2025 Community Health Implementation Strategy and Plan

California Hospital Medical Center

Adopted October 2025

Dignity Health®
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At-a-Glance Summary

Community Served	California Hospital Medical Center is located at 1401 S. Grand Ave., Los Angeles, CA, 90015. The hospital tracks ZIP Codes of origin for all patient admissions and includes all who received care without regard to insurance coverage or eligibility for financial assistance. The hospital defines its primary service area that includes 36 ZIP Codes in 10 cities within Los Angeles County, 17 of which are located in the City of Los Angeles, and 10 that are in South LA, and comprises of portions of Los Angeles County Service Planning Areas (SPAs) 4, 6, 7, and 8. CHMC serves 1,822,453 racially diverse residents.
Significant Community Health Needs Being Addressed	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs the hospitals intends to address with strategies and programs are: • Mental Health • Housing • Diabetes • Injury & Violence • Substance Use • Nutrition, Physical Activity & Weight • Access to Health Care Services
Strategies and Programs to Address Needs	The hospital intends to take several actions and to dedicate resources to these needs, including: **Mental Health** CA Bridge Program CA Behavioral Health Clinic Family Preservation Program Hope Street Margolis Family Center Wraparound Services Program Welcome Baby Frequent Utilizer Systems Engagement (FUSE) Program Centinela Valley Mental Health Project Emotional Wellbeing Support Group **Housing** Community Health Improvement Grants Frequent Utilizer Systems Engagement (FUSE) Program Hope Street Margolis Family Center LA Partnership Community Health Improvement Grants **Diabetes** Diabetes Empowerment Education Program Heart HELP (Healthy Eating Lifestyle Program)

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St. Francis Center LA

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

Written comments on this report can be submitted to the California Hospital Medical Center’s COMMUNITY HEALTH OFFICE, 1401 S Grand Avenue, (Leavey Hall, room 314) Los Angeles, CA 90015 or by e-mail to barbara.gonzalez@commonspirit.org.

Our Hospital and the Community Served

About the Hospital

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

California Hospital Medical Center (CHMC), located in downtown Los Angeles, is a 318-bed, nonprofit, acute care hospital that has served the community for over 130 years and is a member of Dignity Health. CHMC provides comprehensive services, including a Level II Trauma Center, a comprehensive cardiac program with a cath lab, the Los Angeles Center for Women's Health, an obstetrics program, a Level III Neonatal Intensive Care Unit (NICU), and specialized surgical services. The hospital is focused on community health, offering wellness programs, and recently completed construction of a new Grand Tower to enhance its facilities, including a new Emergency Department, Trauma Unit, and an advanced NICU.

Our Mission

The hospital's dedication to assessing significant community health needs and helping to address them in conjunction with the community is in keeping with its mission. As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Financial Assistance for Medically Necessary Care

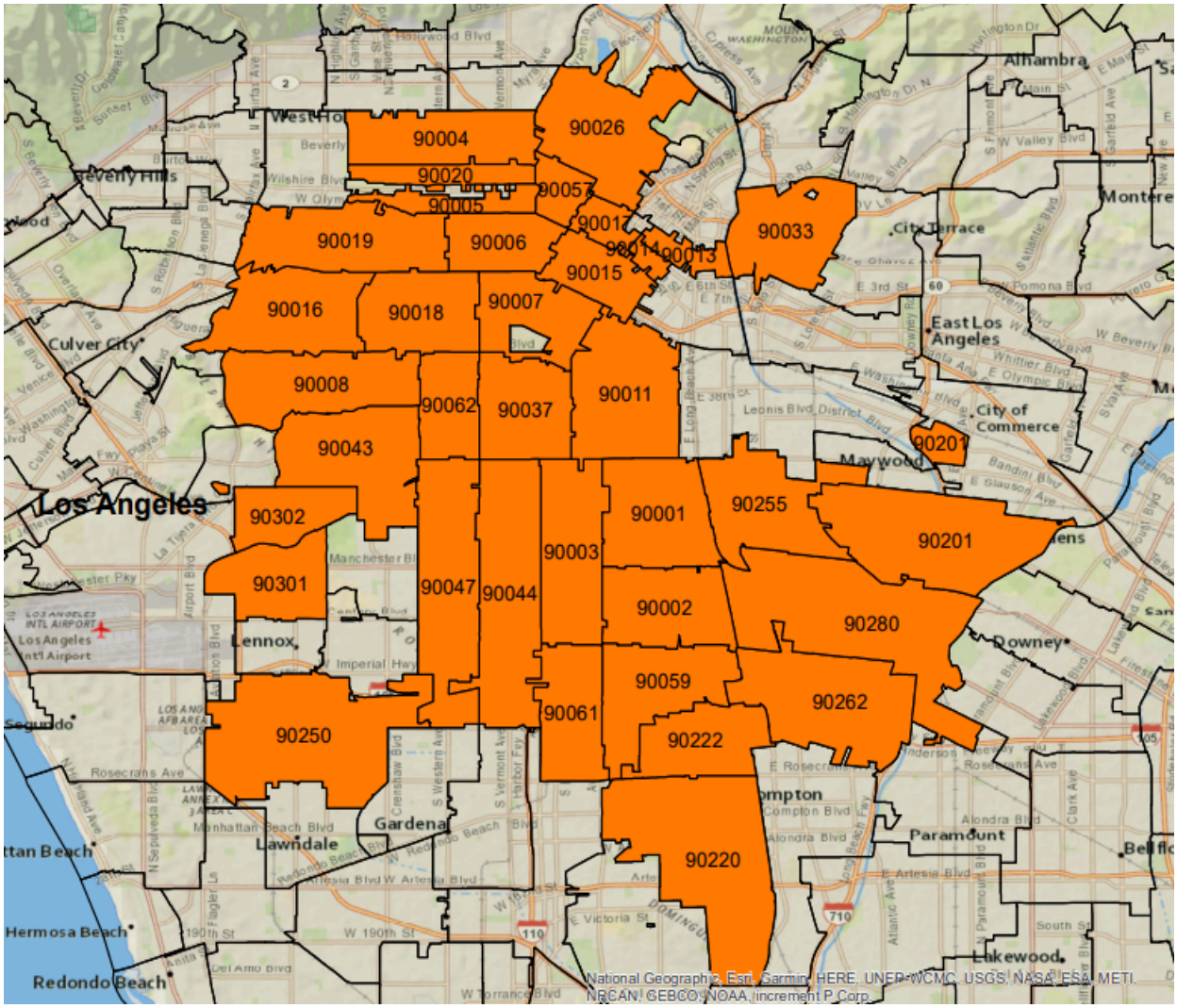
It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay.

This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.

Description of the Community Served

California Hospital Medical Center is located at 1401 S. Grand Ave., Los Angeles, CA, 90015. The hospital tracks ZIP Codes of origin for all patient admissions and includes all who received care without regard to insurance coverage or eligibility for financial

assistance. The hospital defines its primary service area that includes 36 ZIP Codes in 10 cities within Los Angeles County, 17 of which are located in the City of Los Angeles, and 10 that are in South LA, and comprises of portions of Los Angeles County Service Planning Areas (SPAs) 4, 6, 7, and 8. CHMC serves 1,822,453 racially diverse residents.



- The population of the CHMC service area is 1,822,453. Children and youth ages 0-17, make up 23.65% of the population, 65.5% are adults, ages 18-64, and 10.76% of the population is seniors, ages 65 and older. The largest portion of the population in the service area identifies as Hispanic/Latino (67.3%), 16.1% of the population identifies as Black/African American, 7.1% as Asian, 6.8% as White. Approximately 15.43% of the population identifies as multiracial (two or more races), 0.2% are American Indian/Alaskan Native and 0.1% are Native Hawaiian/Pacific Islander. In the service area, 34.2% of the population, 5 years and older, speak only English in the home. Among the service area population, 9.4% of people <65 and older do not have health insurance and 52.4% of the people have medicaid. Approximately, 21.4% of people are below the 100% federal poverty level.

Community Assessment and Significant Needs

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

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

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

Significant Health Needs

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

Significant Health Need	Description	Intend to Address?
Mental Health	Mental health is not simply the absence of a mental health condition—it is also about the presence of well-being and the ability to thrive. Many factors influence our ability to thrive and experience optimal well-being, such as family and community relationships, access to opportunities, and environmental circumstances. For example, depression increases the risk for many types of physical, long-lasting (chronic) conditions.	☑
Housing	A lack of housing, encompassing both the absence of a stable home and unaffordable, poor-quality housing, negatively impacts community health by increasing physical and mental illness, fostering instability, and limiting access to basic needs.	☑
Diabetes	Diabetes is a chronic health condition where the body struggles to regulate blood sugar (glucose) because of insufficient insulin production or ineffective insulin use. This leads to high blood sugar levels over time, which can	☑

Significant Health Need	Description	Intend to Address?
	cause serious complications like heart disease, vision loss, and kidney disease.	
Injury & Violence	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.	☑
Substance Use	Substance use is the use of tobacco products, illegal drugs, prescription or over-the-counter drugs, or alcohol. Excessive use of these substances, or use for purposes other than those for which they are meant to be used, can lead to physical, social or emotional harm.	☑
Nutrition, Physical Activity & Weight	Poor nutrition and physical inactivity increase the risk of chronic conditions like obesity, depression, type 2 diabetes, heart disease, and some cancers—which can lead to disability and premature death.	☑
Access to Health Care Services	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.	☑

2025 Implementation Strategy and Plan

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

Planned activities are consistent with current significant needs and the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant, such as

changes in community needs or resources to address them.

Creating the Implementation Strategy

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

CHMC's community health programs involve departments beyond Community Health and Mission in their planning and operation. Hospital and health system participants included CHMC Senior Leadership Team, leadership of Hope Street Margolis Family Center 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 Frequent Utilizers Systems Engagement, leadership of CommonSpirit Health Violence/Human Trafficking Response and CHMC Community Health Advisory Committee.

CHMC engaged hospital leaders 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. As a result of the review of needs and application of the above criteria, CHMC chose to focus on: access to care, behavioral health (mental health and substance use), birth indicators, chronic disease (including overweight and obesity and food insecurity), housing insecurity and homelessness, and violence and injury prevention.

For each health need the hospital plans to address, the Implementation Strategy describes: actions the hospital intends to take, including programs and resources it plans to commit, anticipated impacts of these actions, and planned collaboration between the hospital and other organizations. In most cases, the strategies identified to address the selected needs are based on existing programs that have evidence of success. For some strategies, CHMC is part of a larger collaborative initiative.

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.
- Existing programs with evidence of success/impact;
- Research into effective interventions (example sources follow);
    - https://www.thecommunityguide.org/
    - https://odphp.health.gov/healthypeople/tools-action/browse-evidence-based-resources
- Expanding or adapting a partner's program;
- Access to appropriate skills or resources;
- Ability to measure impact;

- Goal to address a vital condition.

Community Health Core Strategies

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

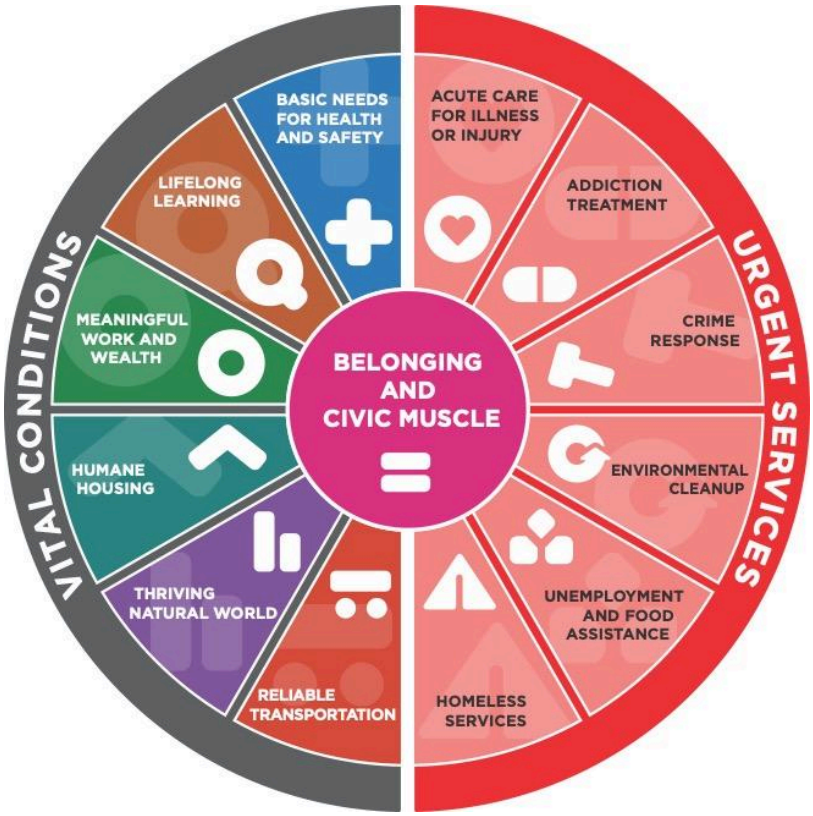
- **Core Strategy 1**: Extend the care continuum by aligning and integrating clinical and community-based interventions.
- **Core Strategy 2**: Implement and sustain evidence-informed health improvement strategies and programs.
- **Core Strategy 3**: Strengthen community capacity to achieve equitable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

Vital Conditions and the Well-Being Portfolio

Community health initiatives at CommonSpirit Health use the Vital Conditions framework and the Well-Being Portfolio[1] to help plan and communicate about strategies and programs.

Investments of time, resources, expertise and collaboration to improve health and well-being can take different approaches. And usually, no single approach can fully improve or resolve a given need on its own.

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



What are Vital Conditions?
These are characteristics of places and institutions that all people need all the time to be healthy and well. The vital conditions are related to social determinants or drivers of health, and they

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

are inclusive of health care, multi-sector partnerships and the conditions of communities. They help create a community environment that supports health.

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

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

Well-Being Portfolio in this Strategy and Plan

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

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

Strategies and Program Activities by Health Need

Health Need:	**Mental Health**				
Population(s) of Focus:	Community members in downtown Los Angeles and South Los Angeles.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
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 by identifying patients who would benefit from initiating medication for addiction treatment (MAT) or mental health services.	☑	☑	☑	US: Addiction Treatment VC: Basic Needs for Health and Safety
CA Behavioral Health Clinic	Supports the emotional and psychological well-being of children and their families by providing individual, family, and group psychotherapy, psychiatric and case management services.	☑	☑	☑	VC: Basic Needs for Health and Safety
Family Preservation Program	Screens parents for depression/anxiety and IPV. Screens children for adverse childhood experiences (ACEs) and mental health or behavioral issues and provides referrals.	☑	☑	☑	VC: Basic Needs for Health and Safety
Wraparound Services	Wraparound Program provides community-based support and individualized	☑	☑	☑	VC: Basic Needs for Health and Safety

Health Need:	**Mental Health**				
	planning for children, including those with severe emotional and behavioral disorders and their families.				
Welcome Baby	Home visitors screen for perinatal mood and anxiety disorders (PMADs), Intimate Partner Violence (IPV) and substance use disorders, and refers individuals needing treatment to community resources.	☑	☑	☑	VC: Basic Needs for Health and Safety
Frequent Utilizer System Engagement (FUSE)	The FUSE 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 John Wesley County Hospital Institute Inc.	☑	☑	☑	US: Homeless Services VC: Basic Needs for Health and Safety
Emotional Wellbeing Support Group	Community Health Promoters deliver mental health workshops and provide community resources.	☑	☑	☑	VC: Basic Needs for Health and Safety
Community Health Improvement Grants	Offers grants to nonprofit community organizations that provide mental health.	☐	☐	☑	US: Homeless Services VC: Basic Needs for Health and Safety
Planned Resources:	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.				
Planned Collaborators:	Key partners include schools and school districts, community and faith-based organizations, UniHealth Foundation, Dignity Health Southern California Hospitals, Providence Health and LA County agencies.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
• Increased access to mental health in the community. • Improved screening and identification of mental health. • Identify patients and client's social needs • Increase ability of local community-based organizations to address mental health.	• Number of Screenings • Number connected to community resources • Number of individuals participating in programs	• Social Determinants of Health screenings • Community Health Dashboard

Health Need:	**Housing**				
Population(s) of Focus:	Community members in downtown Los Angeles and South Los Angeles.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Dignity Health Homeless Health Initiative	Provides three social workers to assist with discharge planning for homeless patients seen in the ED.	☑	☐	☑	US: Homeless Services
Frequent Utilizer System Engagement (FUSE)	The FUSE 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	☑	☑	☑	US: Homeless Services

Health Need:	**Housing**				
	health care services through a collaboration of Housing Works and John Wesley County Hospital Institute Inc.				
Hope Street Margolis Family Center (HSMFC)Early Head Start, Early Childhood	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.	☑	☑	☑	US: Homeless Services
LA Partnership	The hospital is a participant in the LA Partnership, which is composed 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.	☑	☑	☑	US: Homeless Services
Community Health Improvement Grants	Offers grants to nonprofits community organizations that provide housing and homelessness programs and services.	☐	☐	☑	US: Homeless Services
Planned Resources:	The hospital will provide social workers, health care providers, case managers, philanthropic cash grants, outreach communications, and program management for this initiative.				
Planned 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.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
• Improved health care delivery to persons experiencing homelessness. • Increased access to community-based services for persons	• Number of referrals	• Electronic Health Record

experiencing homelessness. ● Connect patients to Enhanced Care Management Services. ● Increase the number of patients connected to interim and permanent housing. ● Engagement in local and market level initiatives.	● Number of patients connected to services ● Number of collaboratives engage in	● Frequently Utilizer System Engagement Tracking

Health Need:	**Diabetes**				
Population(s) of Focus:	Community members in downtown Los Angeles and South Los Angeles.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Diabetes Empowerment Education Program (DEEP)	Participants with pre-diabetes & diabetes learn tools and techniques to prevent and manage diabetes. Participants are provided resources.	☑	☑	☐	VC: Basic Needs for Health and Safety
Heart Healthy Eating Lifestyle Program	Five-week curriculum to help minimize risk for cardiovascular disease through healthy eating and cooking, maintaining an active lifestyle, and addressing risk factors such as overweight/obesity, hypertension, and cholesterol. Refers participants who are food insecure to CalFresh, WIC and other food assistance programs as appropriate.	☑	☑	☐	VC: Basic Needs for Health and Safety
Community Health Screenings	The hospital lab provides free health screenings including cholesterol, glucose, A1c, blood pressure, and BMI, education and referrals.	☑	☑	☑	VC: Basic Needs for Health and Safety

Health Need:	**Diabetes**				
Cardiovascular Awareness Classes	A presentation about CVD risk factors is given and participants are invited to lifestyle workshops to positively influence modifiable risk factors in their lives.	☑	☑	☐	VC: Basic Needs for Health and Safety
Planned Resources:	The hospital will provide health care providers, phlebotomists, patient navigators, health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators:	Key partners include: Schools, FQHCs, Southside Coalition of Community Health Centers, LA County Department of Public Health, youth organizations, faith-based groups, senior centers, and community-based organizations. The hospital will provide health care providers, hospital lab technicians, community health promoters, patient navigators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
• Increased identification and awareness of diabetes • Increased compliance with the disease prevention recommendations. • Enroll patients and community members in diabetes education programs. • Conduct health screenings.	• Increase referrals to the Diabetes Empowerment Education Program • Increase number of patients participating and completing the Diabetes Empowerment Education Program • Increase number of health	• Electronic Health Record • Community Health Dashboard

	screenings	

Health Need:	**Injury & Violence**				
Population(s) of Focus:	Community members in downtown Los Angeles and South Los Angeles.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
CA Behavioral Clinic	Children ages 0-21, with Medi-Cal receive mental health services. Parents may receive dyadic care with their child.	☑	☑	☑	US: Crime Response VC: Basic Needs for Health and Safety
Family Preservation Program	Family preservation services are short-term, family-focused services to assist families in crisis by improving parenting and family functioning while keeping children safe.	☑	☑	☑	VC: Basic Needs for Health and Safety
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.	☑	☑	☑	VC: Basic Needs for Health and Safety
Human Trafficking Response Initiative	The Human Trafficking Response Task Force provides training to identify potential victims of sex and/or labor trafficking in the ED and other hospital units. The survivor advocates from CAST	☑	☑	☑	VC: Basic Needs for Health and Safety

Health Need:	**Injury & Violence**				
	LA and Journey Out work in the ED to assist staff in identifying potential victims and encourage potential victims to accept services.				
Violence Prevention and Gun Safety Program	The program aims to provide violence prevention efforts in community and workplace violence. The gun safety program provides gun safety education to community members in Los Angeles County and healthcare professionals.	☑	☑	☑	US: Crime Response VC: Basic Needs for Health and Safety
Stop the Bleed	Stop the Bleed trains, equips and empowers the public to help in a bleeding emergency before professional help arrives.	☐	☑	☑	US: Crime Response VC: Basic Needs for Health and Safety
Hope Street Margolis Family Center	Screens parents for depression/anxiety and intimate partner violence (IPV). Screens children for mental health and behavioral issues. Refers parents and children who need treatment to community resources.	☑	☑	☑	VC: Basic Needs for Health and Safety
Welcome Baby	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.	☑	☑	☑	VC: Basic Needs for Health and Safety
Planned Resources:	The hospital will provide case managers, health care providers, health educators, social workers, philanthropic cash grants and outreach communications in support of this initiative.				
Planned Collaborators:	Key partners include: community-based organizations, CAST LA, Journey Out, faith community, public safety agencies, city agencies, schools and school districts, community health centers, UniHealth Foundation and youth organizations.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
• Increased access to programs in the community that focus on reduced violence and injury prevention. • Connect patients with wrap-around services	• Increase the number of people that have access to care. • Increase number of people connected with wrap around services • Increase number of people to community based services	• Electronic Health Record • Stronger Families Database

Health Need:	**Substance Use**				
Population(s) of Focus:	Community members in downtown Los Angeles and South Los Angeles				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
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.	☑	☑	☑	US: Acute Care

Health Need:	**Substance Use**				
	Utilizes a trained navigator to identify patients who would benefit from initiating medication for addiction treatment or mental health services.				
Frequent Utilizer System Engagement (FUSE)	The FUSE 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 John Wesley County Hospital Institute Inc.	☑	☑	☑	VC: Basic Needs for Health and Safety
Planned Resources:	The hospital will provide social workers, health care providers, case managers, philanthropic cash grants, outreach communications, and program management for this initiative.				
Planned Collaborators:	Key partners include community clinics, FQHCs, community-based organizations, faith groups, public health, city agencies and homeless services organizations. The hospital will provide health care providers, substance use navigators, community health educators, case managers, philanthropic cash grants, outreach communications, and program management support for these initiatives.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
• Increase substance use services in the community • Improved screening and identification of mental health and substance use needs	• Increase enrollment in CA Bridge Program • Increase number of follow up appointments and connection to services	• Electronic Healthcare Record

Health Need:	**Nutrition, Physical Activity & Weight**				
Population(s) of Focus:	Community members in downtown Los Angeles and South Los Angeles				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Heart HELP (Healthy Eating Lifestyle Program)	Five-week curriculum to help minimize risk for cardiovascular disease, cholesterol, and diabetes through healthy eating and cooking, maintaining an active lifestyle, and addressing risk factors such as overweight/obesity, hypertension, and cholesterol. Referrals provided.	☑	☑	☐	VC: Basic Needs for Health and Safety
Nutrition Education	Participants receive one-time nutrition classes to empower individuals to make informed choices about food and nutrition to adopt and maintain, improve overall health, and reduce the risk of chronic diseases.	☑	☑	☐	VC: Basic Needs for Health and Safety
Diabetes Empowerment Education Program	Participants with pre-diabetes & diabetes learn tools and techniques to prevent and manage diabetes. Participants are provided resources.	☑	☑	☐	VC: Basic Needs for Health and Safety
Community Health Screenings	The hospital lab provides free health screenings including cholesterol, glucose, A1c, blood pressure, and BMI.	☑	☑	☑	VC: Basic Needs for Health and Safety

Health Need:	**Nutrition, Physical Activity & Weight**				
Welcome Baby	Families learn about child development milestones. Assess baby and mom for nutrition and access to food. Referrals provided as needed.	☑	☑	☑	VC: Basic Needs for Health and Safety
Hope Street Margolis Family Center	Programs provide comprehensive health and nutrition services, which include nutrition education for both children and their families, promoting healthy eating habits.	☑	☑	☐	VC: Basic Needs for Health and Safety
Replate	The Replate program is a technology-driven food recovery and redistribution service that connects the hospital with surplus food to communities experiencing food insecurity. It operates a matching platform with integrated logistics to manage the delivery of food donations, aiming to reduce food waste, alleviate hunger, and promote environmental sustainability.	☑	☑	☑	VC: Basic Needs for Health and Safety
Community Health Improvement Grants	Offers grants to nonprofit organizations that address food insecurity.	☐	☐	☑	VC: Basic Needs for Health and Safety
Food Systems Strategy	Participates in the CommonSpirit systemwide committee to address food insecurity issues in the community, including reducing barriers to accessing healthy food.	☑	☑	☐	VC: Basic Needs for Health and Safety
Planned Resources:	The hospital will provide health care providers, phlebotomists, patient navigators, health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators:	The hospital will partner with local schools, community based organizations, faith based organizations, community health advocates, and department of public health.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
• Increased identification and treatment of chronic diseases • Increased compliance with disease prevention recommendations (screenings and lifestyle and behavior changes) • Increasing life expectancy and improving overall well-being	• Increase chronic disease awareness in the community • Increase number of nutrition classes • Increase number of participants enrolled in the Heart HELP program • Increase number of community health screenings	• Community Health Tracking

Health Need:	**Access to Health Care Services**				
Population(s) of Focus:	Community members in downtown Los Angeles and South Los Angeles				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Financial Assistance	CHMC provides financial assistance to those who have health care needs and are uninsured, underinsured, ineligible for government programs or otherwise unable to pay.	☑	☐	☐	VC: Meaningful Work and Wealth

Health Need:	**Access to Health Care Services**				
Para su Salud	Enrollment assistance to individuals and families to sign up for health and dental health insurance benefits.	☑	☑	☐	VC: Basic Needs for Health and Safety
Coordinated Care Initiative	The goal of the project is to ensure patients follow up with their primary care doctor following a hospitalization or a visit to the ER.	☑	☑	☑	VC: Basic Needs for Health and Safety
Frequent Utilizer System Engagement	The FUSE 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.	☑	☑	☑	VC: Basic Needs for Health and Safety
Hope Street Margolis Family Center	Assists families in accessing health and dental health insurance coverage. Assists families in establishing a medical home for each family member.	☑	☑	☐	VC: Basic Needs for Health and Safety
Health Screenings	The hospital lab provides free health screenings including cholesterol, glucose, A1c, blood pressure, and BMI.	☑	☑	☐	VC: Basic Needs for Health and Safety
Planned Resources:	The hospital will provide health care providers, phlebotomists, enrollment counselors, community health educators, case managers, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators:	Key partners include community clinics, FQHCs, CBOs, faith organizations, public health, city agencies and homeless services organizations. The hospital will provide health care providers, lab technician, enrollment counselors, community health educators, case managers, philanthropic cash grants, outreach communications, and program management support for these initiatives.				

Health Need:	**Access to Health Care Services**

Anticipated Impacts (overall long-term goals)	Measure	Data Source
● Increased access to health care for the medically underserved, ● Reduced barriers to care, and increased availability ● Access to primary and specialty care services	● A decrease in the identification of social needs via the Social Determinants of Health screenings ● Reduction in unnecessary ED visits and hospitalizations	● Electronic Health Record

Program Highlights

CHMC was awarded the American Heart Association/American Stroke Association's Get with the Guidelines® - Stroke Gold Plus Quality Achievement Award in 2025. This award highlights the hospital's commitment to ensuring stroke patients receive the most appropriate treatment, according to nationally recognized, research-based guidelines, and the latest scientific evidence. CHMC also received the Stroke Elite Honor Roll and Type 2 Diabetes Honor Roll Award.