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2020

COMMUNITY BENEFIT REPORT



 **City of Hope.**[®]

CityofHope.org

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EXECUTIVE SUMMARY

City of Hope is pleased to submit a report of our community benefit activities for Fiscal Year 2020 (from October 1, 2019 to September 30, 2020). 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.

This is the third report on City of Hope’s progress in addressing the prioritized health needs in the 2016 Community Health Needs Assessment and subsequent 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 Fiscal Year 2020 was **\$251,124,246** (Figure 1).

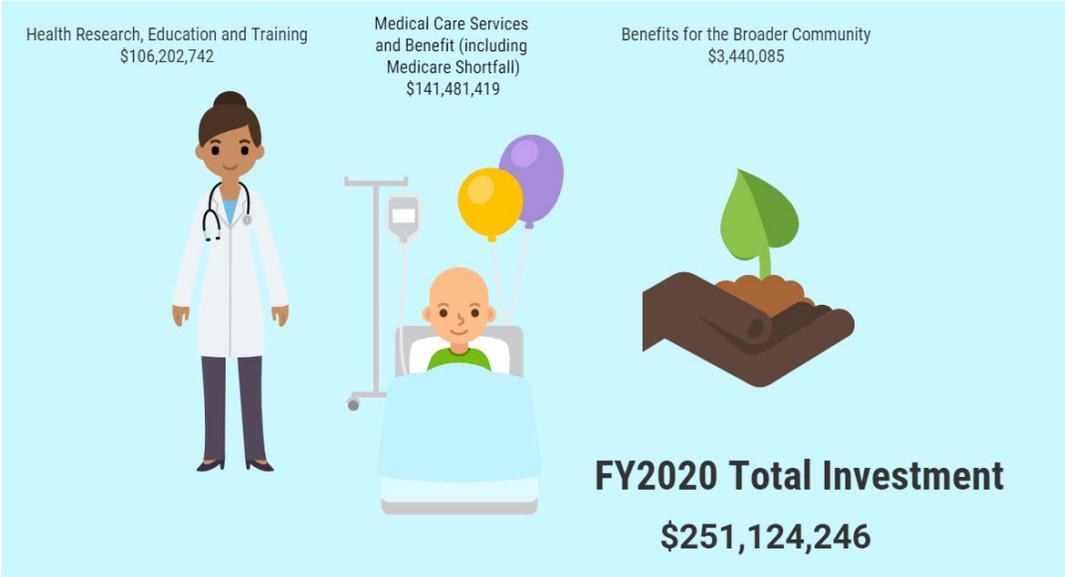


Figure 1. FY2020 Community Benefit Investments

This past year 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 the 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 or make requests for additional data. 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 one of 51 National Cancer Institute-designated comprehensive cancer centers in the nation. This designation reinforces our leadership role in cancer care, basic and clinical research, and the translation of research into practical benefit.

City of Hope has been a pioneer in patient and family-centered care and remains committed to the tradition of delivering exceptional, compassionate care for patients and families. Each day, we live our credo:

“There is no profit in curing the body if, in the process, we destroy the soul.”

Our leading-edge research programs, centered in Beckman Research Institute of City of Hope, have led to many groundbreaking discoveries:

- Numerous breakthrough cancer drugs, including Herceptin, Rituxan, Erbitux and Avastin, are based on technology pioneered at City of Hope and are saving lives worldwide.
- Millions of people with diabetes benefit from synthetic human insulin, developed through research conducted at City of Hope.
- As a leader in bone marrow transplantation, City of Hope has performed more than 16,000 bone marrow and stem cell transplants and operates one of the largest and most successful programs of its kind in the United States.

To further support our mission of excellence, City of Hope helped found the National Comprehensive Cancer Network (NCCN), an alliance of leading cancer centers devoted to patient care, research and education, that defines and sets national standards for cancer care. A primary goal of the NCCN is to ensure that the largest number of patients in need receive state-of-the-art treatment.

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.

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.

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Statement of Social Responsibility

For City of Hope, social responsibility is more than our duty — it is our calling. Our commitment to community benefit is shaped by our legacy of compassion. Our workforce reflects the diversity of our patients and their families. Our “green” campus features energy-efficient equipment, low-emission vehicles and an innovative water use program. We express compassion through community outreach, addressing health education, disease prevention and more. We take pride in a social partnership that benefits the world today and will continue do so for future generations.

The Community We Serve

City of Hope is located in Duarte, California, a richly diverse community of almost 22,000 situated at

the base of the San Gabriel

Mountains roughly 21 miles

northeast of Los Angeles

(Figure 2). Duarte is

recognized as a leader in

community health

improvement efforts, as

demonstrated by its charter

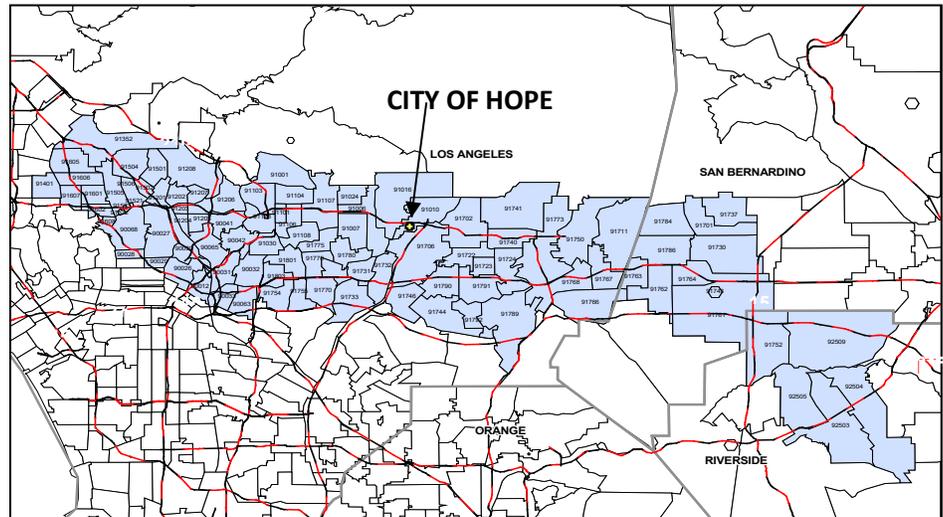


Figure 2. City of Hope's primary service area

membership in California's Healthy City initiative. Additionally, Duarte has taken a leadership role in

community health improvement and is a willing partner with City of Hope in multiple initiatives.

Race/Ethnicity

Within the Service Planning Area 3 (SPA 3), the highest concentration of Latinos are in Pomona, while

Pasadena has the highest concentration of Blacks and whites. Alhambra has the highest population of Asians.

Native Americans and Hawaiian/Pacific Islanders reside in higher numbers within Baldwin Park and El Monte.

The population within the SPA 3 is 44.7% Latino, 19.3% white, 29.9% Asian, and 3.6% Black/African-American.

Irwindale, La Puente and South El Monte have the highest concentration of the Latino population, with a rate

of 93.3%, 84.7%, and 82%, respectively (Figure 3).

SPA 3 by Race/Ethnicity

- Latino: 44.7%
- White: 19.3%
- Asian: 29.9%
- African American: 3.6%

Patterning by Race/Ethnicity

- Latinos: La Puente, El Monte
- Whites: Sierra Madre
- Asians: Monterey Park, Walnut
- African American: Altadena

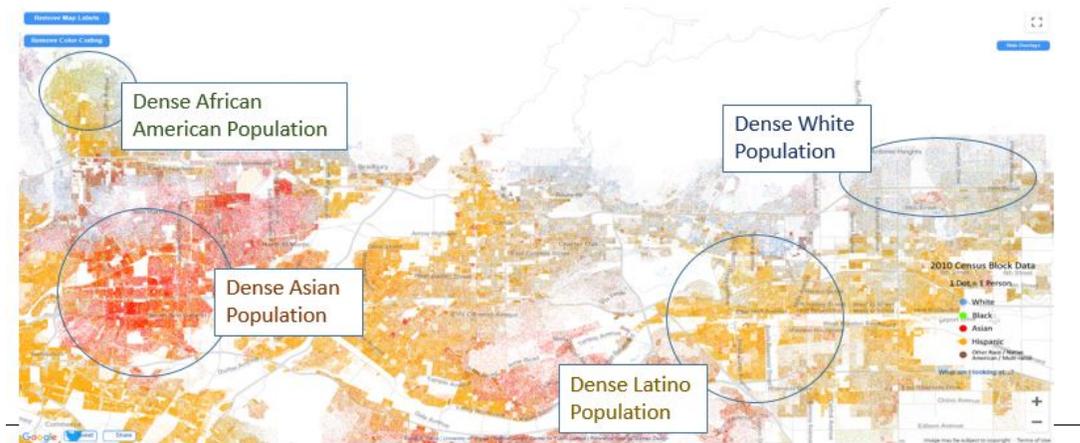


Figure 3. This map shows a portion of the SGV service area spanning from Pasadena on the left to Claremont on the right. Racial dot map: <http://racialdotmap.demographics.coopercenter.org/>

Our primary service area extends far beyond Duarte to include Los Angeles, Orange, Riverside, San Bernardino and Ventura counties — where City of Hope operates 30 locations. Together, these five counties are home to the majority of California’s multicultural and ethnic residents. Among these counties, the Latino population grew to 46.1%, while the white population declined to 31.6%. The Asian and Black populations appear stable at 12.9% and 6.3%, respectively. In comparison to California, these counties have a significantly higher concentration of Latino population — the state rate stands at 38.8% — and a significantly lower concentration of white population — a margin gap of 6.3%, with the state having the higher rate of 37.9%. The state populations also consists of 13.9% Asians and 5.5% Black/African-Americans. San Bernardino County has the highest percentage of Latinos (52.3%) and Blacks (8%), Ventura County has the highest percentage of whites (46.1%) and Orange County has the highest concentration of Asians (19.5%).

Projections for the counties in our service area suggest that the number of Latino residents will continue to rise, and the number of white residents will continue to fall. Latinos are expected to represent the

majority of the population (more than 50%) by 2030 in Los Angeles and San Bernardino counties. The number of Black and Asian residents is expected to remain stable throughout the five counties. (State and County Population Projections by Race/Ethnicity, 2010-2060. State of California, Department of Finance; 2019.)

Language

With the exception of 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 has the highest rates of foreign language speakers in Spanish (39.3%) and other Indo-European languages (5.3%). All but Orange County have rates of Spanish speakers in the home greater than the state rate of 28.7%. Los Angeles and Orange counties have the highest proportion of households speaking Asian languages. Their rates, 10.9% and 14.5%, respectively, are also greater than the state rate of 9.9%.

Given the distribution of languages spoken, it is perhaps self-evident that Los Angeles County has a higher proportion of the population feeling linguistically isolated compared to California overall (17.9%).¹ These rates are slightly lower than they were in 2014 when population for linguistic isolation trended at 25.8% for Los Angeles county and 19.1% for the state (Figure 4.) When language is examined by city, certain cities disproportionately favor one foreign language over another. More than two-thirds of La Puente (70.4%) and South El Monte (67%) residents speak Spanish at home. On the other hand, less than 10% of households in Sierra Madre (8.5%), San Marino (8.2%), Bradbury (7.7%) and Arcadia (6.6%) speak Spanish. Seven cities had at least half of it's residents speaking Asian or Pacific Islander languages in the home: Monterey Park (56.7%), Rosemead (56.2%), San Gabriel (55.4%), Rowland Heights (53.3%), Temple City (52.4%) and Arcadia (51.5%), Altadena (7.1%) and Pasadena (7.1%) have the highest percentage of residents who speak some other Indo European Language. (U.S. Census, American Community Survey, 2013-2017

Social Determinants of Health

Figure 4. Language Spoken at Home by County. U.S. Census, American Community Survey, 2013-2017.

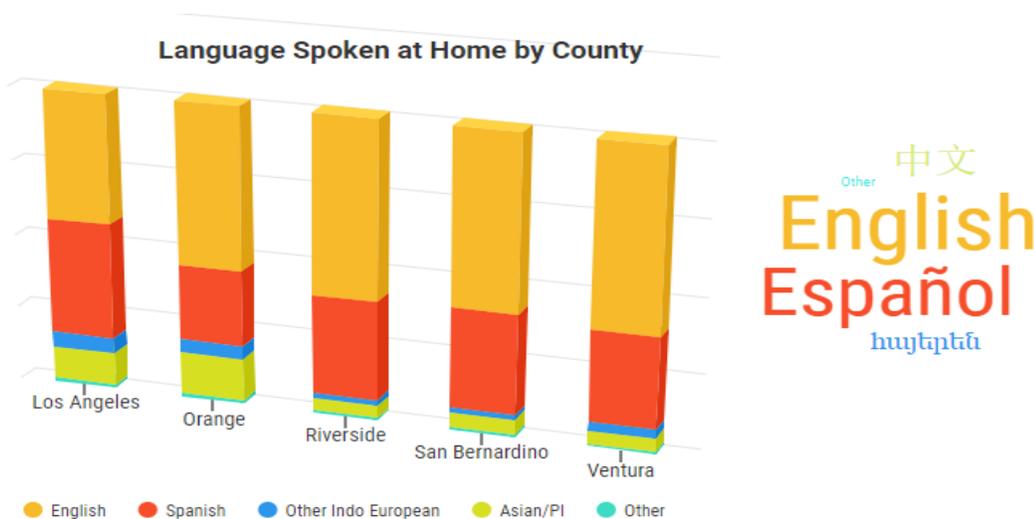
¹ Linguistic isolation describes the population over age five who speak English “less than very well.”

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. (<https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>) 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.

Poverty

In SPA 3, eight cities have poverty levels greater than the state’s rate of 15.1%. They include Pasadena (15.5%), Monterey Park (15.8%), Azusa (16.4%), La Puente (18%), Rosemead (18%), South El Monte (18.7%), Pomona (20.7%), and

the highest level in El Monte, where almost one out of four (22.6%)



of the population lives below the poverty level. 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 2017, the Federal Poverty Level for an individual stood at annual income of \$12,060, while for a family of four it was \$24,600. 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.²

² "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. In SPA 3, 12 cities rank below the state in the rate of college-educated adults 25 years or older, including South El Monte and Irwindale, which have the lowest rates, at 6.2%, and 7.5%, respectively. The highest percentage of residents with a high school diploma are Baldwin Park (32.5%), Citrus (31.8%) and Valinda (30.2%). Though La Puente has low rates of college-educated adults (8.3%), it does have a larger portion of residents with no high school education (24%) or a high school diploma (29.7%) than the majority of peer cities in SPA 3. El Monte (26.7%) and South El Monte (29.4%) have the largest proportions of residents with no high school education.

Vulnerable Populations

Poverty and education attainment are predictive of at-risk or vulnerable populations. As depicted in figure 5³, City of Hope, located in Duarte, is surrounded by vulnerable communities.

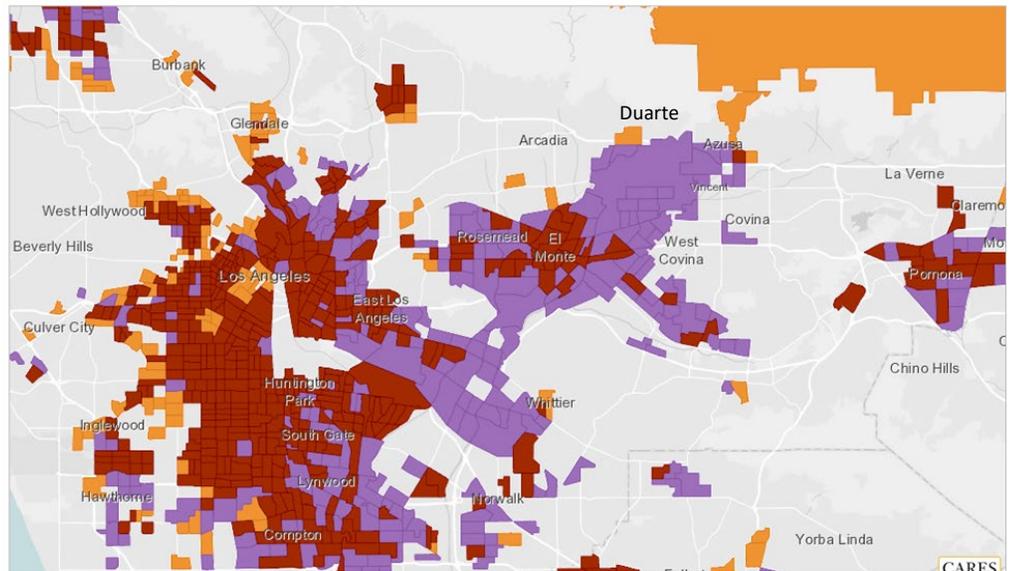


Figure 5. Map of Vulnerable Populations in City of Hope Service Area. Source: American Community Survey 5-Year Estimates, 2013-2017.

Communities with 30% or

more of residents in poverty are shown in orange. Communities in which 25% or more of residents lack a high school education are shown in purple. The overlap of high poverty and low educational attainment is depicted in red and indicates communities with vulnerable populations.

³ Map developed by Community Commons, available here: <http://www.communitycommons.org/entities/60847319-e438-44be-a5c3-5b8d298845e1>

The unique composition of these five counties makes them vulnerable on many levels and reinforces the need for community benefit programs. From our 2016 Community Health Needs Assessment, we learned that:

- Cancer deaths are highest in San Bernardino County, driven mostly by lung, breast, prostate and colorectal cancers.
- Los Angeles County has the highest rates of cancer deaths due to liver, bile duct and stomach cancers.
- Cancer rates and mortality tend to be lowest among Asians. The rate of death from cancer tends to be highest among Blacks.
- The rate of cancer diagnosis is highest among whites.
- Black women and men in all five counties are diagnosed later and more likely to die from cancer than adults of other races.
- In Riverside County, 39.2% of teenagers (ages 12-17 years) are overweight.
- In San Bernardino County, 34% of all adults are obese.
- In Los Angeles County, Asian Pacific Islander women have the lowest rate of receiving a Pap test in the last three years (65.9%), as compared with whites (83.9%), Latinas (86.3%) and Blacks (89.3%).
- All five counties in the service area exceed the Healthy People 2020 objective for colorectal cancer screening. However, only 67.4% get the exam at the recommended age.

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 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. To coordinate these efforts, City of Hope has a designated Department of Community Benefit. This enables us to leverage all resources necessary to foster a collaborative work environment that relies on the connections between the City of Hope National Medical Center and all other entities that are part of the City of Hope 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
- 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
- Our Savior Center
- Planned Parenthood Pasadena and San Gabriel Valley
- Set of Life, Inc.

- YWCA – San Gabriel Valley

To ensure council members represent local vulnerable populations, or are experts in issues important to vulnerable communities, 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

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.

During Fiscal Year 2020, co-chairs, Christian Port and Tashera Taylor, held four meetings with the CBAC. One was held in person and three were virtual meetings. During the course of this year, the CBAC reviewed the 2019 CHNA and worked together to prioritize the needs for



Christian Port (Planned Parenthood of Pasadena and San Gabriel Valley) and Tashera Taylor (Foothill Unity Center) served as co-chairs during Fiscal Year 2020.

the 2021-2023 Implementation Strategy. In spite of COVID-19, they reviewed and revised the Healthy Living Grant program and participated in the virtual Healthy Living Conference. Additionally the CBAC embarked on a journey of several listening sessions entitled: Using a Race Equity Lens to Advance Community Health and Social Justice. Through the expertise of Diamond Lee (liberationbydesign.com), council members explored

issues that might cause unconscious bias based on their life experiences. Collectively, the CBAC hopes to use what they learn in these sessions to ensure that the services they provide, with their organizations and on their own, does so with solutions and strategies that promote racial, health and social equity. Nancy Clifton-Hawkins, M.P.H., M.C.H.E.S.® is City of Hope's community benefit senior manager. 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



2018-2021 COMMUNITY HEALTH NEEDS IMPLEMENTATION STRATEGY



After the review of the results in the 2016 Community Health Needs Assessment (CHNA), in October 2016, the Community Benefit Advisory Council assisted in the prioritization of the CHNA and set the framework for the design of the 2018 to 2021 Implementation Strategy. The strategy can be downloaded and reviewed by [clicking here](#). Completion of the 2016 CHNA was critical in City of Hope's efforts to plan and implement programs and services to the vulnerable living in our service area. Next, you will find the methodology used to gather data and prioritize health needs in that 2016 assessment.

COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS AND RESULTS

2016 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. One way to ensure we do this is by developing a strategy to address the main opportunities identified in our 2016 CHNA.

For the 2016 CHNA, City of Hope collected primary data from focus groups, interviews and surveys. Secondary data on the leading causes of death, illness and social determinants of health was also collected to help us explore the health and socioeconomic issues that cause some of our area residents to experience health inequities. Our Community Benefit team took this data to community focus groups and asked the participants, “What does this mean to you? How do you believe that these issues are impacting you and your community?” We then presented the community’s views regarding the data and asked our CBAC members what their thoughts were about the assessment findings and we asked them to prioritize the issues (discussed in the pages that follow).

Summary of 2016 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:

Significant Health Needs	Rank Order Score (Total Possible Score of 4)
Access to health care	3.85
Mental health	3.72
Cancer	3.65
Heart disease	3.56
Overweight and obesity	3.54
Substance abuse	3.34

Table 1. Significant health needs ranked by priority. In Los Angeles County, 43% of people in 2011 died before they reached age 75, which the Los Angeles County Department of Public Health deems “premature.” In SPA 3, coronary heart disease was the leading cause of death and premature death.

Leading Causes of Death	Leading Causes of Premature Death
1. Coronary Heart Disease	1. Coronary Heart Disease
2. Chronic Obstructive Pulmonary Disease	2. Suicide
3. Stroke	3. Liver Disease
4. Lung Cancer	4. Motor Vehicle Crash
5. Alzheimer's Disease	5. Lung Cancer

Table 2. Leading causes of death and premature death in SPA 3 (2011) Source: LA County Department of Public Health, Mortality in Los Angeles County, 2014.
<http://publichealth.lacounty.gov/dca/data/documents/mortalityrpt11.pdf>

Prioritization of Community Health Needs

At a meeting of the City of Hope Community Benefit Advisory Council (CBAC), council members were given the Community Health Needs Assessment (CHNA) results. After listening to a report on the findings (both the health data and the community input) CBAC members were asked to prioritize the findings using the instructions in Figure 6. Each health issue was written on a large poster paper and attached to the wall of the meeting room in random order. Colored dot stickers were given to each participant. Different colors were used to represent different levels of importance, with red being highest and descending down through blue, green and yellow.

Prior to placing their colored dot stickers, the CBAC members chose to combine categories that had shared elements. For example, heart disease and obesity/overweight were added to a new category called Chronic Disease. Substance abuse was added to the Mental Health category.



2016 Community Health Needs Assessment Process

How the prioritization process will work:

1. Take topic/issues and ask: To what extent does this issue relate to each of the criteria below?

Size: # of persons affected	Feasibility: City of Hope's ability to reasonably impact issue given available resources/expertise
Seriousness: Degree to which the problem leads to death, disability and impairs one's quality of life	Value: The importance of the problem to the community
Trends: Whether or not the health problem is getting better or worse in the community over time	Consequence of Inaction: Risks associated with causing greater problems if not addressed at the earliest opportunity
Equity: Degree to which specific groups are affected by problem	Social Determinants/Root Causes: Whether or not a problem is a root cause or social determinants of health that impacts one or more health issues.
Intervention: Any existing strategies proven to be effective in addressing the problem	

2. Decide on the way you would like City of Hope to prioritize this issue.

- a. Red=#1
- b. Blue = #2
- c. Green = #3
- d. Yellow = #4

Access To Health Care	Heart Disease
Mental Health	Obesity/Overweight
Cancer	Substance Abuse

3. Then we come to an agreement on it all.

Figure 6. Community Benefit Advisory Council prioritization instructions

At the end of the exercise, the identified needs were organized in the following manner:

1. **Access to care** – Need for culturally relevant partnerships that decrease barriers to care
2. **Chronic disease prevention** – Need for information on healthy living, specifically related to how nutrition and physical activity impact cancer and diabetes
3. **Mental health** – Need for supportive partnerships that increase access to mental health care/services
4. **Cancer prevention and early detection** – Specifically related to lung, colorectal, prostate and women's cancers

When asked why they placed cancer in the last category, the CBAC members responded that they believed that addressing access to care, chronic disease prevention and mental health would systematically reduce the overall risk of cancer. In addition, the CBAC members recognized the fact that these categories are broad

reaching. In our focus groups, surveys and interviews, the CBAC members added depth to these categories, which helped us understand the needs within each.

Plan To Address Needs

Although addressing these priorities is ambitious, we believe we have formulated a realistic [implementation strategy](#) that addresses these issues in a way that make the most sense for a comprehensive cancer center. We will continue to seek new pathways to meet the needs of our vulnerable residents and explore innovative strategies to maximize collaborations as a means to building sustainable programs in our local communities. Ultimately, we provide positive contributions to the collective impact of other hospitals, organizations, schools, churches and government entities in our service area.

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 2016 needs assessment, the CBAC will convene four times per year to review progress and budgeting related to the 2018 to 2021 Implementation Strategy. CBAC members also select awardees for the two City of Hope grant programs and conduct fidelity checks for funded programs.

Congratulations!



Figure 2020 Healthy Living Grant Recipient: Circle of Hope. www.circleofhopeinc.org

Anticipated Impacts on Health Needs

When we look at the four priority areas identified by our community, we need to think about the priorities through the framework already available to us in the [Healthy People 2020 Leading Health Indicators](#). Each priority has a measurable outcome indicator. While it may be unrealistic to believe that City of Hope can make a significant impact on the national goal, 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 recommended objectives below:

- 1. Access to Care – Culturally relevant partnerships that decrease barriers to care**
- 2. Chronic Disease Prevention – Healthy living, specifically related to how nutrition and physical activity impact cancer and diabetes**
- 3. Mental Health – Supportive partnerships that increase access to mental health care/services**
- 4. Cancer prevention and early detection, specifically as they relate to lung, colorectal, prostate and women’s cancers**

Moving forward, City of Hope will align its efforts at addressing the Healthy People 2020 Indicators above. 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 efforts to decrease the disparities preventing our local residents from a good quality of life.

Needs Not Addressed

Unlike many nonspecialty hospitals, City of Hope will not dive deeply into the root causes of health inequities and social determinants of health such as poverty and homelessness. Since the social determinants of health and root causes of health disparities are intertwined with risk factors for cancer and diabetes, we 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 that 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 2020 Programs/Services

Amid COVID-19, planned conferences, farmers markets and other in-person events were cancelled. Teams had to rethink the concept from an in-person occasion to a virtual environment. Conferences, workshops and other programs quickly pivoted and delivered services online, which is exciting because it

allowed us to see that we could reach more people with our services than before. What follows is a reflection of the adaption of programs during the time of the COVID-19 social distancing measures. Each initiative has specific goals that benefit the community. Some of the initiatives have been thriving for years, others are new based on the latest CHNA. Some are organization-wide, while others are conducted by

Program Activity *Beckman Research Center	Core Principles				Strategic Priorities			
	Vulnerable Populations	Primary Prevention	Seamless Continuum of Care	Community Capacity Building	Access to Care	Healthy Living	Mental Health	Cancer Prevention
Workforce Development								
<ul style="list-style-type: none"> 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)								
<ul style="list-style-type: none"> Cooking Classes Community Nutrition, Diabetes and Cancer Prevention Classes Community Health Fairs Healthy Living – Community Building Grants Kindness Grants Community Gardens-Farmer’s Markets Hopeful.org – Online Cancer Support Cancer Support Groups School Wellness 	X	X	X	X	X	X	X	X
Diversity Initiatives								
<ul style="list-style-type: none"> CA Diversity Council Diversity Resource Groups (Asian American Community, Connecting People of African Descent for Hope, Latinos for Hope, Pride in the City, Women’s Professional Network, Young Professionals Network) 	X	X	X	X	X	X	X	X
Health Care Support Services								
<ul style="list-style-type: none"> Patient Resources Coordination Transportation Village Stays 	X	X	X				X	
Seamless Continuum of Care								
<ul style="list-style-type: none"> Bereavement Support Grp Community Nutrition, Diabetes and Cancer Prevention Classes Community Health Fairs 	X	X	X	X	X	X	X	X
Medical Professional Education								
<ul style="list-style-type: none"> Pharmacy Nursing Nutrition Social Work Continuing Medical Educ. Health Education 	X	X	X	X	X		X	X

Figure 7: FY2020 Strategic Priority Programs

a specific department. Figure 7 provides a quick overview of our Fiscal Year 2020 programs and services.

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 the City of Hope 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 Fiscal Year 2020 community benefit programs and services: **Healthy Living, Community Capacity Building and Kindness Grants; Greater San Gabriel Valley Hospital Collaborative; Cooking, Nutrition and Community Garden programs**. 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.

		Impacts	
Core Principle	Vulnerable Populations		<input checked="" type="checkbox"/>
	Primary Prevention		<input checked="" type="checkbox"/>
	Seamless Continuum of Care		<input checked="" type="checkbox"/>
	Community Capacity Building		<input checked="" type="checkbox"/>
Strategic Priorities	Access to Care		<input checked="" type="checkbox"/>
	Healthy Living		<input checked="" type="checkbox"/>
	Mental Health		<input checked="" type="checkbox"/>
	Cancer Prevention Early Detection		<input checked="" type="checkbox"/>

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 Fiscal Year 2018 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 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

		Impacts	
Core Principle	Vulnerable Populations		<input checked="" type="checkbox"/>
	Primary Prevention		<input checked="" type="checkbox"/>
	Seamless Continuum of Care		
	Community Capacity Building		<input checked="" type="checkbox"/>
Strategic Priorities	Access to Care		<input checked="" type="checkbox"/>
	Healthy Living		<input checked="" type="checkbox"/>
	Mental Health		<input checked="" type="checkbox"/>
	Cancer Prevention Early Detection		<input checked="" type="checkbox"/>

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 Fiscal Year 2020, the **Healthy Living Community Grant** Program dispensed \$40,000 to eight organizations that demonstrated a creative, yet sustainable, approach to promoting healthy living through good nutrition, physical activity, cancer or diabetes prevention, or smoking cessation. The 2020 Healthy Living Cohort included: The Foundation for Living Beauty,

BREATHE California of Los Angeles County, Antelope Valley Partners in Health, Pasadena Educational Foundation, Eco Urban Gardens, Pomona Environmental Advocacy for Community Health, Happy50Plus and Circle of Hope. Their programs are described below:

The Foundation for Living Beauty

New Ways to Support Women with Cancer, will provide much needed support for women with cancer. Living Beauty will transform programs so that they can be held online. They will hold five online day retreats that will focus on meditation, yoga, pain management and nutrition. The Foundation for Living Beauty’s focus is to aid in a woman’s healing during her cancer journey, from all aspects of her life, while providing tools to continue the healing on her own.

BREATHE California of Los Angeles County

BREATHE LA will conduct three one-hour Adult Lung Health Workshops with a lung screening for up to 50 people. Workshop attendees will be able to determine their COPD risk and all who score in a high-risk range will receive a referral to their primary care physician to share test results. While there is no cure for chronic lung disease, the Adult Lung Health Workshops will provide education, awareness and empowerment in support of early detection and identification of COPD among individuals in high-risk, high-need areas within the Greater San Gabriel Valley.

Antelope Valley Partners in Health

Antelope Valley - Diabetes Education Empowerment Program (AV-DEEP) is designed to help people with pre-diabetes, diabetes, relatives and caregivers to gain a better understanding of diabetes self-care. Eight unique learning modules on improving eating habits, increasing physical activity, self-care strategies, preventing diabetes-related complications and utilizing resources will be given during a six week program. DEEP classes will be held onsite and at their local Community Wellness Homes. They will look towards ways to adapt to the COVID-19-safe physical distancing guidelines.

Pasadena Educational Foundation

Power Kids Diabetes Prevention Program, in partnership with Huntington Hospital, will address diabetes prevention in children and youth through a seven-week program of nutrition, education and physical activity, focusing on those who are overweight or are at increased risk for later obesity and type 2 diabetes. This nonjudgmental family model program is designed to avoid making children and youth feel ashamed of their weight.

Eco Urban Gardens

Rosemead High School Best of Thymes Farm Stand will offer up afternoon/evening and weekend gardening workshops that will transform the school lot into a community garden. Throughout the year students will be hosting a Farm Stand at the school and local farmers market. Students will learn entrepreneurial skills like hosting a farm stand, understanding seasonal organic produce, nutritional density value, differentiating between organically grown produce and industrially farmed food, and

marketing.

Pomona Environmental Advocate for Community Health (PEACH)

Urban Farming and Socio-Ecological Resilience will conduct key informant interviews from community garden managers and participants to better understand how the community garden has contributed to their resilience during the COVID-19 crisis. They will develop and implement online urban farming classes to help vulnerable residents in Pomona.

Happy50Plus

Enriching the Life of Older Chinese/Asian American Pacific Islanders through Innovation will use a creative approach to reach underserved older, monolingual Chinese-Americans. Through their multifaceted components and life-enhancing in person events, older Chinese-Americans will take part in interactive, informative and fun events meant to reduce social isolation and increase physical and mental health among older Chinese/AAPI adults.

Circle of Hope

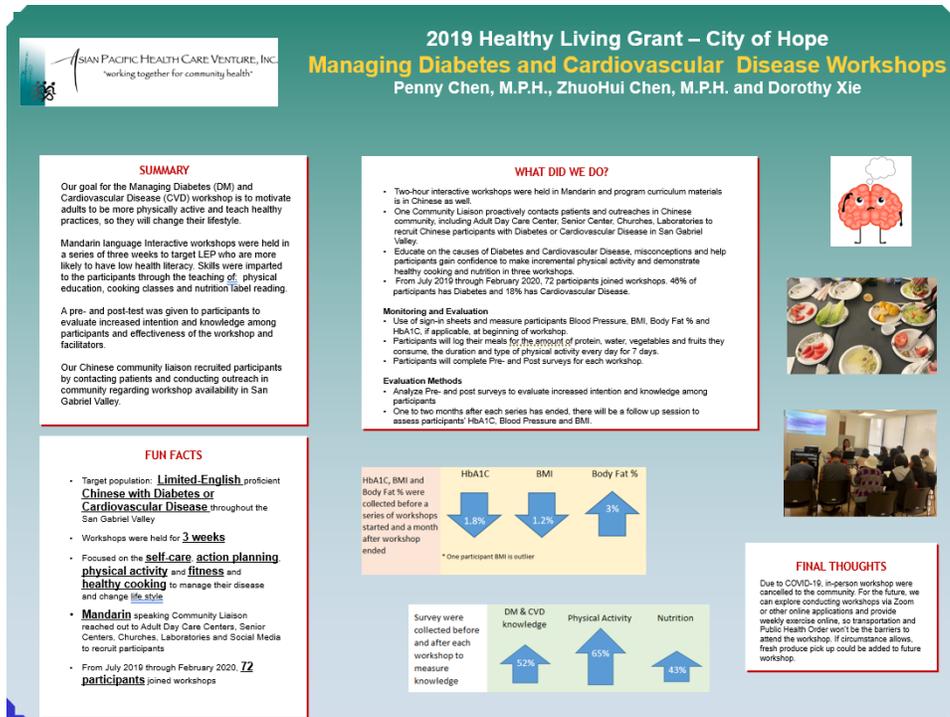
Cancer Wellness Programs are targeted towards underserved cancer patients and survivors in their community. Focus will be on physical activity, good nutrition and mental health of cancer survivors. Classes will be offered in group, individual and virtual settings through Zoom, Facebook Live and other social platforms. They believe with all their hearts that no one should fight cancer alone, and envision a time where every hand will be held and every fear addressed.

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.

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.

At the end of the funding cycle when new grants were awarded, the 2019 grantees participated in a half-day conference, where they shared their program results with the community and acted as mentors to the



Asian Pacific Health Care Ventures: Poster Session

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 criteria 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.” The recipients of the two \$5,000 2020 Healthy Living Community Capacity Building Grants are:



Families Together of Orange County Community Health Center will provide food for families in need during COVID-19. FTOCCHC is a look-alike community health center in Tustin. During this crisis, while health services

have declined, the need for food has substantially increased. This grant will allow them to quadruple their program to offer more food and food options, health education materials and recipes for families in need. The food program will take place twice each month outside, and here too social distancing will occur. The team at Families Together of Orange County is committed to serving the local community. They are a family of professionals dedicated to making a difference in the Orange County area.



Project Angel Food (PAF). For life, for love, for as long as it takes PAF prepares and delivers healthy meals to feed people impacted by serious illness, bringing comfort and hope every day. They are uniquely positioned to address the nutritional needs of Los Angeles County residents, including in underserved areas like the San Gabriel Valley, who are battling serious illness, with their home-delivered medically tailored meal (MTM) and nutrition services program. They will serve MTMS to 2,600 clients in LA County, including underserved areas such as the San Gabriel valley, where they will serve 160 clients.

Food security has become a major factor in the community’s ability to thrive during these uncertain times. Both **Families Together of Orange County Community Health Center** and **Project Angel Food** has received the \$5,000 grant to serve communities that are especially vulnerable because of the impact of COVID-19.

COVID-19 Relief Community Building Funds

As Fiscal Year 2020 progressed, we realized that we would have a cost savings because many of our programs went virtual. This virtual transition allowed us to save funds that would have otherwise been invested in venues and program-related costs. As a result of the virtual format we identified a savings of \$30,000 that we could use to address important needs of local organizations who were serving the vulnerable.

The following are organizations that the CBAC selected to receive COVID-19 Relief Community Building Funds:



Seeds of Hope: This \$5,000 grant will support their efforts to ensure access to healthy, nutritious food by providing fresh fruits and vegetables to families struggling with food insecurity – especially during this crisis.

Orange County Asian and Pacific Islander Community Alliance (OCAPICA): The pandemic has hit the Native Hawaiian and Pacific Islander community hard. OCAPICA will use the \$10,000 grant to support their mental health outreach for teenagers. OCAPICA is dedicated to enhancing the health, social and economic well-being of Asians and Pacific Islanders in Orange County, California.





National Health Foundation (NHF): COVID-19 has put an extra ordinary bind on our health system. A \$15,000 grant will support the NHF’s efforts to provide recuperative care to homeless and home-insecure patients as they recover from illness. The mission of NHF is to improve the health of individuals and underresourced communities by taking action on the social determinants of health. Their vision is that all people, regardless of who they are or where they live, can achieve their highest level of health.

Kindness Grants

The Kindness Grants were created in 2018 to support City of Hope employees who want to do good in their



community. During Fiscal Year 2020, five programs were funded totaling \$20,000. These employee-driven projects are described below:

Be Kind to YOURself – Submitted by Amanda Eglseder: This health fair, titled “Be KIND to YOUrself, will address both cancer prevention and early detection. At no cost to them, attendees will have the opportunity to receive cancer screenings, access several supportive care resources that are available in the Santa Clarita Valley and participate in physician-led educational workshops. Due to COVID-19, the program pivoted to providing financial support to cancer patients in their community. The financial support included: co-payments, insurance premiums, medications, physical therapy, screenings and labs.

HCT Caregivers Educational Support Program – Submitted by Dhruvi Ramchandani: This program will develop a train-the-trainer model that can be replicated in all our local communities impacted by post-transplant caregiving. The program capitalizes on an interdisciplinary oncology care team to create a class that supports home care of the HCT patient while directly addressing caregiver self-care needs. The core interdisciplinary project team consists of oncology clinical social workers, registered nurses, a health educator and consultative members (hematology physicians, dietitians, occupational therapy). There is a network of support and compassion between facilitators and participants, as well as between the participants themselves.

Sickle Cell Disease and AwarenessForum – Submitted by Jazma Tapia and Caree Carson: Connecting People of African Descent aims to hold an all-day community forum regarding sickle cell disease. The setting will include a discussion panel and presentations on the science of sickle cell disease in layman’s terms. The science panel will be comprised of a scientist, a physician, a nurse and a community-advocate scientist. The patient panel will comprise of sickle cell disease patients, cured or not, and patient-advocates. When the science panel speaks, this will give patient and patient-advocates the opportunity to listen in on the science of the disease. In exchange, when the patient and patient-advocate speak, this will give doctors and scientists an opportunity to observe and listen in on patient views about their experiences. The most striking impact of this program is the highlight that it gave to the belief, by participants, that institutional racism and discrimination has impacted access to sickle cell treatment and cures (Figure 8).

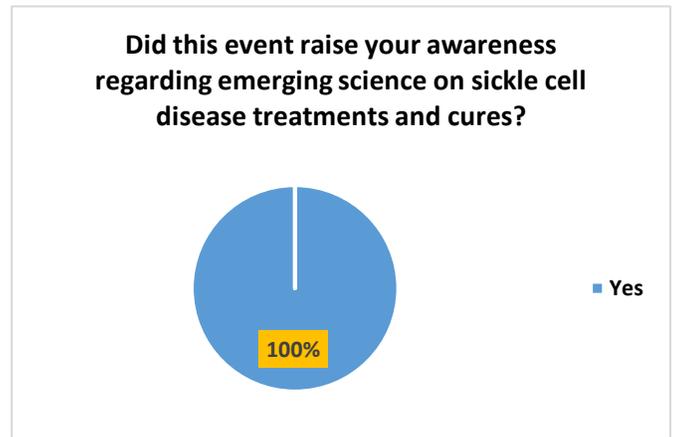
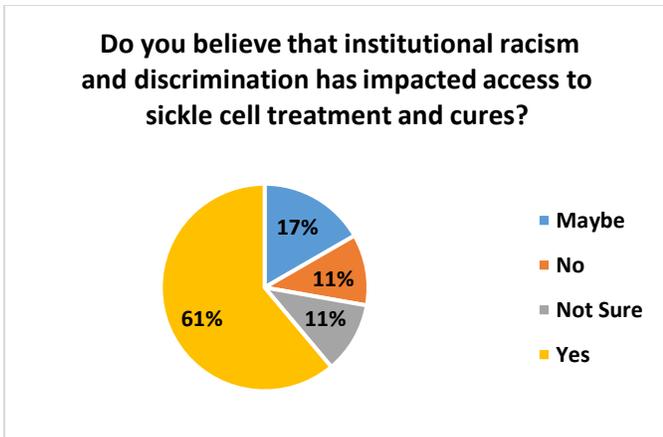


Figure 8. Sickle Cell Awareness Forum Evaluation Results

Voices of Hope – Submitted by Kelly Hansen: The Voices of Hope Laryngectomy Group will address access to care, chronic disease prevention and mental health. It’s incredibly important to our head and neck program here at City of Hope for the subset of laryngectomy patients (only 30+ surviving patients at any given time) and those laryngectomees living in the area to have a forum to develop a community. This support group will began in January 2020.

PROSTATE AND BREAST CANCER VIRTUAL FORUM

Friday, September 25
11 a.m. to noon

Event organized by
Women's Professional Network

A subgroup of
diversity+inclusion

Join the Women's Professional Network as we kick off the awareness months for prostate and breast cancer. We will have City of Hope doctors speak on both prostate and breast cancer, along with patient speakers. We will have giveaways for all attendees. You must register and attend the event to be eligible for the giveaways. For additional information, please email wprn@coh.org.

Host:

Sarah Steiner, Senior Vice President, Organizational Transformation

Speakers:

Michael Caligaris, M.D., Director and Steve Campbell, Physician-in-Chief, Diagnostic Case

Laura Kravitz, M.Ed.

Loretta Brumback, Ph.D.

Terry Colgan, Executive Director, Clinical Laboratories

Community Breast and Prostate Screening Event – Submitted by Victoria Taylor–McKinley: This is a one-day educational symposium which will help educate people on the importance of breast and prostate health. During the event, they will coordinate services for community members to receive free mammograms and prostate screenings, have City of Hope doctors speak and educate attendees on breast and testicular health (which will include self-examinations) and we will have experts provide education on wellness and healthy eating.

Five important community-based programs were delivered to a diverse audience within the San Gabriel Valley. Through the Kindness Grants program we learned about the creativity and desire of our

employees to do good work in the community.

Greater San Gabriel Valley Hospital Collaborative

The Greater San Gabriel Valley Hospital Collaborative began meeting in mid-2018. The Hospital



Collaborative is an initiative of and facilitated by the Health Consortium of Greater San Gabriel Valley (Health Consortium).

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. The Greater San Gabriel Valley

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 Community Health Needs Assessments (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.

- 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 Senior Manager for Community Benefit serves as the co-chair of this effort.

Enterprisewide Collaborations – Cooking, Nutrition and Community Garden Programs

City of Hope is proud of the accomplishments of the programs across the enterprise. The Department of Community Benefit has worked collaboratively and in partnership with the Conrad N. Hilton Foundation and internal partners throughout the institution from Diabetes and Endocrinology to Enterprise Support Services and Beckman Research Institute of City of Hope. This partnership is part of a larger five-year initiative to reduce the incidence of cancer and diabetes. Below is an update of the activities that we engage in during Fiscal Year 2020.



Savoring Hope Cooking Classes

One such collaboration is the Savoring Hope cooking classes. These interactive classes are led by City of Hope’s Executive Chef Christian Eggerling and a health educator. During the Fiscal Year 2020, nearly 500 community members



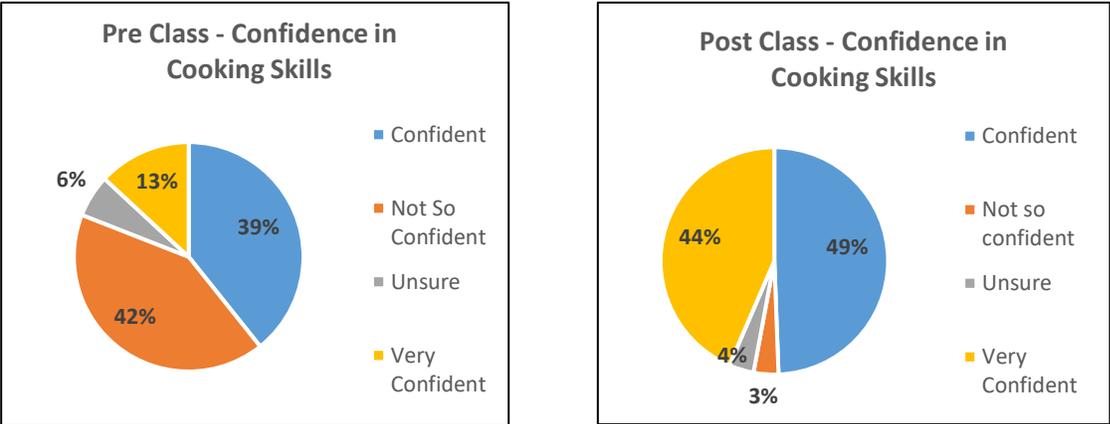
Cooking Classes Before and After COVID-19 Social Distancing Mandates

(both City of Hope staff and members of our local community) participated in 11 different cooking

	Impacts	
Core Principle	Vulnerable Populations	<input checked="" type="checkbox"/>
	Primary Prevention	<input checked="" type="checkbox"/>
	Seamless Continuum of Care	
	Community Capacity Building	<input checked="" type="checkbox"/>
Strategic Priorities	Access to Care	<input checked="" type="checkbox"/>
	Healthy Living	<input checked="" type="checkbox"/>
	Mental Health	
	Cancer Prevention Early Detection	<input checked="" type="checkbox"/>

demonstration classes. Throughout the year, both in-person and online, students learned to make a variety of healthy food items from watermelon gazpacho to quinoa tabbouleh. To learn more about Savoring Hope cooking classes, [click here](#).

As health educators, we know that the best way to share new information is to hide it inside a fun activity. During the Savoring Hope cooking classes, students also learn about the rich nutrient-dense ingredients and their roles in promoting good health. Additionally, there are three objectives meant to increase participant skills and confidence in re-creating healthy meals (Figures 9, 10, 11). This increase in confidence results in a reduction of barriers to cooking more nutritious meals.



Figures 9, 10. Confidence in Cooking Skills Before and After Taking

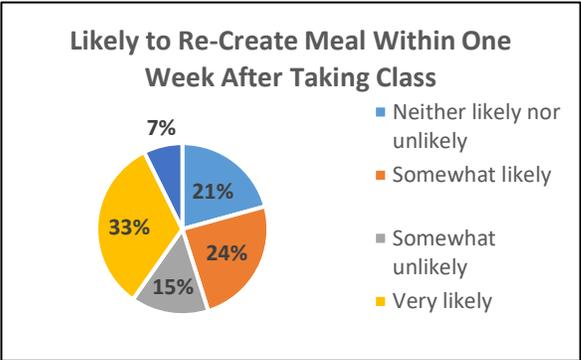


Figure 11. Likelihood of Recreating Meal After Taking Class

Kid Run Farmers Market

While City of Hope continued the partnership with the Arroyo High School and Eco Urban Gardens (See the Healthy Living Grants section to learn about their Best of Thymes Garden) to build the Culinary and Technical Education farm program there, we also expanded efforts to support wellness at other schools in the



Students from La Primera Elementary School running their own farmers market

San Gabriel Valley. We expanded the school-based farmers market program by involving another K-5 school in South El Monte, La Primera. City of Hope procured the produce from a local community-supported agricultural nonprofit called Food Roots. The team from City of Hope (including our AmeriCorps volunteer) trained the students and adults in the skills necessary to run a farm stand at the school. Training topics included: inventory, setting up the stand, how to determine costs and profits, and produce storage. The goal of the market was not to make a profit — rather, it was to discover a model that would help a school start and sustain a market at their school. City of Hope purchased the produce, display and marketing materials. La Primera provided the scale, petty cash, cash box and students/leadership to run the market. The students were challenged to find a way to increase profits at the market. One strategy they identified was to recycle T-shirts and charge \$1/bag. Unfortunately, COVID-19 social mandates required us to cancel the remaining farmers markets at La Primera. We hope to restart the program at La Primera when it becomes safe to gather again. This year we had the privilege of hosting a Masters in Public Health intern from Loma Linda University, Riwa Ghalayini. Luckily for us, she conducted the evaluation of La Primera farmers market. What we discovered is that the farmers market positively impacted the children who participated in the program. We

observed increases in eating vegetables at dinner and fruits for snacks. Nearly 70% of the students felt that they learned how to run a farm stand.

Over 80% think that having a farmers market at their school was a good idea. We learned a lot also. Giving the school and student leaders the opportunity to create this program in the “cultural context” of their school enabled them to build a sustainable program. For example, the first farmers market broke even and the second made a 50% profit. The experience and the program is so popular that other schools wanted to replicate the program. Schools are currently closed, but we remain hopeful that what we learn will allow us to create more markets in the coming year.



Implementation and Evaluation of a Student Led Farmers' Market at La Primaria Elementary School in El Monte, CA.



Riwa Ghalayini, RDN, MPH Student
Instructor: Sharilyn Andersen, MPH, Faculty Advisor(s): Celine Heskey, DrPH, MS, RD, Site Supervisor(s): Nancy Clifton-Hawkins, MPH, MCHES
 Practicum and Internship Office, School of Public Health, Loma Linda University, Loma Linda, CA 92350

Abstract

Background: Fruits and vegetables have an important role in the prevention of chronic diseases. A small farmers' market in a school of a low-income community will promote the consumption of fresh produce among residents.

Purpose:

- To encourage the consumption of fresh produce
- To assess the impact of the farmers' market on students

Method: The monthly Farmers' Market, funded by City of Hope, at La Primaria Elementary school will be run by students from the THINK Together program. Pre- and post-surveys will be used to assess the impact of the project.

Result: Students showed some improvements in their knowledge, behavior and intake, yet results were not statistically significant. Another post-test will be completed at the end of the school year.

Methods

Implementation of the Farmers' Market:

- This project is funded by City of Hope – Community Benefit Department as part of Schools Wellness
- Students from the THINK Together program were chosen to manage the Farmers' Market
- Students participated in a workshop to understand the project, their responsibilities and how to handle produce
- Prior to the first farmers market, all the elementary students attended a nutrition education session on the importance of fruits and vegetables
- The Farmers' Market will take once a month and will be located at the school's playground

Evaluation of the students' knowledge, behaviour and intake:

- Pre-test:** Students in the 3rd, 4th and 5th grades were asked to complete a questionnaire before the first farmers' market and the nutrition class
- Post-test:** Students in the 3rd, 4th and 5th grades were asked to complete a questionnaire after the second farmers' market



Conclusion

As part of their work in decreasing health disparities within the greater Los Angeles area, the Community Benefit department at City of Hope dedicates a part of their budget for activities related to school wellness. This year, they collaborated with La Primaria Elementary School in El Monte, CA to design, manage and implement a farmer's market at their school to encourage fresh fruits and vegetables consumption within their low-income community including students, parents and neighborhood residents.

The results of the first evaluation showed slight improvements in the students' knowledge, behavior and intake. Another evaluation is scheduled to be done at the end of the school year as this project will be still running until June. It is important to note that the work of the teachers and the students together, through an integrated learning process, helps to establish and ensure the sustainability of this project. Programs looking to implement a similar project should consider including an educational component in their implementation, such as educational sessions on different nutrition topics and healthy cooking classes for caregivers and students.

Background

Healthy eating habits established during childhood will continue into adulthood and will have a positive impact on the children's health as they grow up. Prevention of chronic diseases such as diabetes, heart disease and some cancers, has been associated with a diet rich in fruits and vegetables. Studies have shown that children have a lower intake of fruits and vegetables compared to the recommendations, and those living in a low socio-economic status have even a lower consumption.¹ Those results highlight the need for interventions that would reduce disparities and provide children with better food sources, especially those living in low-income communities.

The city of El Monte has the highest level of poverty in San Gabriel Valley with almost one out four of the population living below the poverty level, which is greater than the state's rate.²

Having a farmers' market in a school of a low-income community encourages the students, the parents and the neighborhood residents to increase their consumption of fresh produce.

Results



Discussion

- The results of the pre- and post-surveys showed improvements in the students' knowledge, behavior and intake related to fruits and vegetables. However, those results were not statistically significant. This may be due to the short duration between the two tests, especially that the farmer's market had just started.
- This student-led project allowed them to gain new skills related to managing a farmer's market. More students will be rotating and trained for different positions to benefit from this new experience.
- For the first market, the project did break-even with no profit. However, they were able to make 50% more money in profit from the second one.

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- Dannefer, R., Bryan, E., Osborne, A. & Sacks, R. (2016) Evaluation of the Farmers' Markets for Kids programme. *Public Health Nutrition* 19(18), 3397-3405. doi:10.1017/S1368890016001725

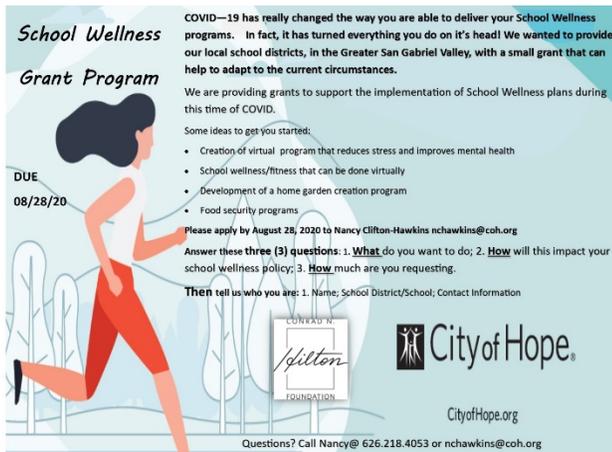
Acknowledgements

Thank you to Ms. Nancy Clifton-Hawkins for her support and guidance.

Thank you to the staff and students of La Primaria Elementary school for their efforts, enthusiasm and professionalism.

Thank you to Marci Andersen and Dr. Heskey for their continuous help and support.

School Wellness



School Wellness Grant Program

COVID—19 has really changed the way you are able to deliver your School Wellness programs. In fact, it has turned everything you do on it's head! We wanted to provide our local school districts, in the Greater San Gabriel Valley, with a small grant that can help to adapt to the current circumstances.

We are providing grants to support the implementation of School Wellness plans during this time of COVID.

Some ideas to get you started:

- Creation of virtual program that reduces stress and improves mental health
- School wellness/fitness that can be done virtually
- Development of a home garden creation program
- Food security programs

Please apply by August 28, 2020 to Nancy Clifton-Hawkins nchawkins@coh.org

Answer these three (3) questions: 1. **What** do you want to do; 2. **How** will this impact your school wellness policy; 3. **How** much are you requesting.

Then tell us who you are: 1. Name: School District/School; Contact Information

DUE 08/28/20

City of Hope FOUNDATION

CityofHope.org

Questions? Call Nancy@ 626.218.4053 or nchawkins@coh.org

This year we continued the School Wellness Grant program for local school districts. During this fiscal year we wanted to do something that would support school wellness programs during COVID-19 social distancing. In total, \$5,000 was provided to four (4) school districts. Their creative ideas are described below:

El Monte Union High School District: **“Bridging the Breakfast Gap”** supports this endeavor by seeking to materially improve children’s food security, health, behavior and educational outcomes — lessening the adverse effects linked to families’ running out of food before the end of the month. Continuing pandemic conditions have increased El Monte’s community unemployment — now 22.7%. In mid-July, El Monte registered the highest number of COVID-19 infections and deaths in the San Gabriel Valley, further reducing a family’s ability to care for children. “Bridging the Breakfast Gap” is designed to support school wellness policy activities in the face of these changing community conditions.

San Gabriel Unified School District (SGUSD): **“After-School Virtual Fitness Program”** enables students to sign up for classes that would meet twice a week for three weeks. Students would be able to participate in a live session that would include a nutrition, stretching and cardio component. There will be K-6 and 7-12 groups which would allow access to all levels and accessibility needs. San Gabriel Unified’s Wellness Policy is codified in BP 5030 and “recognizes the link between student health and learning” and promotes “physical activity.” In light of the reduction in physical education minutes required in the trailer bill AB 98, there are many students who will not have access to physical activity in the way they would have during a normal high school schedule. This additional fitness component would allow SGUSD to better meet the goals of our wellness policy while our students are in a virtual learning environment.

Pasadena Unified School District (PUSD): **“Grab-n-Grow”** kits are created for 3rd grade elementary students (250 to 300 students at four elementary schools) living in and attending school in northwest Pasadena. Schools in northwest Pasadena are above 80% or more free/reduced meal participants. PUSD Master Gardener, Jill McArthur, will be designing the curriculum on CANVAS’ LMS platform. CANVAS is the delivery platform for both synchronous (livestream) and asynchronous (pre-recorded) used by PUSD teachers to build digital learning environments for our students. The lessons will be available through CANVAS for easy access and delivery. The hands-on learning experience will be through “Grab-n-Grow” Kits. Each kit will contain vegetable seeds, soil, containers, a ruler, a small hand lens and a plant observation journal. Students will watch a planting lesson on how to assemble their kit and plant along with the lesson. This activity can be replicated several times throughout the year, helping the students to develop an understanding of seasonal produce.

When the weather changes, we will shift the contents of the kits to grow microgreens. Microgreens have a short growth cycle and are anywhere from 5% to 40% more nutritious than a mature vegetable. Students will be able to observe the growth over a brief period and eat and share the nutritious product within 10 days. This short growth cycle will allow the students to taste several different kinds of vegetables that they may not have otherwise had the opportunity or interest to taste. As the year progresses, students will be asked to compare what is happening with their growth kit to what they observe outdoors. Any opportunity to step outdoors will be welcome even if it is just to be on a small balcony or in a courtyard. Students can share their plants and journal entries at synchronous class meetings. Perhaps they can have simultaneous taste tests of microgreens. There is nothing like a shared meal to bring people together. Pasadena Unified School District Wellness Policy focuses on many areas of student wellness incorporating the Whole School, Whole Community, Whole Child CDC model (WSCC). The model addresses the importance of engaging students as active participants in their own learning and health. We know education and the school environment play a critical role in promoting the health and safety of our students and help them to establish lifelong healthy habits — even more so now during this unprecedented time. Our goal is to continue the effort of building healthier youth even when they are away from school and their normal school garden environment.

Mountain View School District: “Family Engagement and Extending Learning” is a program that will seek to promote wellness principles during the new COVID-19 lifestyle. The school day is now remote and children have easy access to snacks throughout the day. There is an opportunity to continue school wellness programs and provide healthy suggestions to families and empower students to make healthier food choices. This program will develop materials and parent leadership training modules to positively impact families and provide them with a skill set to make healthier food choices within their families. The district’s recently updated wellness policy is based on the WSCC model. This model has moved us from working in silos, where wellness or health was often relegated solely to pupil services or the food service department, to a more integrated approach where we now collaborate with other departments within the district, parents and community members.

With the series of pivots that COVID-19 has forced our school districts to take during this past fiscal year, City of Hope is delighted to support their efforts. Sometimes the stress of change brings forth the best in innovation — we believe these school districts exemplify this most.

Garden of Hope

THANK YOU FOR SUPPORTING
GARDEN OF HOPE

WHO ARE WE?
The Garden of Hope is a collaborative and educational edible urban garden located inside City of Hope Duarte campus. We provide gardening activities and resources necessary to develop your own green thumb.

OUR MISSION
Rebuild people's relationship with their food and the environment through urban agriculture, food preservation and therapeutic horticulture



Garden is located at City of Hope by the Buena Vista Ave entrance across from Flash building.
2240 Buena Vista St., Duarte, CA 91010

For information contact:
Alan Melgoza-Calderon
Americorp VIP Fellow
amelgozcalderon@coh.org



There is something special about sharing the farm/garden experience with others. It breaks down barriers and allows us to develop relationships surrounded in trust with our most vulnerable communities. Our Garden of Hope has become a local gathering place for the community, both internal and external, of City of Hope. Patients come out to the garden between doctor visits and often pick fresh produce to incorporate into their next meal. City of Hope and community volunteers, Garden Sprouts, dedicate hours helping to maintain the garden. While COVID-19 did impact the way people interacted with the Garden of Hope, we were still able to deliver programs and experiences that continued to enrich the lives of those in our community. Throughout this fiscal year we offered workshops that focused on using produce from the garden to enhance a person's life. Prior to COVID-19, we managed to deliver a medicinal salve workshop using lavender and lemon balm from the garden. We taught people that they could create and nurture a succulent terrarium with plants collected from across the campus, even those with the belief that they could not grow anything. Once COVID-19 hit, we had to

rethink how we delivered programs. Our AmeriCORPS volunteer, Alan Melgoza Calderon, worked in collaboration with the City of Duarte in promoting Victory

Gardens and distributed seed packets with instructions for gardening to the local community. Through it all, we were able to maintain our Garden Sprout program and kept the Garden of Hope alive and thriving throughout the summer months. Recognizing the need to bring the Garden of Hope closer to the patient and employee experience, we also created a Garden of Hope North. Located just in front of the City Café, it



**INFUSED HERB SALVES
MAKE AND TAKE**
HOSTED BY GARDEN OF HOPE
MONDAY DECEMBER 16th | 5:00 PM

Guests learn how to make a lavender lemon grass infused medicinal herb salve. Followed by a lavender plant identification. You will learn how to make a tea from white and purple rose and lavender plus the benefits of lemon grass, lavender, and lemon balm (green, summer, and blue) from the Garden of Hope. A growing workshop where the salve you will carry as a reminder to the medicinal of nature.

LOCATION
2240 Buena Vista St. City of Hope
2240 Buena Vista St. City of Hope, CA 91010

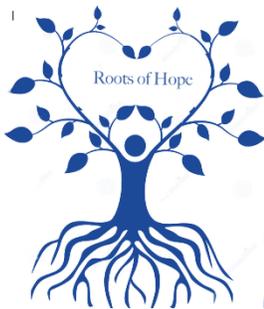
WORKSHOP FEES:
All proceeds from the workshop will be used to support the Garden of Hope.
RSVP by DECEMBER 12th
To book or for more information contact Alan Melgoza Calderon
amelgozcalderon@coh.org



produces mostly herbs and smaller crops that can be utilized in the food services program. After receiving training from our AmeriCorps volunteer, the Nourishing Hope team took the lead in maintaining this garden. We look forward to bringing people back into the garden in the next fiscal year.



Roots of Hope



There are other programs being delivered to the community via the Conrad N. Hilton and City of Hope Partnership. The Roots of Hope program collaborates with the Episcopal Church’s Seeds of Hope program in the Los Angeles region. COVID-19 caught this program in the middle of on-ground implementation. Like many of the other programs, they pivoted and assessed their participants and core trainers for online learning ability. They also used this year to increase capacity by creating a new partnership with the Claremont Graduate University to build a regional approach and secular branch of the program. This collaboration has increased the number of lifestyle coaches and locations that the program is going to be delivered to. Additionally, this program achieved CDC recognition so that they can begin billing for this program. This is an important point because long after the funding from our City of Hope and Conrad N. Hilton Partnership ends, Roots of Hope will be sustainable. The Roots of Hope goal is to impact 88,000 congregants in 144 churches across Los Angeles county and expand into Asian Pacific Islander communities in the

continental United States and territories in the South Pacific.

Internal Partnerships

It is important to recognize the participation of the hardworking individuals who contributed to over 241 community education and support group events across this institution and in the vulnerable communities City of Hope serves. There has been an obvious thought shift from exclusively increasing patients who receive services at City of Hope, towards getting critical cancer prevention awareness information into our most underrepresented communities that is both culturally and linguistically appropriate-regardless of where they receive care. This year we saw significant increases in these type of programs in the African-American, Chinese and Hispanic communities, where trust building is critical to the success of reducing health inequities. The Populations Sciences: Eat, Move, Live program adapted programming to include a simulcast translation into Mandarin. Our Multi-ethnic Marketing Department contributed to a significant number of programs that were held in our communities of color. These transitions took place with a lens focused on the social determinants of health that allowed our teams to move forward and provide much needed programs and services to our communities in need.

COMMUNITY BENEFIT INVESTMENTS

How Benefits Were Defined

The quantifiable community benefits provided by City of Hope in Fiscal Year 2020 are listed in Table 3. Consistent with community benefit standards, only activities funded by the 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, 2015 Edition," was used to determine whether activities met the criteria for inclusion as a quantified community benefit. The criterion also meets Internal Revenue Service 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

Community Benefit Categories	Net Benefit
CHARITY CARE ⁴	5,957,448
UNPAID COSTS OF MEDI-CAL ⁵	0
OTHERS FOR THE ECONOMICALLY DISADVANTAGED ⁶	0
EDUCATION AND RESEARCH ⁷	106,202,742
OTHER FOR THE BROADER COMMUNITY ⁸	3,440,085
TOTAL COMMUNITY BENEFIT PROVIDED EXCLUDING UNPAID COSTS OF MEDICARE	114,957,591
UNPAID COSTS OF MEDICARE ⁵	135,523,971
TOTAL QUANTIFIABLE COMMUNITY BENEFIT	251,124,246

Table 3. Fiscal Year 2020 Quantifiable Community Benefit

City of Hope also provided a wide range of benefits to our communities that is not reflected in Table 3 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.

⁴ Charity Care includes traditional charity care write-offs to eligible patients at reduced or no cost based on the individual patient's financial situation.

⁵ 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.

⁶ Includes other payors for which the hospital receives little or no reimbursement (County indigent).

⁷ Costs related to the medical education programs and medical research that the hospital sponsors.

⁸ Includes non-billed programs such as community health education, screenings, support groups, clinics and support services.

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 Fiscal Year 2020 investment (**\$251,124,246**) and reported on the strategies prioritized in our 2018 to 2021 Implementation Strategy Plan. The main focus areas of our Fiscal Year 2020 community benefit programs and services: **Healthy Living, Community Capacity Building and Kindness Grants; Greater San Gabriel Valley Hospital Collaborative; Cooking, Nutrition and Community Garden programs** 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. COVID-19 social distancing mandates required us to pivot quickly to address needs. This has been a great opportunity for us to look for new models to deliver care and programs. The racial inequities that continue to play out has put a spotlight on diversity, equity and inclusion. This further



Healthy Living Grantee - Wonderfully Made. A collaboration among historically Black churches in Duarte and Monrovia. View their video report [here](#).

demonstrated the need for intentionality when planning programs and caused many people not previously involved in community benefit programs and services to reach out to understand.

We have been fortunate to have the internal expertise of the Multi-ethnic marketing and outreach team to collaborate with others and increase access to our most at-risk

communities, provide cancer prevention education and promote cancer awareness in the most culturally sensitive and appropriate ways possible.

While this document represents the last status report on the 2018-2020 Implementation Strategy, we hope that it provided you with an idea of the direction we are moving towards with the 2021-2023 Implementation Strategy. The designation of Community Benefit as an institutional priority 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

2016 Needs Assessment Tools

Focus Groups and Interviewees

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.

Focus Groups

Agency and Agency Location	Participant Description	Language	Number of Participants
Second Baptist Church (Monrovia)	African-American adults	English	12
Second Baptist Church (Monrovia)	Teens, ages 14-18	English	20
Duarte Senior Center (Duarte)	Seniors	English	11
Asian Youth Center (San Gabriel)	Asian-American adults	English and Mandarin	12
Our Saviour Center (El Monte)	Hispanic/Latino adults	Spanish	10
TOTAL			65

Interview Key Informants

Name		Title	Organization
1	Tim Alderson	Executive Director	Seeds of Hope Episcopal Diocese of Los Angeles
2	Mary Borja	Health Services Chair	El Monte City School District
3	Lisa Dowd	Health Services Coordinator	Duarte Unified School District
4	Florence Lin	Community Relations Manager	Asian Youth Center
5	Jasmine Lopez	Volunteer	El Consilio
6	Maggie Lopez	Clinic Administrator, Azusa Clinic	El Proyecto del Barrio
7	Jim Morris	Executive Director	Men Educating Men About Health
8	Jennifer Rivera	Community Liaison Public Health Supervisor, Community Health Services	Los Angeles County Department of Public Health, SPAs 3 and 4
9	Cindy Sarabia	Volunteer, School-age Department	Antelope Valley Partners for Health
10	Tashera Taylor	Client Services Director	Foothill Unity Center
11	Jamie Thai	Chief Financial Officer	Garfield Health Center
12	Corina Ulloa	Director, Nutrition Services	West Covina Unified School District
13	Rev. George Van Alstine	Co-pastor	Altadena Baptist Church
14	Sonja Yates	Executive Director	San Gabriel Valley Habitat for Humanity
15	Lucy Young	Senior Director	Herald Cancer Center

Community Survey Summary

A survey was made available to community partners from November 2015 to January 2016 through Survey Monkey. An introduction to the survey explained the purpose of the survey and assured participants that participation was voluntary and that they would remain anonymous. We received 38 responses. Survey results are below:

Table 83. Age of Respondents

Age	Percent
20-29	15.0%
30-39	12.5%
40-49	22.5%
50-59	27.5%
60-69	17.5%
70-79	5.0%

Table 84. Insurance Coverage

Insurance coverage	Percent
No health care insurance	10.5%
Medicaid/Medi-Cal	7.9%
Medicare	10.5%
Employer-based insurance (includes HMO)	68.4%
Other or don't know	2.7%

What is the biggest health issue facing your community?

Health Issues	Number of Respondents
Diabetes	13
Obesity	10
Heart disease	8
Addiction/drug abuse/smoking	4
Access to health care, insurance coverage	4
Cancer	3
Air quality/pollution	3
Mental health	2

Asthma	1
HIV/AIDS	1
Aging population	1
Safety	1
Homelessness	1

What kinds of problems do you or your family face obtaining care or support services?

- We cannot afford it. Money and the lack of health insurance get in the way.
- The cost and the approval for my services
- Sometimes staff is insensitive. They are worried about money and quantity instead of quality.
- Selecting reliable specialists and costs
- Not being able to pay or not being able to see a doctor because medical insurance won't approve authorizations
- Making the time to address health needs.
- Limited appointment availability (e.g., earliest appointment isn't available for weeks)
- Cost of prescription meds, cost of dental care
- The lack of information about the various health services available in Pasadena. From my own experience, I have noticed that some parents don't know where clinics are located, and they know that it would be costly to take them to Huntington Hospital.
- The healthcare maze and out-of-pocket expenses
- Availability of appointments, money for co-pays
- Fighting with insurers over billing

- Language barrier/transportation for elders
- Taking time off work during the day. I would like to see more doctors offer regular evening hours.

What would make it easier for you and your family to obtain care?

- Zero co-pay
- Universal health care as offered by other industrialized nations in the world
- Talking with a social worker who has a lot of patience
- Resources and staff that are culturally appropriate and in-language. Also, navigators that can help patients with follow-up and help translate medical forms.
- Transportation. My parents are elderly and don't like to drive. I sometimes have to take time off work to drive them to their doctor visits.
- Reduce the cost and make health care more affordable
- Having more work flexibility or having office hours that are not urgent care (e.g., on the weekends)
- Not waiting so long for an appointment
- More specialty care practitioners
- More family clinics with flexible times to see doctors
- Local urgent care or after-hours services with early/late appointment hours
- Interpreters available to help people understand and navigate the system
- Health insurance
- A place that shows all the resources in the area
- Encourage discussion of mental health issues in Asian-American culture

- Encourage Asians to seek jobs in mental health and other allied health and public health fields to ensure cultural and linguistic competency in serving the local San Gabriel Valley residents (and California).
- Private physicians and pharmacists (and their staff) should be knowledgeable in community resources and supportive resources to share with their patients.
- Better understanding of how to access insurance opportunities

What type of support or services do you see a need for in this community?

- Transportation
- Language materials available in API languages
- Translations (especially Spanish and Asian languages such as Chinese, Vietnamese, Tagalog, etc.)
- Support from people who would like to see healthier food options. Advocacy, education of elected officials
- Patient navigation
- Obesity prevention
- Mental health services
- Sex education
- Alcohol abuse prevention
- Drugs and tobacco use prevention
- Teen resources and services for pregnant teens
- Support for single seniors
- Low-income clinics or hospitals
- Forums on diabetes prevention and care

- Obesity prevention and care
- Education in all languages, more outreach in the community, having support groups to teach the community
- Access to affordable preventive checkups
- Mental health providers that talk with people and not just give pills
- Low-cost dental services
- Let our community know that there is information and resources available for them.
- Health insurance for those of us who own homes, but do not make enough to pay for health insurance
- Health care staff that speak our language, understand our culture and know there are cultural beliefs, barriers and strengths influencing health and accessing care
- I don't know where to get resources and have to go to too many different places.
- Childcare, parks and recreation services, afterschool programs, senior centers, adult educational programs and community centers
- Behavioral health must improve. There cannot be waiting lists. People who suffer from mental disorders need to have mental/behavioral health available immediately.

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.

Community Resources

Significant Health Needs	Community Resources
Access to care	<ul style="list-style-type: none"> • 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.

	<ul style="list-style-type: none"> • 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 • C-Care • 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	<ul style="list-style-type: none"> • Clínica Médica Familiar (Family Medical Clinic) has clinics twice a year.

	<ul style="list-style-type: none"> • 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 questions, written information and links to websites.
Heart disease	<ul style="list-style-type: none"> • American Heart Association • Set for Life • Labor Union Conference • Curbside CPR classes offered by the Fire Department.

	<ul style="list-style-type: none"> • 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. 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	<ul style="list-style-type: none"> • 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.

	<ul style="list-style-type: none">• 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 Health• Aurora Clinic
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	<ul style="list-style-type: none"> • Pacific Clinics • Asian Pacific Health Care Venture has Chinese language mental health services.
Overweight and obesity	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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

	<ul style="list-style-type: none">• Unity One• Los Angeles County Sherriff's drug and alcohol prevention programs• Parent University• Narcotics Anonymous• Asian Youth Center program helping cities create smoke-free parks.
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Appendix B

Financial Assistance Policy

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



Written: 05/25/17
Reviewed: 07/28/20
Revised: 07/12/17; 08/13/20
Page: 1 of 4

Provision of Patient Assistance
Items to Patients Who
Demonstrate Financial Need

APPROVALS:

SLT: 08/13/20; MEC: 08/03/20; BOD: 2Q-20

Scope: Medical Center

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 its 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

8/13/2020 6:11 PM

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	<ul style="list-style-type: none"> A. Compile a list of vendors (“<i>Contracted Vendors</i>”) that have agreed to a pre-negotiated payment rate from COH as payment in full for furnishing medically necessary post-discharge services (the “<i>Contracted Vendors List</i>”). 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	<ul style="list-style-type: none"> 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. Village: Please see the following COH policies: (1) <i>Village Stay Criteria (Hope and Parsons)</i>, and (2) <i>Village – Billing and Collections</i>. 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	<ul style="list-style-type: none"> 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

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RESPONSIBLE PERSON(S)/DEPT.	PROCEDURE
Case Management and Supportive Care Departments	<p>List) must first be approved by the Director of Case Management.</p> <p>L. Document provision of any Assistance in the EHR.</p> <p>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:</p> <ol style="list-style-type: none"> 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 Corporate Compliance Department. <p>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:</p> <ol style="list-style-type: none"> 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 Corporate Compliance Department. <p>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> <p>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 Corporate Compliance Department.</p> <p>Q. Any requested Assistance outside of the parameters above must be approved, in advance, in writing by COH's Corporate Compliance Department.</p> <p>R. Report any Assistance provided to the Department administrative support</p>

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RESPONSIBLE PERSON(S)/DEPT.	PROCEDURE
	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: Corporate Compliance

Related Policies:

1. Charity Care
2. Village Billing and Collections
3. Village Stay Criteria (Hope and Parsons)

Appendix One – Acronyms, Terms and Definitions Applicable to this Policy

1. **City of Hope (“COH”)** – City of Hope National Medical Center (“COHNMC”), 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



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)

Charity Care Policy

APPROVALS:

SLT: 07/31/19; MEC: 08/05/19; BOD: 2Q-19

Scope: Medical Center Medical Foundation (Hospital-Based Services Only)

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.

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- 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.

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- 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.

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- 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

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\$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

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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

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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.

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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15000 E. Duarte Road, Duarte, CA 91010

CityofHope.org/community-benefit

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