St. Mary Medical Center

Community Benefit 2024 Report and 2025 Plan

Adopted November 2024

Dignity Health.
St. Mary Medical Center

Dignity Health
St. Mary Medical Center

A message from

Carolyn Caldwell, President, and Dr. Felton Williams Chair of the Dignity Health St. Mary Medical Center Community Board.

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

St. Mary Medical Center shares a commitment with others to improve the health of our community and promote health equity, and delivers programs and services to help achieve that goal. The Community Benefit 2024 Report and 2025 Plan describes much of this work. This report meets requirements in California (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. 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 2024 (FY24), St. Mary Medical Center provided **$52,463,615** in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred **$7,480,620** in unreimbursed costs of caring for patients covered by Medicare fee-for-service.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2024 Report and 2025 Plan at its October 24, 2024 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 the Community Health Department at 562-491-4840.

Carolyn Caldwell, FACHE
President

Dr. Felton Williams
Chairperson, Board of Directors

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At-a-Glance Summary

Hospital HCAI ID: 106190053

Report Period Start Date: July 1, 2023

Report Period End Date: June 30, 2024

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

Community Served	Dignity Health St. Mary Medical Center serves the cities of Long Beach and Bellflower in Los Angeles County. Long Beach is the seventh most populated city in California with a total population of 528,729. The hospital service area is located in Service Planning Area (SPA) 8 in Los Angeles County, which is shared with the City of Long Beach Department of Health and Human Services, Long Beach Memorial Medical Center, Millers Children's and Women's Hospital, The Children's Clinic "Serving Children and Their Families" dba TCC Family Health and Kaiser Permanente of South Bay.
Economic Value of Community Benefit	**$52,463,615** in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits **$7,480,620** in unreimbursed costs of caring for patients covered by Medicare fee-for-service. The hospital's net community benefit expenses for services to vulnerable populations and to the broader community are listed by category in the Economic Value of Community Benefit section of this report.
Significant Community Health Needs Being Addressed	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are: • Access to healthcare services • Housing and homelessness • Mental health • Preventive practices • Violence and injury prevention

FY24 Programs and Services

The hospital delivered several programs and services to help address identified significant community health needs. These included:

Access to Healthcare
CalAIM
CARE Program
Community Care Hubs
Community Health Improvement Grants Program
Financial Assistance
Families in Good Health
Low Vision Center

Housing and Homelessness
Community Grants Program

Mental Health
CARE Program
Community Health Improvement Grants Program
Mental Health First Aid program

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

Violence and Injury Prevention
Community Health Improvement Grants Program
Families in Good Health
Violence and Human Trafficking Prevention and Response Team

FY25 Planned Programs and Services

Access to Healthcare
CalAIM
CARE Program
Community Care Hubs
Community Health Improvement Grants Program
Financial Assistance
Families in Good Health
Low Vision Center

Housing and Homelessness
Community Health Improvement Grants Program

Mental Health
CARE Program
Community Health Improvement Grants Program
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Violence and Injury Prevention
Community Health Improvement Grants Program
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Violence and Human Trafficking Prevention and Response Team

This document is publicly available online at:
https://www.dignityhealth.org/socal/locations/stmarymedical/about-us/community-benefits
Written comments on this report can be submitted to the St. Mary Medical Center Community Health Office, 1050 Linden Avenue, Long Beach, CA 90813. To send comments or questions about this report, please email Kit Katz, Director, Community Health at Kit.Katz@CommonSpirit.org

Our Hospital and the Community Served

About St. Mary Medical Center

St. Mary Medical Center is a member of Dignity Health, which is a part of CommonSpirit Health. Located at 1050 Linden Avenue, Long Beach, CA 90813, St. Mary Medical Center was founded in 1923 by the Sisters of Charity of the Incarnate Word. The facility has 389 licensed beds. Major programs and services include: cardiac care, prenatal and childbirth services, families and seniors, bariatric surgery, stroke recovery, critical care, a 39-bed intensive care unit, a level IIIB NICU with 25 beds and a Disaster Resource Center. The hospital's Emergency Department is a level II trauma center and the Paramedic Base Station for the area. St. Mary Medical Center is a designated Baby-Friendly® hospital. We are also a Certified Advanced Primary Stroke Center and an LA County-designated STEMI Receiving Center. The CARE Clinic is a Pre-Exposure Prophylaxis (PrEP) Center of Excellence, which helps meet the needs of those affected or at risk of HIV in our community through treatment, education and

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

St. Mary Medical Center is located in Long Beach, California and is a city within Los Angeles County. Long Beach is the 36th largest city in the nation, the seventh largest city in California and is the second largest city within the greater Los Angeles area. It is home to approximately 500,000 people and one of the most ethnically diverse communities in the United

States with a strong sense of community and unique neighborhoods. Long Beach is known for large Cambodian, Hispanic/Latino and Black/African American communities and a growing population of adults 65 and older.

While a few of the communities enjoy a higher standard of living, the majority of the communities served have greater needs. St. Mary Medical Center serves 12 ZIP Codes in 2 cities, 11 of which are located in the City of Long Beach. To determine the service area, St. Mary Medical Center takes into account zip codes that are based on the top 75-80% of discharges.

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

Total population	528,729
Race	
Asian/Pacific Islander	10.9%
Black/African American – Non-Hispanic	12.0%
Hispanic or Latino	54.3%
White Non-Hispanic	18.3%
All others	4.4%
% below poverty level	13.1%
Unemployment	5.8%
No high school diploma	25.0%
Medicaid	34.4%
Uninsured	9.0%

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. The hospital makes the CHNA report widely available to the public at: https://www.dignityhealth.org/socal/locations/stmarymedical/about-us/community-benefits, and upon request from the hospital's Community Health office.

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.

Community Groups that Attended or Engaged in the CHNA:
- Long Beach CHNA Collaborative
- Long Beach Forward

Vulnerable Populations Represented by These Groups
- Racial and ethnic groups experiencing disparate health conditions, including Black/African American, American Indian, Alaska Native, Asian Indian, Cambodian, Chinese, Filipino, Hmong, Japanese, Korean, Laotian, Vietnamese, Native Hawaiian, Guamanian or Chamorro, Samoan, or other non-white racial groups as well as individuals of Hispanic/Latino origin, including Mexicans, Mexican Americans, Chicanos, Salvadorans, Guatemalans, Cubans, and Puerto Ricans.
- Socially disadvantaged groups, including the following:
  - The unhoused
  - Communities with inadequate access to clean air and safe drinking water, as defined by an environmental California Healthy Places Index score of 50% or lower.
  - People with disabilities
  - People identifying as lesbian gay, bisexual, transgender or queer
  - Individuals with limited English proficiency

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, specialty care, vision care and dental care services. Health insurance coverage is considered a key component to ensure access to health care. Barriers to care can include lack of transportation, language and cultural issues.	Yes
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.	Yes
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	

Significant Health Need	Description	Intend to Address?
	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.	Yes
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.	Yes
Mental health	*Mental health* includes our emotional, psychological, and social well-being. It affects how we think, feel, and act.	Yes
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.	
Pregnancy and birth outcomes	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.	
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.	Yes
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.	
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.	Yes

* These significant needs will be addressed within the scope of the Preventive Practices need.

Significant Needs the Hospital Does Not Intend to Address

Taking existing hospital and community resources into consideration, St. Mary Medical Center will not directly address economic insecurity, education, overweight and obesity, pregnancy and birth outcomes, and substance use as priority health needs. Knowing that there are not sufficient resources to address all the community health needs, St. Mary Medical Center chose to concentrate on those health needs that can most effectively be addressed given the organization's areas of focus and expertise. The hospital has insufficient resources to effectively address all the identified needs and, in some cases, the needs are currently addressed by others in the community.

2024 Report and 2025 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 FY24 and planned activities for FY25, 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 hospital leaders and the Community Health Advisory Committee to examine the identified health needs according to these criteria. The CHNA served as the resource document for the review of health needs as it provided statistical data on the severity of issues and also included community input on the health needs. As well, the community prioritization of the needs was taken into consideration.

Community input or contributions to this community benefit plan included community focus groups. A focus group consists of residents of the St. Mary service area as well as other community stakeholders who may provide programs and/or services.

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

- The programs and initiatives described here were selected on the basis of 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 issues. Staff time and financial resources for this issue are counted as part of our community benefit effort.
- Focus Area: The hospital as acknowledged competencies and expertise to address the issue and the issue fits with the organizational mission.

Community Health Core Strategies

Driven by a commitment to equity and social justice, we envision a future where health and well-being are attainable by all regardless of background or circumstance.

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 three core strategies for community health improvement activities. These strategies help to ensure that program activities overall address strategic aims while meeting locally-identified needs.

- Extend the care continuum by aligning and integrating clinical and community-based interventions.
- Strengthen community capacity to achieve equitable health and well-being.
- Implement and sustain evidence-based health improvement program initiatives.

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: Access to Health Care

Strategy or Program	Summary Description	Active FY24	Planned FY25
Bazzeni Wellness Center/Mobile Unit	• No cost health education and health screenings.	X	X
CARE Center	• HIV medical and dental services • Psychosocial services • PrEP	X	X

Every Woman Counts	Mammography services and breast care for low income women.	X	X
Families in Good Health (FiGH)	• Cover California • Welcome Baby Program • Public benefit navigation	X	X
Low Vision Center	• Provides no cost vision screening, optical aids, education and referrals for persons with limited vision	X	X
Mary Hilton Family Clinic	• OB and perinatal services to low income women	X	X

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, the Welcome Baby Program, community-based organizations, the LGBTQ Center, schools and school districts, faith groups, public health and city agencies.

Health Need: Food Insecurities *

Strategy or Program	Summary Description	Active FY24	Planned FY25
Community Health Improvement Grants Program	• Offers grants to nonprofit community organizations that provide access to food for those in need (examples: food banks, medically tailored home delivered meals.)	X	X

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

Collaborators: The hospital will collaborate with food banks and meal service providers.
*For FY25, this health need will be combined with preventive practices

Health Need: Housing and Homelessness

Strategy or Program	Summary Description	Active FY24	Planned FY25
Community Health Improvement 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 and homelessness are anticipated to result in: improved health care delivery to persons experiencing homelessness and increased access to community-based services for persons experiencing homelessness.

Collaborators: Key partners include: housing developers, city agencies, funders, faith community, community clinics, community-based organizations, and housing agencies.

Health Need: Mental Health

Strategy or Program	Summary Description	Active FY24	Planned FY25
CARE (Comprehensive AIDS Resource and Education) Program	• HIV medical and dental services • Psychosocial services • PrEP	☒	☒
Community Health Improvement Grants Program	Offers grants to nonprofit community organizations that provide mental health programs and services.	x	x
Mental Health America of Los Angeles	Provides comprehensive mental health services using a one-stop integrated model. St. Mary funds an LCSW who is assigned to the ED to provide social services to low income and homeless individuals who are frequent users of the ED.	x	X

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

Collaborators: Key partners include: schools and school districts, community-based organizations, the UniHealth Foundation, Dignity Health Southern California Hospitals, law enforcement, and regional collaboratives that seek to support mental health and case management needs.

Health Need: Preventive Practices
(Including Chronic Disease, COVID-19 Prevention and Food Insecurity)

Strategy or Program	Summary Description	Active FY24	Planned FY25
CARE (Comprehensive AIDS Resource and Education) Program	• HIV medical and dental services • Psychosocial services • PrEP	☒	☒
Community Health Improvement Grants Program	Offers grants to nonprofit community organizations that provide preventive practices programs.	x	x
Every Woman Counts	Mammography services and breast care for low income women.	x	x
Families in Good Health (FiGH)	• Provide education at community events • Provide PPE and at-home tests to clients • Make appointments for community members to get COVID-19 vaccines. • Provide COVID-19 workshops in English, Spanish and Khmer • Offer disease management programs	x	x
Food Systems Advisory Committee	Participate in CommonSpirit system wide committee to address food insecurity issues in the community, including reducing barriers to accessing healthy food.	x	x
Mobile Care Unit	The mobile van provides health care screenings, education and outreach to communities at high-risk of negative health outcomes.	x	x
The Salvation Army	Local food bank for homeless and low income families. TSA provides food boxes for low income families.	☒	☒

Goal and Impact: The hospital's initiatives to address prevention are anticipated to result in: increased access to preventive care services in the community, increased identification and treatment of chronic diseases, and increased compliance with preventive care and disease prevention recommendations (screenings, vaccines, and life style and behavior changes).

Collaborators: Key partners include: public health, youth organizations, faith community, LGBTQ community, community clinics, senior centers and community-based organizations.

Health Need: Violence and Injury Prevention

Strategy or Program	Summary Description	Active FY24	Planned FY25
Community Health Improvement Grants Program	Offers grants to nonprofit community organizations that provide mental health programs and services.	☒	☒
Families in Good Health (FiGH)	Will explore ways to provide community outreach and education to address violence and injury prevention.	X	x
Violence and Human Trafficking Prevention and Response Team	Provides education to assist providers and staff to identify patients who may be impacted by abuse, neglect, or violence, including human trafficking.	☒	☒

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

Collaborators: Key partners include: schools and school districts, community-based organizations, law enforcement, and regional and local collaboratives.

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 FY24, the hospital awarded the grants below totaling $199,594. The figures below represent grant awards that the hospital made in conjunction with. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Health Needs Addressed	Amount
Century Villages at Cabrillo	Pathways to Health – Phase 4	Food Insecurities Housing and Homelessness Mental Health	$ 74,797
Precious Lambs Preschool	Trauma Informed Care	Food Insecurities Housing and Homelessness Mental Health	$ 50,000
Mental Health America of Los Angeles	HealthLink Project	Housing and Homeless Mental Health	$ 74,797

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.

CARE Center	
Significant Health Needs Addressed	❑ Access to health services-- HIV testing, HIV treatment, STD testing and treatment, HCV testing and treatment ❑ Food insecurity—CARE Food Pantry, homeless emergency food and personal necessities program ❑ Behavioral health—Counseling provided by LCSWs specializing in LGBTQ and HIV-related issues ❑ Preventive practices—HIV testing, HIV Biomedical Prevention (PrEP & PEP), and HIV Treatment as Prevention (TasP).
Program Description	The CARE program is a multidisciplinary HIV care and support project, based on the campus of St. Mary Medical Center. Clients of the CARE program receive integrated high quality medical, dental, health, and psychosocial services to a heavily impacted population of low-income men, women, and children living with HIV and for those at high risk for acquiring HIV.
Population Served	The program serves individuals who are infected with HIV or who are at high risk of acquiring HIV. This includes uninsured or underinsured men who have sex with men, transgender persons, homeless individuals, those with behavioral health & substance use disorders, persons of color, seniors, young adults and people facing food insecurity.

Program Goal / Anticipated Impact	The program's goal is to continue emphasis on supporting clients' 1. Retention in HIV care and PrEP care 2. Achieving and maintaining ongoing viral suppression for those who are infected with HIV. 3. Starting high risk individuals on PEP and PrEP. 4. Provide individual and group behavioral health therapy to those in need 6. Provide nutritional support to clients with food insecurity.
FY 2024 Report	
Activities Summary	• Provided a comprehensive, "one-stop shop" for HIV medical and support services. • Clinical staff provided intensive follow-up for patients who missed appointments, or were otherwise at risk for falling out of care. • Provided opt-out HIV testing to high risk ED patients. • Provided free, walk-in STD testing at CARE Clinic. • Provided PEP on demand in ED and in CARE Clinic to patients with a high risk exposure to HIV in the past 72 hours. • Provided PrEP to HIV negative patients at high risk for HIV infection. • Provided behavioral health therapy and referrals to those in need. • Provided food assistance to those with food insecurity.
Performance / Impact	• 85% of CARE patients were 'retained in care' in FY24. This is defined based on the standard of at least one HIV medical care visit in each 6 month period of a 12 month measurement period. This indicator decreased 2% compared to FY23. • 94% of CARE patients maintained complete HIV viral suppression in FY24. This indicator decreased slightly by 1% compared to previous year. • There were a total of 753 biomedical prevention and STI patient visits in FY24. This represents a 5% decrease compared to FY23. • In FY24, there were a total of 1,205 behavioral health visits provided. Overall, this represents a 16% increase compared to FY23. • In FY24, 2188 food allotments were distributed to food pantry clients. This represents a 1% increase compared to FY23. • In FY24, there were approximately 575 emergency food bags distributed to the community. This represents a 5% increase compared to FY23. • In June 2024 there were a total of 135 patients on Long-Acting Injectable therapy (q every 2 months) for HIV treatment and prevention, eliminating the need to take pills daily. In June 2023 there were 102 patients on LAIs. This represents a 24% increase.
Hospital's Contribution / Program Expense	CARE committed a total of approximately 14.5 FTEs to ED testing, biomedical prevention services, long-acting antiretroviral therapy administration, patient retention/linkage to care, nutritional services, and

	behavioral health services. Current grant funding to covers approximately 9.75 FTEs, with a gap of 4.75 FTEs.
FY 2025 Plan	
Program Goal / Anticipated Impact	The program's goal is to continue emphasis on supporting clients' 1. Retention in HIV care and PrEP care 2. Achieving and maintaining ongoing viral suppression for those who are infected with HIV. 3. Testing of those who are at high risk for HIV and other STDs. 4. Starting high risk individuals on PEP and PrEP. 5. Provide individual and group behavioral health therapy to those in need 6. Provide nutritional support to clients with food insecurity 7. CARE will continue to offer long-acting injectable antiretroviral therapy to patients as an alternative to daily oral medications. ● 90% of CARE patients will be 'retained in care' for FY25. This is defined based on the standard of at least one HIV medical care visit in each 6 month period of a 12 month measurement period. ● 97% of CARE patients will achieve and maintain complete HIV viral suppression. ● Increase the total number of biomedical prevention (PrEP and PEP) visits to 950 in FY25. ● Provide 1,300 behavioral health visits for individual and group therapy. ● Distribute 2,300 allotments of food through CARE food pantry. ● Increase the total number of patients receiving long-acting injectable antiretroviral therapy to 200.
Planned Activities	The principal program activities for FY 2025 will match those of FY 2024, with a focus on transitioning more HIV positive and negative patients to long-acting injectable medications. These activities will enhance patients' quality of life, and reduce transmission of HIV in our community.

Families in Good Health	
Significant Health Needs Addressed	● Health care access ● Mental Health ● Preventive practices ● Violence and injury prevention ● Pregnancy and birth outcomes
Program Description	FiGH is committed to providing outreach and education to vulnerable populations in Long Beach. FiGH provides healthy relationship workshops, youth advocacy, home visitations, benefits enrollment, prevention & intervention, and outreach. Welcome Baby Program, Healthy Families America,

	Parenting workshops, and disease management programs. Workshops are held in English, Khmer, and Spanish.
Population Served	Families in Good Health is a multilingual, multicultural health and social education program for the Southeast Asian, Latino, and other communities in Long Beach. Its mission is to help the community make informed choices and gain access needed health and social resources.
Program Goal / Anticipated Impact	• EM3 (Educated Men with Meaningful Messages) is an advocacy and health education program for youth ages 14-19. The program offers culturally competent mentoring, career exploration, cultural activities, community engagement, leadership training, and workshops on healthy relationships. EM3 also focuses on advocacy and policy change by amplifying youth stories on violence, language access, access to healthy nutrition, and mental health. Over the years, the program has provided guidance and direction to thousands of at-risk multi-ethnic youth. • Families in Good Health implements a Community Wellness Program that provides culturally appropriate resources. The Community Wellness Program promotes wellness in the Long Beach Asian Pacific Islander community by prevention and intervention services that culturally sensitive and in their native language. CWP conducts workshops on physical and mental health, support groups, and wellness activities. • Families in Good Health implements a Parenting with Nonviolence workshops with Cambodian older adults addressing and preventing violence within the home. The program equips Cambodians parents/caregivers with strategies to address the negative impact of violence, adverse childhood experiences, and their root causes stemming from gender inequity and limited empathy, through "parenting with nonviolence" philosophy and practices. • Welcome Baby Program is a free, voluntary home visitation program for expectant parents and parents with newborns. Our parent-coaches provide prenatal and postnatal education, and guidance on post-partum care, infant development milestones. • Healthy Families America is a home visiting program that works with expectant mothers through pregnancy, continuing up to five years after the baby's birth. Family Support Specialists provide education and support in the home.
FY 2024 Report	
Activities Summary	• Provided Asian Pacific Islanders (API) Stop The Hate workshops/trainings • Provided home visitation for newborns • Provided a college tour and financial literacy for EM3 Youth • Provided a Khmer monthly workshops on Mental Health • Provided Khmer Walking Group to promote physical activity • Provided parenting workshops • Provided enrollment, referrals, linkages, and navigation for Cambodian older adults for healthcare access • Provided spiritual activities • Provided 600 case management

	• Provided outreach and education on COVID vaccines, flu shots, and benefits enrollment programs • Provided peer-led and family support groups • To promote positive mental and physical health practices among youth and older adults • To prepare youth for college and entry into the workforce
Performance / Impact	• 85% of Welcome Baby participants receive home safety and security information by the 9 month home visit • 95% rate for Medi-Cal eligible infants received health insurance by the 2-month visit. • 59% of WB hospital visits, 13% of RN visits, 9% of Parent Coaches visits involved father/partner • 75% of enrolled HFA clients received at least 75% of the appropriate number of home visits • 80% HFA referrals were provided within one month • 80% of HFA participants received the one-month home visit • 99% for WB of target children are up-to-date with immunizations at 9 month visits • 90% for HFA of target children are up-to-date with immunizations at 9 month visits • 100% youth graduated from High School • 100% of EM3 high school graduates have enrolled in a 4-year universities • 100% of EM3 youth said that the program prepared them for a better future • 80% of Cambodian older adults improved mental health knowledge, beliefs, and attitudes • 75% of Cambodian older adults increased in social connectedness • 85% of Cambodian older adults increased in health promoting behaviors • 92% of Cambodian older adults increased in healthcare access and utilization
Hospital's Contribution / Program Expense	FiGH committed 25 FTEs to home visitation, outreach, education, and referrals. In addition, 5 FTEs to youth development, Cambodian older adults, prevention & intervention, social support groups, and case management.
FY 2025 Plan	
Program Goal / Anticipated Impact	To collaborate and partner with organizations on relevant advocacy efforts and policy changes that empower the family system and those residing in the community. Provide education, workshops and resources to the populations served by FiGH.
Planned Activities	• To prepare and empower the mother before and after labor • To promote infant and child development • To promote health care coverage and support individuals in navigating and utilizing preventive and treatment services • To provide education and resources to empower individuals in self-managing their health • To stimulate systems changes that support healthy lifestyles through infrastructure change or policy change

	• To promote the leadership capacity of youth • To promote positive mental and physical health practices among youth and older adults • To prepare youth for college and entry into the workforce

	**Every Woman Counts**
Significant Health Needs Addressed	• Access to health services • Preventative practices
Program Description	In partnership with community healthcare providers, we were able to offer mammography screening services to women aged 40+ and diagnostic mammography services to men and women of any age through the Every Woman Counts Program, for those who qualify. In addition to diagnostic services, assistance is offered to patients with positive cancer findings by enrollment into the Breast and Cervical Cancer Treatment Program and coordination of care by our staff RN.
Population Served	Low/no income, uninsured/underinsured women age 40 and older for screening mammograms. Low/no income, uninsured/underinsured women and men of all ages for diagnostic breast care imaging services.
Program Goal / Anticipated Impact	Increase awareness regarding the importance of preventative screenings for breast cancer and programs available to all who qualify.
FY 2024 Report	
Activities Summary	Collaborated with California Collaborative, Cancer Support Community South Bay and community physicians to offer an educational workshop for breast care on site.
Performance / Impact	3435 patients were evaluated under the Every Woman Counts program. Using our electronic tracking system, we were able to follow the patient throughout the cycle of breast care.
Hospital's Contribution / Program Expense	St. Mary Medical Center provides assistance with enrollment into the Every Woman Counts Program. A registered nurse offers a continuum of care throughout the patient's entire case.
FY 2025 Plan	
Program Goal / Anticipated Impact	We will continue to work with healthcare providers and community advocates to increase awareness regarding the importance of preventative screenings for breast cancer
Planned Activities	Collaborative efforts with California Collaborative, American Cancer Society, various breast cancer support groups as well as with the community healthcare providers to hold educational gatherings on/off campus.

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.

Work Place Violence
A schedule of available WPV training was established in collaboration with the education department for the remainder of the year with the goal to have all assigned staff complete the two hour WPV training before the holidays.

Disaster Resource Center and Trauma Education
Pedestrian Safety
Stop the Bleed
Disaster and evacuation drills

Replate Impact
42 million people in the US experience food insecurity. Donating surplus food to Replate, helps reduce the glaring environmental, social and economic issue of food waste. 5,605 pounds of food were donated, supplying 4,671 meals.

Economic Value of Community Benefit

The economic value of all community benefit is reported at cost. Patient financial assistance (charity care) reported here is as reported to the Department of Health Care Access and Information in Hospital Annual Financial Disclosure Reports, as required by Assembly Bill 204. The community benefit of financial assistance, Medicaid, other means-tested programs and Medicare is calculated using a cost-to-charge ratio to determine costs, minus revenue received for providing that care. Other net community benefit expenses are calculated using a cost accounting methodology. Restricted offsetting revenue for a given activity, where applicable, is subtracted from total expenses to determine net benefit in dollars.

332 St. Mary Medical Center (Long Beach)					
Complete Summary - Classified (Programs) Including Non Community Benefit (Medicare)					
For period from 07/01/2023 through 06/30/2024					
	Persons	Expense	Offsetting Revenue	Net Benefit	% of Expenses
Benefits for Poor					
Financial Assistance	2,803	$13,759,842	$0	$13,759,842	2.9%
Medicaid	59,751	$235,431,245	$220,503,837	$14,927,408	3.2%
Community Services					
A - Community Health Improvement Services	27,361	$5,190,120	$3,501,588	$1,688,532	0.4%
C - Subsidized Health Services	10,386	$15,402,886	$6,287,366	$9,115,520	1.9%
E - Cash and In-Kind Contributions	46	$1,141,765	$0	$1,141,765	0.2%
G - Community Benefit Operations		$240,655	$153,669	$86,986	0.0%
Totals for Community Services	37,793	$21,975,426	$9,942,623	$12,032,803	2.6%
Totals for Benefits for Poor	100,347	$271,166,513	$230,446,460	$40,720,053	8.7%
Benefits for Broader Community					
Community Services					
B - Health Professions Education	417	$13,057,120	$1,519,595	$11,537,525	2.5%
F - Community Building Activities		$557,899	$351,862	$206,037	0.0%
Totals for Community Services	417	$13,615,019	$1,871,457	$11,743,562	2.5%
Totals for Broader Community	417	$13,615,019	$1,871,457	$11,743,562	2.5%
Totals - Community Benefit	100,764	$284,781,532	$232,317,917	$52,463,615	11.2%
Medicare	8,345	$46,747,184	$39,266,564	$7,480,620	1.6%
Totals Including Medicare	109,109	$331,528,716	$271,584,481	$59,944,235	12.8%

*For the Medicaid provider fee program effective for the two-year period of January 1, 2023 - December 31, 2024, the State of California received Centers for Medicare & Medicaid Services approval in December 2023. As such, during the fiscal year July 1, 2023 - June 30, 2024, the hospital recognized provider fee net income of $53,915,915 covering 18 months dating back to January 2023. Subtracting the six months of net provider fee attributable to the prior fiscal year, FY24 Medicaid net benefit would be $32,561,779 and total community benefit including Medicare would be $77,578,606.

Hospital Board and Committee Rosters

Hospital Community Board
Roster 2024

Ali Jamehdor, M.D. Emergency Room Physician, St. Mary Medical Center	Arlene Vernon, M.D. – **Chief of Staff** Emergency Room physician, St. Mary Medical Center	Carolyn Caldwell, President/CEO St. Mary Medical Center
Chester Choi, MD GME/Residents Program St. Mary Medical Center	Chris Steinhauser Retires, Superintendent Long Beach Unified School district	Cynthia Chao, D.O. Private Practice Physician
Felton Williams, Ph.D **- Chair** Retired Board President Long Beach Unified School District	Gina Maguire Long Beach Board of Water Commissioners	Gloria Willingham, Ph.D – **Vice Chair** Chair, Goddard College Board of Trustees
John Arens Financial Planner Balboa Financial Services	John Javien, M.D. Cardiologist, St. Mary Medical Center	Lisa Lighthall Haubert, MPT, DPT, KEMG Board Certified Kinesiologist, California State University Long Beach
Robina Smith, M.D. General Surgeon	Sandy Cajas President, Hispanic Chamber of Commerce	Sharifa Batts, DBA Long Beach City Equity and Human Relations Commissioner
Sr. Mary Kieffer Dominican Sisters	Sunny Zia Long Beach Community College District Trustee	Vattana Peong **- Secretary** Executive Director, The Cambodian Family Community Center
Community Board Coordinator **Kristy Valle** **(o) 562-491-9080** **(c) 310-210-6720** **Kristine.valle@commonspirit.org**		

Community Health Advisory Committee Members – a subcommittee of the Community Board

Community Board representatives:

- Vattana Peong – Executive Director, The Cambodian Community Center
- Sandy Cajas - President, Regional Hispanic Chamber of Commerce

Community members:

- Sofia Hodjat – Department of Health Services Healthy Aging Coordinator
- Anette Alvarez – American Gold Star Manor Resident Services Program and Events Director
- Bill Cruikshank – Executive Director Meals on Wheels of Long Beach
- Jonathan de Armas – Island Pitch LLC, Owner/Chief Solutions Architect
- Wayne Chaney – Long Beach Fire Department Station #8
- Gregory Sanders – Lead Pastor of the Rock Christian Fellowship and Present of the Long Beach Ministries Alliance
- Genevieve Brill Murphy – Owner Heavenly Home Care, Inc.
- Jewell Baraka – Survivor Advocate Journey Out

Staff:

- Kit G. Katz – Chair – St. Mary Director of Community Health
- Rose Wright – St. Mary Foundation Director of Grants
- Rev. Stan Kim – St. Mary Director of Mission Integration
- Kim Hurley – CSH System Director Clinical Behavioral Health Equity