved. Promote the establishment of a strong infrastructure within WB and PAT and HFA sites to sustain these family strengthening service Measurable, observable, and attainable objectives including: • Outcomes-changes in health/mental health status, developmental status, attitudes, behaviors, knowledge, skills, practices, or policies • Outputs-the direct result of activities and typically expressed as the number or scope of services and/or products that are delivered or produced • # staff trained/yr.

	• #families served/yr. • Major Deliverables-tangible products that are submitted in fulfillment of contract requirements WB and PAT and HFA training, implementation, and cross-site professional development. WB and SHV technical assistance. Stronger Families Database efforts and coordination. WB and SHV evaluation and fidelity oversight. Marketing and Communication Perinatal and Early Childhood Home Visitation Consortium Regional Breastfeeding Consortium Key Partner coordination and reporting requirements
Planned Activities	LABBN, First 5 LA, and Work2Live comprise the Family Strengthening Oversite Entity (FSOE). PAC/LAC and MCHA are no longer part of FSOE. Planned activities are unchanged from last year.

Health Ministry Program/ Community Health

Significant Health Needs Addressed	• **Need 2** Access to Health Care • **Need 3** Mental Health • **Need 4** Chronic Diseases • **Need 7** Food Insecurity **Need 11** Overweight and Obesity
Program Description	CHMC sponsors the Manager of Community Health, Parish Nurse, and community health promotora (CHW) at over 55 schools, churches, and community sites to provide health screenings, health education and information, and referral services. Each site selects their health education classes from a menu of choices offered annually. Health Ministry staff also participates in some local health fairs
Population Served	Low-income adults living in our service area, parents whose children attend schools in our service area, parents of children served by HSFC; overweight and obese children ages 5-12 who are referred to our HELP program and at least one parent of each child.
Program Goal / Anticipated Impact	**Health screens**: Number of individuals screened for obesity (BMI), hypertension (BP), prediabetes/diabetes (HbA1c), hyperlipidemia (cholesterol), and anemia (Hgb); number of health screening events; number and type of referrals made **Heart HELP:** • increase the proportion of adults with hypertension who meet guidelines for BMI; saturated fat consumption; sodium intake; physical activity; and smoking cessation • increase the proportion of adults with hypertension who take the prescribed medications to lower their blood pressure, increase the

	proportion of adults with hypertension whose blood pressure is under control • Increase the proportion of adults aged 20 yr and older who are aware of the symptoms of and how to respond to a heart attack or stroke **Healthy Eating Lifestyle Program**: (HELP) Reduce weight or weight velocities; BMI < 85% for age in children • Normal lipid levels (if initial screening cholesterol > 200) • Reduce % of body fat • Improve exercise tolerance • Self-reported: o Improve food selection – more "gold and silver" selections and less "bronze and brick" selection o Decrease consumption of sugar-sweetened beverages and fast food o Increased exercise frequency: goal 1 hr, at least 3 times/wk o Reduce screen time to < 2 hr/day o Improved exercise and nutrition self-efficacy **Diabetes Empowerment Education Program** (DEEP) • Reduce diabetes risk factors, including obesity and hypertension • Increase knowledge of diabetes and its risk factors • Increase self-management skills • Manage psychosocial issues • Facilitate short- and long-term behavioral change **Healthy Living aka CDSMP**: • Improve health behaviors: exercise, cognitive symptom management, and communication with physicians • Improve self-efficacy • Improve health status: fatigue, shortness of breath, pain, role function, depression, and health distress • Reduce visits to ED and hospitalizations **Question, Persuade, and Refer (QPR)**, a suicide prevention program: • Recognize the warning signs of suicide • Know how to offer hope • Know how to get help and save a life
FY 2022 Report	
Activities **Summary**	Normally we provide free health screens for common chronic conditions at Health Ministry sites and Hope Street Margolis Family Center (HSFC); Provide referrals to primary care clinics when screening tests are positive and/or if participant does not have a medical home; Participate in local health fairs as requested; Offer free workshop series in English and/or Spanish at schools, churches, and community sites, including at community clinics and HSFC, in CHMC's service area. Workshop series include: Heart HELP, H.E.L.P., DEEP, and CDSMP. Conduct health screens before and after workshop series to document impact of program participation However, due to the pandemic we were unable to offer very many health screens, participate in any health fairs, or offer any in-person workshop series. All workshop series were virtual which is sometimes a challenge for our population due to poor computer literacy, access to WiFi, and access to smart phone or computer.

Performance / Impact	**Health Screens:** 124 individuals screened; 633 total screens done; 48 referrals to medical home; 17 other referrals given**.** **Heart HELP :** 10 series in English with total of 62 enrolled; 42 completed. 23 series in Spanish with 343 enrolled and 309 completed. **CVD Awareness:** 6 classes; 12 participants **DEEP:** 1 series in English with 25 enrolled and 6 completed. 2 series in Spanish with 28 enrolled and 4 completed **Diabetes Awareness:** 3 one-on-one classes **HELP:** no classes given **CDSMP:** no classes given **Stress Management:** 11 classes given with 239 participants **Community Health Fairs:** none occurred due to pandemic **Emotional Support Group:** 11 monthly sessions conducted with 138 participants **Nutrition:** 20 classes conducted with 22 participants **Mind Matters:** 2 classes conducted with 38 participants **MHFA:** no classes given **YMHFA:** no classes given **QPR:** 6 classes given with 61 participants **Telehealth services:** provided for 601 participants
Hospital's Contribution / Program Expense	CHMC hires all staff for Health Ministry Program and provides a spacious office, office furniture, supplies, computers, printers, and testing equipment and supplies. It cost CHMC $325,445 to support the program in FY22
FY 2023 Plan	
Program Goal / Anticipated Impact	**Health screens**: Number of individuals screened for obesity (BMI), hypertension (BP), prediabetes/diabetes (HbA1c), hyperlipidemia (cholesterol), and anemia (Hgb); number of health screening events; number and type of referrals made **Heart HELP**: • increase the proportion of adults with hypertension who meet guidelines for BMI; saturated fat consumption; sodium intake; physical activity; and smoking cessation • increase the proportion of adults with hypertension who take the prescribed medications to lower their blood pressure, increase the proportion of adults with hypertension whose blood pressure is under control • Increase the proportion of adults aged 20 yr and older who are aware of the symptoms of and how to respond to a heart attack or stroke **Healthy Eating Lifestyle Program: (HELP)** Reduce weight or weight velocities; BMI < 85% for age in children • Normal lipid levels (if initial screening cholesterol > 200) • Reduce % of body fat • Improve exercise tolerance • Self-reported: o Improve food selection – more "gold and silver" selections and less "bronze and brick" selection

	o Decrease consumption of sugar-sweetened beverages and fast food o Increased exercise frequency: goal 1 hr, at least 3 times/wk o Reduce screen time to < 2 hr/day o Improved exercise and nutrition self-efficacy **Diabetes Empowerment Education Program (DEEP)** • Reduce diabetes risk factors, including obesity and hypertension • Increase knowledge of diabetes and its risk factors • Increase self-management skills • Manage psychosocial issues • Facilitate short- and long-term behavioral change **Healthy Living aka CDSMP**: • Improve health behaviors: exercise, cognitive symptom management, and communication with physicians • Improve self-efficacy • Improve health status: fatigue, shortness of breath, pain, role function, depression, and health distress • Reduce visits to ED and hospitalizations **Question, Persuade, and Refer (QPR**), a suicide prevention program: • Recognize the warning signs of suicide • Know how to offer hope • Know how to get help and save a life
Planned Activities	Recruit, hire, and train Parish Nurse. All other planned activities are the same as 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.

- In 2021, California Hospital Medical Center, Los Angeles, partnered with Homeboy Industries, the preeminent gang rehabilitation program in the U.S. which provides jobs to people with barriers to employment, to bring on a secondary electronic waste recycler for decommissioned medical equipment. Through the program, they processed eight tons of secondary e-waste, including electronics, end-of-life medical equipment, refrigerators, batteries and fluorescent lamps. Some are large items that would otherwise have ended up in the landfill.

- The above example is one of the reasons that Dignity Health - California Medical Center, recently earned the **Practice Greenhealth Emerald Award**, which recognizes the top 20 percent of award applicants and signals advanced sustainability programs and exemplary scores in a range of categories. For the seventh year in a row, California Hospital Medical Center won the Practice Greenhealth's Emerald Award.

- In addition, in 2022 CHMC won the **Green Building Award**. The Green Building category is presented to hospitals that have demonstrated LEED and other green building achievements over the past five years. These hospitals emphasize policies that show a commitment to or requirement for LEED-level construction standards for all major new builds or renovations. Achievements include energy and water efficiency, safer materials, regional sourcing, integration of nature and other mechanisms to create high-performance healing environments. CHMC was one of ten hospitals in the country that received this award

- CHMC was also recognized as a **2022 top "Best in Class" Consumer Loyalty Award** winner by NRC Health. The Consumer Loyalty Award winners "are celebrated for achieving an extraordinarily high score on NRC Health's Loyalty Index, a composite of seven different critical aspects of consumer loyalty," NRC Health said. "Healthcare organizations have their work cut out for them as the industry continues to evolve post-pandemic, which makes the progress these winning institutions have made in not only building - but sustaining - consumer loyalty all the more commendable. Our hats off to the winners and keep up the great work."

- Fortune/Merative named CHMC to **100 Top Teaching Hospitals in U.S**. as a result of better clinical and operational performance indicators, including survival rates, patient complications, healthcare-associated infections, mortality, and readmission rates. This honor is a reflection of the hospital's outstanding Residency Program that helps ensure tomorrow's medical professionals have all the tools and knowledge needed to deliver excellent, high-quality care.

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

Economic Value of Community Benefit

9/29/2022					
306 California Hospital Medical Center					
Complete Summary - Classified Including Non Community Benefit (Medicare)					
For period from 7/1/2021 through 6/30/2022					
	Persons	**Expense**	**Offsetting Revenue**	**Net Benefit**	**% of Expenses**
Benefits For Poor					
Financial Assistance	**13,475**	**23,369,043**	**0**	**23,369,043**	**4.5%**
Medicaid	**70,243**	**314,438,737**	**162,419,174**	**152,019,563**	**29.1%**
Community Services					
A - Community Health Improvement Services	63,406	24,038,343	20,675,009	3,363,334	0.6%
C - Subsidized Health Services	0	76,634	0	76,634	0.0%
E - Cash and In-Kind Contributions	2	573,571	0	573,571	0.1%
G - Community Benefit Operations	0	819,454	0	819,454	0.2%
Totals for Community Services	**63,408**	**25,508,002**	**20,675,009**	**4,832,993**	**0.9%**
Totals for Poor	**147,126**	**363,315,782**	**183,094,183**	**180,221,599**	**34.6%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	1,783	599,683	123,366	476,317	0.1%
B - Health Professions Education	99	8,919,460	1,886,057	7,033,403	1.3%
C - Subsidized Health Services	6,484	4,848,404	4,132,900	715,504	0.1%
E - Cash and In-Kind Contributions	0	33,916	0	33,916	0.0%
F - Community Building Activities	0	13,703	0	13,703	0.0%
G - Community Benefit Operations	0	11,250	0	11,250	0.0%
Totals for Community Services	**8,366**	**14,426,416**	**6,142,323**	**8,284,093**	**1.6%**
Totals for Broader Community	**8,366**	**14,426,416**	**6,142,323**	**8,284,093**	**1.6%**
Totals - Community Benefit	**155,492**	**377,742,198**	**189,236,506**	**188,505,692**	**36.1%**
Medicare	**4,635**	**17,711,986**	**9,279,765**	**8,432,221**	**1.6%**
Totals with Medicare	**160,127**	**395,454,184**	**198,516,271**	**196,937,913**	**37.8%**

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 & Chair
Communications and Conveyance Committee

Gudata S. Hinika, M.D.
Medical Director
CHMC Trauma Program

Linda G. Lopez
CEO
Impact Strategies

Patricia Lott — Quality & Medical Staff Relations Subcommittee, Chair
Realtor
Coldwell Banker Realty

Ralph Mayer, M.D.
Chief of Medical Staff
Ex-officio – Voting Member

Alina Moran
President
California Hospital Medical Center
Ex-officio – Voting Member

Sarah Scher
CEO
Cooperative of American Physicians

Russana Rowles
Retired