City of Hope®

2022

Community Benefit Report

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EXECUTIVE SUMMARY

City of Hope is pleased to submit a report of our community benefit activities for Fiscal Year 2022 (from October 1, 2021, to September 30, 2022). The State of California's Community Benefit law (SB697) requires nonprofit hospitals to address the needs of their communities through programs designed to help prevent diseases and improve the health status of its citizens.

Fiscal Year 2022 Community Benefit investments

This report is intended to share the progress City of Hope has made in addressing the health needs in the 2019 Community Health Needs Assessment and subsequent 2021-2023 Implementation Strategy. Throughout this document, we will demonstrate an understanding of the diverse needs of the multicultural communities we serve and a commitment to the creation of the infrastructure necessary to carry out an extensive array of community projects. Our traditional community education efforts in cancer prevention and cancer risk reduction are also reflected. The total value of our community benefit investments during the Fiscal Year 2022 was $365,569,788. This represents a $59,037,131 increase over Fiscal Year 2021.

Much like last year, COVID-19 has given us a new perspective on our own ability to pivot and reimagine our programs and services within the context of addressing needs and being safe. Moving forward we will continue to explore new areas that provide us the opportunity to impact underserved communities in our quest to bridge the health disparities gap. In doing so, we invite you to be active partners in helping us meet the needs of our communities. Please take the time to explore our report – we welcome you to share your comments with us. Send all comments to: CommunityBenefit@coh.org. This report, as well as our implementation strategy, is available for download on our website at CityofHope.org/community-benefit.

WHO WE ARE: CITY OF HOPE

Founded in 1913, City of Hope is a national leader in cancer care. We provide each patient with an individualized, comprehensive care experience and deliver the highest quality treatment and expertise. We are one of only 53 National Cancer Institute (NCI)-designated comprehensive cancer centers in the U.S. The NCI designation recognizes excellence in treatment, research and expertise to address the many features of the disease, whether in early or late stage, and for common or rare types of cancer. City of Hope is also proud to be a founding member of the National Comprehensive Cancer Network (NCCN), reflecting our national leadership in advancing research and treatment. NCCN member institutions are recognized for their world-renowned expertise and for treating complex, rare and aggressive forms of cancer. Most importantly, we firmly believe in providing value across the entire patient journey. At City of Hope, this is measured by the experiences and outcomes that our treatments and dedicated team provide. Our goal is to care for the whole person, so that life during treatment and after cancer can be rich and rewarding.

Our Unique Approach to the Delivery of Care for You and Your Loved Ones

Compassion and discovery are at the heart of our approach. Thanks to the expertise and dedication of our physicians and staff, we can treat rare and complex cancers that others cannot. Our scientists, clinicians and specialists work under one roof, meaning that each patient receives coordinated care from a team of doctors. City of Hope patients benefit from our extraordinary capabilities and leading-edge technological advances, such as the application of robotics to remove disease to utilize innovative methods to deliver chemotherapy to treat tumors that would otherwise be unreachable, the use of genetically re-engineered white cells to target and attack a patient's cancer cells, and the use of advanced imaging techniques to more precisely deliver radiation therapy. Our support also extends to our community through our network of clinical locations. We work with our patients and their families at each step of the journey, providing interdisciplinary supportive services, including psychology, patient education, support groups such as Couples Coping With Cancer, social work, physical and occupational therapy, and nutritional and financial counseling. Underpinning this approach is our excellence in turning tomorrow's treatments into today's tailored patient plans and therapies. We are committed to delivering the most leading-edge treatment options to our patients and discovering new ways to combat a wide variety of cancers.

Delivering Optimal Outcomes for Our Patients

NCI-designated comprehensive cancer centers like City of Hope are the reason that cancer mortality rates have fallen over the past four decades. City of Hope consistently demonstrates higher survival rates and

better outcomes compared to other health care providers. Our patients recognize our commitment and our ability to provide life-changing outcomes.

Why Our Research and Innovation Matters

City of Hope is a leader in research and innovation, which continually enhances our ability to provide novel and differentiated approaches to cancer care. With our scientists, clinical staff and manufacturing specialists working side by side, advances in treatment can travel from laboratory to patient with lifesaving speed.

- Clinical trial participation is a critical aspect of care for many patients living with cancer. Our patients have access to nearly 1,000 clinical trials investigating potentially groundbreaking treatments. City of Hope enrolled 1 in 4 patients in clinical trials in 2021, including nearly 80 clinical trials in breast cancer alone. These trials provide unique treatment options to City of Hope patients and pave the way for important breakthrough therapies.
- City of Hope is a pioneer in bone marrow and stem cell transplants. As one of the largest and most successful programs of its kind in the U.S., our program attracts patients from across the nation and around the world.
- Numerous breakthrough cancer drugs, including Herceptin, Erbitux, Rituxan and Avastin, are based on technology pioneered by City of Hope.
- City of Hope is at the leading edge of an immunotherapy called chimeric antigen receptor therapy — also known as CAR T cell therapy — with one of the most comprehensive programs in the world, and nearly 80 clinical trials either in process or completed, targeting various hematologic and solid tumors, including brain tumors.

Although City of Hope is a treatment choice for patients from around the world, we also serve our community and are proud to serve it well. We have a rich history of developing health and wellness programs with community partners – programs that continue to thrive and grow. Because cancer and diabetes are complex, multifaceted and all too common in our area, partnerships for community benefit are an integral part of our mission. These partnerships allow us to focus on Health Equity not just for City of Hope patients, but for everyone regardless of zipcode. Through the Cancer Care is Different and Cancer Care Equity Act that Governor Newsome signed into law effective on January 1, 2023, more people will have access to lifesaving cancer care at any designated cancer center in California.

Mission Statement

City of Hope is transforming the future of health. Every day we turn science into practical benefit. We turn hope into reality. We accomplish this through exquisite care, innovative research, and vital education focused on eliminating cancer and diabetes.

Statement of Corporate Social Responsibility

Built by the passion of volunteers determined to improve the health of their community, City of Hope has a legacy of over 100 years of caring — both caring about and caring for our people, our patients, our community and even our planet.

- At City of Hope, we've created a working environment rich with diversity. Our employment mirrors the varied cultures of our patients and their families.
- We serve patients and caregivers by recognizing not only differences in language, but also other differences, such as culture, faith and family structures.
- Though our mission is global, we know our commitment begins right here in our own community. We've proudly built partnerships with our neighbors, offering health screenings, convenient access to care, information regarding disease prevention and healthy lifestyles, and educational programs to encourage local youth interested in research and health care careers.
- Because we know that the health of our planet affects all our endeavors, City of Hope also strives to be a leader in responsible stewardship of natural resources. To that end, we have created a model "green" medical campus, with special attention to areas such as water consumption, energy consumption and air quality.

Our Diversity, Equity and Inclusion Belief Statement

We believe diversity, equity and inclusion is key in serving our mission to provide compassionate patient care, drive innovative discovery and advance vital education focused on eliminating cancer and diabetes in all of our communities. Our commitment for Diversity, Equity and Inclusion ensures we bring the full range of skills, perspectives, cultural backgrounds and experiences to our work — and that our teams align with the people we serve in order to build trust and understanding. We are dedicated to fostering a community that embraces diversity — in ideas, backgrounds and perspectives. This is reflected in our work and represented in our people.

Communities We Serve

City of Hope primary service area

City of Hope is headquartered in the city of Duarte, situated at the base of the San Gabriel Mountains just 21 miles northeast of Los Angeles. Our services, however, extend far beyond our immediate community and, in fact, impact five major counties (Los Angeles, Orange, Riverside, San Bernardino and Ventura) where City of Hope operates 35 clinical network locations .

The majority of our patients come from Los Angeles County, specifically from communities within Service

Planning Area 3 (SPA 3). City of Hope itself is within SPA 3, which includes 34 cities, such as Alhambra, Altadena, Arcadia, Azusa, Baldwin Park, Claremont, Covina, Diamond Bar, El Monte, Glendora, Irwindale, Monrovia, Monterey Park, Pasadena, Pomona, San Dimas, San Gabriel, San Marino, Temple City, Walnut and West Covina.

Race/Ethnicity[1]

In SPA 3, the highest population of Latinos is in Pomona and El Monte. Altadena and Pasadena have the highest concentration of Black people. Alhambra and Monterey Park have the highest population of Asians in SPA 3. And Pasadena and Sierra Madre are where the most residents identifying as white reside. Native Americans and Hawaiian/Pacific Islanders reside in higher numbers within Pasadena, Pomona and West Covina — a shift from the 2013 to 2017 data showing Baldwin Park and El Monte as cities with the highest populations of Native Hawaiians/Pacific Islanders and American Indian/Native Americans within SPA 3. The race/ethnic breakdown of SPA 3 population is: 44.7% Latino, 17.6% white, 31.6% Asian and 3.2% Black/African American. From 2017 to 2020, there was a slight decrease among the white population (19.3% in 2017) and an increase among the Asian population (29.9% in 2017).

Low and high range proportions of ethnic groups by SPA 3 city

[1] U.S. Census 2020 Redistricting Data

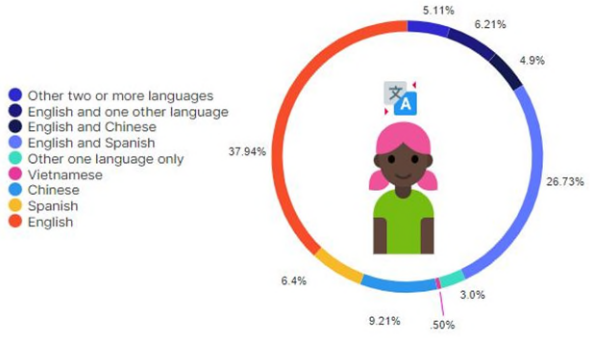
The chart above illustrates the low and high range proportions of ethnic groups by SPA 3 city. In 2017, Irwindale, La Puente and South El Monte had the highest concentration of the Latino population, with a rate of 93.3%, 84.7% and 82% respectively. In 2020, the three cities remained home to the highest concentration of the Latino population with 90.8% in Irwindale, 81.7% in La Puente and 79.6% in South El Monte.

The highest proportion of the white population is in Sierra Madre at 62.5%, similar to, though slightly lower than 2017, when the same proportion stood at 66.6%. This rate has dropped nearly 3% from 2013-2017 and continued to drop from 2018-2020 by another 4.1%.

The highest population of Asians reside in Walnut (67.1%) and Monterey Park (66%). The 2020 Census also shows Asian populations comprising over 60% of the population in numerous other cities including Walnut (67.1%), Monterey Park (66%), Arcadia (64.6%), Rosemead (64%), Temple City (63.5%), San Gabriel (63.4%), Rowland Heights (61.3%) and San Marino (60.6%).

Altadena had the highest concentration of Black/African Americans in 2017 (21.7%) and in 2020 (16.7%) despite a decline over the three-year period. Pasadena also had a higher proportion of Black/African Americans (7.8%).

Language[2]



SPA3 Languages Spoken at Home. Source: California Health Interview Survey, 2020.

Apart from Los Angeles County, the remaining counties of interest to City of Hope all have at least half of their respective populations speaking English only in the home. Los Angeles County continues to have the highest rates of foreign-language speakers in Spanish (38.7%) and other Indo-European languages (5.4%). All but Orange County have rates of Spanish speakers in the home greater than the state rate of 24.5%. Los Angeles and Orange counties have the highest proportion of households speaking Asian languages. Their rates, 10.8% and 15.2% respectively, are also greater than the State rate of 10%.

When language is examined by city, nearly two-thirds of La Puente and South El Monte households speak

[2] 2019 U.S. Census ACS 1 Year Estimates

Spanish at home, whereas less than 10% of households in Arcadia (6.6%), Sierra Madre (5.1%), San Marino (4.9%) and Bradbury (4.1%) speak Spanish. Over half of households within the cities of Rosemead, Rowland Heights, San Gabriel, Monterey Park (53.9%), and Temple City (51.6%) speak an Asian or Pacific Islander language at home. Altadena, Bradbury and Pasadena have the highest percentage of households who speak some other Indo-European Language.

Social Determinants of Health

Social determinants of health are conditions in the environment where people live, work and play that affect a wide range of health and quality-of-life outcomes and risks. For example, living in poverty and not having a high school diploma can have a major impact on health outcomes. For this report, we will examine the intersections between poverty, educational attainment and how this makes people vulnerable.

Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved 12/08/22, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Poverty

In SPA 3, eight cities have poverty levels greater than or equal the state rate of 12.6%. They include: Azusa (14.3%), Baldwin Park (12.6%), El Monte (17.4%), Pasadena (14.0%), Pomona (17.3%), Rosemead (13.5%) and South El Monte (21.1%).

The federal government measures the number of people in poverty with thresholds established and updated annually by the U.S. Census (Federal Poverty Level). In 2022, the Federal Poverty Level for an individual stood at annual income of $13,590 while for a family of four it was $27,000[3]. In California, where the cost of living is high, research indicates that families can earn two or more times the Federal Poverty Level and still struggle to meet their basic needs.[4]

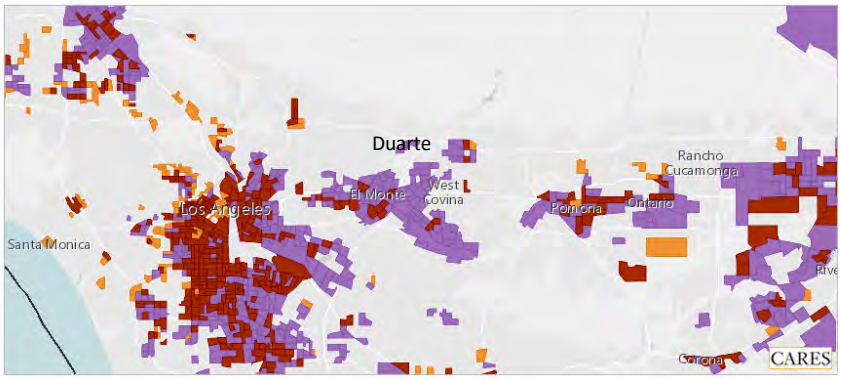
[3] Annual Update of the HHS Poverty Guidelines https://www.federalregister.gov/documents/2022/01/21/2022-01166/annual-update-of-the-hhs-poverty-guidelines. Accessed (January 28, 2022)

[4] "Making Ends Meet: How Much Does It Cost to Support a Family in California?" (December, 2017). California Budget and Policy Center. Available at https://calbudgetcenter.org/wp-content/uploads/Making-Ends-Meet-12072017.pdf Accessed [June 13, 2019]

Educational Attainment

One of the key drivers of health is educational attainment — low levels of education are often linked to poverty and poor health[5]. In SPA 3, 14 cities rate below the state in the rate of college educated adults, ages 25 and older. South El Monte (7.7%) and La Puente (9.1%) have the lowest rates of college graduates in SPA 3. South El Monte and El Monte have the highest percentage of those with no high school education, 29.1% and 24.5% respectively. The highest percentage of residents with a high school diploma are found in Baldwin Park (29.5%), Industry, (34.8%), La Puente (30.6%) and Valinda (30.4%). Walnut (38.4%) and San Marino (40.1%) have the highest percentage of college-educated adults over the age of 25. San Marino also has the second-highest household median income at $164,423. Though South El Monte has the lowest percentage of college graduates and the highest percentage of residents with no high school education, they have a higher percentage of high school graduates (27.3%) than the state (20.4%).

Vulnerable Populations



Map of vulnerable popluations in City of Hope service area. Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates.

Poverty and educational attainment are predictive of at-risk or vulnerable populations. As depicted in the figure below[6], City of Hope, located in Duarte, is surrounded by vulnerable communities. Hotspot communities with residents at 200% below the poverty threshold are

[5] Raghupathi, V., Raghupathi, W. The influence of education on health: an empirical assessment of OECD countries for the period 1995–2015. Arch Public Health 78, 20 (2020). Zajacova A, Lawrence EM. The Relationship Between Education and Health: Reducing Disparities Through a Contextual Approach. Annu Rev Public Health. 2018 Apr 1;39:273-289. doi: 10.1146/annurev-publhealth-031816-044628. Epub 2018 Jan 12. PMID: 29328865; PMCID: PMC5880718.

shown in the map above. The purple areas demonstrate communities where residents have less than a high school education. The mustard-colored areas are where people live below the federal poverty level. The reddish brown is illustrative of communities where residents have both less than a high school education and live below the federal poverty level. The unique composition of these five counties makes them vulnerable on many levels and reinforces the need for community benefit programs. From our 2022 Community Health Needs Assessment we learned:

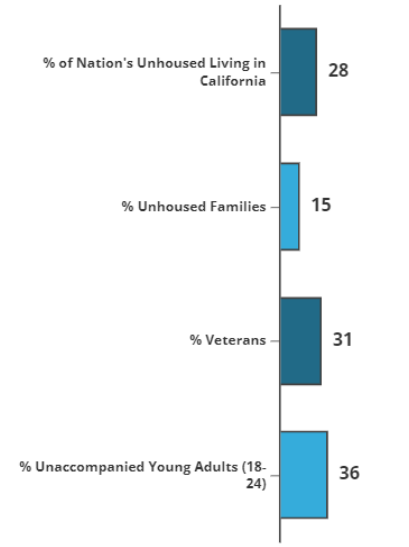
COVID-19 Lived Experience by SPA3 and County

	SPA 3	LAC	OC	SB	RIV	CA
Treated unfairly because of race/ethnicity	1.7	2.5	1.5	1.4	2.6	1.9
Experienced difficulty paying for basic necessities	8.0	10.6	8.6	7.1	12.4	9.2
Experienced difficulty paying rent/mortgage	8.7	10.3	7.8	8.5	8.0	8.4
Lost job	16.0	15.5	10.9	7.3	10.8	13.2
Had reduced hours/income	24.2	25.5	25.7	25.9	18.8	23.8
Worked from home	30.2	30.0	29.9	19.2	21.6	29.6

In SPA 3, while residents appeared to have less difficulty paying for basic necessities (8%), they did experience greater difficulty in paying rent or mortgage (8.7%). Nearly a third of those employed in California transitioned to working from home, as was the case in Los Angeles and Orange counties. Fewer residents in San Bernardino County (19.2%) and Riverside County (21.6%) could opt to work from home. Rates of job loss were highest in Los Angeles County, particularly SPA 3, where the loss rate was 16% compared to the loss rate in the state at 13.2% or in San Bernardino County at 7.3%.

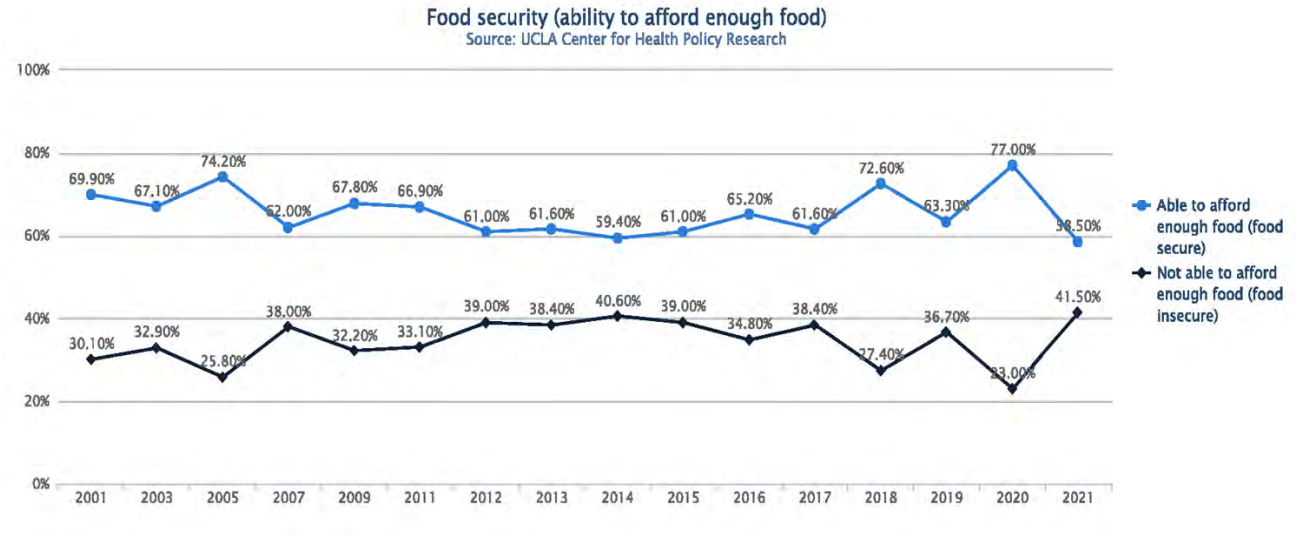
The Unhoused

In Los Angeles County, the total unhoused counts increased over three years (2017-2020), resulting in a public health crisis. The total unhoused count increased by 18.7% to 67,198, while the total unsheltered count increased by 24.4% to 51,092. A more recent count (2022) by the Los Angeles Homeless Services Authority reveals that between 2020 and 2022 the rate of increase had moderated to 4%. Approximately 12% of the total count (now at 69,144) experience chronic unhousing. Over two-thirds are male. Among those ages 18 and older, 1 in 4 experience substance abuse or mental illness. Most persons experiencing homelessness are Latino/Hispanic (56%), white (25%) and Black (17%). In SPA 3, the rate of unhoused has increased by 2%.



Food Insecurity

Prior to the COVID-19 pandemic, food insecurity in Los Angeles County had started to decline. However, despite the reduction, communities of color, immigrant communities and those living in poverty continued to experience barriers to accessing healthy food.



Source: UCLA Center for Health Policy Research, California Health Interview Survey, 2021

Mental Health

Individuals risk substance abuse, self-destructive behavior and suicide if left untreated. In California, 1 out of 10 adults experiences psychological distress in a given year. Almost all the counties have distress levels that exceed the state rate (12.2%) except for Los Angeles County and Orange County, which have psychological distress levels at 11.9%. In addition, some adults report that their mental health state impaired their family life within the year. San Bernardino County has the highest reported rate of impaired family life at 23.8%. Orange County and SPA 3 had the lowest rate of impaired family due to poor mental health at 16.8%.

Los Angeles County has the lowest reported prescription medication usage for mental health issues at 7.8%. Adults in SPA 3 have a lower rate of prescription medicine usage at 7% and also have the lowest rate for impaired work, family life and social life compared to the rates of the other counties, prepandemic.

Impairment Due to Poor Mental Health in the Past 12 Months

Report Area	Impaired Work	Impaired Family Life	Impaired Social Life	Has Taken Prescription Medicine for Emotional/Mental Health Issue in Past Year
Los Angeles County	21.1%	20.9%	21.0%	7.8%
SPA 3	16.8%	16.8%	17.6%	7.0%
Orange County	20.9%	16.8%	22.3%	10.9%
Riverside County	21.3%	17.3%	19.2%	10.2%
San Bernardino County	17.1%	23.8%	19.1%	7.8%
Ventura County	21.7%	17.8%	20.6%	13.8%
California	21.0%	19.0%	21.2%	9.8%

Source: California Health Interview Survey, 2020

Prior to COVID-19, social health issues, or Social Determinants of Health, were major drivers for health equity and access to care. COVID-19 has highlighted the inequities in our local communities. Many of the health issues that impact our service areas have a direct correlation between race/ethnicity, language, poverty and educational attainment. By recognizing the shared social determinants of health and by listening to our community, we are able to more effectively identify the drivers of the conditions impacting the communities City of Hope serves.

ORGANIZATIONAL COMMITMENT

Oversight and Management of Community Benefit Activities

Since community health improvement is a key component of City of Hope's mission, a large number of employees, in a variety of departments, participate in planning and implementing community benefit activities.

Angela L. Talton, senior vice president and chief diversity, equity and inclusion officer

To coordinate these efforts, the Department of Community Benefit is housed within the Division of Diversity, Equity and Inclusion where the team is lead by system senior vice president and chief diversity, equity and inclusion officer, Ms. Angela L. Talton. This positioning enables us to leverage all resources necessary to foster a collaborative work environment that relies on the connections between City of Hope National Medical Center and all other entities that are part of City of Hope's enterprise.

To assist in the oversight of all community benefit activities, City of Hope relies upon the expertise of our Community Benefit Advisory Council (CBAC). The CBAC was established in November 2014 and is comprised of members from community organizations and health care providers listed below:

- American Association for Retired People
- American Cancer Society
- Arcadia Methodist Hospital
- Center for Non-Profit Management
- City of Azusa – Recreation and Family Services
- City of Duarte – Senior Services
- City of Pasadena Health Department
- Duarte Unified School District
- Foothill Unity Center
- Los Angeles County Department of Health Services – Region SPA 3
- Planned Parenthood Pasadena and San Gabriel Valley
- Set of Life Inc.
- YWCA – San Gabriel Valley

To ensure council members represent local vulnerable populations, we sought individuals with the following areas of expertise:

- Residence in a local community with disproportionate, unmet, health-related needs
- Knowledge and expertise in primary disease prevention
- Experience working with local nonprofit, community-based organizations
- Knowledge and expertise in epidemiology
- Expertise in the analysis of service utilization and population health data
- Deep knowledge and work with disadvantaged populations

The Department of Community Benefit also established an internal hub comprised of City of Hope staff members who are responsible for contributing to community benefit programs and services. They meet on a quarterly basis to discuss federal reporting requirements, receive technical assistance and learn about City of Hope's processes for ensuring our programs address priorities outlined in our Implementation Strategy. Additionally, this group has an internal webpage that provides links and resources to community benefit best practices and internal tools for sharing and building collaborations that strengthen the quality of staff contributions.

Miki Carpenter, Ph.D.
Director
Community Resources
Department – City of Azusa

Patricia Duff Tucker, M.S.
Set for Life, Inc.
Founding Member

Ms. Miki Carpenter and Ms. Patricia Duff Tucker serve as the co-chairs of CBAC. Throughout FY2022, CBAC met four times virtually. During the course of this year, CBAC work toward achieving strategies identified in the 2021-2023 Implementation Strategy. Members reviewed and awarded the Healthy Living Grants and Kindness Grants, conducted virtual site visits of the grantees, participated in the virtual Healthy Living Conference and provided guidance as we embarked on the development of our 2022 Community Health Needs Assessment. Nancy Clifton-Hawkins, M.P.H., M.C.H.E.S.® , is City of Hope's director of community benefit. Clifton-Hawkins is available to answer questions regarding the delivery and accountability of community benefit programs and services at City of Hope and can be reached at CommunityBenefit@coh.org.

COMMUNITY BENEFIT PLANNING PROCESS

All community benefit programs at City of Hope are filtered through the lens of the Five Core Principles established by the Public Health Institute:

1. Emphasis on disproportionate or vulnerable populations with unmet health needs within City of Hope's primary service area as measured by culture, race or language disparities, age, poverty and lack of education

2. Emphasis on primary prevention: health education, disease prevention and health protection

3. Building community capacity by mobilizing community stakeholders as full partners and engaging them in sustainable strategies that address both symptoms and underlying causes

4. Building a seamless continuum of care to optimize the ability of community resources to manage cancer and diabetes, prevent patients from falling through the cracks and minimize the need for future, and often more complex medical care

5. Collaborative governance to ensure the community has a voice in, and partners with, projects initiated with City of Hope

After the review of the results in the 2019 Community Health Needs Assessment (CHNA), in October 2019, CBAC assisted in the prioritization of the CHNA during a special meeting held in December 2019. The process was facilitated by both Nancy Clifton-Hawkins and CBAC member Maura Harrington. The framework for the design of the 2021 to 2023 Implementation Strategy was set during this convening. The strategy can be downloaded and reviewed by clicking here. Completion of the 2019 CHNA was critical in City of Hope's efforts to plan and implement programs and services to the vulnerable living in our service area. The 2021-2023 Implementation Strategy was officially adopted by the City of Hope National Medical Center Board during their February 2020 meeting. Next, you will find the methodology used to gather data and prioritize health needs in that 2019 assessment.

COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS AND RESULTS

2019 Community Health Needs Assessment Methodology

City of Hope's service area is richly diverse in language, culture, religion and ethnicities. With this diversity comes a large variation in factors that put individuals at risk for health issues such as cancer and diabetes. Sociocultural factors — for example, the level of education achieved or the language spoken at home — can increase or decrease the risk of preventing or contracting a life-threatening illness. Serving our community and providing programs and services to our local residents designed to reduce risk and improve access to health care are paramount to our success as a nonprofit hospital. The best way to learn about our community's needs is to simply ask them. That is exactly what we did. In partnership with our SPA 3 Hospital Collaborative, Huntington Hospital, Methodist, Emanate Health and Kaiser Permanente – Baldwin Park, City of Hope embarked on a comprehensive journey to discover how our collective community believes they are doing and what they believe they need to be healthy.

Our 2019 Community Health Needs Assessment process was designed to (1) develop a deeper understanding of community health care needs, (2) inform each hospital's community benefit plan for outreach and services that complement and extend clinical services, and (3) improve disease prevention and overall health status. Both primary data via community input and secondary data were collected to inform community health priorities and needs, as well as assets and gaps in resources.

Secondary Data

Secondary data for the hospital service area was collected and documented in data tables with narrative explanations. The tables include the data indicator, the geographic area represented, the data measurement (e.g., rate, number or percent), county and state comparisons (when available), data source, data year and an electronic link to the data source. The report includes benchmark comparison data that measures Mercy data findings with Healthy People 2020 objectives. Healthy People 2020 is a national initiative to improve public health by providing measurable objectives and goals that are applicable at national, state and local levels.

Primary Data

Analysis of secondary data yielded a preliminary list of significant health needs, which then informed primary data collection. The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets to address needs and discover gaps in resources. For this CHNA, we obtained information through focus groups, a community survey, and interviews with key community stakeholders, public health and

service providers, members of medically underserved, low-income and minority populations in the community, and individuals or organizations serving or representing the interests of such populations.

Focus Groups

Representatives of select subpopulations were convened to advance understanding of the lived experience of residents in City of Hope's service area. Subpopulations represented in focus groups included seniors, Spanish-speaking residents, Mandarin-speaking residents, African American residents, homeless residents and LGBTQ residents. Nineteen focus groups were convened between January and October 2019.

Interviews

Interviews with key stakeholders provided opportunities to gather in-depth insights from experts in particular subfields of public health and social services in targeted communities. A total of 32 individual interviews were conducted for this CHNA, from February through July 2019.

Summary of 2019 Community Health Needs Assessment Results

Secondary data analysis provided a preliminary list of significant health needs, which then informed primary data collection. The primary data collection process helped validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations and ascertain community assets to address needs.

To determine size and seriousness, health indicators identified in the secondary data collection were measured against benchmark data, specifically California rates and Healthy People 2020 objectives, whenever available. Health indicators that performed poorly against one or more of these benchmarks were considered to have met the size or seriousness criteria. Additionally, primary data sources (interviews, focus groups and survey participants) were asked to identify and validate community and health issues. Information gathered from these sources helped determine significant health needs.

Significant Health Needs

The following significant health needs were determined:

- Access to Care
- Cancer
- Chronic Disease
- Economic Insecurity
- Housing Insecurity and Homelessness
- Mental Health
- Overweight and Obesity
- Substance Use

Community input on these health needs is detailed throughout the CHNA report: (https://bit.ly/2W37jvq)

Resources to Address Significant Needs

Through the focus groups, surveys and interviews, community stakeholders and residents identified community resources that can help address the significant health needs. These resources are presented in the appendix.

Stakeholder Prioritization of Community Health Needs

Our CBAC met on December 19, 2019, to identify the top health needs to be prioritized over the next three years. Based on findings from the primary and secondary data collections, participants learned about the identified health needs within City of Hope's community service areas. After the data presentation, everyone was instructed to rate these leading indicators in relationship to seriousness, size of problem (number of people impacted), trends, equity, feasibility, value, consequence of inaction, social determinants/root causes and effective strategies to address problem. Then they were instructed to represent their priorities by placing colored dots on the charts. Red #1, Blue #2, Green #3 and Yellow #4. People were also invited to elaborate on their prioritized issues with comments that can help us shape the overall strategies for the 2021 Implementation Strategy. Results were as follows:

CBAC members prioritizing health needs

2019 Stakeholder Prioritized Health Needs

Rank	Health Needs
1	Access to Care
2	Mental Health and Substance Use
3	Economic and Housing Insecurity

Rank	Health Needs
4	Chronic Disease
5	Cancer Prevention

It is important to know that while there were eight identified areas of need, those schooled in public health language will see that the CBAC combined topics because they felt that the root causes and shared risk factors were similar and, by addressing them collectively rather than individually, we could have a greater impact. Thus, you will see that mental health was combined with substance abuse. In recent years, mental health researchers have found that creating an integrative approach for mental health and substance use disorders made more sense and provided greater support for the patients[7,8]. Chronic disease was combined with obesity/overweight because the shared risk factors and methods for addressing those risks are similar. Within the Community Benefit Initiatives portion of the report, we provide a detailed description of how we are addressing the identified needs.

Plan to Address Needs

It would be unreasonable to think that City of Hope can solve all the issues identified in the needs assessment. Given our expertise and resources as a cancer institution, we need to find pragmatic ways to work with our community to address the identified needs. First, we need to acknowledge that the prioritized categories are even more complex than presented above. Next, we need to view the issues through the lens of the Public Health Institute's "Five Core Principles" (Page 17). As we plan programs, we must ask ourselves, "How will our work impact the lives of vulnerable people in a way that supports prevention, builds a seamless continuum of care and enables the community to take ownership of their health issues? How can we be a leader in creating a healing environment?" From here, we can tackle the five identified categorical needs by designing program/services and building collaborations that will work to lessen the impact on local residents.

[7] Ungar, M., Liebenberg, L., Ikeda, J. (2014). Young people with complex needs: Designing coordinated interventions to promote resilience across child welfare, juvenile corrections, mental health and education services. The British Journal of Social Work, **44**, 675–693.

[8] Clark, H. W., Power, A. K., Le Fauve, C. E., Lopez, E. I. (2008). Policy and practice implications of epidemiological surveys on co-occurring mental and substance use disorders. Journal of Substance Abuse Treatment, **34**(1), 3–13.

CBAC members who prioritized the 2019 CHNA results

Collaborations

City of Hope is an institution that is overflowing with compassionate individuals. In order to address the needs of our community, we will leverage these rich resources to design interventions that specifically target the identified issues within our service areas. Internal teams are already trained to change the way they see their work by using a community benefit lens that focuses on how programs will impact the health of the vulnerable community first. Externally, City of Hope will call on the diverse relationships it has nurtured with local organizations, schools and universities, governments, other nonprofit hospitals and the multitude of compassionate souls that serve the vulnerable. By collaborating with our local communities, we can work together to meet the needs of our most vulnerable populations in culturally appropriate ways. Additionally, by including our community stakeholders in planning our community benefit programs and services, we ensure these programs are built on trust and shared vision. This provides a strong foundation for programs that will survive and thrive within the community we serve.

Oversight

As mentioned previously, to ensure City of Hope's reportable community benefit programs and services are targeting those areas identified in the 2019 needs assessment, the CBAC will convene four times per year to review progress and budgeting related to the 2021-2023 Implementation Strategy. CBAC members also select awardees for the two City of Hope grant programs and conduct fidelity checks for funded programs.

Anticipated Impacts on Health Needs

When we look at the five priority areas identified by our community, we need to think about them through a realistic framework that allows us to address issues with strategies that make the most sense given City of

Hope's capacity to do so. Each priority has a broad measurable outcome indicator. While it may be unrealistic to believe that City of Hope can make a significant impact regarding these priorities, mindful programming and collective impact will enable us to make changes to the communities we serve. As an institution, we will aim our programs and services at our residents, focusing on the following recommended strategies:

1. Access to Care — Specifically related to implicit bias, structural racism, policy, systems, environment and cross-sectoral collaborations that address the social determinants of health

2. Mental Health — Upstream programming to address access, policy and quality services that serve both the adult and youth communities

3. Economic and Housing Insecurity — Creation and support of meaningful relationships, with key players in the housing and economic arenas, for the purpose engaging community in the development of solutions to encourage more affordable housing and economic opportunities

4. Chronic Disease Prevention — Support community-led efforts at addressing prevention strategies that promote healthy living.

5. Cancer — Create a safe and trusting bridge to cancer education, prevention and treatment services/care from diagnosis to treatment.

Moving forward, City of Hope will align its efforts at addressing the indicators above. Yearly, the CBAC will assist in prioritizing strategies with the same lens they used to prioritize the health needs in the CHNA (e.g., feasibility, size of issue). We will develop more specific outcome measures as programs are planned and delivered. A yearly report will be published describing the efforts we have made to address these issues. Comments from our local community will be accepted throughout the year and used to strengthen City of Hope's resolve to decrease the disparities that prevent our residents from experiencing a good quality of life.

Needs Not Addressed

As a specialty hospital, City of Hope is not mandated to address issues that may not align with its specialty. However, because the social determinants of health and root causes of health disparities are intertwined with risk factors for cancer and diabetes, we will make every effort to include language and programming that will ensure we focus our community benefit investments on the most vulnerable. The Five Core Principles will be used to set the tone for all programs and services, and guarantee focus remains on those communities with disproportionate unmet health needs.

Monitoring and Evaluation

We believe that taking a business approach to planning and evaluating the identified initiatives will ensure their long-term sustainability. We realize that evaluation is necessary to measure success, as well as to identify areas needing improvement. The process can result in more effective initiatives. City of Hope is working to identify

the best methods of monitoring and evaluating the impact of the initiatives identified in this document. In order to efficiently deploy resources and maximize results, City of Hope's annual budget will include the operating funds required to manage, track and report on the outcomes and impacts of all community benefit programs and initiatives.

COMMUNITY BENEFIT INITIATIVES

Overview of Fiscal Year 2022 Programs and Services

Amid another year of COVID-19, planned conferences, farmers markets and other in-person events were not hosted. Teams continued to deliver important events via a virtual environment. Like last year, we find that our reach was greater, meaning people from throughout the country were able to participate in our programs. What follows is a reflection of our work during FY2022. Each initiative has specific goals that benefit the community. Many initiatives have been thriving for years, while others are new based on the FY2019 Community Health Needs Assessment. Some are organization-wide, while others are conducted by a specific department. The grid here provides a quick overview of our FY2022 programs and services.

	Core Principles				Strategic Priorities				
Program Activity *Beckman Research Center	Vulnerable Populations	Primary Prevention	Seamless Continuum of Care	Community Capacity Building	Access to Care	Mental Health	Economic and Housing Insecurity	Chronic Disease Prev. – Healthy Living	Cancer Prevention
Workforce Development									
• Student Mentoring/Interns • Train, Educate and Accelerate Careers in Healthcare • Science Education Partnership Award Program*	x	X		x	x			x	x
Community Health Awareness/Healthy Living (Screening, Lectures/Classes Support Groups)									
• Community Nutrition, Diabetes and Cancer Prevention Classes • Community Health Fairs • Healthy Living – Community Building Grants • Kindness Grants • Community Gardens • Hopeful.org – Online Cancer Support • Cancer Support Groups • School Wellness	x	x	x	x	x	x	x	x	x
Diversity Initiatives									
• Employee Resource Groups (Asian American Community, Connecting People of African Descent for Hope, Indigenous People Alliance, Latinos for Hope, Pride in the City, Veterans for Hope, Women's Professional Network, Young Professionals Network) • Diversity Training COH Leadership	x	x		x	x		x	x	x
Health Care Support Services									
• Patient Resources Coordination • Transportation • Village Stays • Food Insecurity	x	x	x		x	x	x	x	x
Seamless Continuum of Care									
• Community Nutrition, Diabetes and Cancer Prevention Classes • Community Health Fairs • Cancer Care is Different	x	x	x	x	x		x	x	x
Medical Professional Education									
• Pharmacy • Nursing • Social Work • Health Education	x	x	x	x	x			x	x

FY2022 Strategic Priority Programs

Key Community Benefit Initiatives

Many programs are created and provided to the community on an annual basis, while others are created to address needs or requests as they arise. As City of Hope's team continues its exploration into community benefit investments throughout the institution, we may find that some programs no longer make sense or should be redesigned to ensure impacts are focused on the needs of our local community. Conversely, new programs may be created to address the emerging needs and integrate strategies that engage City of Hope teams in more community-based collaborations. What follows is a status report on the main focus areas of our FY2022 community benefit programs and

	Impacts	
Core Principle	Vulnerable Populations	✔
	Primary Prevention	✔
	Seamless Continuum of Care	✔
	Community Capacity Building	✔
Strategic Priorities	Access to Care	✔
	Economic and Housing Insecurity	✔
	Mental Health	✔
	Healthy Living	✔
	Cancer Prevention Early Detection	✔

services: **Healthy Living, Community Capacity Building and Kindness Grants; Food Insecurity - Greater San Gabriel Valley Hospital Collaborative, Garden of Hope and Produce for Patients, and the Cancer Care Patient Equity Bill.** The colorful boxes in each section are meant to provide a snapshot of the programs. At a glance, the reader will be able to identify what core principles and strategic priorities are addressed through each focus area.

Healthy Living, Community Capacity Building, Kindness Grants

The Healthy Living Community Grant Program is the vehicle that we use to identify organizations that can deliver innovative programs designed to address one or more of our strategic priorities around access to care, healthy living, mental health or cancer prevention. In addition to the Healthy Living grant, in FY2018, we created a special grant category to encourage our employees, who have good ideas, to do something great for their community, called Kindness Grants. Our Community Benefit Advisory Council (CBAC) members review all the applications and make the selections for both the Healthy Living and Kindness grant programs. Council members also conduct site visits of Healthy Living grantees. Not only is it rewarding to help local organizations, but these groups provide City of Hope with more insight into the needs of vulnerable local populations. They also teach City of Hope about ways to support community efforts that tackle health disparities in culturally appropriate and specific ways. Throughout the funding period, City of Hope continues

to support these organizations by providing technical assistance and networking opportunities. To learn more about the Healthy Living Grants click here.

Healthy Living Grant

During FY2022, the funding for the **Healthy Living Community Grant** Program doubled and dispensed $100,000 to 14 organizations (versus $40,000 and 8 organizations in 2021) that demonstrated a creative, yet sustainable, approach to promoting healthy living through good nutrition, physical activity, cancer or diabetes prevention, or smoking cessation. The 2022 Healthy Living Cohort included a diverse slate of awardees that spanned the Greater Los Angeles and Orange County regions. These impressive organizations are: The Empower THEM Collective, Foothill Unity Center Inc., Long Beach Immigrant Rights Coalition, Optimist Youth Homes and Family Services, Vietnamese American Cancer Foundation, Long Beach Day Nursery, California Health Collaborative, Pomona Hope, Therapeutic Play Foundation, Inland Valley Hope Partners, Boys and Girls Club Metro Los Angeles, Wayfinder Family Services, Antelope Valleys Partners in Health and EcoUrban Gardens. Their programs are described below:

	Impacts	
Core Principle	Vulnerable Populations	✔
	Primary Prevention	✔
	Seamless Continuum of Care	✔
	Community Capacity Building	✔
Strategic Priorities	Access to Care	✔
	Economic and Housing Insecurity	✔
	Mental Health	✔
	Healthy Living	✔
	Cancer Prevention Early Detection	✔

The Empower THEM Collective

Have the Audacity to Be Seen: Services will be focused in the Antelope Valley, which is the northern part of Los Angeles County. They are addressing access to care, mental health, and food and housing security. they are using their signature service *The Art of Storytelling* to elevate the stories of real people who are experiencing the three health issues they have selected. They spotlighted the unique challenges that Antelope Valley faces, where lack adequate transportation, access to health care, affordable housing and food complicate a person's life. The short films highlight the beauty of their community and the struggles they experience. Once the short films have been completed, they will host a hybrid (virtual and in-person) screening of the films, inviting community members, local leaders and political officials to participate in the viewing. They desire to open a dialogue between the people and those who can initiate change so that we develop solutions that are realistic and impactful. From there we hope to continue the moment and engage key decision makers at all levels in order to advocate for policy change in the region.

Foothill Unity Center Inc.

Café Bistro: Foothill Unity Center Inc. is the San Gabriel Valley's primary provider of integrated services with our core programs that focus on helping the disadvantaged, low-income and unhoused individuals and families who are underserved. As an expansion of their services Café Bistro is offered at their Monrovia and Pasadena sites targeting the unhoused population. Café Bistro, provides a more relaxed and comfortable setting, is available during the food distributions and at the mobile shower program (offered during the distributions) at the Monrovia site on Mondays from 1 to 3:30 p.m., Wednesdays from 9 to 11:30 a.m., and Fridays from 9 to 11:30 a.m., and from our Pasadena sites on Tuesdays from 9 to 11:30 a.m., Wednesdays from 9 to 11:30 a.m. and Fridays from 9 to 11:30 a.m. Participants receive nutritious meals and beverages, education on nutrition and health screenings that include checking blood pressure as well as addressing mental health topics, including depression and strategies to address depression. All complete initial assessments that include a baseline health assessment, including date of last doctors' visits, blood pressure readings, weight, medical history, and allergies. Staffing will include 150 nursing students from California State University Los Angeles and Azusa Pacific University, who rotate in throughout the year, to work with our Health Program team, who are able to provide services in English, Spanish and Chinese.

Café Bistro employee getting ready to serve the local unhoused at Foothill Unity Center Inc.

Long Beach Immigrant Rights Coalition

Thriving and Healthy Immigrant Families: Innovation and creativity is key in how Long Beach Immigrant Rights Coalition (LBIRC) approaches complex social, political, economic and immigrant injustices that are faced in the community. LBIRC is often at the forefront of ensuring that community members and their voices are not only heard, but how we shape our movement and work. Through this project, LBIRC connected immigrant families with access to care via digital education workshops utilizing social media, and their online web series "Información Sin Fronteras'' (Information Without Borders), and simultaneously connected community members with development and leadership building opportunities through their Leadership Academy programming. Their community organizing components provide community members with opportunities to learn about: historical and racial oppression, political advocacy, how to testify in front of the local city council, *Know Your Rights* legal education and access resources for housing rights support. Community members of the mutual aid food nutrition program will have the opportunity to be a part of a research study entitled, "Pandemic Impacts on Access to Services for Im/migrant Communities in Long Beach" led by Professor Lauren Heidbrink, Ph.D., at California State University Long Beach, where this research will later serve as a critical tool to shift local policies that impact and shape health equity for BIPOC and monolingual speaking im/migrant families in Long Beach, ultimately transforming the health equity and political landscape for community.

Optimist Youth Homes and Family Services

Dedicated Housing Units and Support Services for Transitional Aged Youth Experiencing Homelessness: In partnership with the Los Angeles Community College District, Optimist provided housing at their Highland Park Campus; a supportive environment for high-risk community college students, including former foster youth. Community colleges provide affordable, accessible educational opportunities, yet housing remains a challenge. Seventeen percent of community college students experienced homelessness in 2019, according to The Hope Center for College, Community, and Justice. Optimist's commitment to youth does not end when a foster child turns 18. This funding supported housing, school supplies and materials to assist residents. This facility provides housing and supportive services at no cost to the students as they attend college. By

leveraging and expanding our existing contract with the Los Angeles Department of Mental Health, the Los Angeles Community College District and private philanthropy, Optimist will provide housing, meals, mental health counseling, and career development and employment supports.

Vietnamese American Cancer Foundation

Community Shop and Screen: the Vietnamese American Cancer Foundation's (VACF) ***Community Shop and Screen*** project mitigated health disparities in the Vietnamese American community by addressing the socioeconomic and linguistic barriers to care for an overall improvement in quality of life of underserved Vietnamese Americans through early cancer detection and prevention. The COVID-19 pandemic has exposed the major impact of social determinants of health on community and individual well-being. VACF's expertise and capacity to connect with the community is evident within the history and accomplishments of its community health programming. ***Community Shop and Screen*** addressed cancer prevention, access to care and food insecurity. The project pivoted VACF's current program activities to include a "farmer's market" day where individuals are able to "shop" for food items at an outdoor market and "screen" for cancer as appropriate, all free of charge. VACF worked with a lab partner and volunteer doctors to provide on-site blood draw to screen for Hepatitis B and C (linked to high rate of liver cancer) and FIT kits to screen for colorectal cancer to those who are at higher risk and have limited access to health resources. VACF's health educators provided in-language education, and their health navigators will conducted appropriate follow-ups after screenings to make sure that clients understand the results and were linked to the care they need, especially those with abnormal results.

VACF staff helping out another grantee, EcoUrban Gardens, harvest lemongrass

Long Beach Day Nursery

Innovative Early Intervention for Early Care and Education: Long Beach Day Nursery's (LBDN) Early Intervention Program (EIP) provides observations, assessments and intervention strategies for vulnerable children with identified special needs, social/emotional challenges and/or behavior concerns, as well as support for our families and teachers. Their EIP program incorporates a collaborative approach that involves the child, family, teacher, consulting psychologist, LBDN EIP specialist, and early intervention interns. Identifying special needs and intervening early is absolutely vital. Any child enrolled at LBDN who demonstrates a need for access to integrated care in the form of limited language skills, learning disabilities, health issues, developmental delays, problems with attention and focus, speech impairment, and social, behavioral or family challenges received early intervention assistance at LBDN. EIP services are offered year-round, at no cost to the families. When concerns were identified, EIP ensured that everyone involved — parents, teachers, the children (as appropriate), LBDN's child psychologist and EIP specialist, and early intervention interns — are engaged in communications to ensure that suitable intervention strategies are developed and implemented. This collaborative approach is critical to successful outcomes, as it facilitates consistency, family involvement and positive parenting. Parents and families were referred to additional community services or to other specialists, if warranted. Furthermore, staff makes contact and works in cooperation with other agencies in which the child and family are involved. This ensures a comprehensive focus on what is best for the child and amplifies the potential of assisting the child reach their fullest potential.

California Health Collaborative

ABC: Alcohol to Breast Cancer: In order to raise awareness of the link between breast cancer and alcohol consumption, they hosted a virtual meeting to present the research that shows drinking alcohol increases one's risk of breast cancer, discuss strategies to raise public awareness, and invite diverse Los Angeles County stakeholders united in promoting LGBTQI+ Latinx health and wellness to joined in a tailored social media campaign throughout the month of October. This project was an extension of the Alcohol Research Group's existing evidence-based Drink Less for Your Breasts campaign. The ARG at the Public Health Institute has been conducting research on the impacts of alcohol on health for over 60 years. The Drink Less for Your Breasts campaign brings together pre-existing and novel research to demonstrate the increased risk of breast cancer associated with alcohol consumption.

Pomona Hope

Year Round With Pomona Hope: Year-Round With Pomona Hope is more than an after-school tutoring program or summer camp. It is a tight-knit community with deeply invested adults who care for youth. They utilize volunteers who assist in facilitating enrichment workshops, parents who collaborate with staff to inspire curriculum topics and high school students who take the lead in planning community events. We believe in the importance of a holistic approach to after-school education. For this project they provided daily, focused homework and tutoring time and some academic enrichment workshops like STEM and reading intervention. With an emphasis on the physical, social and mental well-being of their students. These topics are addressed through weekly workshops, such as community garden, art, and mental health and daily workshops like gym games.

Therapeutic Play Foundation

San Gabriel Valley AAIMM Black Maternal Mental Health Support Group: Therapeutic Play Foundation (TPF) provided screenings of registered mothers through an automated online screening tool. The facilitator, with support from the project leader, review the results of the screening and address any mental health concerns that may be evident. The facilitator contacts the participants ahead of the monthly session to connect and see if there are any other services that they could benefit from. The facilitator making contact worked as an additional screening to ensure the clients responses were not biased in any way during the online screening. Appropriate action is taken based on the mental wellness of the client. The participants received monthly sessions that addressed coping strategies, life transitions and self-care, and focus on developing a bond between participants. The activities utilized talk therapy techniques — art supplies for an art-focused, therapeutic outlet, yoga or a session with a Black gynecologist, obstetrician and/or pediatrician. Collaborator agencies partnered with TPF to help conduct outreach events and recruit participants to garner community engagement and program awareness. A primary outcome was to see improvement for moms that went through at least six sessions of this group. The improvement was reflected in a comparison question that asks about their level of support and stress level at intake and at exit of the group.

Inland Valley Hope Partners

Hope Partners @ Amy's Farm Expansion: Our Hope Partners @ Amy's Farm program is a creative cooperative effort between a for profit business in Ontario and their nonprofit food bank: exchanging volunteer workers for large produce donations to their food pantries. Expansion of this program into the South Pomona service area, utilizing unused land belonging to the Pomona Unified School District adjacent to our Urban Mission food pantry allows for a sustainable resource for more fresh produce to be available to the food insecure

clients, increased outreach into the South Pomona area, and gave elementary school children the opportunity to learn about chemical free gardening while engaging in community service.

Boys and Girls Club Metro Los Angeles

Boys and Girls Club Metro Los Angeles (BGCMLA) Social-Emotional, Trauma-Informed Programming: The requested funding was used to enhance the trauma-informed social-emotional programming and ensured they could provide trauma-informed care for 515 members at the Challengers, Watts/Willowbrook and Bell Gardens Clubhouses during the school year and 200 members during the summer program.

Trauma – Informed Social Emotional Learning — All members participated in Positive Action, a seven-unit curriculum that guides a child through self-concept, actions for body and mind, managing yourself, treating others well, honesty, continuous self-improvement and a review, using the Thoughts-Actions-Feelings Circle as a framework. Members also joined SMART Moves – Social Emotional Wellness, a nationally acclaimed, comprehensive prevention and education program designed to increase participants' peer support, enhance life skills, build resiliency and strengthen leadership skills.

Mental Health Supports — Wellnest partnered with BGCMLA to provided an eight-week program (45-minute sessions once per week) to help members work on processing common reactions to trauma, communicating with friends and families, and strategies for relaxation, problem solving and planning for the future. Members who need more intensive mental health treatment were referred to additional services.

Staff training — All new BGCMLA program staff participated in 10 hours of training on how to identify and respond to signs of mental illness and substance use disorders in youth. Their goal is that all Youth Development Professionals and program leadership will be certified in trauma-informed care. They will continue to provide training for our staff so that they can further improve their knowledge in this area.

Wayfinder Family Services

Special Education School: The Special Education School is one of the only state-certified, nonpublic schools in Southern California to teach individualized curricula to elementary and high school age youth (5 to 22) with severe disabilities, including vision loss, autism, hearing impairment, Down syndrome, seizure disorders and cognitive delays. Most students are low- or nonverbal. Their school is uniquely qualified to improve our vulnerable students' lives by providing enriching educational programming at no cost to their families, 88% of whom are low-income. Students learned how to be more self-sufficient in their daily lives in a supportive environment. Self-advocacy and vocational goals were assigned to identify interests and preferences, as well as social-emotional skills to learn to engage with others and maintain safety in a variety of settings. To build coping skills and resiliency, they offered a wide range of emotional and behavioral counseling services to children and families. Additionally, Wayfinder is committed to helping students adopt healthy living habits before adulthood so they may lead fulfilling lives. Prior to the pandemic, Wayfinder provided all students with weekly physical education sessions taught by our recreation programs manager to receive the specialized cardiovascular, strength and balance training needed to overcome their sedentary lifestyles. Most students did not participate in any physical activity outside of school, often because their parents are overwhelmed by the idea of incorporating exercise at home when their children cannot

Allison Burdett and Sara Breen from Wayfinder Family Services

Giant Kale at EcoUrban Gardens Farm Lab on Arroyo Highschool Campus

complete everyday tasks independently. Currently, teachers are leading movement breaks and physical education activities in students' stable cohorts.

Healthy Living Grant "Bigger Ask" Grants

During FY2022, we wanted to see what would happen if we gave an opportunity to previous Healthy Living grantees to apply for a $10,000 or $25,000 grant. How would they build upon what we have already given them to take their organization up to the next level? In the inaugural year, we awarded the Bigger Ask grant to these two organizations:

EcoUrban Gardens

Volunteer Program Expansion & Outreach: Awarded the $25,000 grant, EcoUrban Gardens (EUG) focused on strengthening its volunteer corps to improve program impact. EUG expanded volunteer opportunities to all their programs by implementing a new application and interview process to build a volunteer corps. EUG invested in recruiting at community events, created a volunteer handbook and volunteer training program to improve the familiarity of roles, and handout Q&A to address future volunteer needs. EUG implemented a volunteer data tracking system to better track volunteer hours, target recruitment/participation goals, trends, and identify high-value volunteers for efficiency and impact. EUG highlighted exceptional volunteers with gifts and recognition in the newsletter/SMM. EUG expanded its volunteer corps with outreach education through engaging community partners. EUG expanded on existing partnerships and sought new ones. The outreach education included door-to-door canvassing, informational booths at business centers, and workshops and surveys. EUG invested in educational and take-away materials, printed and online marketing materials and press kits. Press kits were developed for distribution prior to events. Volunteers assisted with outreach, gathering feedback/data and documenting community events. A pro-bono volunteer coordinator was trained to assist in implementing a sustainable volunteer corps. The outreach education workshops enriched communities by engaging new consumers and improve EUG visibility by targeting the community at large. Hosting workshops at community partner locations (private and public sectors) helped EUG reach a wider audience, and therefore identify and recruit dependable volunteers. EUG also hosted events in their Farm Labs in collaboration with community partners and offered garden workshops to partners for their own events. Additionally, EUG surveyed neighborhoods to review consumers' needs and access to gardens, develop a dialog for healthy living and improve community engagement.

Volunteer recruitment on Instagram

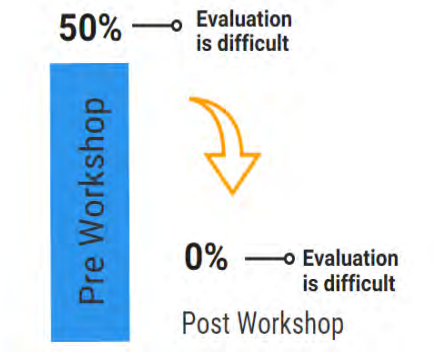
Antelope Valley Partners for Health

HPV Education and Vaccine Pop-Up Clinics: With the $10,000 2022 "Bigger Ask" grant, Antelope Valley Partners for Health (AVPH) aimed to increase the HPV Vaccine Uptake and Cancer Prevention Pop-Up Clinics, increasing from two to four large-scale clinics in the Antelope Valley. This would include one per grant quarter, reaching 50 to 75 vaccinations per clinic — totaling 200 to 300 HPV vaccinations in the grant term. In addition, AVPH provided education sessions, community outreach and engagement surrounding HPV education and awareness, increase vaccine uptake and increase access to these preventative services within

the Antelope Valley – reaching 1000 to 1500 community members through community events, social media, virtual and in person education sessions.

We Build Community Capacity

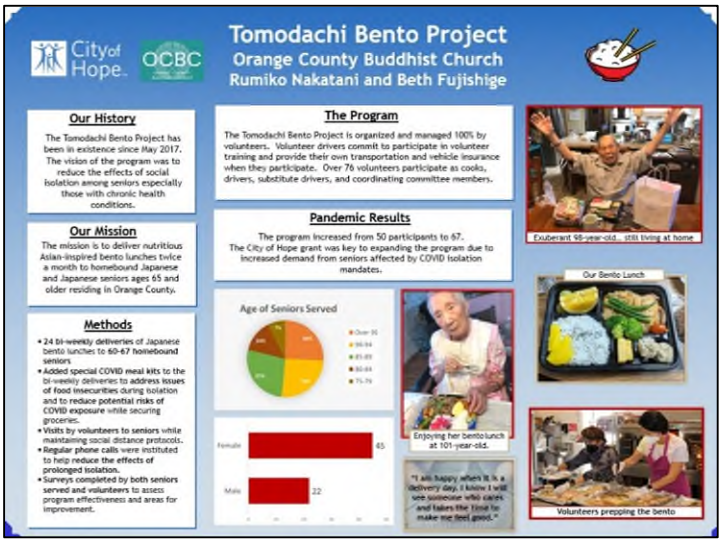
In order to build capacity, all grantees are being provided with ongoing technical assistance and mentoring support to ensure evaluation data is collected and the programs align with their funded outcomes.



Changed belief in difficulty in conducting program evaluation. February 2022, Evaluation Workshop

City of Hope's CBAC members will conduct site visits later in the year for each grantee and provide feedback where necessary. Ultimately, this grant program is about building community and capacity around efforts that support health and wellness in our service area. Our grantees overwhelmingly raised their own belief in their ability to conduct program evaluation. Fifty percent did believe that evaluation was difficult at the onset of the training. By the end, minds were cultivated and strengthened, and not one participant felt that evaluation was difficult. This is a testimony to the work we do to build their capacity and to ultimately tell their story as a means to leverage future support and to sustain the changes that they sparked in their own communities.

At the end of the funding cycle when new grants were awarded, the 2021 grantees participated in a half-day conference, where they shared their program results with the community and acted as mentors to the new round of Healthy Living Grant recipients. In June 2022, the eight 2021 healthy living grantees shared their findings after a year of implementing programs during a virtual conference. All 2021 grantees made 15-minute presentations and held a virtual poster session. While the programs varied from cancer support to community gardening to building resilience during COVID-19, all shared a common theme: to improve the lives of the vulnerable living throughout our region. You can access their virtual poster session via our Community Benefit webpage. Below is an example of one particular program that made a difference in the lives of elderly Japanese in an Orange County community, the Tomodachi Bento Project. The students at Mountain View High School, in El Monte, used their funds to convince other students that eating a meat substitute was just as delicious as eating meat. They also made a fun video of their project. You can view that on YouTube via this link.



The important message to take home from the Healthy Living Grant Program is that "small is beautiful," meaning you can do a lot of good with not a lot of money. Local organizations can benefit from smaller grants that increase their productivity, increase the scale of a previous effort or launch a pilot program without making a large investment.

Community Capacity Building Grants

During the grant review process, the CBAC members found that some proposals did not fit the critiera for a one-year project, yet these proposals are worthy as they meet the specific needs of the local vulnerable community. To address this, the council created a new funding category called the Community Capacity Building Grant. City of Hope also awarded **Community Building** grants for organizations whose work reflects an identified need, but do not fit the parameters of the Healthy Living Grant. This year we are pleased to announce the **2022 City of Hope Community Building** grant recipients:

[City of Azusa – Community Resources Department]

Recreational Youth Sports & Healthy Living: The target population includes both male and female residents of Azusa, ages 10 to 14. Through the youth recreational sports programs, they selected a group to measure cardiorespiratory (aerobic) fitness, flexibility and balance over a period of six to eight weeks. Baseline measures were established preseason and reevaluated during weeks 6 or 8. The initial approach established a baseline that will compare data overtime from Azusa youth sports programs. Future goals include implementing physical fitness interventions compared to a control group to evaluate the intervention effectiveness and improve health related outcomes. This data will be synthesized into a community health dashboard to improve cross-sector collaboration and integrated services that target the needs of the

community. As a three-pilot project for future health evaluation and program/service creation, our long-term goal is to integrate Active Living and Healthy Eating principles, education and strategies.

Abdi's Foundation Inc.

Smile America Abdi Foundation Center was funded to support their annual Thanksgiving food drive. Those experiencing food insecurity jumped dramatically through 2022, and this foundation will help to get food to those who need it.

We are still living with the impact of the pandemic. Children and teens are not as physically active as they were prior to the social isolation because programs were shut down or there was a lack of open space where they lived. With respect to hunger, people are still having a difficult time paying their bills and must now rely on community food programs to feed their families. Both **the City of Azusa – Community Services Department and Abdi's Foundation** received the $5,000 grant to live out their vision and serve communities that are especially vulnerable because of the impact of COVID-19.

COVID-19 Relief Community Building Funds

Much like FY2021, as FY2022 progressed, we realized that we would, again, have a surplus of funds given many of our programs went online. This virtual transition provided us with more dollars available for giving. We identified a savings of $40,000 that we could use to address the important needs of local organizations that were serving the vulnerable. The following represent three organizations that the CBAC selected to receive COVID-19 Relief Community Building Funds to focus on the increased burden of providing linkages to social health programs (food, housing, financial).

211 – Los Angeles County — Support case management teams that respond to community requests for support with all needs
Seeds of Hope — Provides linkages to local food resources that support community members facing food insecurity. Examples are links to food delivery, food banks and enrollment support in CalFresh programs for the neighboring five-county region.
Project Angelfood — Delivers medically tailored meals to community members who are facing serious medical conditions and food access issues.

Kindness Grants

The Kindness Grants were created in 2018 to support City of Hope employees who want to do good in their community. During FY2022, a variety of individual employees and work teams were awarded grants to support their amazing ideas that will continue to resonate in the lives of every person who has been touched by their work.

HS2RN Virtual Reality (VR) Career Days **Strategy Focus:** Access to Care **Submitted By:** Chris Tarver Nursing Excellence **Amount Awarded:** $1,360	Utilizing a unique approach to career days and to interest high school students into joining City of Hope's HS2RN program, we used a virtual experience of our campus and a collaborative team approach. Partnering with Nursing Coalition for Equity, Diversity and Social Justice, as well as employee resource groups, specifically Connection People of the African Descent for Hope (CPAD) and Latinos for Hope, to create VR using a 360 camera of campus tours, nursing unit tour, and short, welcoming interviews. Students accessed the tour through a QR code on the student's smartphone and viewed through a VR reusable headset. This program helped to open up careers to nursing, to our diverse community and, ultimately, help us to provide a nursing workforce that is more representative of the people who live in City of Hope's service area.

A Guide to a Healthier You: Black Hair and Skin Care Forum **Strategy Focus:** Cancer **Submitted by:** Vernetta Griffin Talitha Tyler **Amount Awarded:** $5,000	To accomplish the cancer prevention and early detection strategy, Connection People of African Descent for Hope (CPAD) held a community forum to discuss beliefs and attitudes about using products that have harmful chemicals for Black women with breast cancer. Attendees learned about specific ingredients in both hair and skin products that are harmful and how to make better selections when purchasing. This was a hybrid event and the online platform allowed CPAD to broaden its reach across the country and strengthen collaborative efforts with other organizations dedicated to community and health literacy, especially around cancer. 
Transgender Sharps Supply for HRT Patients at Planned Parenthood of Pasadena/San Gabriel Valley **Strategy Focus:** Access to Care Economic/Housing Insecurity **Submitted by:** Malcolm Jay Pride in the City – Employee Resource Group **Amount Awarded:** **$2,000**	A trans needle exchange program was chosen because, due to health care inequalities, many people who medically transition using hormone replacement (HRT) do not have access to insurance that covers medical supplies like sharps containers, clear syringes and needles and single-use supplies like alcohol wipes and Band Aids that are necessary to ensure safe self-administration of medications. This can often lead to individuals paying high out-of-pocket fees that are not affordable or reusing supplies, putting them at high risk for injection complications. At present, 73% of TransCare patients pay out-of-pocket for their visits, and providing needle kits to these patients will be increase access to needed supplies. By helping coordinate a needle exchange program, Pride in the City has helped

	members of the trans community who cannot access or afford their own supplies.
Throws for Our Elderly in Convalescent Homes Strategy Focus: Chronic Disease Submitted by: Monica Villalobos Surgical Oncology South Bay Amount Awarded: $1,500	A visitation program to decrease feelings of loneliness and depression among senior residents living in local convalescent homes
Orange County Black History Parade and Cultural Fair Strategy Focus: Access to Care, Mental Health, Economic and Housing Insecurity, Chronic Disease and Cancer Submitted by: Shedrick Collins Sr. Information Security Amount Awarded: $2,500	Support the work of the Orange County Heritage Council http://oc-hc.org an organization focused on the Black community and development of events and activities that promote positive family and cultural interaction. This Kindness Grant boosted efforts to increase knowledge and awareness of important to health screenings, schedule annual checkups and change their eating habits to prevent multiple types of cancer, in the Orange County Black community.
Mental Health Awareness: Black Minds Matter Strategy Focus: Mental Health Submitted By: Victoria Taylor McKinley Chief Financial Office Amount Awarded: $3,500	To decrease impact of COVID-19 and social microaggressions has on the mental health of African American women living in the Greater San Gabriel Valley and South Los Angeles communities, Victoria Taylor McKinley delivered a mental health forum to support a safe environment for Black women to explore their own feelings and emotions. She did this in collaboration with the Crenshaw Church of Christ and other faith-based partners, organizations, Black-owned businesses, as well as the fraternities and sororities in the region. In her own words, "I'm motivated to do a project for African American

<table>
<tr>
<td> 
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<td>women because we suffer from mental health issues and are 50% less likely to get help.”
 
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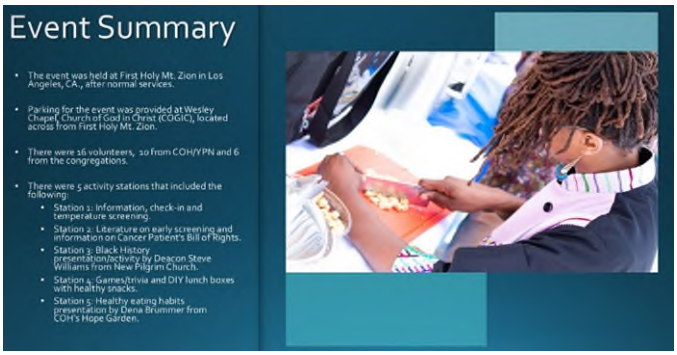
<td>Cancer Awareness Day

Strategy Focus:
Access to Care, Chronic Disease, Cancer

Submitted By:
Christopher McKinley, Yuddy Jesus, Vanessa Macias, Jenn Phan, YPN Leadership Team

Amount Awarded:
$3,000
 
</td>
<td>Cancer Awareness Day will utilize primary prevention strategies to provide materials and information on diabetes and cancers. This event will be held on a Sunday after church service and the three participating churches will direct their congregations to the location where it will be held. They aim to create an environment that is both educational and engaging. Attendees will be actively participating in activities and interacting with community and City of Hope representatives at different booths/stations throughout the event. They will also provide education regarding important health topics, such as the Cancer Patients Bill of Rights, health disparities and diseases that disproportionately affect minorities, risk factors and early detection practices.</td>
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Food Insecurity — Greater San Gabriel Valley Hospital Collaborative, Garden of Hope and Produce for Patients

The Hospital Collaborative is an initiative of and facilitated by the Health Consortium of Greater San Gabriel Valley (Health Consortium) and began meeting in mid-2018. The mission of the Health Consortium is to strengthen the health care safety net and optimize seamless access to high quality physical health, mental health and substance use disorder services in the Greater San Gabriel Valley. This area includes both the San

Gabriel and Pomona Valleys, stretching from Pasadena to Pomona and incorporating the geographic area defined by Los Angeles County as Service Planning Area (SPA) 3.The Greater San Gabriel Valley Hospital Collaborative, funded in part by the UniHealth Foundation, serves to (a) work collaboratively to streamline and coordinate data collection for CHNAs across the hospitals and (b) develop a coordinated strategy to address regional mental health needs. The Hospital Collaborative has also initiated participation in a Homelessness & Health Care Patient Navigator pilot project with the United Way of Greater Los Angeles. The six nonprofit hospitals that comprise the Hospital Collaborative are City of Hope, Emanate Health, Huntington Hospital, Kaiser Permanente Baldwin Park, Methodist Hospital and Pomona Valley Hospital Medical Center. In addition to the nonprofit hospitals, the Hospital Collaborative also includes the two local public health departments that serve this geographic area - L.A. County Department of Public Health and Pasadena Public Health Department. As a direct result of this partnership, the hospitals committed to identifying high confidence social determinants of health and worked on strategies to resolve those issues. In June 2021, the UniHealth Foundation funded the Hospital Collaborative to coordinate a regional project, the *Greater San Gabriel Valley Food for All Initiative,* to reduce food insecurity among economically and medically vulnerable hospital patients at participant hospitals. Primary project participants include five of the six Hospital Collaborative members: Huntington Hospital, Methodist Hospital, City of Hope, Kaiser Permanente Baldwin Park and Emanate Health. These partners currently engage in food insecurity work at different levels, and this initiative would facilitate each to progress accordingly. Initiative components include:

SPA 3 Hospital Collaborative partners

1) <u>Food Insecurity Screening and Tracking</u>**:** Each hospital will incorporate a food insecurity screening component to the admission or discharge process using a validated screening tool. Results will be tracked electronically via the Unite Us/Coordinated Community Network referral platform, which will provide both hospital and regional data on changes and improvements over time.

2) <u>Partnerships With Local Community Based Organizations (CBOs)</u>**:** All patients identified as food insecure will be linked with Seeds of Hope (SOH) for emergency food services and/or to Project Angel Food (PAF) for delivery of medically tailored meals (MTMs), both selected due to their expertise and services. SOH cultivates community wellness through food justice and food pantries and has adopted use of the Tangelo App to facilitate home-delivered access to fresh food for low-income and other vulnerable individuals. PAF's mission is to prepare and deliver healthy meals to feed people impacted by serious illness and can accommodate 39 different MTM plans.

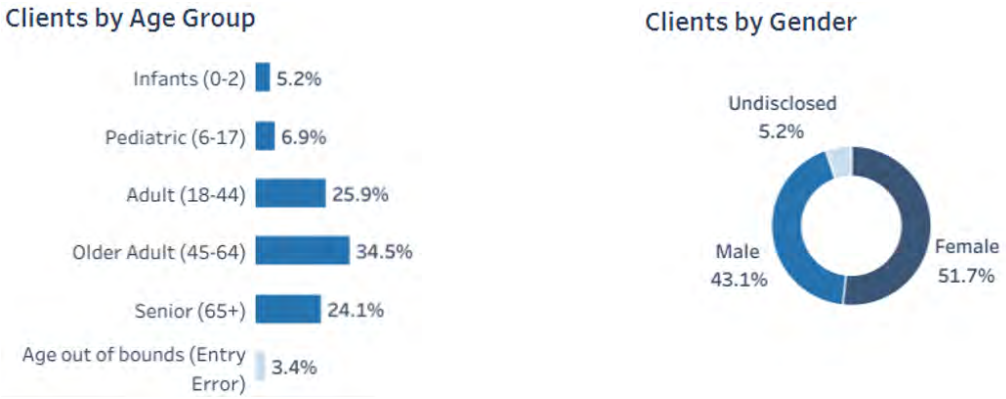
3) <u>Sustainability of Food Security Support</u>**:** Hospitals will explore strategies for long-term sustainability of food security resources for their patients and the CBO partners, such as:
    - Institutionalizing commitments to addressing food security through internal policies that identify comprehensive strategies and hospital leadership

- Planning for alignment with potential reimbursement opportunities
- Ongoing financial contributions to the CBOs
- Using evaluation data to inform project implementation.
- Preparing and disseminating a report on initiative results, lessons learned and the collaborative experience

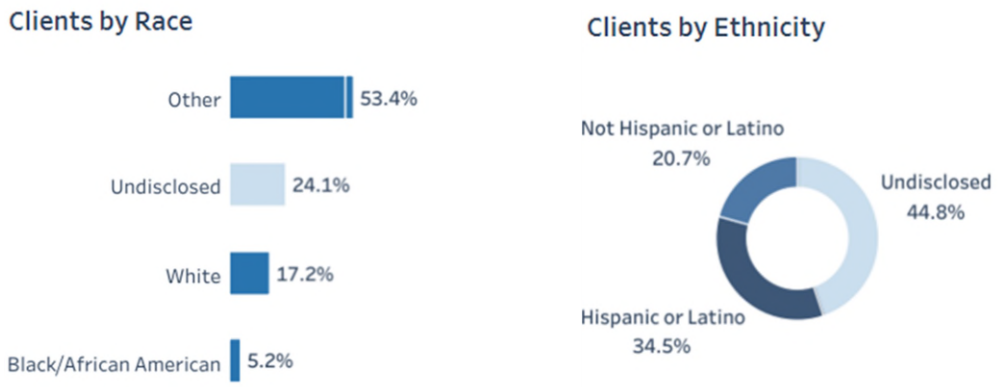
The strength of a regional approach to addressing the social determinants of health is critical. With the collaboration of the six nonprofit hospitals in the San Gabriel Valley, we aim to move the needle on issues that directly impact our most vulnerable residents. City of Hope's director of community benefit serves as the co-chair of this effort. Data from the last fiscal year are displayed below:

Through 10/31/22	Referrals			
	PAF	SOH	Total Referrals	Unique Clients
USC Arcadia Hospital with null	22	41	63	44
USC Arcdia Hospital wo null	12	19	31	28
City of Hope with null	8	21	29	26
City of Hope wo null	7	11	18	18
Emanate Health with null	12	0	12	12
Emanate Health wo null	2	0	2	2
KP Baldwin Park with Null	**92**	28	120	118
KP Baldwin Park wo Null	**27**	11	38	38
Huntington Hospital*	14	16	30	
Totals with null	**134**	**90**	**224**	**200**
Totals without null	**48**	**41**	**89**	**86**

* Waiting for updated numbers from Findhelp
null: organizational referrals pending in the Unite Us platform

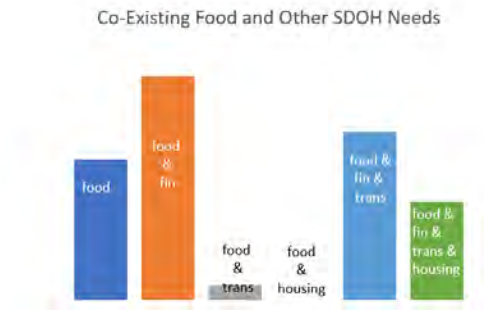


Food for All Client Data for all SPA3 Hospital Partners. Client age and gender.



Food for All Client Data for all SPA 3 hospital partners. Clients by race and ethnicity

In addition to supporting the Food for All collaborative, City of Hope created a multidisciplinary team from across the clinical and administrative teams to address food insecurity of our most vulnerable patients. During FY2022, we continued to ask patients if they were food insecure. We created a process where patients who believed that they experience food insecurity were able to request a 20 lb bag of food upon discharge. Between October 2021 and September 2022, we were able to provide 50 bags of food to patients. In July 2022, we began a pilot project to see what resources would be necessary to address four social determinants of health domains (housing, financial and transportation, in addition to food) of our inpatients and in four outpatient clinics. During 2022, patients who had food insecurity usually had at least one other need. In order to address these needs, we created workflows that connected patients with community resources via the UniteUs Platform. All of this began with the work of the Food for All program and our collaboration with the SPA 3 Hospital Collaborative. It is important to note the significance of how a regional approach to addressing social determinants of health, can influence how we provide comprehensive and compassionate care within our own walls. We are grateful for the partnership both internally and externally, LA Regional Food Bank and Seeds of Hope, Health Consortium of the San Gabriel Valley and the SPA 3 hospitals collaborative for their incredible support of bringing programming, like this, to people in need.



2022 City of Hope patients with co-existing SDOH needs

Garden of Hope

We broke ground for the Garden of Hope in September 2018. Since that time the garden has evolved into a space where everyone is equal, where hope is felt and spirits soar. During FY2022 we adopted another AmeriCorps Volunteer through our collaboration with the Foothill Unity Center Inc. This has allowed us to not only provide a great volunteering experience for our master gardener, we have been able to grow our volunteer and programming efforts too. During this last year we convened a garden advisory board made up of City of Hope staff as well as patients. Since our first meetings with the board, we have crafted a new set of programmatic strategic pillars centered around food justice, environmental stewardship, knowledge and well-being.

This year we have held monthly lunch and learns around gardening knowledge and sustainability. We have participated in enterprise-wide events that promoted awareness surrounding racial and ethnic affinity groups. Roots of Resliance was held during Black History month and showcased the experience of Black farmers. During Asian Pacific Islander Month, we shared the experience of local API farmers. Our monthly volunteer events bring out community members and City of Hope staff to support the maintenance needs of the garden as well as learning valuable gardening skills that they can take home and back to their communities. The bounty from the garden is shared with community members, patients and local food banks.

Kid Run Farmer's Markets

Making efforts to "normalize" the farming and garden experience we have continued to sponsor "Kid Run Farmer's Markets" with La Primaria Elementary School in the city of El Monte. As soon as the school gave the go-ahead for events, with COVID-19 security measures in place, we starting planning two markets held at the

school. While our initial investments in tools for the markets fell into the FY2021 report, this left our total costs for this past year very low. However, the school reported a $1,200 profit from both markets held at the end of their 2022 school year. Even though that investment is small, the impacts are large. From this venture, we continued to purchase the product from a local Community Support Agriculture organization, Food Roots. Fifth graders from this school were trained as market managers, client relations staff, cashiers and marketing teams. The teachers worked with the children to increase profits by producing grocery sacks from upcycled T-shirts and supplementing with fresh fruit from local families. We are still looking for a model that will become a sustainable effort with hopes of expanding into the El Monte School District middle schools with a final pathway to the high schools where they can connect with the Farm Lab and community gardens throughout the school trajectory.

Cancer Care Is Different Advocacy

A PROJECT OF

City of Hope · Cancer Action Network · California Chronic Care Coalition · Leukemia & Lymphoma Society · Susan G. Komen · Lazarex Cancer Foundation · Be The Match · NBCA · The Latino Cancer Institute · California Black Health Network · Triage Cancer · Stanford Health Care · Cedars Sinai

The Cancer Care Is Different coalition, consisting of City of Hope and partners, such as the American Cancer Society Cancer Action Network, the Leukemia & Lymphoma Society, Susan G. Komen and the California Chronic Care Coalition, among others, is driven by the belief that the best chance of a cure for a patient is the first chance at a cure.

CANCERCARE IS DIFFERENT

On Sept. 28, 2022, Govenor Gavin Newsome signed the California Cancer Care Equity Act (SB 987) (CCCEA) into law. By expanding access to specialized cancer care for Medi-Cal patients who receive a complex cancer diagnosis, this important bill, which went into effect Jan. 1, 2023, will benefit and save countless lives. Backed by City of Hope since the beginning, the bill was introduced by Sen. Anthony Portantino (SD-25) in April 2022 and passed by both chambers of the California Legislature unanimously. SB 987 represents a

critical first step in delivering on the promise of the California Cancer Patients Bill of Rights resolution, which recognizes that cancer patients should receive appropriate, timely and equitable access to expert cancer care and was adopted by the Legislature in 2021.

The CCCEA will help remove current obstacles that prevent access to innovative care for Medi-Cal beneficiaries — who represent approximately one-third of California's population. At present, many patients on Medi-Cal experience inferior survival rates compared to patients on private insurance.

Notably, African Americans and Hispanics have the highest rates of Medi-Cal enrollment in California, at 44.3% and 44.9%, respectively.

Cancer care is expensive, but mistreating patients is more expensive, particularly in human costs. When patients with rare or complex cancers have access to care at a comprehensive cancer center, they often experience better outcomes at lower costs. Research has documented significant differences in outcomes, including survival, if a patient is seen at a community hospital versus a National Cancer Institute-designated comprehensive cancer center.The Cancer outcomes uniquely rely on the accuracy and speed of initial diagnosis, choice of therapy and access to appropriate clinical trials. SB 987 is one major step that gives hope that more Californians will be able to access the care that gives them the best chance to beat cancer, regardless of their insurance or ZIP code.

Cross Institution Collaborations

It is important to recognize the participation of the hardworking individuals who contributed to over 168 community education events across this institution and in the vulnerable communities City of Hope serves. There has been an obvious thought shift from exclusively increasing patients toward our services to getting critical cancer prevention awareness information into our most underrepresented communities that is both culturally and linguistically appropriate. To do this work Community Benefit collaborated most notably with teams in Enterprise Growth and Innovation, Government and Community Relations, Nutrition, Rehabilitation, DEI, the Employee Resource Groups, and Nursing. Individual employees and entire teams showed up to help distribute produce to patients. Community members and teams dug in and help to plant and harvest in the

Garden of Hope. It has been another amazing year and we are full of gratitude for all those generous friends, collaborators and community members who have supported us and helped us to serve those in need.

COMMUNITY BENEFIT INVESTMENTS

How Benefits Were Defined

The quantifiable community benefits provided by City of Hope in FY2022 are listed in the table below. Consistent with community benefit standards, only activities funded by City of Hope National Medical Center (versus Beckman Research Institute of City of Hope, City of Hope Medical Foundation or Philanthropy) are included.

The Catholic Health Association's publication, "A Guide for Planning and Reporting Community Benefit, 2022 Edition," was used to determine whether activities met the criteria for inclusion as a quantified community benefit. The criterion also meets Internal Revenue Service (IRS) reporting and accounting requirements. Activities were grouped under the broad categories defined in SB 697 and were further divided into classifications consistent with IRS Schedule H.

Methods Used to Collect Data and Derive Values

Financial data on medical care services and health research were provided by City of Hope's Finance Department. The method used to calculate the value of Medi-Cal and Medicare services was estimated direct and indirect cost per case, minus reimbursement received.

Data on benefits for the broader community were obtained by contacting individual medical center departments. To calculate the value of personnel services, estimated hours devoted to an activity were multiplied by hourly wage and the fringe benefits were added to that number. In-kind donations were calculated at face value. Dollars have been rounded to the nearest hundred.

Value of Quantifiable Benefits

FY22 Community Benefit Categories	FY22 Net Benefit
CHARITY CARE[1]	25,726,000
UNPAID COSTS OF MEDI-CAL[2]	79,828,596
OTHERS FOR THE ECONOMICALLY DISADVANTAGED[3]	(58,873,101)
EDUCATION AND RESEARCH[4]	117,532,113
OTHER FOR THE BROADER COMMUNITY[5]	10,839,788
TOTAL COMMUNITY BENEFIT PROVIDED EXCLUDING UNPAID COSTS OF MEDICARE	175,053,396
UNPAID COSTS OF MEDICARE[2]	190,516,392
TOTAL QUANTIFIABLE COMMUNITY BENEFIT	**365,569,788**

FY2022 Quanitifiable Community Benefit

City of Hope also provided a wide range of benefits to our communities that is not reflected in the table because they are not included in the definition of operational costs for community benefit. These include, but are not limited to, technical assistance provided to governmental agencies and community organizations, contributions to research literature and leadership on community boards.

[1] Charity Care includes traditional charity care write-offs to eligible patients at reduced or no cost based on the individual patient's financial situation.

[2] Unpaid costs of public programs include the difference between costs to provide a service and the rate at which the hospital is reimbursed. Estimated costs are based on the overall hospital cost to charge ratio. This total includes the revenue and expense associated with the state Quality Assurance Program. City of Hope recognized net revenue from the Quality Assurance Program, which is recorded as $0 Medi-Cal shortfall.

[3] Includes other payors for which the hospital receives little or no reimbursement (county indigent).

[4] Costs related to the medical education programs and medical research that the hospital sponsors.

[5] Includes non-billed programs such as community health education, screenings, support groups, clinics and support services.

Garden of Hope, Garden Sprouts take a break.

CONCLUSION

City of Hope strives to decrease health disparities in our service area by creating an institution-wide emphasis on community benefit to organize thoughtful collaborations that address root causes of barriers to good health. This year, we provided evidence on the total FY2022 investment of **$365,569,788** and reported on the strategies prioritized in our 2021-2023 Implementation Strategy Plan. The main focus areas of our FY2022 community benefit programs and services: **Healthy Living, Community Capacity Building and Kindness Grants, Food Insecurity - Greater San Gabriel Valley Hospital Collaborative, Garden of Hope and Produce for Patients,** and the **Cancer Care Patient Equity Bill** have been described in detail**.** We also had an incredible amount of cross-institutional collaborations that have utilized the lens of health disparities and the social determinants of health to create new partnerships and leverage current relationships to deliver services to our most diverse and vulnerable communities. With the pandemic still in our minds, we have been emerging from the fog and began to do more in-person interactions with our community. We have learned that we can extend our reach to the communities we serve by continuing our online programming. The racial inequities that continue to play out has put a spotlight on diversity, equity and inclusion. With our institution's commitment to diversity, equity and inclusion, we will continue to be intentional when planning programs and involving a more diverse group of individuals in delivering community benefit programs and services.

This document represents our efforts at addressing the community prioritized 2021-2023 Implementation Strategy during FY2022. The designation of the Department of Community Benefit as an institutional priority and placing it within the Office of Diversity, Equity and Inclusion has heightened the sense of urgency to create strong, useful programs that meet the needs of the vulnerable populations in our service area. We will continue to view existing and future programs through a lens that places vulnerable populations at the forefront of the planning process. We are confident this institutional commitment will foster more collaboration among City of Hope employees and our community stakeholders. Prioritizing community benefit allows for a more strategic focus on issues that are critical to our service area, while creating pathways for health and healing.

Appendix A
2019 Needs Assessment Tools

Primary Data Collection Participants

Community input was obtained from focus groups, surveys and interviews that engaged public health professionals, community members and representatives from organizations that represent medically underserved, low-income and/or minority populations. These focus groups and interviews included the following:

Emanate Health Foundation Board
West Covina Unified School District
Pasadena Unified School District
Foothill Unity Center
San Gabriel Valley Economic Partnership
Citrus Valley Association of Realtors
United Methodist Church
Herald Christian Health Center
Day One
Majestic Realty
Foothill Family Services
Health Consortium of the Greater San Gabriel Valley
Pasadena Public Health Department
El Monte Comprehensive Health Center

Los Angeles County Department of Mental Health
Altadena Baptist Church
Our Saviour Center
Baldwin Park Adult and Community Education
All Saints Church
Duarte Unified School District
ChapCare
Asian Youth Center
Pacific Clinics
Los Angeles County Department of Public Health, SPA 3
GEM Fellowship Program
American Cancer Society, Inc. - California Division
Seeds of Hope Episcopal Diocese
Antelope Valley Partners for Health
Young & Healthy
East San Gabriel Valley Coalition for the Homeless
LGBTQ Seniors
African-American Residents in Monrovia, Pasadena, Covina, and Lancaster
Spanish-speaking Latina Moms in Pasadena
San Gabriel Valley Health Consortium
Chinese Cancer Patients
Huntington Hospital Community Benefit Committee

Primary Stakeholder Interview Questions

Interview Questions and Notes

Please tell me about your organization and your programs/services? Tell me about the community or communities you serve? (The demographic of the community they serve, e.g. immigrant (from where?), languages spoken, types of jobs they have, are they renters or home owners, do they have free and reduced price lunch rates, etc.).

What are the most significant health issues or needs in the community (communities) you serve? How do these health issues or needs affect people's daily lives?

Which of these are the top three priority needs/issues, considering both their importance and urgency?

What factors or conditions contribute to these health issues? (e.g., social, cultural, behavioral, environmental, or medical) *[Note: Ask for up to three issues.]*

Who or what groups in the community are most affected by these issues? (e.g., youth, older residents, racial/ethnic groups, specific neighborhoods) *[Note: Ask for up to three issues.]*

What are some major barriers or challenges to addressing these issues? *[Note: Ask for up to three issues.]*

1. In general, for the community?
2. Specifically, what challenges does your organization face in serving your target populations and addressing these issues (besides funding)?

What do you think are effective strategies for addressing these issues?

What resources exist in the community to help address these health issues? (e.g., people, organizations or agencies, programs, or other community resources)

What else is important for us to know about significant health needs in the community?

1. What are the needs that your programs/services are trying to meet?

2. From your experience, what are the factors that have the greatest impact on their health?

3. What inhibits or promotes the secure, consistent access to and use of health care for residents of the service area?

4. What are the differences in health-care needs and health-care outcomes between first and second generation Latinos. First generation being foreign born and second being U.S. born.

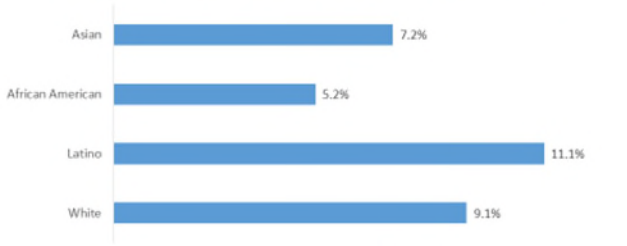
5. Would you like to add any additional information?

Community Voice Summary

Below is a summary of the community voices we heard while conducting the focus groups and interviews. We placed them next to the leading indicators so that they reader could see clearly the impact of those issues on the participants' lives:

Increasing concern about mental health

People in SGV who have ever seriously thought about committing suicide...



"Do you feel stressed? No, sick! You feel feo. *Alone, like you don't know where to go. The stress of not being able to find a place to live is too much for a person."*

Everyone is at-risk...
- Across all life stages
- Across age, race/ethnicity, education, and income

Some groups...
- Are more impacted
- Have less access to resources

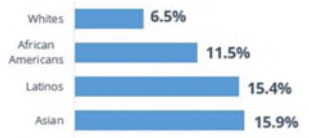
Stress and depression can be exacerbated by...
- Economic instability
- Social isolation

Source: UCLA Center for Health Policy Research, California Health Interview Survey (CHIS). Accessed online at: http://ask.chis.ucla.edu/ on February 5, 2020. Pooled across years 2017-2018 for statistical stability.

Health Care is increasingly unaffordable and inaccessible

42% of Greater SGV residents were unable to pay for basic necessities due to medical debt in 2017[8]

1 out of 3 adults in the Greater SGV delayed medical care due to cost or lack of insurance in 2018[9]



"In our area, I don't know what is happening, I don't know if the doctors are already booked or have total capacity for the Medical patients but they are full, and the patients get referred to places outside of the area, which is very difficult because they don't have transportation."

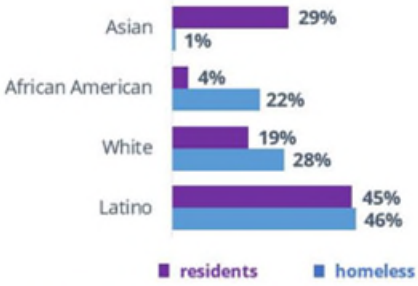
% of SPA 3 residents who did not have a usual place to go when sick or needing health advice in 2018[10]

Source: UCLA Center for Health Policy Research, California Health Interview Survey (CHIS). Accessed online at: http://ask.chis.ucla.edu/ on February 5, 2020.

Housing insecurity and homelessness are at crisis levels

There were 4,489 homeless individuals in the Greater SGV in 2019; 63.3% of these were unsheltered homeless[11]

72% Nearly 3 out of 4 homeless in the Greater SGV were newly homeless. The newly homeless are vulnerable to trauma and illness that can impact health and wellbeing in the long term[12]



"The increase in rent has really killed people. People are starting to qualify for homeless services because they've doubled up, tripled up in houses. Homeless in schools – it's not the same definition as HUD. In public schools, you can be in a garage, transitional, doubled up and count as homeless – we have 500 kids who are "homeless" now."

African Americans are only 4% of the total population, but comprise 22%--more than one out of five--of the homeless residents of the Greater SGV[13]

Source: UCLA Center for Health Policy Research, California Health Interview Survey (CHIS). Accessed online at: http://ask.chis.ucla.edu/ on February 5, 2020. Pooled across years 2017-2018 for statistical stability.

Economic and food insecurity are straining families and systems

One third of Greater SGV Cities have household incomes below the $67,169 state median.[14] In order to afford median asking rent in Los Angeles County, household income needs to be at least $98,841[15]

Only half of Greater SGV adults said affordable fruits and vegetables are *always* available in their neighborhood.[16]

In a 2018 survey, 49% of Latinos in the Greater SGV report being able to afford enough food each month, 67% of Whites and 88% of Asians[17]

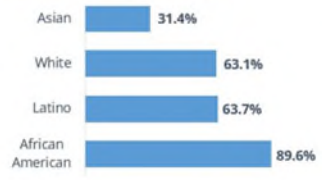
"I see the communities with a tremendous financial strain – working class families and seniors on fixed incomes."

"Being in a stressful situation, you're in fight or flight, you're not thinking down the line, you're thinking "how am I getting food today?" You don't think if the food is healthy or how it will affect your teeth. So preventive care is not a priority."

Source: UCLA Center for Health Policy Research, California Health Interview Survey (CHIS). Accessed online at: http://ask.chis.ucla.edu/ on February 5, 2020. Pooled across years 2017-2018 for statistical stability.

Chronic conditions, including obesity, heart disease, and cancer…

Overweight or Obese in SPA 3 in 2018[18]



Heart disease mortality rates in Los Angeles County are nearly twice as high for Black men as for all other men.[19]

"It's hard to manage sugar and eating healthy even when you have access and means to afford it. Disproportionally lower income populations are more impacted as they have less money and are managing multiple jobs. They have less time to make healthy meals and less income to afford health options. For the same reasons, homeless people have a huge difficulty staying healthy."

Deepening understanding of the role of social and environmental determinants.

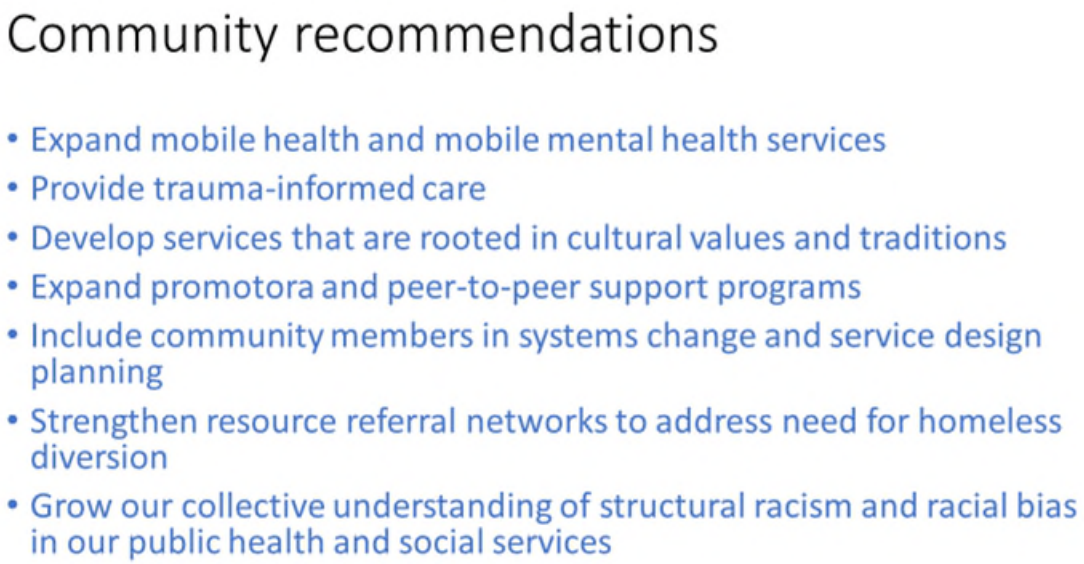
Emerging efforts are looking at disparities and equity issues.

In California, the ratio of incidence to mortality for all cancer types is highest for African Americans: 45% of African Americans diagnosed with cancer will die of that cancer. This is true for 35% of Whites.[20]

Source: UCLA Center for Health Policy Research, California Health Interview Survey (CHIS). Accessed online at: http://ask.chis.ucla.edu/ on February 5, 2020.

Some populations are especially vulnerable

- Immigrants, particularly undocumented
- Speakers of languages other than English
- African Americans
- Chronically homeless
- Those at risk of homelessness
- Aging seniors
- Individuals and families on fixed incomes
- LGBTQ+ populations



Community Resources

City of Hope solicited community input through key stakeholder interviews, a community survey and focus groups to identify programs, organizations and facilities potentially available to address significant health needs. This is not a comprehensive list of all available resources. For additional resources, refer to 211 LA County at www.211la.org/ and Think Health LA at www.thinkhealthla.org.

Significant Health Needs	Community Resources
Access to care	• Clinica Ramona in El Monte provides one year of health coverage for free. • Community Health Alliance of Pasadena (ChapCare) • Set for Life hosts health expos with health screenings. • Senior Advocacy Program, a county program for seniors primarily in nursing homes • CVS and Rite Aid offer flu shots and screenings. • Foothill Transit offers bus service from Duarte to Pasadena. • Duarte Senior Center publishes a newsletter that identifies resources. • City of Hope Health Fair • Herald Christian Health Center • Tzu Chi Foundation

	• Cleaver Family Wellness Clinic and food pantry • Good Samaritan Hospital • Parish Nurses offer screenings with referrals for more services. • El Monte School District developed a Family Center in El Monte, which includes a number of services and community organizations. • AltaMed • Western University provides dental services at two dental clinics at schools. • Duarte School District's Health Services Center focuses on getting kids access to health insurance. • Foothill Unity Center food bank • Department of Health Services clinic in El Monte • Latinos for Hope (City of Hope group) goes out into the community and informs/educates about what's available. • Certified Enrollment Counselors at El Proyecto del Barrio help patients understand eligibility, enrollment, and keep them on their programs to maintain their benefits. • East Valley Community Health Center • Antelope Valley Community Clinic • Antelope Valley Children's Center • Antelope Valley Partners for Health • Palmdale Regional Medical Center • Antelope Valley Hospital • Garfield Health Center • Asian Community Center • Kaiser Permanente • Huntington Hospital • City of Pasadena Public Health Department • Chinatown Service Center
Cancer	• Clínica Médica Familiár (Family Medical Clinic) has clinics twice a year. • Brotherhood Labor League Annual Men's Conference • City of Hope offers cancer screenings at health fairs. • Set for Life offers mammograms. • Children's Hospital Los Angeles • Southern California Health Conference at Pasadena Civic Center • Cleaver Clinic • American Cancer Society has resources that can help with transportation and navigation assistance. • Susan B. Komen

	• My Health LA patients provides emergency Medi-Cal for women 40+ with breast cancer and for women of any age with cervical cancer through the Every Woman Counts program. • Prostate Cancer Research Institute annual conference • MEMAH (Men Educating Men About Health) annual conference partners with City of Hope to do digital rectal exams. • Garfield Health Center provides mammograms and colorectal cancer screening. • Herald Cancer Association offers support, consultation, answers to questions, written information and links to websites.
Heart disease	• American Heart Association • Set for Life • Labor Union Conference • Curbside CPR classes are offered by the Fire Department. • Tzu Chi Foundation • Children's Hospital Los Angeles • Los Angeles County Department of Public Health Service • City of Azusa has a Wellness Center. • El Proyecto Del Barrio does medication management and assistance. • Clinic pharmacy dispensary provides some additional medications • Los Angeles County Department of Health Services, Healthy Choice the Easy Choice are working to have healthier options more accessible, including exercise breaks in meetings, etc. • Foothill Unity Center offers a walking program and checks blood pressure. • Health plans provide educational materials about foods to eat and foods to avoid. Some have been translated by health plans.
Mental health	• Alma Services • Spirit Family Services • Enki Mental Health Center • Foothill Unity Center provides referrals and services for families and the homeless. • National Association for the Mentally Ill • Tri-Cities Mental Health serves Pomona, La Verne and Claremont. • Los Angeles County Department of Mental Health • Foothill Family Service offers some group services. • Libraries provide information on where to access services. • Whittier Hospital has a lot of free classes. • El Monte School district added a district social worker and school counselor.

	• Pacific Clinics/Asian Pacific Family Center • Foothill Family Services • D'Veal Family & Youth Services • District Homeless Coordinator has information about referrals for kids. • Duarte School District has partnerships with providers (Foothill Family Services and D'Veal) to come into the schools and provide services. • Asian Coalition helps people find resources. • Each Mind Matters, the California Mental Health movement • Mental Health Services Act • Asian Youth Center hosts a mental health day. • Health Consortium of Greater San Gabriel Valley is looking to build more connections between physical and behavioral health providers. • Healthy Neighborhoods initiative from Department of Mental Health pilot site in El Monte. Department of Mental Health Service Area Advisory Committee includes consumers and tries to deal with issues of access. • Santa Anita Family Services • Foothill Family Services • Arcadia Mental Heath • Aurora Clinic • Pacific Clinics • Asian Pacific Health Care Venture has Chinese language mental health services.
Overweight and obesity	• San Gabriel Valley Service Center has free Zumba, yoga, line dancing and aerobics classes. • Women, Infant and Children offers nutrition classes. • Our Saviour Center has nutrition and cooking classes. • Community centers offer exercise programs such as Zumba and walking. • Senior centers • Each city has some exercise programs. • Swim programs for school-age children • Some nonprofits organize physical education and/or nutrition education/healthy snacks, such as Boys & Girls Clubs. • City of Duarte hosts a Biggest Loser contest and sponsors city walks. • Duarte Senior Center offers referrals and some free services, including a hiking club.
Drugs, alcohol, tobacco	• Alcoholics Anonymous • Azteca • California's anti-tobacco campaign • Policies that prevent tobacco use in public settings and more enforcement of laws that prevent tobacco sales to minors • American Cancer Society • Unity One

	• Los Angeles County Sherriff's drug and alcohol prevention programs • Parent University • Narcotics Anonymous • Asian Youth Center program is helping cities create smoke-free parks.

Appendix B
Financial Assistance Policy

Policy and Procedure Manual
Administrative Manual
Administrative Institutional
Department: Supportive Care

Written: 05/25/17
Reviewed: 07/28/20; 01/11/21
Revised: 07/12/17; 08/13/20; 01/13/21
Page: 1 of 4
APPROVALS:
SLT: 01/12/21; MEC: 01/13/21; BOD: 4Q-20
Scope: _X_ Medical Center _X_ Foundation

City of Hope

Provision of Patient Assistance Items to Patients Who Demonstrate Financial Need

I. PURPOSE / BACKGROUND

City of Hope's Supportive Care Department, Case Management Department and Village Operations (the "*Departments*") may, from time to time, provide financial assistance to patients to further City of Hope's ("COH") charitable purpose, to support the overall wellbeing of patients who would otherwise be unable to independently pay for necessary items and services and to better ensure patient access to, and continuity of, requisite medical care. Such financial assistance (collectively, "*Assistance*") may include assistance with transportation to and from appointments at COH (whether in the form of gas cards or transportation vouchers), grocery store gift cards, lodging assistance, and assistance for medically-necessary post-discharge clinical care. The purpose of this policy is to provide guidelines by which such Assistance will be offered and provided by the Departments to COH's patients.

II. POLICY

A. Available Assistance will only be discussed with patients who have already (1) been admitted to COH, or (2) selected COH as their healthcare provider such that COH has started developing a plan of care for the patient.

B. Assistance will not be marketed or advertised by the Department or any other COH personnel.

C. Assistance will be offered only to low-income patients upon the patient's disclosure of financial need.

1. The Department will assess the patient's financial need prior to the provision of any Assistance. Assistance will only be available to patients who meet the requirements set forth below in Procedure Section G.
2. With the exception of Lodging Assistance, assistance provided shall be intended solely for use by the patient and not by the patient's family members or other parties.
3. Documentation of this assessment, and any proof of financial need submitted by the patient, will be documented in the COH Electronic Health Record (EHR).
4. Assistance will not be used for service recovery, risk management, or patient relations.

D. Where Assistance entails COH paying for medically necessary post-discharge services, COH will select such vendors based on patient convenience, and whether the vendor provides quality and reliable services at reasonable, fair market value rates.

E. The Department will track all Assistance provided by patient name and medical record

number using a spreadsheet to document the type and value of Assistance, and date when the Assistance was given. Tracking logs will be maintained by the Department for a minimum of ten (10) years.

F. Any cost centers used to obtain Assistance will not be reported on COH's Medicare cost report.

G. Assistance will not be reported as charity care.

III. PROCEDURE

RESPONSIBLE PERSON(S)/DEPT.	PROCEDURE
Director of Case Management Department, with support from the Managed Care Department	A. Compile a list of vendors ("*Contracted Vendors*") that have agreed to a pre-negotiated payment rate from COH as payment in full for furnishing medically necessary post-discharge services (the "*Contracted Vendors List*"). B. Confirm that the pre-negotiated payment rates are consistent with fair market value. C. Select Contracted Vendors based on patient convenience and the quality and reliability of their services. D. Confirm that the Contracted Vendors are not referral sources to COH. E. Annually review and update the Contracted Vendors List.
Case Management and Supportive Care Departments	F. Discuss Assistance only with patients who have already (1) been admitted to COH, or (2) selected COH as its healthcare provider, such that COH has started developing a plan of care for the patient. G. Assess patient financial need as follows: Supportive Care and Case Management: A patient with Medi-Cal is deemed to have demonstrated financial need and is eligible for Assistance. A non-Medi-Cal patient will be deemed to have demonstrated financial need if he or she meets the current COH Charity Care income criteria. The following additional factors may be considered in assessing financial need: Supplemental Security Income or other government assistance program participation; financial hardship due to reduction or loss of income due to medical condition; unplanned or unexpected treatment-related expenses that patient cannot cover; increase in out-of-pocket costs associated with treatment plan that patient cannot cover. H. Document determination of patient financial need in the EHR. I. Explore other types of available aid (e.g., grants, food stamps, etc.). J. Offer and provide Assistance to the patient as appropriate and explain that such Assistance may not be repeatable and may require a new assessment of financial need.
Case Management and Supportive Care Departments	K. For any Assistance involving medically necessary post-discharge care paid for by COH, select vendor from the Contracted Vendors List. Any exceptions (i.e., selecting a vendor not identified on the Contracted Vendors List) must first be approved by the Director of Case Management. L. Document provision of any Assistance in the EHR.

RESPONSIBLE PERSON(S)/DEPT.	PROCEDURE
	M. For transportation assistance, the total value will not exceed $1,200 per year per patient. Exceptions to these caps must first be approved as follows: 1. Assistance above the annual cap of $1,200 but below $3,000 per patient per year must be approved in writing, in advance, by the Director of the department providing the Assistance. The Department Director shall only approve this additional assistance for an immediate and/or exigent need where the patient is otherwise unable to obtain resources to address the need in the necessary timeframe. 2. Assistance exceeding the amounts in the immediately preceding paragraph, or that does not meet the foregoing criteria for approval by the Department Director, must be approved, in advance, in writing by COH's Ethics & Compliance Department.
	N. For grocery store cards, the total value will not exceed $400 per year per patient. Exceptions to these caps must first be approved as follows: 1. Assistance above the annual cap of $400 but below $1,000 per patient per year must be approved in writing, in advance, by the Director of the department providing the Assistance. The Department Director shall only approve this additional assistance for an immediate and/or exigent need where the patient is otherwise unable to obtain resources to address the need in the necessary timeframe. 2. Assistance exceeding the amounts in the immediately preceding paragraph, or that does not meet the foregoing criteria for approval by the Department Director, must be approved, in advance, in writing by COH's Ethics & Compliance Department.
	O. Lodging Assistance (lodging at the Hope and Parson Villages, or a local hotel when the Villages are full) will not exceed $2,500 per patient per year. Assistance above that limit must be approved in writing in advance by the Department's Executive Director.
	P. Assistance for medically-necessary post-discharge clinical care coordinated through Case Management is subject to the following requirements: (1) All requests for Assistance for medically-necessary post-discharge clinical care up to a value of $5,000 per patient per year must be approved in advance, in writing by Director of Case Management. (2) Requests in excess of $5,000 must be approved, in advance, in writing by COH's Ethics & Compliance Department.
Case Management and Supportive Care Departments	Q. Any requested Assistance outside of the parameters above must be approved, in advance, in writing by COH's Ethics & Compliance Department.
	R. Report any Assistance provided to the Department administrative support staff member responsible for documenting and tracking Assistance.
	S. Document patient name, medical record number, Assistance type, Assistance value and Assistance date in the spreadsheet maintained by Department.

Owners: Director, Clinical Social Work; Executive Director, Case Management
Sponsors: Senior Vice President, Chief Nursing and Patient Services Officer; Chief Medical Officer
Collaborators: Ethics & Compliance

Related Policy:
1. Charity Care

Appendix One – Acronyms, Terms and Definitions Applicable to this Policy
1. **City of Hope ("COH")** – City of Hope National Medical Center ("COHNMC") and City of Hope Medical Foundation ("COHMF" and "Foundation") also referred to as City of Hope ("COH") for purposes of this policy.
2. **EHR** – Electronic Health Record
3. **Medical Center** – Refers to all facilities covered by City of Hope National Medical Center's hospital license.

Appendix C
Charity Care Policy

Policy and Procedure Manual
Administrative Manual
Administrative Institutional
Department: Revenue Cycle

City of Hope

Written: 11/05
Reviewed: 09/30/16; 02/07/18; 07/17/19
Revised: 10/10/16; 08/05/19
Page: 1 of 8 (Attachments)
APPROVALS:
SLT: 07/31/19; MEC: 08/05/19; BOD: 2Q-19
Scope: _X_ Medical Center _X_ Medical Foundation (Hospital-Based Services Only)

Charity Care Policy

I. PURPOSE / BACKGROUND

The purpose of this Charity Care Policy (the "Policy") at the City of Hope National Medical Center ("COHNMC") is to improve the quality of health care and assure that care is accessible to the maximum number of people possible within the resources available at COHNMC. Meeting the needs of uninsured and underinsured patients is an important element in COHNMC's commitment to the community.

This policy seeks to demonstrate COHNMC's commitment to its patients and their families and the communities it serves with COHNMC's unique mix of services, which integrate biomedical advancements in research, education and clinical care.

This policy seeks to promote access to the resources of COHNMC consistent with its mission and its Code of Conduct.

To be an effective steward of COHNMC's resources, the Board of Directors ("the Board") strives to preserve the financial health of COHNMC. To this end, the Board promotes a high quality, patient friendly and effective billing and collection system, while continuing a commitment to support and subsidize the medically necessary care of patients who require financial assistance. This policy was adopted with the intention of satisfying the requirements set forth in Section 501(r) of the Internal Revenue Code of 1986, as amended (the "Code"). Accordingly, any interpretation of this policy should be consistent with Section 501(r) of the Code.

II. POLICY

A. **Patients Covered:** An individual is eligible for financial assistance at COHNMC for free care if the individual meets all of the following conditions: (1) the individual meets the criteria for care at COHNMC for a primary diagnosis of cancer, diabetes, HIV/AIDS, hematologic disease or for treatment with hematopoietic cell transplantation; (2) the individual meets the income eligibility criteria set forth in Section II.F below and the *Charity Care Guidelines Table;* and (3) the individual is a legal resident of the United States, as confirmed by passport, social security card and/or election validation documentation.

B. **Financial Assistance Provided:** If a patient is accepted for charity care, the patient will receive the financial assistance necessary to ensure that services covered under this policy as defined in Section II.G below ("Services") received during the applicable time period are free to the patient. To further clarify, there is no sliding discount scale for financial assistance once a patient at COHNMC qualifies for charity care; the patient receives all Services at a 100% discount.

8/7/2019 10:52 AM

C. **Amounts Generally Billed:** In providing charity care, COHNMC is required by law to consider the amounts generally billed to individuals who have insurance covering emergency or other medically necessary care ("Amounts Generally Billed" or "AGB") and to guarantee that patients accepted for charity care will not be charged more than AGB for other medically necessary services. COHNMC uses the prospective Medicare method for calculating AGB and, as stated in Section II.B, COH will not charge patients more than AGB for other medically necessary services because these patients will receive Services free of charge.

D. **Duration of time for which charity care is approved:** A patient will be accepted for charity care for a period of one year. If a longer period of charity care is requested, the patient will be re-evaluated, using the same criteria as were initially applied and outlined within this policy.

E. **Charity Care Guidelines Table:** The *Charity Care Guidelines Table*, attached to this Policy as Attachment A, takes into account income and family size, and is based on the federal poverty level (FPL) guidelines established and updated annually by the Department of Health and Human Services. The *Charity Care Guidelines Table* will be updated annually by the Vice President of Revenue Cycle based on updates to the FPL.

F. **Income Eligibility:**

1. **Income Below 600% of FPL:** An individual will be considered for charity care if his or her Income (or family's Income) is less than 600% of FPL, as provided in the Charity Care Guidelines Table.

2. **Patient Assets:** In order to provide consistency with City of Hope's ("COH") mission and proper stewardship of COH charity dollars, all monetary assets of the patient or patient's legal guardian are taken into account in reviewing a charity care application, with the exception of the following assets: (a) amounts in patient retirement or deferred compensation plans qualified under the Internal Revenue code; (b) the primary residence where the patient or the patient's family resides; (c) automobile needed to transport working family members to and from work; and (d) savings accounts with less than two months of annual income.

G. **Services Covered:** This policy covers all medically necessary services that COHNMC typically provides to its patients, which are generally directly related to an eligible patient's treatment for a primary diagnosis of cancer, diabetes, HIV/AIDS, hematologic disease or for treatment with hematopoietic cell transplantation are covered by this policy. COH does not normally provide medically necessary care in other contexts (e.g., COH does not operate an emergency department or provide emergency medical care to the population at large); however, to the extent COH did provide other medically necessary services to its patients, beyond the services covered by this policy as described above, COH would do so without regard for the individual's ability to pay for the care. Only charges for services provided at hospital-based City of Hope locations and the City of Hope Retail Pharmacy are covered under Charity Care. COH's "List of Providers" is attached to this policy for reference. Other services provided by outside parties, including but not limited to Home Health Services that are excluded from Medicare Coverage Guidelines, and services rendered at non-hospital-based City of Hope Medical Foundation Community Sites are not covered. COHNMC does not operate an emergency department.

For purposes of this policy, questions or issues about medical necessity will be resolved by COHNMC's Chief Medical Officer, or his/her designee, in consultation with the Charity Care Committee.

H. **Nondiscrimination:** In making decisions regarding the provision of charity care pursuant to this policy, COHNMC does not discriminate on the basis of age, sex, race, religion, creed, disability, sexual orientation, or national origin. All determinations regarding patient financial obligation are based solely on financial need and patients may be considered for charity care at any time that the inability to pay becomes evident to the patient or COHNMC, regardless of any prior determinations under this policy. A patient may apply for charity care at any time after receiving care.

I. **Access to Charity Care – Guiding Principles, Patient Application Process and City of Hope Review Procedures:**

1. **Guiding Principles:**

   a. Patients are able to apply for charity care or are identified as potential charity care applicants by COHNMC staff at multiple institutional entry points, such as new patient services, inpatient and outpatient admitting and registration. All front line administrative and clinical staff, including COHNMC affiliated physicians, social service staff and Patient Advocates are encouraged to identify patients and refer them to Financial Support Services ("FSS"), a division of Patient Access. *Identification of patients who are eligible for charity care can take place at any time during the rendering of services or during the billing and collection process.*

   b. If an initial determination is made that the patient has the ability to pay all or a portion of the bill, such a determination does not prevent the patient from applying for financial assistance at a later date.

   c. COHNMC makes the financial assistance policy widely available to the public including providing written notice of its charity care program on all patient-friendly-bill statements, and upon request gives consideration to offering charity care, before outstanding accounts are sent to collection. COHNMC does not advance outstanding accounts to collection while patient is attempting to qualify for charity care, or attempting in good faith to settle payment.

   d. COHNMC renders charity care on a uniform and consistent basis according to this policy.

   e. COHNMC may reevaluate patients designated as eligible for charity care at any time and will reevaluate each patient's eligibility at least annually.

2. **Patient Application Process:**

   Applicants must agree to and cooperate with a review of income and assets. The following financial screening will be required prior to acceptance for charity care:

   a. Patient financial information is gathered through the *Financial Evaluation Form.*

      i. Patients are required to submit various documents to substantiate financial circumstances and proof of income, including paycheck stubs, W-2 forms, income tax returns, unemployment or disability statements, and savings and bank account statements. To the extent a patient has filed for Chapter 7 bankruptcy, a patient may submit the bankruptcy discharge, which is a court order approving the bankruptcy, to demonstrate need for financial assistance if such discharge is dated within the prior 2 years of the time period in which the patient is seeking charity care.

ii. FSS counselors assist patients in completing charity care applications to provide maximum consistency.

b. If it appears that the patient might be eligible for Medi-Cal or another state health program, FSS refers the patient to a vendor who assists COHNMC in assisting patients with Medi-Cal and Medicare Part B applications. It is the responsibility of the patient or his/her family to apply for such coverage with assistance from COHNMC's application vendor and proof of a completed application must be provided to COHNMC.

c. Patients who do not qualify for charity care may be eligible for financial assistance outside of this policy as stated in the COH policy, "Patient Discounts and Free Services."

3. **City of Hope Review Process:**

Charity care applications will be processed by FSS to determine if financial qualifications are met. After financial qualification is verified by FSS, approval or denial for charity care for patients requiring assistance for their entire treatment plan is determined by COH's Charity Care Committee (the "Committee") and for limited services and/or renewals is determined in accordance with subsection (f) below):

a. Composition of the Charity Care Committee: The Committee is comprised of representatives from each clinical program at COH, including the Chair or designee from Hematology/Hematopoietic Cell Transplantation; Medical Oncology; Surgery; Pediatrics; and Supportive Care Medicine. In addition, membership will include representatives from the administration, including Financial Support Services (FSS); Chief Medical Officer; Case Management; and Patient Access. A representative from the COH Ethics Committee will be included, as well as a community/patient representative.

b. The Committee will meet bi-weekly, or as needed, to review patient applications.

c. The Committee will determine patient eligibility for coverage for their entire treatment plan by considering a financially eligible patient's medical condition, the ability of COHNMC to provide the type of care required, and the availability of COH charity care resources.

d. Other considerations for approval or denial by the Committee will include the following: Priority will be given to patients who live in the Southern California area as well as patients who have cancer, hematologic diseases, HIV/AIDS, or diabetes, and whose conditions are treatable or curable by methods available at COHNMC.

e. In circumstances of disagreement between Committee members concerning approval or denial of charity care, the Chief Medical Officer or his/her designee will make the final decision.

f. Applications for services and renewal of charity care will be reviewed by FSS counselors. Approvals may be granted incrementally by:

Up to $5,000 – Approved by Financial Counselor, Financial Support Services

$5,001 to $25,000 – Approved by Manager, Financial Support Services

$25,001 to $50,000 – Approved by Sr. Manager, Patient Financial Services

$50,001 to $100,000 – Approved by Sr. Director, Patient Financial Services

$100,001 and greater – Approved by Charity Care Committee

g. Following receipt of completed application and financial qualifications verified by FSS, a "Charity Care Pending" insurance plan will be appended to the patient's demographic record. This will suppress any patient billing and collections efforts while awaiting decision on the application. Once a decision is made and communicated to the patient, the demographic record will be updated accordingly.

h. Outside of this policy, the Committee, at its discretion, may grant approvals on cases that do not meet all of the criteria specified in the policy for patients who remain in active primary treatment or those who have had a reoccurrence of disease. An approval may be granted if it is determined that an interruption in care will likely compromise the patient's clinical outcome. Interruptions in care include, but are not limited to the following:

- Expired Breast and Cervical Cancer Treatment Program Restricted coverage
- Conditions of participation requiring the patient to have a Primary Care Physician (PCP) in the community
- Treatment/services that are restricted in the community
- Existing COH patients converting to non-contracted Managed Care Plans (Medicare and Medi-Cal) –COH Physician reviews and determines that patient's safety and survival will be comprised from interruption of ongoing treatment at COH.

J. **Patient Notification:** Applicants for charity care are notified of decisions in writing. When possible, notification to new patients is included in the New Patient's Acceptance Letter.

K. **Patient Right to Appeal:** Each patient denied charity care will be given the right to appeal. If a patient is denied charity care, all reasons for denial are included in the notice provided and the patient is informed about how to appeal rights and procedures. Appeals will be reviewed and determined by the Vice President of Revenue Cycle and the President of COH's Medical Staff. Should the Vice President of Revenue Cycle and the President of COH's Medical Staff not agree, the matter will be referred to the Chief Executive Officer, whose decision will be final.

Within 14 days of receipt of a request for appeal from a patient who has been denied charity care, the patient and FSS will be notified whether the initial determination will be affirmed or reversed.

L. **Respect of Confidentiality and Privacy:** All patients are treated with dignity and fairness in the financial application process and COHNMC respects the confidentiality and privacy of those who seek financial assistance.

1. FSS personnel receive training regarding requirements for confidentiality and privacy of all patient information, including patient financial information. No information obtained in a patient's application for financial assistance may be released except in compliance with applicable federal and state laws and COHNMC policy.

2. Conversations regarding financial assistance are conducted in private unless otherwise requested by a patient (e.g., outpatient waiting areas when patients choose

not to leave the waiting area). In these cases, privacy is maximized to the extent possible.

M. **Patient Responsibility:** In order to receive charity care pursuant to this policy, patients are responsible for cooperating fully with application and financial assessment procedures, and to agree to financial screening of income and assets, as outlined in Section II.I.2. To be eligible for charity care, patients must cooperate by filling out forms for financial assistance and, if eligible, applications for government-sponsored insurance such as Medi-Cal. An applicant for charity care will be required to demonstrate compliance with this requirement.

N. **Communication of Charity Care Process to Patients and Community:**

1. **Public Awareness:**

   a. COHNMC is committed to building awareness of the Charity Care Policy through a variety of mechanisms including: (i) visible signage within COHNMC (such as posters or notices in key admitting and registration areas, point of service brochures in waiting areas); (ii) COHNMC's website; (iii) in routine, written notification given at the time of admission to COHNMC, and (iv) in bill statements showing outstanding patient self-pay balances. All notices will include a toll-free number and how to access a FSS counselor. COHNMC will provide a copy of the "Charity Care Policy" upon request.

   b. COHNMC is committed to using the primary languages of the major ethnic and cultural communities who utilize COHNMC in all materials used in connection with the "Charity Care Policy." Printed information will be available in English, Spanish, and Traditional Chinese languages. Translators in COHNMC's Employee Translation Service will be used to support a variety of language needs.

2. **Staff Training:** Clinical staff, including physicians, front-line administrative and patient financial services staff are trained to be familiar with the "Charity Care Policy" and are updated periodically. Detailed materials for training are prepared and maintained by Patient Financial Services. Materials include information on how to access charity care, standards of cultural sensitivity and how to preserve confidentiality, including best practices and practices not tolerated by COHNMC. All employees are made aware of the availability of charity care as part of employee orientation.

O. **Collections:**

1. Patient accounts are not sent to collection without giving patients adequate time to be evaluated or re-evaluated and to develop alternative payment arrangements. Patient accounts will not be sent to collection pending completion of financial counseling. A patient will be given notice at least seven (7) business days before his or her file is sent to a collection agency.

2. Neither COHNMC nor its third party collection vendors will use wage garnishment or liens on primary residences or any extraordinary collection activity ("ECA") as a means of collecting unpaid hospital bills from patients who are eligible for any form of charity care under this policy.

   a. Although ECA is not authorized and will not be used in connection with this policy, COHNMC is nonetheless required by law to adhere to the following

requirements if ECA were to be used (which it will not): (1) Any third party collection vendor must make reasonable efforts within the Meaning of Section 501(r) of the Code to determine the eligibility of the individual (or another individual responsible for payment of the individual's bill) under this policy; (2) A third party collection vendor shall issue three statements and provide a final notice thirty (30) days before extraordinary collection activity will be taken; and (3)Agreements with third party collection vendors shall require compliance with Section 501(r) of the Code.

b. For more information regarding the activities that may be taken in event of default, please refer to the Self Pay Collection Policy or the Medicare Bad Debt Policy, which COHNMC makes widely available to the public by including on COHNMC's website.

3. All agencies used for collection are advised of COHNMC policy in writing, and the "Charity Care Policy" is incorporated by reference in collection contracts with such agency(ies). COHNMC receives written assurances from agency(ies) that they will adhere to COHNMC standards.

P. **Oversight and Board Responsibilities:**

1. Senior management reviews detailed reports on COHNMC's provision of charity care on a quarterly basis.

2. The Board of Directors is responsible for balancing the critical need for patient financial assistance with the sustainability of COHNMC's resources and its financial integrity in order to serve the broader community. To this end, a Charity Care Report will be prepared by Patient Financial Services and presented to the Charity Care Committee by the Vice President of Revenue Cycle or the Senior Director of Patient Financial Services on a quarterly basis to inform the committee of total financial assistance provided to our patients.

Owner: Director, Patient Financial Services
Sponsor: Vice President, Revenue Cycle

Policy History:
Reviewed: 10/07; 12/09; 09/12; 01/13; 02/14/13; 10/24/14; 02/27/15
Revised: 10/07; 12/09; 03/10; 03/25/13; 03/09/15

Related Policies:
1. Code of Conduct
2. Collections Policy
3. New Patient Application and Acceptance
4. Patient Discounts and Free Services
5. Professional Courtesy Discounts
6. Retail Pharmacy Charity Care Procedures

Appendix One – Acronyms, Terms and Definitions Applicable to this Policy
1. **Charity Care** – Free or partially subsidized health care services, including retail pharmacy services, provided by COHNMC to eligible individuals who meet the criteria set forth in Section II.A of this Policy.
2. **City of Hope ("COH")** – City of Hope National Medical Center ("COHNMC") referred to as City of Hope ("COH") for the purposes of this policy.
3. **City of Hope Medical Foundation ("COHMF")** – Added to the scope of this policy as the professional charges derived from hospital-based services are covered under this policy.
4. **Community Sites** – Refers to non-hospital practices operated by City of Hope Medical Foundation ("COHMF"). Services rendered at non-hospital-based COHMF Community Sites are not covered under this policy.

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5. **Income** – Gross income from all sources.
6. **Medical Center** – Refers to all facilities covered by City of Hope National Medical Center's hospital license.
7. **Medically Necessary Services** – Inpatient or outpatient services deemed medically necessary by a COHNMC medical staff member.
8. **Self-Pay Balance** – The outstanding balance of a COHNMC bill deemed to be a patient's or guarantor's personal responsibility after public or private insurance payments (if any) or denials. A patient's self-pay balance may be further reduced pursuant to this Charity Care Policy. (Guarantor refers to the individual assuming financial responsibility for services received by the patient.)

Attachment A: City of Hope Charity Assistance FPL Guidelines
Attachment B: City of Hope Charity Care: Methodology for Identifying LEP Populations
Attachment C: City of Hope Charity Policy: List of Providers

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Attachment A

CITY OF HOPE
CHARITY CARE ASSISTANCE
FPL GUIDELINES

The following Financial Assistance Eligibility Guidelines are based on the Federal Poverty Guidelines effective April 1, 2019. This schedule delineates the household income thresholds according to the FPL.

2019 FPL GUIDELINES

Number in Household	Annual 100%	Annual 600%	Monthly
1	$12,490	$74,940	$6,245
2	$16,910	$101,460	$8,455
3	$21,330	$127,980	$10,655
4	$25,750	$154,500	$12,875
5	$30,170	$181,020	$15,085
6	$34,590	$207,540	$17,295
7	$39,010	$234,060	$19,505
8	$43,430	$260,580	$21,715
Each additional person, add	$4,420		

Source: https://aspe.hhs.gov/2019-poverty-guidelines

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Attachment B

City of Hope Charity Care: Methodology for Identifying LEP Populations

For 2018 fiscal year, City of Hope ("COH") evaluated the Limited English Proficiency ("LEP") populations among the patients it serves by utilizing EPIC patient data that identified primary language spoken. The identified LEP populations that represent more than 1,000 unique visits or at least 5% of City of Hope's total patients seen* were:

1. Spanish: 1,720 or 8.82% of LEP persons.
2. Mandarin: 629 or 2.72% of LEP persons.

Language	Unique # of Patients	% Patients	# Clinic Visits*	% Clinic Visits
English	21,181	85.38%	101,978	83.07%
Spanish	1,720	6.93%	10,832	8.82%
Chinese - Mandarin	629	2.54%	3,345	2.72%
Armenian	264	1.06%	1,269	1.03%
Chinese - Cantonese	224	0.90%	1,323	1.08%
Korean	182	0.73%	1,200	0.98%

The FAP, FAP application, and plain language summary of the FAP were translated into the following languages:

1. Spanish
2. Traditional Chinese

*Note that COH is a specialty hospital that does not serve any specific geographic community. As a result, COH has assessed the LEP population based on actual patients served by COH rather than the population of the surrounding community.

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Attachment C

City of Hope Charity Care Policy: List of Providers

- **Providers Covered Under the Charity Care Policy:**
  1. City of Hope Medical Group physicians (when services are provided at COH hospital-based locations).*
  2. Third-party contracted providers (when services are provided at COH hospital-based locations and billing is performed by COH).
- **Providers Not Covered Under the Charity Care Policy:**
  1. City of Hope Medical Group physicians (when services are provided at a location other than COH hospital-based locations).
  2. Third-party contracted providers (when services are provided at a location other than COH hospital-based locations).
  3. Third-party contracted providers (when services are provided at COH hospital-based locations but billing is not performed by COH).

There are no other outside providers who provide medically necessary care in COH hospital facilities.

*For more information, see *Charity Care Policy*. For questions, please contact Financial Support Services at (626) 256-4673, ext. 80258.

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