Dignity Health
California Hospital
Medical Center

California Hospital Medical Center

Community Health Implementation Strategy
2018– 2020

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At-a-Glance Summary

Community Served	CHMC is located in a federally designated Medically Underserved Area and serves a Medically Underserved Population (MUA/P ID#04011)(Census tract 2240.10). While CHMC is located in Service Planning Area (SPA) 4 or Metro Los Angeles, its service area also include parts of SPA 6 (South) and SPA 8 (South Bay). CHMC serves 1,699,916 racially diverse residents with a median income of $40,705.
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). Those needs are: 1. Obesity/Overweight 2. Diabetes mellitus 3. Oral Health 4. Alcohol, drug & tobacco use disorders 5. Hypertension 6. Cardiovascular disease 7. Cholesterol 8. Cancer
Planned Actions to Address Needs	The hospital plans to deliver a number of program activities to help address identified significant health needs. These programs, described in the body of the Implementation Strategy, include: • Programming offered through the Hope Street Margolis Family Center including Early Head Start Program, Early Head Start – Childcare Partnership, 3 licensed early care and education centers, the Family Childcare Network, the Hope Street Youth Center, Youth Fitness Program, Family Literacy Program, Pico Union Family Preservation Network, Wraparound Services Program, Early Intervention Program, and CA Behavioral Health Clinic; • LA Best Babies Network's perinatal and early childhood home visitation programs including Welcome Baby, Healthy Families America, and Parents as Teachers and the LA Perinatal and Early Childhood Home Visitation Consortium; • *Para Su Salud*, Health Insurance Enrollment and Outreach Program; • Health Ministry screening and health education programs; o Chronic Disease Self-Management Program o Diabetes Empowerment Education Program o Healthy Eating and Lifestyle Program (H.E.L.P.) o Heart HELP • CCF Coordinated Care Initiative; • UniHealth Transition to Wellness Project; • Family Medicine Residency Program; • the COPE Health Scholars Program; and • Dignity Health Community Grant-funded projects, including the 10th Decile Project.

Dignity Health California Hospital Medical Center's Community Board reviewed, approved and adopted the Community Health Implementation Strategy: 2018-2020 at its October 25, 2018 meeting.

This document is publicly available at www.chmcla.org. At least one community benefit program is highlighted in each edition of the Foundation Update that is published twice each year and mailed to our medical staff, donors, supporters, and Board members. In addition, we send a monthly e-Newsletter re the Hope Street Margolis Family Center to its many donors and supporters, and to our hospital staff and Board members. We also recently began sending a monthly Community Health e-Newsletter to our many community partners. Our calendar of classes and workshops is featured in CHMC's weekly Update Connection e-Newsletter once a month and on the hospital's website. Each year, CHMC publishes its ***Service to Our Community Report*** that summarizes our community benefit programs and services.

Written comments on this report can be submitted to the California Hospital Medical Center's Community Health Office, 1401 S. Grand Ave., Los Angeles, CA 90015 or by e-mail to m.l.yonekura@dignityhealth.org.

MISSION, VISION AND VALUES

California Hospital Medical Center is a part of Dignity Health, a non-profit health care system made up of more than 60,000 caregivers and staff who deliver excellent care to diverse communities in 21 states. Headquartered in San Francisco, Dignity Health is the fifth largest health system in the nation.

At Dignity Health, we unleash the healing power of humanity through the work we do every day, in hospitals, in other care sites and the community.

Our Mission

We are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

- Delivering compassionate, high-quality, affordable health services;
- Serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community to improve the quality of life.

Our Vision

A vibrant, national health care system known for service, chosen for clinical excellence, standing in partnership with patients, employees, and physicians to improve the health of all communities served.

Our Values

Dignity Health is committed to providing high-quality, affordable healthcare to the communities we serve. Above all else we value:

Dignity - Respecting the inherent value and worth of each person.

Collaboration - Working together with people who support common values and vision to achieve shared goals.

Justice - Advocating for social change and acting in ways that promote respect for all persons.

Stewardship - Cultivating the resources entrusted to us to promote healing and wholeness.

Excellence - Exceeding expectations through teamwork and innovation.

OUR HOSPITAL AND THE COMMUNITY SERVED

About California Hospital Medical Center

California Hospital Medical Center (CHMC), founded in 1887, is located at 1401 S. Grand Avenue, Los Angeles, CA. It became a member of Dignity Health, formerly Catholic Healthcare West (CHW) in 2004. The facility has 318 licensed beds, and will begin construction on a new patient tower in early 2019. CHMC has a staff of more than 1800 and professional relationships with more than 400 local physicians. Major programs and services include: emergency and trauma services, women's health, obstetrics, neonatal intensive care, pediatrics, medical/surgical services, cardiac care, stroke care, critical care, orthopedics, and cancer care.

Description of the Community Served

California Hospital Medical Center is located in a federally designated Medically Underserved Area and serves a Medically Underserved Population (MUA/P ID#04011) (Census tract 2240.10). While CHMC is located in Service Planning Area (SPA) 4 of Metro Los Angeles, its service area, also includes parts of SPA 6 (South) and SPA 8 (South Bay). The hospital service area is based on 80% of our hospital discharges to contiguous zip codes. The CHMC service area encompasses a large area that includes all or portions of the following cities/communities, zip codes, and SPAs.

California Hospital Medical Center's Service Area

City/Community	Service Area Zip Codes	Service Area Zip Codes (cont.)	Los Angeles County Service Planning Area (SPA)
Baldwin Hills/Crenshaw	90011	90019	4-Metro
Los Angeles	90037	90013	6-South
Pico Heights	90044	90008	8-South Bay
South Los Angeles	90003	90059	
Athens	90018	90057	
Bell Gardens	90007	90061	
Echo Park/Silver Lake	90062	90255	
Hancock Park	90006	90026	
Hawthorne	90047	90250	
Huntington Park	90015	90004	
Inglewood	90043	90201	
Jefferson Park	90001	90017	
South Gate	90016	90280	
West Adam	90002	90302	
Westlake			
Wilshire			

Almost 1.7 million people (1,699,916) live in CHMC's service area. A majority of residents are Latino and are of Mexican origin. The remaining population is mostly African American. Compared to the County, there is a higher concentration of Latinos and African Americans in the CHMC service area. Two-thirds of the population in CHMC's service area speaks a language other than English at home.

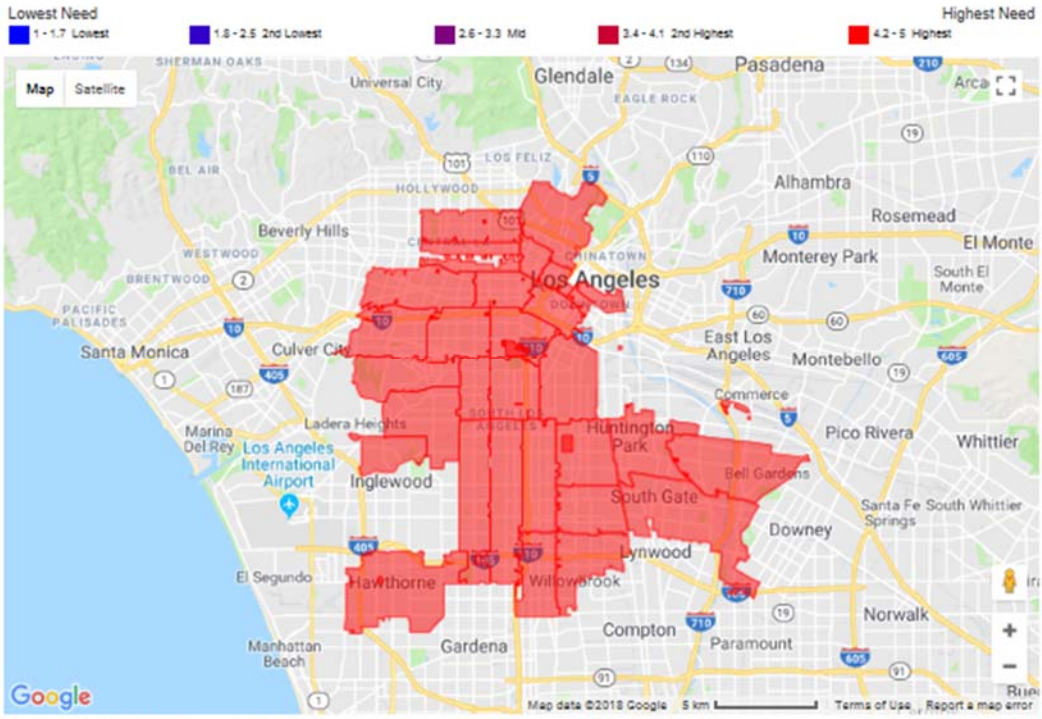
Children under the age of 18 account for 20.6% of the population, while 11.1% are seniors. 38.0% of residents have not received a high school diploma, and household incomes are generally low with a median household income of $40,705. Over 1.5 times as many households have an annual

income of <$15,000 (21.0%), compared to LA County (13.1%). There are twice as many families living below poverty in CHMC's service area (27.2%), compared to LA County (14.9%). A majority of residents living below the poverty level are under 65 years of age. Half (48.7%) of households are experiencing food insecurity.

86.8% of homeless individuals (8, 445), 13% of homeless families (1,228), and 0.2% of homeless unaccompanied minors (25) in Los Angeles County live in CHMC's service area. 27% of these homeless individuals suffer from mental illness, 20% from substance use disorder (SUD), 1.9% from HIV, and 16.9% are physically disabled.

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

- **Demographic Profile of People Living in CHMC's Service Area**
    - Total Population: 1,699,916
    - Hispanic or Latino: 66.8%
    - Race: 6.1% White, 17.1% Black/African American, 8.2% Asian/Pacific Islander, 1.8% Others
    - Median Income: $40.705
    - Uninsured: 12.8%
    - Unemployment: 6.3%
    - No HS Diploma: 38.0%
    - CNI Score: 5
    - Medicaid Population: 48.3%
    - Other Area Hospitals: 6
    - Medically Underserved Areas or Populations: Yes



Mean(zipcode): 4.8 / Mean(person): 4.7 CNI Score Median: 4.8 CNI Score Mode: 5

Zip Code	CNI Score	Population	City	County	State
90001	4.8	59074	Los Angeles	Los Angeles	California
90002	5	55112	Los Angeles	Los Angeles	California
90003	5	73132	Los Angeles	Los Angeles	California
90004	4.6	61837	Los Angeles	Los Angeles	California
90005	4.8	42458	Los Angeles	Los Angeles	California
90006	4.8	60445	Los Angeles	Los Angeles	California
90007	5	43523	Los Angeles	Los Angeles	California
90008	4.6	32334	Los Angeles	Los Angeles	California
90011	5	109569	Los Angeles	Los Angeles	California
90013	5	14653	Los Angeles	Los Angeles	California
90014	4.6	9093	Los Angeles	Los Angeles	California
90015	5	20909	Los Angeles	Los Angeles	California
90016	4.4	49819	Los Angeles	Los Angeles	California
90017	5	28412	Los Angeles	Los Angeles	California
90018	4.8	53382	Los Angeles	Los Angeles	California
90019	4.6	66342	Los Angeles	Los Angeles	California
90020	4.6	40222	Los Angeles	Los Angeles	California
90026	4.6	69683	Los Angeles	Los Angeles	California
90037	5	66120	Los Angeles	Los Angeles	California
90043	4.8	45265	Los Angeles	Los Angeles	California
90044	5	93928	Los Angeles	Los Angeles	California
90047	4.8	49991	Los Angeles	Los Angeles	California
90057	5	45643	Los Angeles	Los Angeles	California
90059	5	42139	Los Angeles	Los Angeles	California
90061	4.8	28962	Los Angeles	Los Angeles	California
90062	5	32941	Los Angeles	Los Angeles	California
90201	4.6	103170	Bell Gardens	Los Angeles	California
90250	4.2	96485	Hawthorne	Los Angeles	California
90255	4.6	77553	Huntington Park	Los Angeles	California
90280	4.4	97904	South Gate	Los Angeles	California
90302	4.2	29816	Inglewood	Los Angeles	California

One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and Truven Health Analytics. The CNI analyzes data at the zip code level on five factors known to contribute or be barriers to health care access: income, culture/language, education, housing status, and insurance coverage. Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zip code in the community. Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores.

Implementation Strategy Development Process

The hospital engages in multiple activities to conduct its community benefit and 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; using five core principles to guide planning and program decisions; measuring and tracking program indicators and impact; and engaging the Community Benefit/Health Committee and other stakeholders in the development of an annual community benefit plan and triennial Implementation Strategy.

Community Health Needs Assessment

The significant needs that form the basis of the hospital's community health programs were identified in the most recent Community Health Needs Assessment (CHNA), which was conducted with Good Samaritan Hospital and St. Vincent Medical Center, and adopted by California Hospital in October 2017.

The hospital conducts a CHNA at least every three years to inform its community heath strategy and program planning. The CHNA report contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods, including: the data used; how the hospital solicited and took into account input from a public health department, members or representatives of medically underserved, low-income and minority populations; and the process and criteria used in identifying significant health needs and prioritizing them;
- Presentation of data, information and assessment findings, including a prioritized list of identified significant community health needs;
- Community resources (e.g., organizations, facilities and programs) potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

CHNA Significant Health Needs

The community health needs assessment identified the following significant community health needs:

Rank	Health Need	Brief Description	Addressing
1	Obesity/Overweight	34.1% of adults in SPA 6 and 24.1% in SPA 8 were obese, compared to 23.5% in LAC; 37.2% of adults in SPA 8 were overweight, compared to 35.9% in LAC. African American and Hispanics were significantly more likely to be obese than other racial/ethnic groups.	yes
2	Diabetes mellitus	12.3% of adults in SPA 6 and 11.6% in SPA 4 have been diagnosed with diabetes, compared to 9.8% in LAC. A majority of adults with diabetes are $\geq$ 50.	yes
3	Oral health	60.7% of adults in CHMC's service area lacked dental insurance compared to 51.8% in LAC. Over 1/3 could not afford to see a dentist.	yes

4	Alcohol, drug, & tobacco use disorders	17.6% of adults in SPA 4 and 16.4% in SPA 8 binge drank in past month compared to 15.8% in LAC. There are an average of 2.2 alcohol outlets/1000 people in CHMC's service area compared to 0.6/1000 people in LAC. 6.9% of adults in CHMC's service area misused prescription drugs and 13.9% used marijuana in past year compared to 5.5% and 11.6% in LAC.	yes
5	Hypertension	24.5% of adults in SPA 8 had HTN compared to 23.5% in LAC. 54.2% of adults aged 65 and older had HTN. 1/3 of African Americans have HTN.	yes
6	Cardiovascular disease	8.6% of adults in SPA 6 and 5.7% in SPA 8 were diagnosed with heart disease compared to 5.7% in LAC. The hospitalization rate for heart failure was higher in CHMC's service area than in CA.	yes
7*	Cholesterol	26.5% in SPA 8 and 25.7% in SPA 4 have high cholesterol compared to 25.2% in LAC	yes
7*	Cancer	Cancer was the second leading cause of death in CHMC's service area. African Americans had a higher incidence of cancer in LAC compared to other race/ethnicities.	yes
8	Sexually transmitted infections (STIs)	The incidence of HIV, syphilis, Chlamydia, and gonorrhea were all significantly higher in CHMC's service area than in LAC.	no

*Cholesterol and Cancer tied for #7.

CHMC is not addressing STIs because we do not have our own primary care clinics where people would typically be screened for these diseases. Moreover, LA County Department of Public Health has many public health clinics where individuals can be screened and treated for STIs free of charge.

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at www.chmcla.org or upon request at the hospital's Community Health office.

Creating the Implementation Strategy

Rooted in Dignity Health's mission, vision and values, California Hospital Medical Center is dedicated to improving community health and delivering community benefit with the engagement of its management team, Community Board and Community Benefit/Health Committee. The board and committee are composed of community members who provide stewardship and direction for the hospital as a community resource (see Appendix A). These parties review community benefit plans and program updates prepared by the hospital's community health director and other staff.

As a matter of Dignity Health policy, the hospital's community health and community benefit programs are guided by five core principles. All of our initiatives relate to one or more of these principles:

- Focus on Disproportionate Unmet Health-Related Needs
- Emphasize Prevention
- Contribute to a Seamless Continuum of Care
- Build Community Capacity

- Demonstrate Collaboration

Assets Assessment

The assessment identified a number of strong community assets. Community assets are documented in the *Hope Street Family Center's Bilingual (English/Spanish) Resource Guide* that is updated annually. Additionally, community resources can be accessed using L.A. County's 2-1-1 system, the largest information and referral (I&R) service in the nation, helping approximately 500,000 individuals and families in Los Angeles County annually. Since 1981, 2-1-1 LA County has provided free, confidential services 24 hours a day, 7 days a week in English, Spanish, and more than 140 other languages via a tele-interpreting service. Services are also provided for individuals with hearing impairments. In addition to being available telephonically, online services are also available at www.211la.org. Last year a new free online resource, similar to 2-1-1, became available at www.1degree.org/la thanks to LA County Department of Health Services.

In addition, CHMC's on-going community benefit programs and services were assessed:

- The Hope Street Margolis Family Center: Early Head Start Program, three licensed early care and education centers, the Hope Street Youth Center, the Youth Fitness Program, Family Childcare Network, Family Literacy Program, Pico Union Family Preservation Network, Wraparound Services Program, Early Intervention Program, and CA Behavioral Health Clinic.
- Los Angeles Best Babies Network: providing training and technical assistance to spread Welcome Baby, a universal home visiting program, and selected evidence-based, more intensive home visiting programs, such as Parents as Teachers and Healthy Families America to 14 other hospitals throughout LA County; LA County Perinatal and Early Childhood Home Visitation Consortium whose membership includes the majority of perinatal and early childhood home visiting programs from throughout LA County.
- *Para Su Salud*, Health Insurance Enrollment and Outreach Program
- Community Outreach and Education Programs: Health Ministry Program; Healthy Eating and Lifestyle Program; Diabetes Empowerment Education Program; Heart H.E.L.P; Chronic Disease Self-Management Program
- Community Partnerships with which CHMC is involved: National Health Foundation's Youth-Driven Healthy South LA Initiative; CCF Coordinated Care Initiative; UniHealth Transition to Wellness Project; LA County National Diabetes Prevention Program Community Advisory Board; Reproductive Health and the Environment in Los Angeles County; LA County Community Health Assessment and Action Partnership (LA Partnership); Women's Health Policy Council for the Los Angeles County Office of Women's Health; Improving Birth Outcomes for African American Infants in LA County; CDPH Community Birth Plan to Decrease Preterm Birth of African American Infants; Preconception Health Council of California

The Community Benefit Planning Workgroup comprised of key community stakeholders and *promotoras* residing in CHMC's service area uses a process that focuses on two levels of decision-making to determine how identified health issues will be addressed:

- Content areas
    - Size of the problem
    - Severity of the problem
    - Economic feasibility
    - Available expertise
    - Necessary time commitment

    - External salience

- Project activities
    - Target population
    - Number of people (i.e., How many people will be helped by this intervention?)
    - Estimated effectiveness/efficiency
    - Existing efforts (i.e., who else is working on this? What is our role? How can we best complement/enhance an existing effort?)

The Workgroup considered the following documents as it began its deliberations:

- FY17 CHMC Community Health Needs Assessment, especially the Prioritized Health Needs
- 2016 Hope Street Family Center Early Head Start Community Needs Assessment
- 2018-2020 CHMC Strategic Plan
- Problems linked to high utilization rates at CHMC
- Prevention Requirements of Level II Trauma Center
- Requirements of Stroke Program
- Plan for a Healthy Los Angeles: A Health and Wellness Element of the General Plan of Los Angeles City, 2014
- Homelessness Los Angeles, CA, Urban Land Institute Advisory Services Panel Report, December 2017

2018-2020 Implementation Strategy

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. It summarizes planned activities with statements on anticipated impacts, planned collaboration, and patient financial assistance for medically necessary care. Program Digests provide detail on select programs' goals, measurable objectives, expenses and other information.

This report specifies planned activities consistent with the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in community assets and resources directed to those needs may merit refocusing the hospital's limited resources to best serve the community.

Strategy and Program Plan Summary

Health Need: Obesity/Overweight	
Strategy or Activity	**Summary Description**
Health Ministry Program	• Parish Nurse will screen adults for obesity/overweight • Parish Nurse will refer obese/overweight adults to CHMC's programs that address physical activity and healthy eating
Diabetes Empowerment Education Program	• Pre-diabetics will learn how to prevent type 2 diabetes by addressing obesity/overweight through increasing their physical activity and healthy eating
Healthy Eating and Lifestyle Program	• Overweight/obese children aged 5-12 yr will be referred to this program by their pediatrician/family physician • The children and their parents will learn to decrease screen time, consumption of fast food, sugar-sweetened beverages, and calorie-dense, nutrient poor foods and to increase their physical activity and consumption of fresh fruits and vegetables and water.
HSFC Early Head Start Program	• Pregnant and parenting women with children aged 0-3 yr will learn about the importance of: exclusive breastfeeding for the first 6 months of life with continued breastfeeding for as long as feasible; the consumption of fresh fruits and vegetables as well as water; the avoidance of fast food, sugar-sweetened beverages, and calorie-dense, nutrient poor foods; and maintaining an active lifestyle in order to prevent obesity/overweight • Menus of licensed childcare centers will conform with nutrition guidelines for Early Head Start/Head Start (EHS/HS)
Licensed childcare center	• Parenting women with children aged 0-5 yr will learn about the importance of: exclusive breastfeeding for the first 6 months of life with continued breastfeeding for as long as feasible; the consumption of fresh fruits and vegetables as well as water; the avoidance of fast food, sugar-sweetened beverages, and calorie-dense, nutrient poor foods; and maintaining an active lifestyle in order to prevent obesity/overweight. • Menus of licensed childcare centers will conform with nutrition guidelines for EHS/HS
Family Childcare Network	• Parenting women with children aged 0-3 yr will learn about the importance of: exclusive breastfeeding for the first 6 months of life with continued breastfeeding for as long as feasible; the consumption of fresh fruits and vegetables as well as water; the avoidance of fast food, sugar-sweetened

	beverages, and calorie-dense, nutrient poor foods; and maintaining an active lifestyle in order to prevent obesity/overweight • Menus will conform with nutrition guidelines for EHS/HS
HSFC Youth Center	• Children aged 7-18 yr will learn about healthy eating, healthy cooking, portion control, the importance of maintaining an active lifestyle and healthy coping strategies for life's stressors
LABBN's expansion of Welcome Baby Program & select home visitation programs	• Home visiting staff will learn about: the importance of, and how to support, exclusive breastfeeding for the first 6 mo of life and as long as feasible thereafter; how to introduce solid foods to infants, portion control, the importance of fresh fruits & vegetables, drinking water and maintaining an active lifestyle; and the importance of limiting sugar-sweetened beverages, fast food, and screen time. • Home visitors will impart this information to families during home visits
CHMC's Welcome Baby Program	• Home visitors will teach families about: the importance of, and how to support, exclusive breastfeeding for the first 6 mo of life and as long as feasible thereafter; how to introduce solid foods to infants, portion control, the importance of fresh fruits & vegetables, drinking water and maintaining an active lifestyle; and the importance of limiting sugar-sweetened beverages, fast food, and screen time. This program is in collaboration with Maternal Child Health Access whose staff do the home visits.
Anticipated Impact: The hospital's initiatives to address obesity/overweight are anticipated to result in: prevention of childhood obesity/overweight; early identification and treatment of obesity/overweight in children aged 5-12 yr.; increased knowledge about the importance of healthy eating and maintaining an active lifestyle; less food insecurity by assisting families to access WIC and CalFresh benefits and local food banks; increased healthy eating, healthy cooking, and physical activity among participating adults.	

Health Need: Diabetes Mellitus	
Strategy or Activity	**Summary Description**
Health Ministry Program	• Parish Nurse will screen for pre-diabetes/diabetes • Pre-diabetics will be referred to: National Diabetes Prevention Programs and/or to DEEP
Diabetes Empowerment Education Program	• Pre-diabetics will learn how to prevent type 2 diabetes by increasing their physical activity and healthy eating and losing weight • Diabetics will learn how to manage their disease and prevent complications
Healthy Eating and Lifestyle Program	• Overweight/obese children aged 5-12 yr will be referred to this program by their pediatrician/family physician • The children and their parents will learn to decrease screen time, consumption of fast food, sugar-sweetened beverages, and calorie-dense, nutrient poor foods and to increase their physical activity and consumption of fresh fruits and vegetables and water. • By decreasing children's overweight/obesity, the program will decrease their risk of developing diabetes
HSFC Early Head Start Program	• Pregnant and parenting women with children aged 0-3 yr will learn about the importance of: exclusive breastfeeding for the first 6 months of life with continued breastfeeding for as long as feasible; the consumption of fresh fruits and vegetables as well as water; the avoidance of fast food, sugar-sweetened beverages, and calorie-dense, nutrient poor foods; and maintaining an active lifestyle in order to prevent obesity/overweight

	• Menus of licensed childcare centers will conform with nutrition guidelines for EHS/HS
Licensed childcare centers	• Parenting women with children aged 0-5 yr will learn about the importance of: exclusive breastfeeding for the first 6 months of life with continued breastfeeding for as long as feasible; the consumption of fresh fruits and vegetables as well as water; the avoidance of fast food, sugar-sweetened beverages, and calorie-dense, nutrient poor foods; and maintaining an active lifestyle in order to prevent obesity/overweight. • Menus of licensed childcare centers will conform with nutrition guidelines for EHS/HS
Family Childcare Network	• Parenting women with children aged 0-3 yr will learn about the importance of: exclusive breastfeeding for the first 6 months of life with continued breastfeeding for as long as feasible; the consumption of fresh fruits and vegetables as well as water; the avoidance of fast food, sugar-sweetened beverages, and calorie-dense, nutrient poor foods; and maintaining an active lifestyle in order to prevent obesity/overweight • Menus will conform with nutrition guidelines for EHS/HS
HSFC Youth Center	• Children aged 7-18 yr will learn about healthy eating, healthy cooking, portion control, the importance of maintaining an active lifestyle and healthy coping strategies for life's stressors • They are encouraged to participate in youth fitness program
LABBN's expansion of Welcome Baby Program & select home visitation programs	• Home visiting staff will learn about: the importance of, and how to support, exclusive breastfeeding for the first 6 mo of life and as long as feasible thereafter; how to introduce solid foods to infants, portion control, the importance of fresh fruits & vegetables, drinking water and maintaining an active lifestyle; and the importance of limiting sugar-sweetened beverages, fast food, and screen time. • Home visitors will impart this information to families during home visits
CHMC's Welcome Baby Program	• Home visitors will teach families about: the importance of, and how to support, exclusive breastfeeding for the first 6 mo of life and as long as feasible thereafter; how to introduce solid foods to infants, portion control, the importance of fresh fruits & vegetables, drinking water and maintaining an active lifestyle; and the importance of limiting sugar-sweetened beverages, fast food, and screen time.
Diabetes Support Group	• Individuals with diabetes learn from their peers in a supportive environment on a monthly basis • Healthy cooking demonstrations are included; individuals share recipes
Chronic Disease Self-Management Program	• In 6 weekly workshops participants with chronic conditions learn how to manage and improve their health. • Topics include: pain management, nutrition, exercise, medication use, emotions, and communicating with doctors
CCF Coordinated Care Initiative	• Patients with diabetes, hypertension or congestive heart failure who have their medical home at South Central Family Health Center, T.H.C. Clinic, UMMA Community Clinic, St. John's Well Child and Family Center, South Baby Family Health Center, or Watts Health Center and are in-patients at CHMC are eligible for this program • Deploys HIE*Lite for patient identification and management • Creates care plans for enrolled patients • Coordinates post-discharge care for hospitalized patients • Reduces 30-day readmissions & ED revisits

LA County Community Health Assessment and Action Partnership (LA Partnership) – Diabetes Prevention Workgroup	• A collaborative made up of community benefit directors of non-profit hospitals and health systems of LA County who have agreed to collaborate on their CHNAs and engage in joint population health improvement strategies • The diabetes prevention workgroup will increase collaboration between hospital, the three local health departments, community organizations, and others engaged in community-based diabetes prevention efforts. • It will invest in upstream prevention strategies to maximize population impact ("making the healthy choice the easy choice") • Promote a coordinated set of strategies in selected high need communities to achieve measurable gains.
LA County DPH- led National Diabetes Prevention Program Community Advisory Board	• This group aims to help spread the NDPP throughout LA County, increase access to the program through commercial and public health plans, including Medicare and Medi-Cal thereby increasing access for high-risk, low-income community members with pre-diabetes.
Anticipated Impact: CHMC's initiatives to prevent type 2 diabetes mellitus are anticipated to result in: prevention of childhood obesity/overweight; early identification and treatment of obesity/overweight in children aged 5-12 yr.; early identification and treatment of pre-diabetes and prevention of diabetes; increased knowledge about the importance of healthy eating and maintaining an active lifestyle; less food insecurity by assisting families to access WIC and CalFresh benefits and local food banks; increased healthy eating, healthy cooking, and physical activity among participating adults. CHMC's initiatives for individuals with diabetes are anticipated to result in: learning to manage their disease, improve their health, and prevent complications.	

Health Need: Mental Health	
Strategy or Activity	**Summary Description**
Health Ministry Program	• Individuals seeking treatment will be referred to community resources
HSFC Early Head Start Program	• Parents will be screened for depression/anxiety and intimate partner violence (IPV) • Parents and/or children 0-3 needing treatment will be referred to community resources
Pico Union Family Preservation Network	• Parents will be screened for depression/anxiety and IPV • Parents and/or children needing treatment for mental health issues will be referred to community resources
Wraparound Services Program	• Parents will be screened for depression/anxiety and IPV • Wraparound Program provides community-based support and individualized planning for children, including those with severe emotional and behavioral disorders (SED),and their families • The Wraparound Team creates an intensive family preservation plan that supports keeping the child at home with their family. • Parents and/or children needing treatment for mental health issues will be referred to community resources
Hope Street Youth Center	• Youth needing treatment for mental health issues will be referred to community resources • Youth are encouraged to participate in Youth Fitness Program • Youth will learn how to manage stress through yoga

CA Behavioral Health Clinic	• Children aged 0-21 yr with Medi-Cal will receive mental health services • Women suffering from PMADs receive dyadic care with their infant/toddler
HSFC Early Intervention Program	• Families with infants or toddlers who have a developmental delay or disability or with an established risk condition likely to result in a delay are eligible for services • Specialists evaluate and assess infants and toddlers and provide EI and family support services for young children birth – 3 yr.
UniHealth Transition to Wellness Project	• This project is a partnership with Jewish Family Services designed to provide service navigation to patients with mental illness treated in ED and inpatient hospital units to connect them with community resources and treatment interventions to improve their overall health and social well-being, reduce Ed utilization and hospital readmissions
LABBN's expansion of Welcome Baby Program & select home visitation programs	• Home visitors routinely screen for PMADs and IPV and refer individuals needing treatment to community resources
CHMC's Welcome Baby Program	• Home visitors routinely screen for PMADs and IPV and refer individuals needing treatment to community resources
10th Decile Project	• This Dignity Health Community Grant-funded project connects the top 10% highest cost, highest need homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services through a collaboration of CSH, Housing Works, and John Wesley Community Health Institute, Inc.
Anticipated Impact: The hospital's initiatives to address mental health issues are anticipated to result in: early identification and treatment of women with depression/anxiety or PMADs thereby improving the developmental trajectory of their infants/toddlers and older children; increase access of children and adults to needed mental health services; teach youth and adults how healthy coping skills; by providing navigation services to high risk individuals with mental illness, increase the likelihood of their accessing treatment services	

Health Need: Oral Health	
Strategy or Activity	**Summary Description**
Health Ministry Program	• Parish Nurse will identify individuals needing oral health services and will refer to local FQHCs with dental clinics
Oral Hygiene Classes	• Promotora will provide oral hygiene classes to adults, especially to diabetics who are at high risk for periodontal disease • She will refer those needing oral health services to local FQHCs with dental clinic or to Eisner Health's Periodontal Clinic
Oral Health Initiative	• This Dignity Health Community Grant funded initiative will provide oral health education, universal screenings, fluoride varnish treatment, and linkage to continued dental services for LAUSD students, their families, and community members visiting school-based health clinics and/or Wellness Centers in the following zip codes: 90001, 90002, 90003, 90005, 90007, 90011, 90015, 90037, 90043, 90044, 90047, 90057, and 90061. • This is a collaboration between the LA Trust for Children's Health, LAUSD, South Central Family Health Center, & St. John's Well Child and Family Center

10th Decile Project	• This Dignity Health Community Grant-funded project connects the top 10% highest cost, highest need homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services through a collaboration of CSH, Housing Works, and John Wesley Community Health Institute, Inc. • Homeless patients often have periodontal disease and require extensive oral health services
Para Su Salud Program	• Enrollers assist individuals and families sign up for health and dental health insurance benefits • Recertification is required every 6 months
Anticipated Impact: CHMC's initiatives to address oral health are anticipated to result in: teaching adults how to maintain their oral health; increase access to oral health services; increase access to periodontal treatment services to medication-dependent diabetics and homeless individuals.	

Health Need: Substance Abuse and Alcoholism	
Strategy or Activity	**Summary Description**
Pico Union Family Preservation Program	• Family preservation services are short-term, family-focused services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. • By preventing adverse childhood experiences (ACEs), one can decrease the likelihood that the child will become an alcoholic or drug addict in the future
Wraparound Services Program	• Wraparound Program provides community-based support and individualized planning for children, including those with severe emotional and behavioral disorders (SED),and their families • The Wraparound Team creates an intensive family preservation plan that supports keeping the child at home with their family. • By preventing adverse childhood experiences (ACEs), one can decrease the likelihood that the child will become an alcoholic or drug addict in the future
HSFC Early Head Start Program	• Early Head Start (EHS) is a Federal initiative providing child development and parent support services to low-income pregnant women and families with children birth to 3 years old • Children who participate have lower rates of child abuse and neglect, thereby decreasing the likelihood that they will become an alcoholic or drug addict in the future
HSFC's Licensed Child Care Centers	• Parents learn the importance of responsive caregiving and keeping their children safe • Early education and parent support services are provided to low-income families with children birth to 5 yr. • By preventing adverse childhood experiences (ACEs), one can decrease the likelihood that the child will become an alcoholic or drug addict in the future
HSFC's Family Childcare Network	• Parents learn the importance of responsive caregiving and keeping their children safe • Early education and parent support services are provided to low-income families with children birth to 5 yr. • By preventing adverse childhood experiences (ACEs), one can decrease the likelihood that the child will become an alcoholic or drug addict in the future
CA Behavioral Health Clinic	• Children aged 0-21 yr with Medi-Cal will receive mental health services

	• By diagnosing and addressing children's mental health needs there is a decreased likelihood that they will become an alcoholic or drug addict in the future
HSFC's Early Intervention Program	• Families with infants or toddlers who have a developmental delay or disability or with an established risk condition likely to result in a delay are eligible for services • Specialists evaluate and assess infants and toddlers and provide EI and family support services for young children birth – 3 yr. • Families who understand the nature of their child's delay or disability are less likely to abuse the child • By preventing adverse childhood experiences (ACEs), one can decrease the likelihood that the child will become an alcoholic or drug addict in the future
LABBN's expansion of Welcome Baby Program & select home visitation programs	• Home visitors teach the families about milestones of child development • Families receiving family support services through home visits are significantly less likely to abuse or neglect their children • By preventing adverse childhood experiences (ACEs), one can decrease the likelihood that the child will become an alcoholic or drug addict in the future
CHMC's Welcome Baby Program	• Home visitors teach the families about milestones of child development • Families receiving family support services through home visits are significantly less likely to abuse or neglect their children • By preventing adverse childhood experiences (ACEs), one can decrease the likelihood that the child will become an alcoholic or drug addict in the future
LA County Perinatal and Early Childhood Home Visitation Consortium	• Membership includes the majority of organizations providing home visiting services in LA County. • Working on the development of a plan to expand home visiting services to reach the majority of new families as per the request from the LA County Board of Supervisors; this is part of the Board's plan to decrease the prevalence of child abuse and neglect and improve child well-being throughout the County
UniHealth Transition to Wellness Project	• This project is a partnership with Jewish Family Services designed to provide service navigation to patients with mental illness treated in ED and inpatient hospital units to connect them with community resources and treatment interventions to improve their overall health and social well-being, reduce ED utilization and hospital readmissions • Some of these patients have co-morbidity of alcoholism or SUD (substance use disorder) and will be referred for treatment
10th Decile Project	• This Dignity Health Community Grant-funded project connects the top 10% highest cost, highest need homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services through a collaboration of CSH, Housing Works, and John Wesley Community Health Institute, Inc.
Anticipated Impact: CHMC's initiatives to prevent child abuse or neglect are anticipated to prevent children from suffering from ACEs which are known to impose neurobiological and psychosocial effects that often results in health risk behaviors (smoking, drinking, substance use) in adolescence which, in turn, result in long-term consequences such as alcoholism, SUD, chronic disease, mental illness, unemployment, criminal behavior, and homelessness. CHMC's initiatives to address child abuse and neglect are anticipated to ameliorate the long-term consequences of ACEs. CHMC's initiatives to address mental illness and homelessness are anticipated to increase access to SUD treatment services to those in need.	

Health Need: Cardiovascular Disease, including Hypertension and Cholesterol	
Strategy or Activity	**Summary Description**
Health Ministry Program	• Parish Nurse screens for hypertension, cholesterol, diabetes, obesity/overweight • Refers those with abnormal results to local FQHC if they do not already have a medical home • If interested in smoking cessation, refers then to DPH smoking cessation assistance program and/or 1-800-NO-BUTTS
Heart H.E.L.P.	• Participants learn how to minimize their risk for cardiovascular disease (CVD) by healthy eating and maintaining an active lifestyle and addressing risk factors like obesity/overweight, hypertension, cholesterol, and diabetes.
Diabetes Empowerment Education Program	• Participants with pre-diabetes learn how to prevent diabetes • Participants with diabetes learn how to manage their disease and improve their health in order to prevent complications • Participants learn that diabetes is a major risk factor for CVD and are encouraged to attend Heart HELP after completing DEEP
Chronic Disease Self-Management Program	• In 6 weekly workshops participants with chronic conditions learn how to manage and improve their health. • Topics include: pain management, nutrition, exercise, medication use, emotions, and communicating with doctors
HSFC Healthy Cooking Demonstrations	• Participants learn how to adapt favorite recipes to be more healthy
CCF Coordinated Care Initiative	• Patients with diabetes, hypertension or congestive heart failure who have their medical home at South Central Family Health Center, T.H.C. Clinic, UMMA Community Clinic, St. John's Well Child and Family Center, South Baby Family Health Center, or Watts Health Center and are in-patients at CHMC are eligible for this program • Deploys HIE*Lite for patient identification and management • Creates care plans for enrolled patients • Coordinates post-discharge care for hospitalized patients • Decreases 30-day readmissions and ED revisits
10th Decile Project	• This Dignity Health Community Grant-funded project connects the top 10% highest cost, highest need homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services through a collaboration of CSH, Housing Works, and John Wesley Community Health Institute, Inc. • Many of these patients have chronic conditions such as hypertension, diabetes, or CVD
Anticipated Impact: CHMC's initiatives to address cardiovascular disease including hypertension and cholesterol are anticipated to result in: early identification and treatment of risk factors for CVD thereby decreasing the rate of heart disease and stroke; better management of hypertension, cholesterol, and CVD and improved health.	

Health Need: Access to Health Care	
Strategy or Activity	**Summary Description**
Para Su Salud Program	• Enrollers assist individuals and families sign up for health and dental health insurance benefits • Recertification is required every 6 months

Health Ministry Program	• Parish Nurse screens for common chronic conditions at a variety of sites throughout our service area • Refers those with abnormal results and those without a medical home to local FQHCs
Charity Care based in financial need	• See CHMC's financial assistance policy
Clinical experience for medical professional students	• CHMC is provides clinical experience to: our own Family Practice residents, USC and UCLA residents, Cedars-Sinai residents, Ross University School of Medicine students, and nursing students from a variety of schools.
COPE Health Scholars Program	• Program participants are $\geq$ 18 yr, accepted to, enrolled in, or graduated from an accredited college or university, pursuing a career in health care & basic CPR certified. • They enroll in an 8-unit certification course through UC Riverside Extension delivered on site at CHMC; serve a minimum of 4-6 hr/wk; accumulate $\geq$ 280 hr in order to formally graduate from the program and receive certification of completion. • They work alongside nurses, physicians, and allied health professionals in clinical and administrative settings at CHMC. • They receive training to assist in basic patient-care tasks such as bathing, changing, and feeding patients as they rotate among the different departments of the hospital
10th Decile Project	• This Dignity Health Community Grant-funded project connects the top 10% highest cost, highest need homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services through a collaboration of CSH, Housing Works, and John Wesley Community Health Institute, Inc.
UniHealth Transition to Wellness	• This project is a partnership with Jewish Family Services designed to provide service navigation to patients with mental illness treated in ED and inpatient hospital units to connect them with community resources and treatment interventions to improve their overall health and social well-being, reduce ED utilization and hospital readmissions
Anticipated Impact: The hospital's initiatives to address access to care are anticipated to result in: gains in public or private health care coverage; increased knowledge about how to access and navigate the health care system; increased primary care "medical homes" among those reached by navigators; workforce development in a safety net hospital.	

Health Need: Cancer	
Strategy or Activity	**Summary Description**
Health Ministry Program	• Parish nurse refers those with signs or symptoms of cancer to local FQHCs for diagnosis and treatment • Refers women who need mammography or cervical cancer screening to Women's Health Center
Chronic Disease Self-Management Program	• In 6 weekly workshops participants with chronic conditions learn how to manage and improve their health. • Topics include: pain management, nutrition, exercise, medication use, emotions, and communicating with doctors
CHMC's Women's Health Center	• Uninsured women are referred to Women's Health Center for free mammography and cervical cancer screening

Anticipated Impact: CHMC's initiatives to address cancer are anticipated to result in: increased screening, identification, and treatment of breast and cervical cancer; learning how to manage and improve health.

Health Need: Birth Outcomes	
Strategy or Activity	**Summary Description**
LABBN's expansion of Welcome Baby Program & select home visitation programs	• Home visiting services start prenatally and can improve birth outcomes by decreasing prematurity and low birth weight • Programs are offered by 14 hospitals throughout LA County including at CHMC • Patients experiencing their first pregnancy are enrolled in Nurse Family Partnership which is run by LA County DPH.
CHMC's Welcome Baby Program	• Home visiting services start prenatally and can improve birth outcomes by decreasing prematurity and low birth weight
HSFC's Early Head Start Program	• Pregnant women can enroll in home-based EHS services • Home visiting services starting prenatally can improve birth outcomes by decreasing prematurity and LBW
Improving birth outcomes for African American babies in LA County	• CHMC was invited to participate in this initiative led by LA County DPH because of our high proportion of African American births • This initiative aims to decrease black infant mortality by decreasing prematurity, LBW, and SIDS.
Decreasing preterm birth of African American Babies in CA	• CHMC was invited to participate in this initiative led by CDPH • This initiative aims to decrease the rate of preterm birth among African American babies in CA by implementing the March of Dimes strategies to prevent prematurity.
LA County Perinatal and Early Childhood Home Visitation Consortium	• Membership includes the majority of organizations providing home visiting services in LA County. • In FY18 developed a plan to expand home visiting services to reach more new families as per the request from the LA County Board of Supervisors • In FY19 implement plan to expand PAT and HFA in Los Angeles County. Services to be offered by certified PAT and HFA providers who will hire additional staff with funding from LACDMH
Anticipated Impact: CHMC's initiatives to improve birth outcomes are anticipated to result in: decreased prematurity and LBW by providing intensive case management, health education, and improved access to needed resources through perinatal and early childhood home visiting programs; decreased disparities in birth outcomes among African American women compared to other racial/ethnic groups in our county and state.	

Health Need: Health Literacy	
Strategy or Activity	**Summary Description**
HSFC' s Family Literacy Program	• Family literacy programs help parents improve both their parenting and literacy skills while providing young children with early childhood education • Parents learn ESL and the importance of child-led play
HSFC's Early Head Start Program	• Beginning with expectant families, healthy, loving relationships between parents and children will lead to success in school and life

	• EHS promotes school readiness in a variety of ways including encouraging parents to talk, read and sing to the infants, toddlers and young children.
HSFC's Licensed Childcare Centers	• Children 0-5 learn school readiness skills at these early care and learning centers that meet the rigorous EHS/HS standards
HSFC's Family Childcare Network	• Children 0-5 learn school readiness skills at these early care and learning centers that meet the rigorous EHS/HS standards
Hope Street Youth Center	• Youth aged 7-18 can access homework assistance, a computer learning lab, and the Youth Fitness Program at this afterschool program • College students provide mentoring and learning opportunities • High school students and their parents participate in College Prep training and local college tours • During the summer, a special STEM Program is offered in collaboration with the Museum of Science & Industry
LABBN's expansion of Welcome Baby Program & select home visitation programs	• Home visitors encourage parents to talk, read, and sing to their infants, toddlers, and young children
CHMC's Welcome Baby Program	• Home visitors encourage parents to talk, read, and sing to their infants, toddlers, and young children
Anticipated Impact: CHMC's initiatives to improve literacy in general and more specifically health literacy are anticipated to result in: improved school readiness; improved success in elementary, middle, and high school; improved college readiness; greater likelihood of pursuing higher education; improved health literacy, i.e., the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.	

Health Need: Injury Prevention – Gang Prevention	
Strategy or Activity	**Summary Description** [
HSFC's Youth Center	• Youth aged 7-18 can access homework assistance, a computer learning lab, and the Youth Fitness Program at this afterschool program • Youth develop relationships with caring adults
HSFC's Youth Fitness Program	• Youth aged 7-18 can participate in a variety of physical activity programs • Youth learn healthy coping skills through yoga
CA Behavioral Health Clinic	• Children aged 0-21 yr with Medi-Cal will receive mental health services • By diagnosing and addressing children's mental health needs there is a decreased likelihood that they will join a gang
Anticipated Impact: CHMC's initiatives to address gang prevention are anticipated to result in: more youth participating in productive learning and fitness activities after school, surrounded by healthy, caring adults with whom they can talk and interact.	

Health Need: Injury Prevention – Child Car Seat Safety and Home Safety	
Strategy or Activity	**Summary Description**
Maternity Tours	• Car seat safety is discussed at Maternity Tours • No infant can be released from the hospital without there being an infant car seat installed in the car • Free car seats are given to all new parents delivering at CHMC
LABBN's expansion of Welcome Baby	• Participating families receive First 5 LA *Kit for New Parents* that discusses car seat safety and making your home safe for an infant/toddler

Program & select home visitation programs	• Home visitors also discuss these topics with families during home visits • Home visitors give all families a home safety kit
CHMC's Welcome Baby Program	• Participating families receive First 5 LA *Kit for New Parents* that discusses car seat safety and making your home safe for an infant/toddler • Home visitors also discuss these topics with families during home visits • Home visitors give all families a home safety kit
Anticipated Impact: CHMC's initiatives to address child car seat safety and home safety are anticipated to result in: less severe injuries if the car that the infant/child is riding in is involved in an accident; less accidental injuries involving infants/toddlers if the parents have used a home safety kit to cover plugs, keep cupboard doors shut (especially those with cleaning supplies, etc), and put up a gate by stairs.	

Health Need: Injury Prevention – Child Abuse and Neglect	
Strategy or Activity	**Summary Description**
Pico Union Family Preservation Network	• Family preservation services are short-term, family-focused services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. • The most common indication for FPS is suspected/documented child abuse or neglect
Wraparound Services Program	• Wraparound Program provides community-based support and individualized planning for children, including those with severe emotional and behavioral disorders (SED),and their families • The Wraparound Team creates an intensive family preservation plan that supports keeping the child at home with their family.
HSFC's Early Head Start Program	• Early Head Start (EHS) is a Federal initiative providing child development and parent support services to low-income pregnant women and families with children birth to 3 years old • Children who participate have lower rates of child abuse and neglect
HSFC's License Childcare Centers	• Parents learn the importance of responsive caregiving and keeping their children safe • Early education and parent support services are provided to low-income families with children birth to 5 yr.
HSFC's Family Childcare Network	• Parents learn the importance of responsive caregiving and keeping their children safe • Early education and parent support services are provided to low-income families with children birth to 5 yr.
CA Behavioral Health Clinic	• Children aged 0-21 yr with Medi-Cal will receive mental health services • If children have been victims of child abuse or neglect, it is important to address their resulting mental health needs as promptly as possible in order to prevent long-term consequences of ACEs
HSFC's Early Intervention Program	• Families with infants or toddlers who have a developmental delay or disability or with an established risk condition likely to result in a delay are eligible for services • Specialists evaluate and assess infants and toddlers and provide EI and family support services for young children birth – 3 yr. • Families who understand the nature of their child's delay or disability are less likely to abuse the child
LABBN's expansion of Welcome Baby	• Home visitors teach the families about milestones of child development

Program & select home visitation programs	• Families receiving family support services through home visits are significantly less likely to abuse or neglect their children
CHMC's Welcome Baby Program	• Home visitors teach the families about milestones of child development • Families receiving family support services through home visits are significantly less likely to abuse or neglect their children
LA County Perinatal and Early Childhood Home Visitation Consortium	• Membership includes the majority of organizations providing home visiting services in LA County. • In FY18 developed a plan to expand home visiting services to reach the majority of new families as per the request from the LA County Board of Supervisors; this is part of the Board's plan to decrease the prevalence of child abuse and neglect and improve child well-being throughout the County • In FY19 implement plan to expand PAT and HFA in Los Angeles County. Services to be offered by certified PAT and HFA providers who will hire additional staff with funding from LACDMH
Dignity Health Human Trafficking Response Initiative	• CHMC has a Human Trafficking Response Task Force that is responsible for implementing the strategy designed by Dignity Health • The local task force is responsible for staff and provider training • The goal is to identify potential victims of sex and/or labor trafficking in our ED and other hospital units. • CHMC works closely with our community partners, LAPD Vice Squad and Coalition Against Slavery and Trafficking (CAST LA).
Anticipated Impact: CHMC's initiatives to prevent child abuse and neglect are anticipated to prevent children from suffering from ACEs which are known to impose neurobiological and psychosocial effects that often results in health risk behaviors (smoking, drinking, substance use, promiscuity) in adolescence which, in turn, result in long-term consequences such as alcoholism, SUD, chronic disease, mental illness, unemployment, criminal behavior, and homelessness. CHMC's initiatives to address child abuse and neglect are anticipated to ameliorate the long-term consequences of ACEs.	

Health Need: Injury Prevention – Family Violence Prevention	
Strategy or Activity	**Summary Description**
Health Ministry Program	• Parish Nurse refers potential victims to community partners providing needed services including shelter services
Pico Union Family Preservation Network	• A support group for women who are victims of IPV is conducted in Spanish every week • An anger management group for men and women is conducted in Spanish every week • A parenting group for men and women is conducted in Spanish every week
Wraparound Services Program	• Wraparound Program provides community-based support and individualized planning for children, including those with severe emotional and behavioral disorders (SED),and their families • The Wraparound Team creates an intensive family preservation plan that supports keeping the child at home with their family. • Parents are referred to the support group for women who are victims of IPV, anger management group, and/or parenting group as needed
HSFC's Early Head Start Program	• Early Head Start (EHS) is a Federal initiative providing child development and parent support services to low-income pregnant women and families with children birth to 3 years old • Participants are routinely screened for IPV and referred for counseling and support as needed

HSFC's Early Intervention Program	• Families with infants or toddlers who have a developmental delay or disability or with an established risk condition likely to result in a delay are eligible for services • Specialists evaluate and assess infants and toddlers and provide EI and family support services for young children birth – 3 yr. • Families are routinely screened for IPV and referred for counseling and support as needed
CA Behavioral Health Clinic	• Children aged 0-21 yr with Medi-Cal will receive mental health services • Some children suffer from PTSD as a result of witnessing IPV involving their parents
LABBN's expansion of Welcome Baby Program & select home visitation programs	• Home visitors routinely screen for IPV and refer victims for counseling services • Home visitors educate the families about the impact of witnessing IPV on the children in the household • Child witnesses are referred for counseling services at CA Behavioral Health Clinic
CHMC's Welcome Baby Program	• Home visitors routinely screen for IPV and refer victims and perpetrators for counseling services • Home visitors educate the families about the impact of witnessing IPV on the children in the household • Child witnesses are referred for counseling services at CA Behavioral Health Clinic
Dignity Health Human Trafficking Response Initiative	• CHMC has a Human Trafficking Response Task Force that is responsible for implementing the strategy designed by Dignity Health • The local task force is responsible for staff and provider training • The goal is to identify potential victims of sex and/or labor trafficking in our ED and other hospital units. • CHMC works closely with our community partners, LAPD Vice Squad and Coalition Against Slavery and Trafficking (CAST LA). • A majority of victims will present to health care with evidence of IPV
Anticipated Impact: CHMC's initiatives to prevent and/or treat family violence are anticipated to result in: less long-term consequences as a result of being a witness to family violence (one of the ACEs); early intervention with mental health services for those who witnessed family violence; comprehensive services to victims of family violence; youth and children developing healthy coping and communication skills so that they don't resort to physical, verbal, or sexual abuse; parents understanding the potential long-term consequences of a child witnessing family violence.	

Anticipated Impact

The anticipated impacts of the hospital's activities on significant health needs are summarized above, and for select program initiatives are stated in the Program Digests on the following pages. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to needed and beneficial care; and help create conditions that support good health. The hospital is committed to measuring and evaluating key initiatives. The hospital creates and makes public an annual Community Benefit Report and Plan, and evaluates impact and sets priorities for its community health program in triennial Community Health Needs Assessments.

Planned Collaboration

California Hospital Medical Center participated in one Community Building Initiative in FY18:

The BUILD Health Challenge Project entitled *Youth-Driven Healthy South Los Angeles*
12 Project Partners
Goal: To develop and implement a community-driven action plan for South Central and Central Alameda neighborhoods that addresses key upstream solutions to tackling obesity, diabetes, and cardiovascular disease.

CHMC's other planned collaborations include:

UniHealth Transition to Wellness Project
2 Project Partners
Goal: To provide service navigation to patients with mental illness treated in the Emergency Department and inpatient hospital units to connect them with community resources and treatment interventions to improve their overall health and social well-being, reduce ED utilization and hospital readmissions

CCF Coordinated Care Initiative
8 Project Partners
Goal: To enhance care coordination across the local healthcare continuum, as patients with chronic diseases, specifically diabetes, hypertension, or congestive heart failure, are discharged from CHMC, in order to improve patient outcomes and reduce readmissions.

Los Angeles Best Babies Network
38 Project Partners
Goal: To expand Welcome Baby to 14 hospitals in Los Angeles County and to spread select intensive home visitation programs, Parents as Teachers and Healthy Families America.

Community Wellness Collaborative Project
5 Project Partners
Goal: To offer wellness activities that prevent chronic diseases through physical fitness and health education at two sites, Hope Street Margolis Family Center and Immanuel Presbyterian Church

10th Decile Project
4 Project Partners
Goal: To connect the top 10% highest cost, highest need homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services

Oral Health Initiative
5 Project Partners
Goal: Increase Kindergarten Oral Health Assessment compliance rate from baseline 30% to 60% at targeted school sites; Decrease active dental disease in student population from baseline 64% in comparable populations to less than 53% as shown by past evaluations; Connect minimum of 50% of students screened at school programs to a dental home; 100% of targeted campuses will establish standard annual kindergarten screening.

CHMC is also involved in the following community-wide collaboratives:

Los Angeles County Community Health Assessment and Action Partnership (LA Partnership)
Goal: To maximize the collective impact of community benefit activities in LA County by promoting best practices and alignment in Community Health Needs Assessments, and prevention-oriented implementation strategies among hospitals and community partners.

Women's Health Policy Council for the Los Angeles County Office of Women's Health
Goal: To serve as the primary source of review and guidance for the Office of Women's Health by: developing a women's health strategic plan for women's health policies, services, and programs; evaluating programs and policies affecting women's health; and prioritizing scientific, medical, ethnical, and policy issues related to improving the health status of women

Los Angeles County Diabetes Prevention Community Advisory Board
Goal: To decrease the incidence of type 2 diabetes in LA County by addressing pre-diabetes through the spread of sites offering NDPP, public and private insurance coverage of the NDPP, and pre-diabetics participating in the NDPP.

Financial Assistance for Medically Necessary Care

California Hospital Medical Center delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services. A plain language summary of the hospital's Financial Assistance Policy is in Appendix C. The amount of financial assistance provided in FY18 is listed in the Economic Value of Community Benefit section of this report.

The hospital notifies and informs patients and members of the community about the Financial Assistance Policy in ways reasonably calculated to reach people who are most likely to require patient financial assistance. These include:

- providing a paper copy of the plain language summary of the Policy to patients as part of the intake or discharge process;
- providing patients a conspicuous written notice about the Policy at the time of billing;
- posting notices and providing brochures about the financial assistance program in hospital locations visible to the public, including the emergency department and urgent care areas, admissions office and patient financial services office;
- making the Financial Assistance Policy, Financial Assistance Application, and plain language summary of the Policy widely available on the hospital's web site;
- making paper copies of these documents available upon request and without charge, both by mail and in public locations of the hospital; and
- providing these written and online materials in appropriate languages.

Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs in the most recent CHNA report. The digests include program descriptions and intervention actions, statements of which health needs are being addressed, any planned collaboration, and program goals and measurable objectives.

Health Ministry Program	
Significant Health Needs Addressed	☒ Significant Health Need 1 Obesity/Overweight ☒ Significant Health Need 2 Diabetes ❑ Significant Health Need 3 Mental Health ☒ Significant Health Need 4 Oral Health ❑ Significant Health Need 5 Substance Use Disorders ☒ Significant Health Need 6 Cardiovascular Disease ❑ Significant Health Need 7 Cancer
Core Principles Addressed	☒ Focus on Disproportionate Unmet Health-Related Needs ❑ Emphasize Prevention ☒ Contribute to a Seamless Continuum of Care ❑ Build Community Capacity ☒ Demonstrate Collaboration
Program Description	CHMC sponsors the Parish Nurse and community health *promotoras* (CHWs) at over 55 schools, churches, and community sites to provide health screenings, health education and information, and referral services. Each site selects their health education classes from a menu of choices offered annually. Health Ministry staff also participates in some local health fairs.
Community Benefit Category	Community Health Improvement Services: A1. Community-based health education A2. Community-based clinical services
Planned Actions for 2018 - 2020	
Program Goal / Anticipated Impact	Eliminate health disparities in CHMC's service area by screening for common chronic conditions and referring people to medical homes for treatment and follow-up. Heart HELP: Educate participants about how to minimize their risk for cardiovascular disease (CVD) by healthy eating and maintaining an active lifestyle and addressing risk factors like obesity/overweight, hypertension, cholesterol, and diabetes. Healthy Eating Lifestyle Program: Educate focus children and their parents about how to decrease the risk of overweight/obese children aged 5-12 from becoming obese adolescents by healthy eating, maintaining an active lifestyle (at least 1 hr of physical activity/day) and reducing screen time to less than 2 hr/day. Diabetes Empowerment Education Program: Educating participants with either prediabetes or diabetes how to reduce or postpone becoming diabetic and/or to decrease their risk of complications from diabetes by maintaining their HbA1c< 7 by losing weight, eating a healthy diet, and maintaining an active lifestyle and taking medication as recommended by their health care provider. Healthy Living aka Chronic Disease Self-Management Program: Increase the ability of people with chronic conditions to manage their health and maintain active and fulfilling lives
Measurable Objective(s) with Indicator(s)	Health screens: Number of individuals screened for obesity (BMI), hypertension (BP), prediabetes/diabetes (HbA1c), hyperlipidemia (cholesterol), and anemia (Hgb); number of health screening events; number and type of referrals made Heart HELP: • increase the proportion of adults with hypertension who meet guidelines for BMI; saturated fat consumption; sodium intake; physical activity; and smoking cessation • increase the proportion of adults with hypertension who take the prescribed medications to lower their blood pressure • Increase the proportion of adults with hypertension whose blood pressure is under control

	• Increase the proportion of adults aged 20 yr and older who are aware of the symptoms of and how to respond to a heart attack or stroke Healthy Eating Lifestyle Program: • Reduce weight or weight velocities; BMI < 85% for age in children • Normal lipid levels (if initial screening cholesterol > 200) • Reduce % of body fat • Improve exercise tolerance • Self-reported: o Improve food selection – more "gold and silver" selections and less "bronze and brick" selections o Increased exercise frequency: goal 1 hr, at least 3 times/wk o Reduce screen time to < 2 hr/day o Improved exercise and nutrition self-efficacy Diabetes Empowerment Education Program: • Reduce diabetes risk factors, including obesity and hypertension • Increase knowledge of diabetes and its risk factors • Increase self-management skills • Manage psychosocial issues • Facilitate short- and long-term behavioral change Healthy Living aka CDSMP: • Improve health behaviors: exercise, cognitive symptom management, and communication with physicians • Improve self-efficacy • Improve health status: fatigue, shortness of breath, pain, role function, depression, and health distress • Reduce visits to ED and hospitalizations • Decrease consumption of sugar-sweetened beverages and fast food
Intervention Actions for Achieving Goal	Provide free health screens for common chronic conditions at Health Ministry sites and Hope Street Margolis Family Center (HSFC) Provide referrals to primary care clinics when screening tests are positive and/or if participant does not have a medical home. Participate in local health fairs as requested Offer free workshop series in English and/or Spanish at schools, churches, and community sites, including at community clinics and HSFC, in CHMC's service area. Workshop series include: Heart HELP, H.E.L.P., DEEP, and CDSMP. Conduct health screens before and after workshop series to document impact of program participation.
Planned Collaboration	We collaborate with ~50 schools, churches, clinics, and community sites in our service area that provide the venues for these screenings and health education workshops.

CCF Coordinated Care Initiative	
Significant Health Needs Addressed	❑ Significant Health Need 1 Obesity/Overweight ☒ Significant Health Need 2 Diabetes ❑ Significant Health Need 3 Mental Health ❑ Significant Health Need 4 Oral Health ❑ Significant Health Need 5 Substance Use Disorders ☒ Significant Health Need 6 Cardiovascular Disease ❑ Significant Health Need 7 Cancer
Core Principles Addressed	☒ Focus on Disproportionate Unmet Health-Related Needs ❑ Emphasize Prevention ☒ Contribute to a Seamless Continuum of Care ❑ Build Community Capacity ☒ Demonstrate Collaboration
Program Description	Using a new health information exchange, HIE*Lite (developed by Trans World Health Services), patients admitted for inpatient care at CHMC, who have diabetes, hypertension, and/or congestive heart failure, and are patients of participating clinics, will be identified for follow-up. The licensed vocational nurse/care coordinator will make bedside visits to identified patients at CHMC within 24 hours of admission; enrolling and helping them transition to outpatient care by getting them a clinic appointment within 72 hours of discharge or less. During the patient's first f/u visit at the clinic, a multidisciplinary team including a physician, physician-extender staff, nutritionist and/or others as appropriate will develop an individualized, evidence-based care plan, encompassing the multiple clinical and ancillary services needed. The care coordinator will place a follow-up call to each enrolled patient within 5 days of discharge and will help as needed with referrals, care coordination, and medication management. For patients requiring further assistance, the care coordinator may make additional calls in the weeks following discharge.
Community Benefit Category	Community Health Improvement Services A3. Health Care Support Services
Planned Actions for 2018 – 2020	
Program Goal / Anticipated Impact	Increase the percentage of eligible patients seen by the LVN/care coordinator within 24 hr of admission to 50% of all eligible patients. Increase the percentage of eligible patients who have a clinic appointment booked before they leave the hospital for within 72 hr of discharge from a baseline of 4.7% of all eligible patients or 6.3% of assessed patients to 80% of eligible patients seen by LVN during their initial hospital stay. Decrease the clinic-originated delays that delay securing an appointment date and time to enable LVN to book clinic appointment for within 72 hr of patient discharge from CHMC. Anticipated impact if appointment booked prior to discharge and kept within 72 hr of discharge: readmission rate of <10% that would be ~50% reduction of baseline 30-day readmission rate
Measurable Objective(s) with Indicator(s)	% of eligible patients seen by LVN/care coordinator within 24 hr of admission. %of eligible patients seen by LVN/care coordinator during hospital admission who have a clinic appointment booked before they leave the hospital for within 72 hr of discharge % of eligible patients who receive a follow-up call from LVN within 5 days of discharge. % of booked clinic appointments that could not be made within 72 hr of hospital discharge because of clinic-originated delays

	30-day readmission rates for eligible patients: inpatient, emergency, and outpatient. Document the diagnosis(es) of readmission patients
Intervention Actions for Achieving Goal	Continue to use HIE*Lite for patient identification and management LVN/care coordinator will visit eligible patients within 24 hr of hospital admission and complete assessment LVN/care coordinator will book clinic appointment for eligible patients during their hospital stay for within 72 hr of hospital discharge. Participating clinics will reserve 5 appointments/day for eligible patients in order to minimize clinic-originated delays LVN/care coordinator will make follow-up calls to eligible patients within 5 days of hospital discharge. During the patient's first f/u visit at the clinic, a multidisciplinary team including a physician, physician-extender staff, nutritionist and/or others as appropriate will develop an individualized, evidence-based care plan, encompassing the multiple clinical and ancillary services needed.
Planned Collaboration	This is a collaboration between MedPoint Management, CHMC, the Southside Coalition of Community Health Centers that includes the following clinics: South Central Family Health Center, T.H.E. Clinic, UMMA Community Clinic, St. John's Well Child and Family Center, South Bay Family Health Center, and Watts Health Center.

Hope Street Family Center Early Head Start Program	
Significant Health Needs Addressed	☒ Significant Health Need 1 Obesity/Overweight ☒ Significant Health Need 2 Diabetes ☒ Significant Health Need 3 Mental Health ☒ Significant Health Need 4 Oral Health ☒ Significant Health Need 5 Substance Use Disorders ☒ Significant Health Need 6 Cardiovascular Disease ☒ Significant Health Need 8 Access to Health Care ☒ Significant Health Need 9 Birth Outcomes ☒ Significant Health Need 10 Health Literacy ☒ Significant Health Need 11 Injury Prevention
Core Principles Addressed	☒ Focus on Disproportionate Unmet Health-Related Needs ☒ Emphasize Prevention ☒ Contribute to a Seamless Continuum of Care ☒ Build Community Capacity ☒ Demonstrate Collaboration
Program Description	Core services of EHS include: early childhood education (ECE); healthcare and mental health services; parenting education; childcare; adult education; and housing, legal, and financial assistance. We have put into place a continuum of home and center-based early childhood education services that responsively meet the individual and changing needs of young families. Options currently available to families include: 1) home-based services with weekly in-home ECE, along with twice-per month socialization opportunities; 2) full-year, full-day center-based ECE, with monthly home visits; 3) combination option services, with daily center-based family literacy services, combined with biweekly in-home ECE; and biweekly in-home ECE, concurrent with enrollment in high-quality childcare and bimonthly visits at the childcare site. Priority for EHS enrollment is given to: pregnant mom with child already enrolled in EHS; homeless families; foster children; children with special needs; parents interested in ESL or high school diploma/GED studies; and families participating in other HSFC programs. Enrollment priorities reflect 2016 HSFC EHS Community Health Needs Assessment data that document a high incidence of developmental disabilities and homelessness within the service area; large numbers of recent immigrant, mono-lingual Spanish-speaking young families; and low adult literacy and educational levels.
Community Benefit Category	Community Health Improvement Services A1. Community Health Education A2. Community-based clinical services A3. Health care support services Community Building Activities: F3. Community support F5. Leadership Development and Leadership training for community members
Planned Actions for 2018 - 2020	
Program Goal / Anticipated Impact	1. Promote children's (infant/toddler) overall development 2. Enhance the capacity of parents to nurture and care for their young children 3. Build on existing services and foster community partnerships to increase services for young children and families 4. Expand staff knowledge, skills, and competencies in working with young children and their families
Measurable Objective(s) with Indicator(s)	Maintain full enrollment throughout the year. At least 10% of EHS children will have a disability

	Goal 1: 100% of classrooms will provide quality environments that support optimal development; 70% of children who receive at least 6 mo. of service will demonstrate age-appropriate development. Goal 2: 80% of parents will acquire skills to support learning and language development; improved school/employments opportunities for 60% of working/studying parents; case management supports for all parents; 100% on-time health screens; 95% current well-child care and immunizations. Goal 3: 60% of parents will participate in leadership and civic engagement opportunities. Goal 4: 75% of teachers will hold a Bachelor's Degree or will be progressing toward a BA; 100% of teachers without a degree will progress toward an Associate's Degree; 100% of staff will demonstrate professional competency.
Intervention Actions for Achieving Goal	Continue to provide EHS services for qualifying families in our service area in accordance with EHS performance standards and guidance as specified in our contract and implementation plan
Planned Collaboration	HSFC has signed MOUs with the following organizations: Angelica Church, St. Marks Church, Crystal Stairs Pathways, Children's Learning Center, Museum of Contemporary Art, Enrichment Works, Community Counseling Services, LAUSD, Pacific Asian Consortium in Employment, UCLA, LA City College, West ED, Bresee Foundation, Chrysallis, First 5 LA, LA Conservation Corp, St. Francis Center, Eisner Health, CHMC-Eisner Health Family Practice, WIC, Pico Union Housing Corp, Esperanza Community Housing Corp, Asian Pacific American Legal Center, Lanterman Regional Center, South Central Regional Center, LA County DHS, LA County DCFS, LA Trade Technical College, Abram Friedman Vocational Education Center.

Family Strengthening Oversight Entity aka Welcome Baby Replication Initiative & Implementation of Select Home Visitation Programs in LA County	
Significant Health Needs Addressed	☒ Significant Health Need 1 Obesity/Overweight ❑ Significant Health Need 2 Diabetes ☒ Significant Health Need 3 Mental Health ❑ Significant Health Need 4 Oral Health ☒ Significant Health Need 5 Substance Use Disorders ☒ Significant Health Need 9 Improving Birth Outcomes ☒ Significant Health Need 10 Improving Health Literacy ☒ Significant Health Need 11 Injury Prevention
Core Principles Addressed	☒ Focus on Disproportionate Unmet Health-Related Needs ☒ Emphasize Prevention ☒ Contribute to a Seamless Continuum of Care ☒ Build Community Capacity ☒ Demonstrate Collaboration
Program Description	The FSOE oversees and supports the standardization of the Welcome Baby Program to ensure adherence to program fidelity by the Welcome Baby sites across the county. The Oversight Entity also provides training and technical assistance to all home visitors, supports to the Select Home Visitation providers and support efforts to develop referral pathways between Welcome Baby and Select Home Visitation providers, as well as other existing home visitation programs in each Best Start Community. Additional responsibilities include the provision of technical assistance to providers utilizing First 5 LA's data management information system; facilitation of cross-site peer learning exchanges; and coordination and support of communication and messaging efforts. LA Best Babies Network (LABBN) is the primary contractor for the FSOE grant from First 5 LA; LABBN is a community benefit of CHMC where the staff is based. The staff is CHMC employees
Community Benefit Category	Community Health Improvement Services: A1 Community health education A2. Community-based clinical services A3. Health care support services Community-Building Activities: F3. Community support F7. Advocacy for community health improvements & safety F8. Workforce development
Planned Actions for 2018 - 2020	
Program Goal / Anticipated Impact	Build and strengthen the knowledge and awareness of WB and SHV staff on theory, research, and topics that will support their working with families using a strengths-based, client-centered and solution-focused approach for strengthening families Promote the development and application of skills by the WB and SHV staff that will support their work with families Provide guidance, coaching, and training to WB and SHV sites to promote implementation of the program models with fidelity Establish a seamless integration of WB into the organizational (hospital) structure Promote the establishment of a strong infrastructure within WB and SHV sites to ensure that program outcomes are achieved Promote the establishment of a strong infrastructure within WB and SHV sites to sustain these family strengthening services

Measurable Objective(s) with Indicator(s)	Measurable, observable, and attainable objectives including: • Outcomes-changes in health/mental health status, developmental status, attitudes, behaviors, knowledge, skills, practices, or policies • Outputs-the direct result of activities and typically expressed as the number or scope of services and/or products that are delivered or produced o # staff trained/yr o #families served/yr • Major Deliverables-tangible products that are submitted in fulfillment of contract requirements WB and SHV training, implementation, and cross-site professional development WB and SHV technical assistance Stronger Families Database efforts and coordination WB and SHV evaluation and fidelity oversight Marketing and Communication Perinatal and Early Childhood Home Visitation Consortium Regional Breastfeeding Consortium Key Partner coordination and reporting requirements
Intervention Actions for Achieving Goal	Coordinate and implement two sets of trainings of core topics for new WB and SHV program staff in conjunction and with participation of MCHA and PAC/LAC as needed annually. Update, as needed, and distribute WB Orientation and Protocols Manuals via online links to 14 WB and all SHV programs annually Provide training and ongoing TA to WB and SHV staff as new features are developed for the Stronger Families Database Provide leadership and oversight for database development activities Convene and facilitate one, full day, peer learning workshop within each of the four regions of LA County annually to provide opportunities for cross-site learning for WB and SHV staff Convene one, full day, peer learning workshop for all WB programs annually and one for all SHV programs annually. Implement 2 Successful Leadership and Change Management Workshop for new WB and SHV staff annually Provide Reflective Practice coaching sessions monthly for WB clinical supervisors and separately for SHV supervisors Conduct annual audits of each WB and/or SHV site for model fidelity, implementation progress, and to identify any challenges and successes according to the established protocol Coordinate with F5LA staff and all external evaluators of WB and/or SHV programs Provide marketing and messaging templates to ensure consistent messaging across WB and SHV sites Convene quarterly meetings of LA County Perinatal and Early Childhood Home Visitation Consortium (LACPECHVC) Plan and convene with Consortium partners monthly workgroup meetings – Referrals, Best Practices, Advocacy and Data
Planned Collaboration	The primary partners of the FSOE are: LABBN, First 5 LA, Maternal Child Health Access (MCHA), and the Perinatal Advisory Council: Leadership, Advocacy & Consultation (PAC/LAC). Our hospital partners are: CHMC, Providence Holy Cross Medical Center, Northridge Hospital Medical Center, Valley Presbyterian Hospital, Citrus Valle Medical Center (Queen of the Valley Campus), White Memorial Medical Center, St. Francis Medical Center, Centinela Hospital, Miller Children's Hospital, Providence Little Company of

	Mary, Torrance Memorial Medical Center, St. Mary Medical Center and Martin Luther King Jr. Community Hospital. Our community partners include: Antelope Valley Partners for Health, Children's Bureau, Child and Family Guidance Center, Child Care Resource Center, Children's Center of Antelope Valley, El Nido Family Center, Friends of the Family, SPIRITT Family Services, Foothill Family Services, Human Services Association, Plaza Community Services, The Whole Child, Shields for Families, Children's Institute, South LA BioMed, LA Child Guidance Clinic, Richstone Family Center, Families in Good Health, The Children's Clinic, and Pacific Asian Counseling Services.

Welcome Baby and Select Home Visitation* Training Topics

Welcome Baby Framework & Orientation
Outreach & Communications: Keeping Our Language Consistent
Reflective Practice*
Home Visitor Safety and Self-Defense*
WB Nurse Visit
WB Parent Coach Visit
Universal Risk Assessment: Bridges for Newborns Screening*
HIPAA and Informed Consent
Data Collection & Performance Improvement
Bonding and Attachment*
Developing Empathy and Parent Child Communication*
Developmental Milestones: Birth to 12 mo; Birth to 5 yr*
Brain Development and Early Infant Development*
Childbirth Education
Preventive Care: Prenatal and Postpartum Care
Preventive Care: Newborn Care; Well-Child Care*
Safe Sleep
Family Planning and Contraception*
Healthy Homes and Home Safety
Perinatal Depression and the PHQ-9*
Child Abuse and Neglect and Mandatory Reporting*
Family Violence
Cultural Competency
Certified Lactation Educator Training (UCSD)
Health Coverage for Pregnant Women and Newborns*
Motivational Interviewing*
Impact of Adverse Childhood Experiences on the Life Course*
Life Skills Progression Training
Stronger Families Database: Data Collection, Tracking and Reporting*

APPENDIX A: COMMUNITY BOARD OF DIRECTORS

OFFICERS

Phillip C. Hill, Chair; Veronica Perez, Vice Chair; and Tammara Anderson, Secretary

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Associate Dean
University of Southern California
Office of Experiential and Applied Learning
USC Dornsife College of Letters, Arts and Sciences

KELLY A. BRUNO
Chief Executive Officer
National Health Foundation

ROBERT BUENTE
President and CEO
1010 Development Corporation

KRIS H. DAVIS, CPCU
Managing Director and Head of Office
Southwest Zone Leader
MARSH

PHILLIP C. HILL
Chair, Hospital Community Board
California Hospital Medical Center

GUDATA S. HINIKA, MD
Medical Director, Trauma Program
California Hospital Medical Center

RALPH MAYER, MD
Chief of Staff
California Hospital Medical Center

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Chief Executive Officer
Cooperative of American Physicians

VERONICA PEREZ
President
Veronica Perez & Associates

MARGARET R. PETERSON, PhD
President
California Hospital Medical Center

MARTHA SAUCEDO
Vice President of Community Affairs
AEG

CARLOS ANTONIO VAQUERANO
Interim Executive Director
Clinica Oscar A. Romero

FERNANDO VILLA
Partner
Allen Matkins

APPENDIX B: OTHER PROGRAMS AND NON-QUANTIFIABLE BENEFITS

The hospital delivers a number of community programs 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.

COPE Health Scholars Program

In June 2015 we implemented the Health Scholar Program, previously known as the Clinical Care Extender Program, designed and administered by COPE Health Solutions and funded by CHMC. This program gives pre-professionals unprecedented access to direct patient care. Program participants become valuable members of the patient-care team, working alongside nurses, physicians, and allied health professionals in clinical and administrative settings. Program participants receive training to assist in basic patient-care tasks such as bathing, changing, and feeding patients as they rotate among the different departments of the hospital.

- Requirements: $\geq$ 18 years old; accepted to, enrolled in, or graduated from an accredited college or university; pursuing a career in health care; Basic CPR certified
- Commitment: enrollment in an 8-unit certification course through UC Riverside Extension delivered on site at CHMC; serve a minimum of 4-6 hr/wk; accumulate $\geq$ 280 hours in order to formally graduate from the program and receive certification of completion.

This year there were a total of 181 Health Scholars. In terms of race/ethnicity: 56% Asian, 32.6% Hispanic/Latino, 32% White, 9.4% African American, 11.6% 2 or more races, 5% other, and 4.4% declined to state. In terms of languages spoken: 5.5% English only, 33.7% Spanish, 18.2% Chinese, 7.8% Korean, 6.6% other Asian, 2.2% Vietnamese, 2.8% Farsi, 2.2% Armenian, 14.4% other. In terms of schools represented: 40% from USC, 23% from various UCs, 15% from CSU, 10% from Community Colleges, 6.6% from out of state, and 5% from other schools. Scholars are currently supporting several clinical departments including medicine/surgery, telemetry, critical care units, couplet care, surgical services, Women's Health Center, pediatrics, antepartum, radiology, labor and delivery, rehabilitation, and education. In FY18 Scholars contributed 29,540 hours of clinical support. The average Health Scholar stays in the program an average of 17 months.

The following are two success stories:

Catherine Yuan

- Former member of the Health Scholar Leadership team
- Currently a teacher for Teach for America in an underserved community
- Plans to apply for medical school in 2019 and continue to support underserved communities around the world

"I learned that communication is very important between all members of the team including our patients. I feel that I have improved my communication skills since joining the program and enjoyed connecting with our patients."

Shadi Saadati

- Joined the Health Scholar Program in August 2016
- Currently works at Los Angeles Women's Health Center as a Clinic Operations Specialist
- Plans to apply for physician assistant school in the near future

"The Health Scholar program confirmed the need to be a compassionate care provider. Our hospital faces a diverse and challenging population but everyone on the team is always supportive and compassionate. The hospital and program showed me what kind of PA I want to be."

For the third year in a row, Dignity Health California Hospital received the coveted "**Greenhealth Emerald Award**" from Practice Greenhealth, the nation's leading organization dedicated to environmental sustainability in health care. The award is one of the Environmental Excellence Awards given each year to honor environmental achievements in the health care sector. The Greenhealth Emerald Award recognizes outstanding hospitals from within the Partner for Change applicants. This competitive award recognizes the top 20 percent of applicants and is focused on advanced sustainability programs and exemplary scores in a range of categories

We also received the **Greening the OR Recognition Award** and the **Environmentally Preferable Purchasing Circle of Excellence Award**. The Greening the OR Award recognizes the facility demonstrating the most success in reducing the environmental impact of its surgical suites. Operating rooms are large contributors to a health care facility's environmental footprint, creating opportunity for significant cost savings and sustainability improvements. In recognition for outstanding accomplishments in sustainability, CHMC received the Circles of Excellence Award in Environmentally Preferable Purchasing. This award honors hospitals for outstanding performance in one specific area, such as reducing

use of toxic chemicals or sourcing food sustainably. These awards highlight hospitals that are pushing the envelope and driving innovation in sustainability performance in each sustainability category.

APPENDIX C: FINANCIAL ASSISTANCE POLICY SUMMARY

Dignity Health's Financial Assistance Policy describes the financial assistance programs available to uninsured or under-insured patients who meet certain income requirements to help pay for medically necessary hospital services provided by Dignity Health. An uninsured patient is someone who does not have health coverage, whether through private insurance or a government program, and who does not have the right to be reimbursed by anyone else for their hospital bills. An underinsured patient is someone who has health coverage, but who has large hospital bills that are not fully covered by their insurance.

Free Care

- If you are uninsured or underinsured with a family income of up to 200% of the Federal Poverty Level you may be eligible to receive hospital services at no cost to you.

Discounted Care

- If you are uninsured or underinsured with an annual family income between 200-350% of the Federal Poverty level, you may be eligible to have your bills for hospital services reduced to the highest amount reasonably expected to be paid by a government payer, which is usually the amount that Medicare would pay for the same services.
- If you are uninsured or underinsured with an annual family income between 350-500% of the Federal Poverty level you may be eligible to have your bills for hospital services reduced to the Amount Generally Billed, which is an amount set under federal law that reflects the amount that would have been paid to the hospital by private health insurers and Medicare (including co-pays and deductibles) for the medically necessary services.

If you are eligible for financial assistance under our Financial Assistance Policy you will not be required to pay more than the Amount Generally Billed described above. If you qualify, you may also request an interest-free extended payment plan. You will never be required to make advance payment or other payment arrangements in order to receive emergency services.

Free copies of the hospital's Financial Assistance Policy and financial assistance application forms are available online at your hospital's website listed below or at the hospital Admitting areas located near the main entrance. (Follow the signs to "Admitting" or "Registration"). Copies of these documents can also be mailed to you upon request if you call Patient Financial Services at the telephone number listed below for your hospital.

Traducción disponible: You may also obtain Spanish and other language translations of these documents at your hospital's website, in your hospital's Admitting area, or by calling your hospital's telephone number.

Dignity Health Financial Counselors are available to answer questions, provide information about our Financial Assistance Policy and help guide you through the financial assistance application process. Our staff is located in the hospital's Admitting area and can be reached at the telephone number listed below for your hospital.

California Hospital Medical Center 1401 South Grand Ave, Los Angeles, CA 90015
Financial Counseling 213-742-5530. Patient Financial Services 888-488-7667
www.dignityhealth.org/californiahospital/paymenthelp