St. Mary Medical Center

Hospital HCAI ID: 106190053

Community Benefit 2025 Report and 2026 Plan

Adopted October 2025

Dignity Health
St. Mary Medical Center
A member of CommonSpirit

A message from

Carolyn Caldwell, President of the Dignity Health St. Mary Medical Center Hospital.

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 2025 Report and 2026 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 2025 (FY25), St. Mary Medical Center provided $94,657,561 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $7,037,523 in unreimbursed costs of caring for patients covered by Medicare fee-for-service, not including Medicare reported as a part of Graduate Medical Education.

The hospital's board reviewed, approved and adopted the Community Benefit 2025 Report and 2026 Plan at its October 2025 meeting.

Thank you for taking the time to review this report and plan. We welcome any questions or comments, which can be submitted using the contact information in the At-a-Glance section of this report.

Carolyn Caldwell, FACHE
Hospital President and CEO

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At-a-Glance Summary

Hospital HCAI ID: 106190053

Report Period Start Date: July 1, 2024 **Report Period End Date**: June 30, 2025

Community Served	Dignity Health St. Mary Medical Center serves the greater Long Beach area including the cities of Compton, Long Beach, Paramount and Wilmington in Los Angeles County.The population of the service area is 681,24 The hospital service area is located in Service Planning Areas (SPAs) 6 and 8 in Los Angeles County.
Economic Value of Community Benefit	$94,657,561 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $7,037,523 in unreimbursed costs of caring for patients covered by Medicare fee-for-service, not including Medicare reported as a part of Graduate Medical Education 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 Care • Chronic Disease • Housing and Homelessness • Mental Health • Prevention
FY25 Programs and Services	The hospital delivered several programs and services to help address identified significant community health needs. These included: • Bazzeni Wellness Center • CARE Program • Community Health Improvement Grants program • Every Woman Counts • Families in Good Health • Financial assistance for medically necessary care • Food Systems Advisory Committee • Mobile Care Unit

FY26 Planned Programs and Services

- Bazzeni Wellness Center
- CARE Program
- Community Health Improvement Grants program
- Every Woman Counts
- Families in Good Health
- Financial assistance for medically necessary care
- Food Systems Advisory Committee
- Mobile Care Unit

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

Written comments on this report can be submitted to the St. Mary Medical Center Community Health Office, 1050 Linden Avenue, Long Beach, CA 90813 or by e-mail to Kit.Katz@Commonspirit.org.

Our Hospital and the Community Served

About St. Mary Medical Center

St. Mary Medical Center is a Dignity Health hospital. Dignity Health is a member of CommonSpirit Health.

St. Mary Medical Center:

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

Our Mission

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

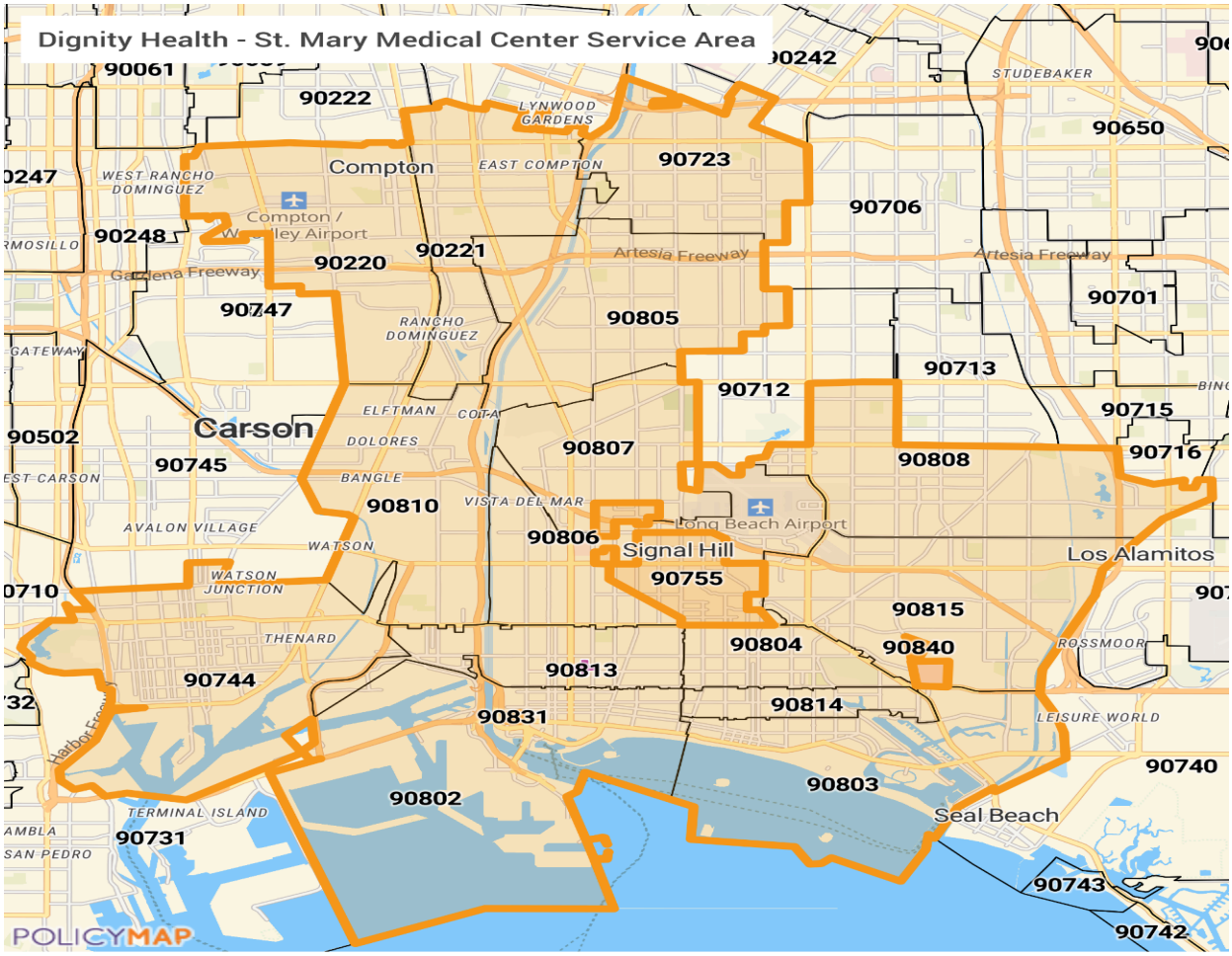
It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay. This hospital has a financial assistance policy that describes the 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

The hospital defines service area as including 15 zip codes in Los Angeles County, 11 of which are in the City of Long Beach. Los Angeles County is subdivided into eight Service Planning Areas (SPAs). The hospital service area comprises portions of SPA 6 and SPA 8.

St. Mary Medical Center Primary Service Area

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



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

The population of the service area is 681,242. Children and youth, ages 0-17, make up 22.9% of the population, 65.4% are adults, ages 18-64, and 11.7% of the population are seniors, ages 65 and older. The largest portion of the population in the service area are Hispanic or Latino residents (55%), 19.5% are White or Caucasian residents, 12.3% are Black or African American residents, 11.9% are Asian residents, and 2.7% of the population are non-Latino multiracial residents, 0.5% are Native Hawaiian or Pacific Islander residents, and 0.2% are American Indian or Alaskan Native residents. In the service area, 47% of the population, 5 years and older, speak only English in the home. Among the area population, 44.3% speak Spanish, 6.7% speak an Asian or Pacific Islander language, and 1.5% speak an Indo-European language in the home.

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

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, 2025.. The hospital makes the CHNA report widely available to the public online and a written copy is available upon request.

CHNA web address:
https://www.dignityhealth.org/socal/locations/stmarymedical/about-us/community-beneifts

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 with the CHNA:

- Long Beach CHNA Collaborative: Long Beach Department of Health and Human Services, St. Mary Medical Center, MemorialCare Long Beach Medical Center, MemorialCare Miller Children's and Women's Hospital, TCC Family Health, a Federally Qualified Health Center.
- Long Beach Forward
- St. Mary Medical Center Community Health Advisory Committee

Vulnerable Populations Represented by These Groups:

- Black/African American
- Asain Indian
- Cambodian
- Hispanic/Latino
- Non-white racial groups
- People with disabilities
- People identifying as lesbian, gay, bisexual, transgender or queer
- Individuals with limited English proficiency

This community benefit report also includes programs delivered during fiscal year 2025 that were responsive to needs prioritized in the hospital's previous CHNA report.

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 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	Y

Significant Health Need	Description	Intend to Address?
	transportation, language and cultural issues.	
Birth Indicators	Poor pregnancy and birth outcomes include low birthweight, preterm births and infant mortality. These are associated with late or no prenatal care, unplanned pregnancy, cigarette smoking, alcohol and other drug use, being HIV positive, obesity, maternal age, and poor nutrition.	
Chronic Diseases	A chronic disease or condition usually lasts for three months or longer and may get worse over time. Chronic diseases can usually be controlled but not always cured. The most common types of chronic diseases are cancer, heart disease, stroke, diabetes, and arthritis.	Y
Economic Insecurity	Economic insecurity is correlated with poor health outcomes. People with low incomes are more likely to have difficulty accessing health care, have poor-quality health care, and seek health care less often.	
Environmental Pollution	Polluted air, contaminated water, and extreme heat are environmental conditions that can negatively impact community health.	
Food Insecurity	The USDA defines food insecurity as limited or uncertain availability of nutritionally adequate foods or an uncertain ability to acquire foods in socially acceptable ways.	
Housing and Homelessness	Homelessness is known as a state of being unhoused or unsheltered and is the condition of lacking stable, safe, and adequate housing.	Y
Mental Health	Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act.	Y
Overweight and Obesity	Overweight and obesity are common conditions that are defined as the increase in size and amount of fat cells in the body. Obesity is a chronic health condition that raises the risk for chronic diseases. Overweight and obesity are linked to a lack of physical activity and unhealthy eating habits.	
Prevention	Preventive practices refer to health maintenance activities that help to prevent disease. For example, preventive care includes vaccines, routine health screenings (mammogram, colonoscopy, Pap smear) and injury prevention strategies.	Y

Significant Health Need	Description	Intend to Address?
Racism and Discrimination	Racism and discrimination in health care are systemic issues that negatively impact patient care and health outcomes, particularly for people of color. These issues manifest as disparities in access, treatment, and quality of care.	
Substance Use	Substance use is the use of tobacco products, illegal drugs, prescription drugs, over-the-counter drugs or alcohol. Excessive use of these substances or use for purposes other than those for which they are meant to be used, can lead to physical, social or emotional harm.	
Violence and Injury	Violent crimes include homicide, rape, robbery and assault. Property crimes include burglary, larceny and motor vehicle theft. Injuries are caused by accidents, falls, hits, and weapons, among other causes.	

Significant Needs the Hospital Does Not Intend to Address

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

Knowing there are not sufficient resources to address all the community health needs, St. Mary Medical Center chose to concentrate on those health needs that can most effectively be addressed given the organization's areas of focus and expertise. The hospital has insufficient resources to effectively address all the identified needs and, in some cases, the needs are being addressed by others in the community.

2025 Report and 2026 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 FY25 and planned activities for FY26, 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...

- Chief Executive Officer
- Physician Liaison
- Business Development
- Chief Medical Officer
- Chief Nursing Officer
- Mission Director
- Chief Philanthropy Officer
- Chief Finance Officer

The programs and initiatives described here were selected based on:

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

- Focus Area: The hospital has acknowledged competencies and expertise to address the issue and the issue fits with the organizational mission.

Community input or contributions to this community benefit plan included...

- St. Mary Medical Center Community Health Advisory Committee which consists of various community partners and agencies that provide services to our community, especially vulnerable populations

The programs and initiatives described here were selected based on:

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

Community Health Core Strategies

The hospital intends that program activities to help address significant community health needs reflect a strategic use of resources. CommonSpirit Health has established three community health improvement core strategies to help 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.
- Implement and sustain evidence-based health improvement program initiatives.
- Strengthen community capacity to achieve equitable 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 goals and anticipated impact, and any collaboration with other organizations in their delivery.

	Health Need: Access to Care		
Strategy or Program	**Summary Description**	**Active FY25**	**Planned FY26**
CARE Program	• The CARE program is a multidisciplinary HIV care and support project, based on the campus of St. Mary Medical Center. • Clients of the CARE program receive integrated high quality medical, dental, health, and psychosocial services to a heavily impacted population of low-income men, women, and children living with HIV and for those at high risk for acquiring HIV	Y	Y
Community Health Improvement Grants Program	• Offer grants to nonprofit community organizations that provide health care access programs and services.	Y	Y
Families in Good Health	• Families in Good Health is a multilingual, multicultural health and social education program for Southeast Asian residents, Latino residents and other communities in Long Beach. • Its mission is to help the community make informed choices and gain access to needed health and social resources. • FiGH also offers disease management programs.	Y	Y

Financial Assistance Program	• Provide financial assistance to those who have health care needs and are uninsured, underinsured, ineligible for a government program or otherwise unable to pay.	Y	Y
Low Vision Center	• Provide no cost vision screening, optical aids, education and referrals for people with limited vision.	Y	Y
Goal and Impact: Increase access to health care for the medically underserved and reduce barriers to care.			
Collaborators: 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: Chronic Disease and Prevention		
Strategy or Program	**Summary Description**	Active FY25	Planned FY26
Bazzeni Wellness Center	• Provide health education, health screenings and chronic disease prevention services.	Y	Y
CARE Program	• 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	Y	Y
Community Health Improvement Grants Program	• Offer grants to nonprofit community organizations that provide chronic disease-and preventive care focused programs and services.	Y	Y
Every Woman Counts	• Provide mammogram services to underserved women	Y	Y

	Health Need: Chronic Disease and Prevention		
	older than age 40. Cervical screenings are offered for women ages 21 and older		
Families in Good Health	● FiGH offers disease management programs.	Y	Y
Mobile Care Unit	● Provide health care screenings, education and outreach to communities at high-risk of negative health outcomes.	Y	Y
Goal and Impact: Increased compliance with chronic disease management recommendations.			
Collaborators: Community-based organizations, public health, faith community, senior service agencies, youth organizations, community clinics, schools and school districts			

	Health Need: Housing and Homelessness		
Strategy or Program	**Summary Description**	**Active FY25**	**Planned FY26**
Community Health Improvement Grants Program	● Offer grants to nonprofit community organizations that provide housing and homelessness programs and services.	Y	Y
		☐	☐
Goal and Impact: Provide philanthropic cash grants to our community partners to help reduce homelessness.			
Collaborators: 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 FY25	Planned FY26
CARE Program	● Provide 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.	Y	Y
Community Health Improvement Grants Programs	● Offer grants to nonprofit community organizations that provide mental health programs and services.	Y	Y
Goal and Impact: Increase prevention, screening, assessment, and treatment of mental health disorders			
Collaborators: Schools and school districts, community-based organizations, law enforcement, and regional collaboratives that seek to support mental health and case management needs			

Community Health Improvement Grants Program

One important way the hospital helps to address community health needs is by awarding restricted financial grants to non-profit organizations working 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 FY25, the hospital awarded the grants below totaling $218,500. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Health Needs Addressed	Amount
Long Beach Rescue Mission	Apostle House	Housing/Homelessness Mental Health	$ 84,250
Mental Health America Los Angeles	HealthLinks	Housing/Homelessness Mental Health Access to Care	$ 84,250
Precious Lamb Preschool	Trauma-Informed Care	Housing/Homelessness Mental Health	$ 50,000

Program Highlights

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

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	● In FY25 88% 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. Retention increased 8% compared to FY24. ● 94% of CARE patients maintained complete HIV viral suppression in FY25. This indicator is unchanged compared to previous year. ● There were a total of 936 biomedical prevention and STI patient visits in FY25. This represents a 20% increase compared to FY24. ● In FY25, there were a total of 1572 behavioral health visits provided. Overall, this represents a 24% increase compared to FY24. ● In FY25, 2297 food allotments were distributed to food pantry clients. This represents a 5% increase compared to FY24. ● In June 2025 there were a total of 139 patients on Long-Acting Injectable therapy for HIV treatment and prevention. In June 2024 there were 135 patients on LAIs. This represents a 3% increase.

Hospital's Contribution / Program Expense	CARE committed a total of approximately 16.0 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 9.35 FTEs, with a gap of 6.65 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 FY26. 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 1,100 in FY26. ● Provide 1,600 behavioral health visits for individual and group therapy. ● Distribute 2,400 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.

	Every Woman Counts
Significant Health Needs Addressed	● Access to health services
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.

	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 2025-2026 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 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 2025-2026 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

Other Community Health and Community Building Programs

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

Health Coach for the CardioRehab Unit

A health coach provides one-one counseling around diet and exercise for cardiac patients.

Diabetes Education

ADA certified diabetes educators provide education to diabetes patients.

Medi-Cal Assistance

Assist uninsured patients to enroll in emergency Medi-Cal.

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 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. Medicare reported here excludes Medicare reported as a part of Graduate Medical Education. 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.

Financial Assistance and Means-Tested Government Programs	Vulnerable Population	Broader Community	Total
Traditional Charity Care	$11,717,873		$11,717,873
Medi-Cal	$57,125,454		$57,125,454
Other Means-Tested Government (Indigent Care)	$0		$0
Sum Financial Assistance and Means-Tested Government Programs	**$68,843,327**		**$68,843,327**
Other Benefits			
Community Health Improvement Services	$3,202,376	$0	$3,202,376
Community Benefit Operations	$52,451	$24,500	$76,951
Health Professions Education	$0	$11,697,626	$11,697,626
Subsidized Health Services	$9,933,116	$0	$9,933,116
Research	$0	$0	$0
Cash and In-Kind Contributions for Community Benefit	$904,165	$0	$904,165
Other Community Benefits	$0	$0	$0
Total Other Benefits	**$14,092,108**	**$11,722,126**	**$25,814,234**
Community Benefits Spending			
Total Community Benefits	**$82,935,435**	**$11,722,126**	**$94,657,561**
Medicare	$7,037,523		$7,037,523
Total Community Benefits with Medicare	**$89,972,958**	**$11,722,126**	**$101,695,084**

*The hospital also invested $657,905 in community building activities, which are reported separately from community benefit expenses in accordance with IRS Schedule H instructions.

Community Health Advisory Committee Roster

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