ENHANCE YOUR COMMUNITY

ENJOY THE BENEFITS

2021

COMMUNITY BENEFIT REPORT

City of Hope®

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EXECUTIVE SUMMARY

City of Hope is pleased to submit a report of our community benefit activities for Fiscal Year 2021 (from October 1, 2020, to September 30, 2021). 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 first report on City of Hope's progress in addressing the prioritized health needs in the 2019 Community Health Needs Assessment and subsequent 2021-2023 Implementation Strategy. Throughout this document, we will demonstrate an understanding of the diverse needs of the multicultural communities we serve and a commitment to the creation of the infrastructure necessary to carry out an extensive array of community projects. Our traditional community education efforts in cancer prevention and cancer risk reduction are also reflected. The total value of our community benefit investments during Fiscal Year 2021 was **$306,532,657** (Figure 1). This represents a $55,408,411 increase over Fiscal Year 2020.

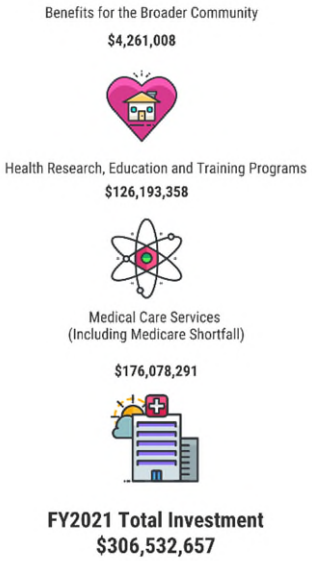

Figure 1. FY 2021 Community Benefit investments

Much like last year, COVID-19 has given us a new perspective on our own ability to pivot and reimagine our programs and services within the context of addressing needs and being safe. Moving forward we will continue to explore new areas that provide us the opportunity to impact 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. Send all comments to: CommunityBenefit@coh.org. This report, as well as our implementation strategy, is available for download on our website at: CityofHope.org/community-benefit.

WHO WE ARE: CITY OF HOPE

Founded in 1913, City of Hope is a national leader in cancer care. We provide each patient with an individualized, comprehensive care experience and deliver the highest quality treatment and expertise. We are one of only 52 National Cancer Institute (NCI)-designated comprehensive cancer centers in the U.S. The NCI designation recognizes excellence in treatment, research and expertise to address the many features of the disease, whether in early or late stage, and for common or rare types of cancer. City of Hope is also proud to be a founding member of the National Comprehensive Cancer Network (NCCN), reflecting our national leadership in advancing research and treatment. NCCN member institutions are recognized for their world-renowned experts and for treating complex, rare and aggressive forms of cancer. Most importantly, we firmly believe in providing value across the entire patient journey. At City of Hope, this is measured by the experiences and outcomes that our treatments and dedicated team provide. Our goal is to care for the whole person, so that life during treatment and after cancer can be rich and rewarding.

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

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

counseling. Underpinning this approach is our excellence in turning tomorrow's treatments into today's tailored patient plans and therapies. We are committed to delivering the most leading-edge treatment options to our patients and discovering new ways to combat a wide variety of cancers.

Delivering Optimal Outcomes for Our Patients

NCI-designated comprehensive cancer centers like City of Hope are the reason that cancer mortality rates have fallen over the past four decades. City of Hope consistently demonstrates higher survival rates and better outcomes, compared to other health care providers. Our patients recognize our commitment and our ability to provide life-changing outcomes.

Why Our Research and Innovation Matters

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

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

Although City of Hope is a treatment choice for patients from around the world, we also serve our community and are proud to serve it well. We have a rich history of developing health and wellness programs with community partners — programs that continue to thrive and grow. Because cancer and diabetes are complex,

multifaceted and all too common in our area, partnerships for community benefit are an integral part of our mission.

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 Corporate Social Responsibility

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

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

Our Belief Statement

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

embraces diversity – in ideas, backgrounds and perspectives; this is reflected in our work and represented in our people.

Communities We Serve

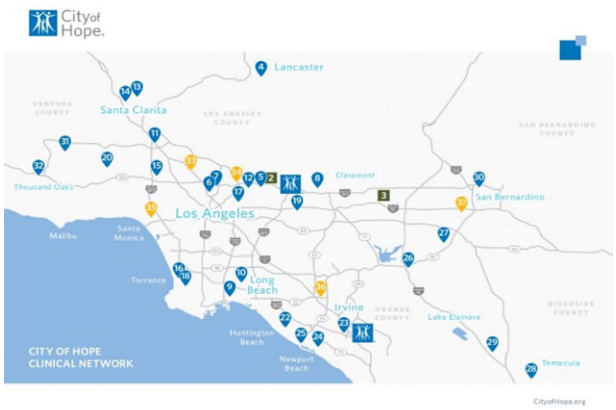


Figure 2. City of Hope primary service area

City of Hope is headquartered in the City of Duarte, situated at the base of the San Gabriel Mountains just 21 miles northeast of Los Angeles. Our services, however, extend far beyond our immediate community and, in fact, impact five major counties (Los Angeles, Orange, Riverside, San Bernardino and Ventura) where City of Hope operates 35 clinical network locations (Figure 2).

The majority of our patients come from Los Angeles County, specifically from communities within Service Planning Area 3 (SPA 3). City of Hope itself is within SPA 3, which includes 34 cities, such as Alhambra, Altadena, Arcadia, Azusa, Baldwin Park, Claremont, Covina, Diamond Bar, El Monte, Glendora, Irwindale, Monrovia, Monterey Park, Pasadena, Pomona, San Dimas, San Gabriel, San Marino, Temple City, Walnut and West Covina.

Race/Ethnicity[1]

Within the 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 is a great visualization of where our various racial and ethnic groups reside. Near Antelope Valley we see larger concentrations of African Americans. Asians call Monterey Park and Walnut home. Whereas large pockets Latinos live in and around the cities of La Puente and El Monte.

[1] U.S. Census 2020 Redistricting Data

SPA 3 by Race/Ethnicity

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

Density of Race/Ethnicity By City

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

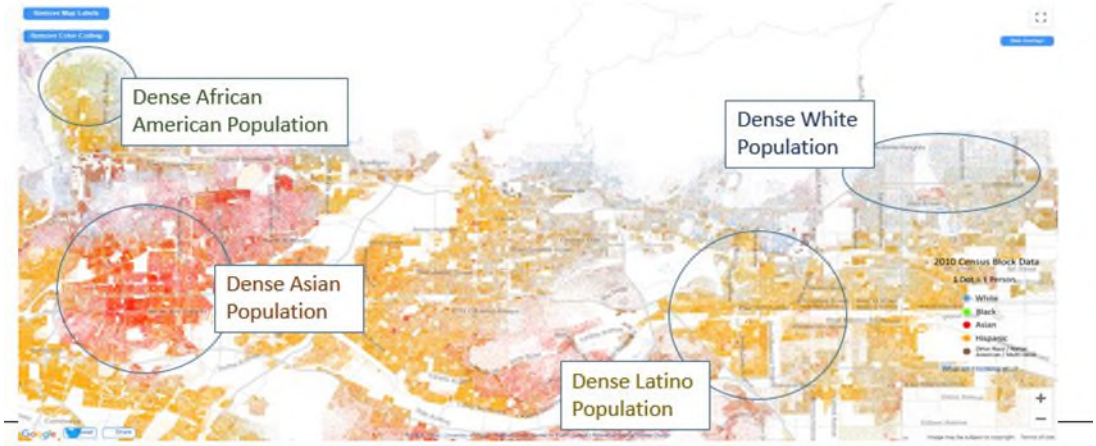


Figure 3. This map shows a portion of the SGV service area spanning from Pasadena on the left to Claremont on the right. map: http://racialdotmap.demographics.coopercenter.org/

As you can see in Figure 4, there have been slight population changes, in our primary five county service area and the State of California, between the 2020 and 2021 fiscal years. Overall for this region, San Bernardino County has the highest percentage of Latinos (53.7%) and Blacks (7.9%), Ventura County has the highest percentage of whites (42.8%) and Orange County has the highest concentration of Asians (21.9%).

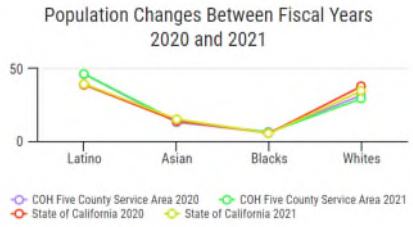


Figure 4. Race/ethnicity changes between fiscal years 2020 and 2021

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[2]

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 (39.2%) 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 28.8%. Los Angeles and Orange counties have the highest proportion of households speaking Asian languages. Their rates, 10.9% and 15.1%, respectively, are also greater than the state rate of 10.1%.

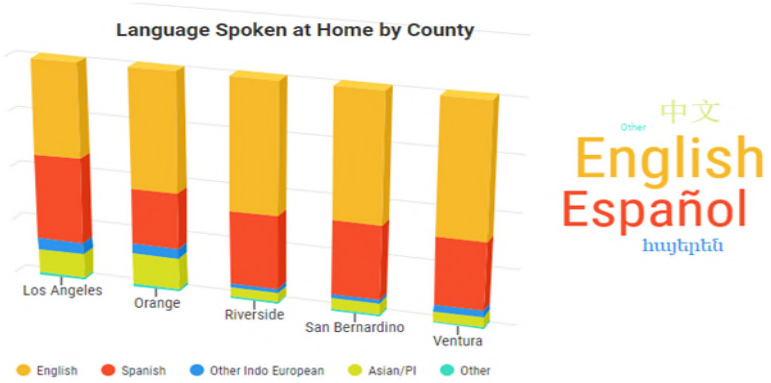


Figure 5. Languages Spoken Home. American Community Survey.

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%).[3] 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 5) When language is examined by city, certain cities disproportionately favor one foreign language over another. More than two-thirds of La Puente (67.8%) and South El Monte (68.1%) residents speak Spanish at home. On the other hand, less than 10% of households in Sierra Madre (6.3%), San Marino (5.2%), Bradbury (7.9%) and Arcadia (6.5%) speak Spanish. Seven cities had at least half of it's residents speaking Asian or Pacific Islander languages in the home: Monterey Park (54.5%), Rosemead (56.1%), San Gabriel (55.8%), Rowland Heights (54.9%), Temple City (52.3%) and Arcadia (50.5%), Altadena (7.6%) and Pasadena (6.2%) have the highest percentage of residents who speak some other Indo European language.

[2] 2019 US Census ACS 1 Year Estimates
[3] Linguistic isolation describes the population over age 5 who speak English "less than very well."

Social Determinants of Health

Social determinants of health are conditions in the environment where people live, work and play that affect a wide range of health and quality-of-life outcomes and risks. (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 11.8%. They include San Gabriel (12.8%), Monterey Park (13%), Pomona (13%), La Puente (13.7%), Azusa (14.2%), Rosemead (14.5%), El Monte (16.3%), Pomona, and the highest level in El Monte, where almost one out of five (19.3%) 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 2022, the Federal Poverty Level for an individual stood at annual income of $13,590 while for a family of four it was $27,000[4]. 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.[5]

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 the cities and unincorporated communities of SPA 3, 33% rank below the state in the rate of college-educated adults 25 years or older. South El Monte and La Puente, which have the lowest

[4] Annual Update of the HHS Poverty Guidelines https://www.federalregister.gov/documents/2022/01/21/2022-01166/annual-update-of-the-hhs-poverty-guidelines. Accessed (January 28, 2022)
[5] "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]

rates of college educated adults, at 10.5%, and 10.9%, respectively. 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 6[6], City of Hope, located in Duarte, is surrounded by vulnerable communities. Communities with 20% of residents that live below the Federal poverty level are shown in orange. Communities in which 30% 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[7].

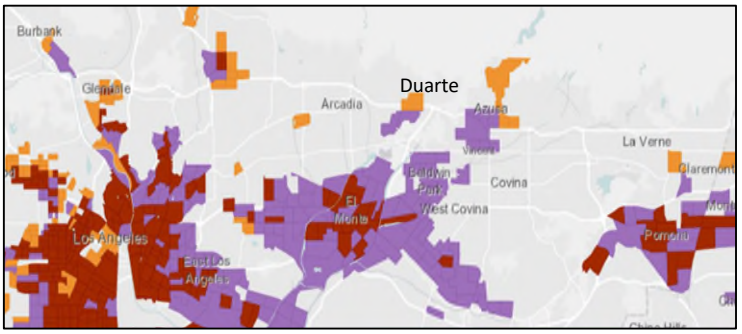


Figure 6. Map of vulnerable popluations in City of Hope service area. Source: American Community Survey 5-Year Estimates, 2015-2019.

The unique composition of these five counties makes them vulnerable on many levels and reinforces the need for community benefit programs. From our 2019 Community Health Needs Assessment (Figures 7-10), we learned:

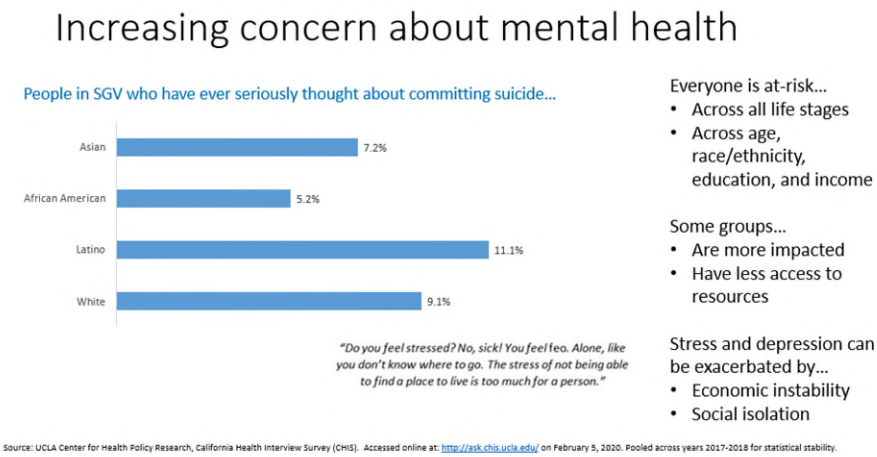


Figure 7. UCLA Center for Health Policy Research, California Health Interview Survey (CHIS) Accessed online at http://ask.chis.ucla.edu (February 5, 2020). Pooled across years 2017 – 2018 for statistical stability

[6] Map developed by Community Commons, available here: http://www.communitycommons.org/entities/60847319-e438-44be-a5c3-5b8d298845e1. Accessed [January 28, 2022]

[7] American Community Survey – 5 Year Estimates, 2015-2019. Accessed (January 28, 2022)

Figure 8. UCLA Center for Health Policy Research, California Health Interview Survey (CHIS) Accessed online at http://ask.chis.ucla.edu (February 5, 2020). Pooled across years 2017 – 2018 for statistical stability

Figure 9. UCLA Center for Health Policy Research, California Health Interview Survey (CHIS) Accessed online at http://ask.chis.ucla.edu (February 5, 2020). Pooled across years 2017 – 2018 for statistical stability

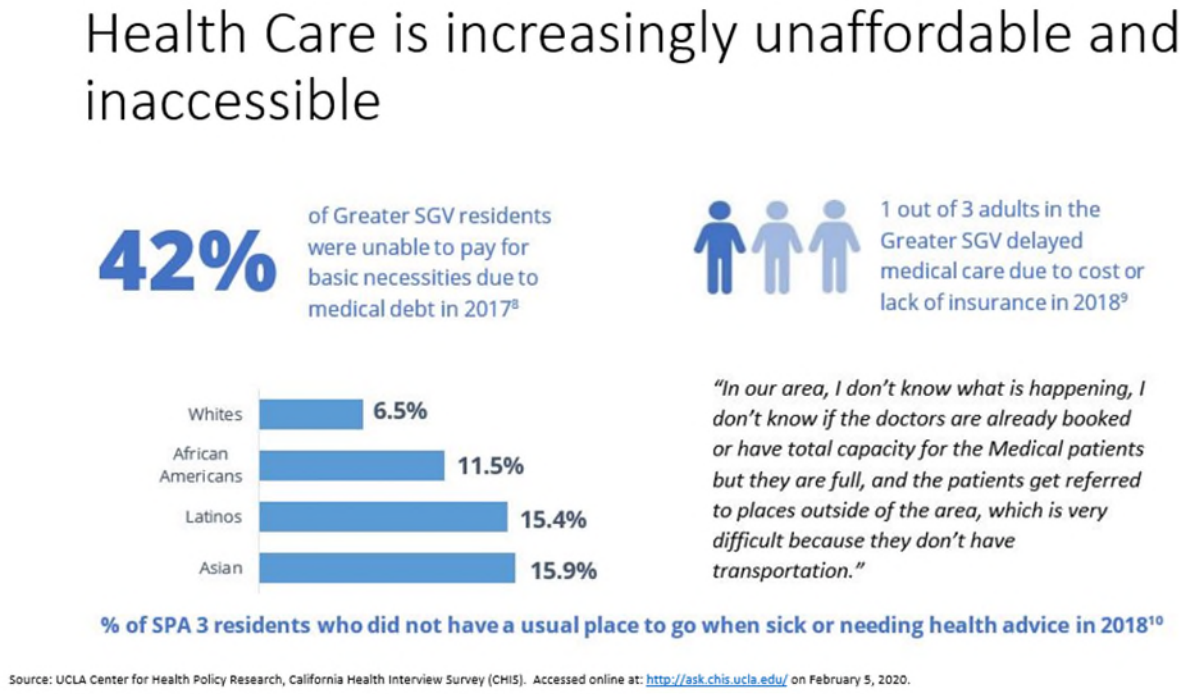


Figure 10. UCLA Center for Health Policy Research, California Health Interview Survey (CHIS) Accessed online at http://ask.chis.ucla.edu (February 5, 2020). Pooled across years 2017 – 2018 for statistical stability

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

ORGANIZATIONAL COMMITMENT

Oversight and Management of Community Benefit Activities

Since community health improvement is a key component of City of Hope's mission, a large number of employees, in a variety of departments, participate in planning and implementing community benefit activities. 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
- Center for Non-Profit Management
- City of Azusa – Recreation and Family Services
- City of Duarte – Senior Services
- City of Pasadena Health Department
- Duarte Unified School District
- Foothill Unity Center
- Los Angeles County Department of Health Services – Region SPA 3
- 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, we sought individuals with the following areas of expertise:

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

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

Miki Carpenter, PhD

Patricia Duff Tucker, MS

During Fiscal Year 2021, we had a change in CBAC leadership. During our April 2021 meeting the CBAC membership elected **Miki Carpenter – City of Azusa** and **Patricia Duff Tucker – Set for Life Inc.** as our new co-chairs. **Ms. Tashera Taylor – Foothill Unity Center Inc**. and **Christian Port – Planned Parent Pasadena San Gabriel Valley**, as the prior co-chairs, served for a total of four years. We are grateful for their leadership and will forever carry the lessons they taught us. Throughout FY2021, the CBAC met four times virtually. During the course of this year, the CBAC began to work toward achieving strategies identified in the 2021-2023 Implementation Strategy. Members reviewed and awarded the Healthy Living Grants and Kindness Grants, conducted virtual site visites of the grantees, 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. We began the journey with Diamond in September 2020 and held two more sessions in October 2020 and January 2021. Collectively, the CBAC hopes to use what they learned in these sessions to ensure that the services they provide, with their organizations and on their own, will apply a lens that promotes racial, health and social equity.

Nancy Clifton-Hawkins, M.P.H., M.C.H.E.S.® is City of Hope's director of community benefit. Clifton-Hawkins is available to answer questions regarding the delivery and accountability of community benefit programs and services at City of Hope and can be reached at CommunityBenefit@coh.org.

COMMUNITY BENEFIT PLANNING PROCESS

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

1. Emphasis on disproportionate or vulnerable populations with unmet health needs within City of Hope's primary service area as measured by culture, race or language disparities, age, poverty and lack of education
2. Emphasis on primary prevention: health education, disease prevention and health protection
3. Building community capacity by mobilizing community stakeholders as full partners and engaging them in sustainable strategies that address both symptoms and underlying causes
4. Building a seamless continuum of care to optimize the ability of community resources to manage cancer and diabetes, prevent patients from falling through the cracks and minimize the need for future, and often more complex medical care
5. Collaborative governance to ensure the community has a voice in, and partners with, projects initiated with City of Hope

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

COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS AND RESULTS

2019 Community Health Needs Assessment Methodology

City of Hope's service area is richly diverse in language, culture, religion and ethnicities. With this diversity comes a large variation in factors that put individuals at risk for health issues such as cancer and diabetes. Sociocultural factors — for example, the level of education achieved or the language spoken at home — can increase or decrease the risk of preventing or contracting a life-threatening illness. Serving our community and providing programs and services to our local residents designed to reduce risk and improve access to health care are paramount to our success as a nonprofit hospital. The best way to learn about our community's needs is to simply ask them. That is exactly what we did. In partnership with our SPA3 Hospital Collaborative, Huntington Hospital, Methodist, Emanate Health, Kaiser Permanente – Baldwin Park, City of Hope embarked on a comprehensive journey to discover how our collective community believes they are doing and what they believe they need to be healthy.

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

Secondary Data

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

public health by providing measurable objectives and goals that are applicable at national, state and local levels.

Primary Data

Analysis of secondary data yielded a preliminary list of significant health needs, which then informed primary data collection. The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets to address needs and discover gaps in resources. For this CHNA, we obtained information through focus groups; a community survey; and interviews with key community stakeholders, public health and service providers, members of medically underserved, low-income, and minority populations in the community, and individuals or organizations serving or representing the interests of such populations.

Focus Groups

Representatives of select subpopulations were convened to advance understanding of the lived experience of residents in City of Hope's service area. Subpopulations represented in focus groups included seniors, Spanish-speaking residents, Mandarin-speaking residents, African American residents, homeless residents and LGBTQ residents. **19 focus groups were convened between January and October 2019.**

Interviews

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

Summary of 2019 Community Health Needs Assessment Results

Secondary data analysis provided a preliminary list of significant health needs, which then informed primary data collection. The primary data collection process helped validate secondary data findings, identify

additional community issues, solicit information on disparities among subpopulations and ascertain community assets to address needs.

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

Significant Health Needs

The following significant health needs were determined:

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

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

Resources to Address Significant Needs

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

Stakeholder Prioritization of Community Health Needs

Our CBAC met on December 19, 2019, to identify the top health needs to be prioritized over the next three years. Based on findings from the primary and secondary data collections, participants learned about the identified health needs within City of Hope's community service areas. After the

data presentation, everyone was instructed to rate these leading indicators in relationship to seriousness, size of problem (number of people impacted), trends, equity, feasibility, value, consequence of Inaction, social determinants/root causes and effective strategies to address problem. Then they were instructed to represent their priorities by placing colored dots on the charts. Red #1, Blue #2, Green #3 and Yellow #4. People were also invited to elaborate on their prioritized issues with comments that can help us shape the overall strategies for the 2021 Implementation Strategy. Results were as follows:

CBAC members prioritizing health needs

2019 Stakeholder Prioritized Health Needs

Rank	Health Needs
1	Access to Care
2	Mental Health and Substance Use
3	Economic and Housing Insecurity
4	Chronic Disease
5	Cancer Prevention

It is important to know that while there were eight identified areas of need, those schooled in public health language will see that the CBAC combined topics because they felt that the root causes and shared risk factors were similar, and by addressing them collectively rather than

individually we could have a greater impact. Thus, you will see that mental health was combined with substance abuse. In recent years, mental health researchers have found that creating an integrative approach for mental health and substance use disorders made more sense and provided greater support for the patients[8],[9]. Chronic disease was combined with obesity/overweight because the shared risk factors and methods for addressing those risks are similar. Within the Community Benefit Initiatives portion of the report, we provide a detailed description of how we are addressing the identified needs.

Plan to Address Needs

It would be unreasonable to think that City of Hope can solve all the issues identified in the needs assessment. Given our expertise and resources as a cancer institution, we need to find pragmatic ways to work with our community to address the identified needs. First, we need to acknowledge that the prioritized categories are even more complex than presented above. Next, we need to view the issues through the lens of the Public Health Institute's "Five Core Principles" (Page 19). As we plan programs, we must ask ourselves, "How will our work impact the lives of vulnerable people in a way that supports prevention, builds a seamless continuum of care and enables the community to take ownership of their health issues? How can we be a leader in creating a healing environment?" From here, we can tackle the five identified categorical needs by designing program/services and building collaborations that will work to lessen the impact on local residents.

[8] Ungar, M., Liebenberg, L., Ikeda, J. (2014). Young people with complex needs: Designing coordinated interventions to promote resilience across child welfare, juvenile corrections, mental health and education services. The British Journal of Social Work, **44**, 675–693.
[9] Clark, H. W., Power, A. K., Le Fauve, C. E., Lopez, E. I. (2008). Policy and practice implications of epidemiological surveys on co-occurring mental and substance use disorders. Journal of Substance Abuse Treatment, **34**(1), 3–13.

CBAC members who prioritized the 2019 CHNA results

Collaborations

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

Oversight

As mentioned previously, to ensure City of Hope's reportable community benefit programs and services are targeting those areas identified in the 2019 needs assessment, the CBAC will convene four times per year to

review progress and budgeting related to the 2021 to 2023 Implementation Strategy. CBAC members also select awardees for the two City of Hope grant programs and conduct fidelity checks for funded programs.

Anticipated Impacts on Health Needs

When we look at the five priority areas identified by our community, we need to think about them through a realistic framework that allows us to address issues with strategies that make the most sense given City of Hope's capacity to do so. Each priority has a broad measurable outcome indicator. While it may be unrealistic to believe that City of Hope can make a significant impact regarding these priorities, mindful programming and collective impact will enable us to make changes to the communities we serve. As an institution, we will aim our programs and services at our residents, focusing on the following recommended strategies:

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

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

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

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

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

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

Hope's resolve to decrease the disparities that prevent our residents from experiencing a good quality of life.

Needs Not Addressed

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

Monitoring and Evaluation

We believe that taking a business approach to planning and evaluating the identified initiatives will ensure their long-term sustainability. We realize that evaluation is necessary to measure success, as well as to identify areas needing improvement. The process can result in more effective initiatives. City of Hope is working to identify the best methods of monitoring and evaluating the impact of the initiatives identified in this document. In order to efficiently deploy resources and maximize results, City of Hope's annual budget will include the operating funds required to manage, track and report on the outcomes and impacts of all community benefit programs and initiatives.

COMMUNITY BENEFIT INITIATIVES

Overview of Fiscal Year 2021 Programs and Services

Amid another year of COVID-19, planned conferences, farmers markets and other in-person events were not hosted. Teams continued to deliver important events via a virtual environment. Like last year, we find that our reach was greater, meaning people from throughout the country were able to participate in our programs. For example the Savoring Hope cooking classes welcomed participants from New York State and British Columbia. Over 1,300 people attended these classes online whereas only 216 would have been able to attend in-person. This is exciting when increasing access to supportive and educational programming is more important than ever. What follows is a reflection of our work during the FY2021. 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 Community Health Needs Assessment. Some are

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

Figure 11: FY2021 Strategic Priority Programs

organization-wide, while others are conducted by a specific department. Figure 11 provides a quick overview of our Fiscal Year 2021 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. Conversly, 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 2021 community benefit programs and services: **COVID-19 Community Response; Food Insecurity; 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	☑
	Primary Prevention	☑
	Seamless Continuum of Care	☑
	Community Capacity Building	☑
Strategic Priorities	Access to Care	☑
	Economic and Housing Insecurity	☑
	Mental Health	☑
	Healthy Living	☑
	Cancer Prevention Early Detection	☑

COVID – 19 Responding to the Community Call for Vaccines

With over 41 million cases in the United States, the coronavirus disease 2019 (COVID-19) elicited public health officials to adapt vaccination methodologies to mitigate the spread of the virus in public settings, such as schools. In March of 2021, California allocated 10% of the state's weekly COVID-19 vaccine supplies to support the vaccination of educators. Both the Los Angeles County Department of Public Health and the Office of Education called upon school district superintendents to establish community partnerships in preparation for aiding in the distribution and administration of vaccines. The Duarte Unified School District subsequently turned to a neighboring comprehensive cancer center, City of Hope National Medical Center, to collaboratively plan, organize and execute a fully operational vaccine clinic. Over a two-month period, City of Hope and the Duarte Unified School District effectively implemented 10 drive-thru COVID-19, which shifted to target not only educators but also community members and successfully administered an estimated 7,600 vaccine doses and vaccinated 3,900 individuals. During the summer of 2021, we conducted key informant interviews to gain further insight into the roles, resources and collaborative efforts involved. Volunteer staff was also surveyed to explore their needs, attitudes and motivations for volunteering in the clinics. Collectively, we learned that understanding the strengths, weaknesses and practical recommendations of all involved stakeholders allowed us to create an effective model for mobilizing resources to meet an emergent community need.

Community members line up for the drive-thru COVID-19 vaccine clinic.

Pharmacy Manager Lisa Serrano prepares individual vaccine doses.

Volunteer nursing staff administered injections at the vaccine stations.

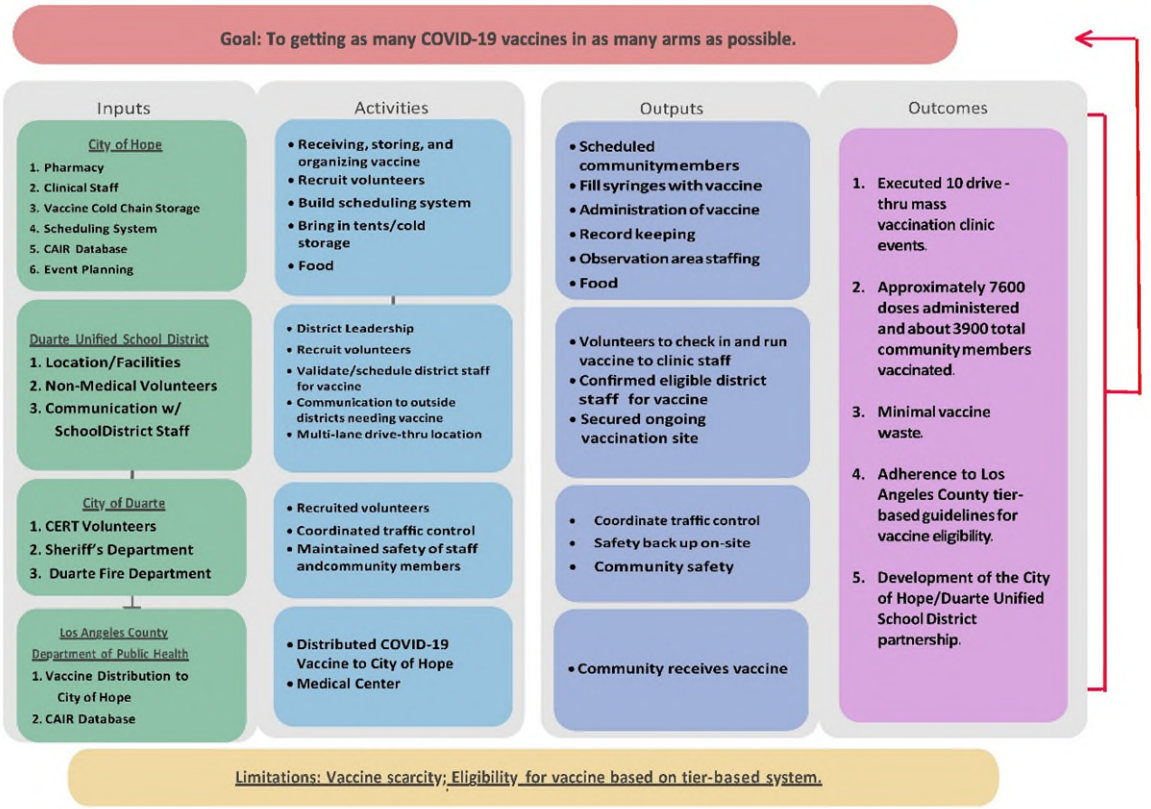


Figure 12. DUSD and City of Hope vaccine clinic logic model. Created by Meagan Echevarria 2021.

Volunteer physicians oversaw the vaccine observations waiting areas.

Food Insecurity - Greater San Gabriel Valley Hospital Collaborative Food for All Program

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 CHNAs across the hospitals; and (b) develop a coordinated strategy to address regional mental health needs. The Hospital Collaborative has also initiated participation in a Homelessness & Health Care Patient Navigator pilot project with the United Way of Greater Los Angeles. The six nonprofit hospitals that comprise the Hospital Collaborative are City of Hope, Emanate Health, Huntington Hospital, Kaiser Permanente Baldwin Park, Methodist Hospital and Pomona Valley Hospital Medical Center. In addition to the nonprofit hospitals, the Hospital Collaborative also includes the two local public health departments that serve this geographic area - L.A. County Department of Public Health and Pasadena Public Health Department. As a direct result of this partnership, the hospitals committed to identifying high indexing social determinants of health and worked on strategies to resolve those issues. In June 2021, the UniHealth Foundation funded the Greater San Gabriel Valley Hospital Collaborative (Hospital Collaborative) to coordinate a regional project, the *Greater San Gabriel Valley Food for All Initiative,* to reduce food insecurity among economically and medically vulnerable hospital patients at participant hospitals. Primary project participants include five of the six Hospital Collaborative members: Huntington Hospital, Methodist Hospital, City of Hope, Kaiser Permanente Baldwin Park and Emanate Health. These partners

SPA 3 Hospital Collaborative partners

currently engage in food insecurity work at different levels and this initiative would facilitate each to progress accordingly. Initiative components include:

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

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

3) **Sustainability of Food Security Support:** Hospitals will explore strategies for long-term sustainability of food security resources for their patients and the CBO partners, such as:
    - Institutionalizing commitments to addressing food security through internal policies that identify comprehensive strategies and hospital leadership
    - Planning for alignment with potential reimbursement opportunities
    - Ongoing financial contributions to the CBOs
    - Using evaluation data to inform project implementation.
    - Preparing and disseminating a report on initiative results, lessons learned and the collaborative experience

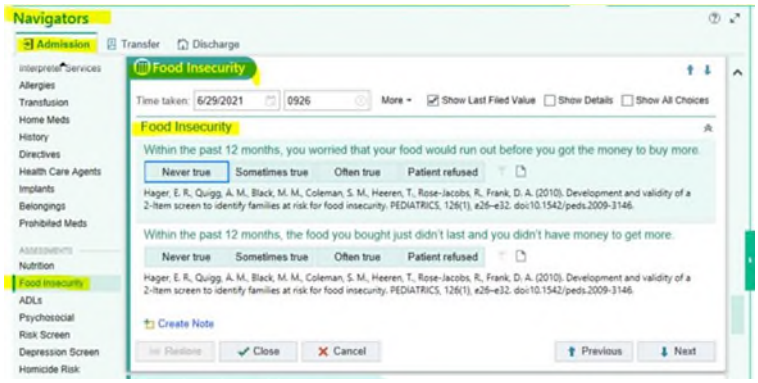
The strength of a regional approach to addressing the social determinants of health is critical. With the collaboration of the six nonprofit hospitals in the San Gabriel Valley, we aim to move the needle on issues that directly impact our most vulnerable residents. City of Hope's Director for Community Benefit serves as the co-chair of this effort.

In addition to supporting the Food for All collaborative, City of Hope created a multidisciplinary team from across the clinical and administrative teams to address food insecurity of our most vulnerable patients. Since forming in March of 2021, the Food Insecurity Taskforce has:

- Assessed prevalence of food insecurity of patients
- Established a food pantry and supported a food drive that collected thousands of pounds of nonperishable food items to be given to identified food insecure patients upon discharge
- Created workflows to ensure that patients identified as food insecure are connected with community food resources upon discharge

- Established a mechanism for identified food insecure patients to be assessed by Patient Financial Services for review of economic insecurity and offer of financial supportive services
- Offered a quarterly fresh produce distribution (Prescription for Produce) to our self-identified financially and food insecure patients.

There has been an effort, across health care, to be responsible for addressing the social needs of patients. At City of Hope we have viewed this as an opportunity to develop sustainable pathways that will ensure that patients are given connections to the resources they need to heal without worrying about where their next meal comes from. Additionally, we are creating a larger platform for addressing three other social needs: housing, financial and transportation insecurity. It all started with the work being established with the Food For All program. It is important to note the significance of how a regional approach to addressing social determinants of health, can influence how we provide comprehensive and compassionate care within our own walls. We are grateful for the partnership both internally and externally, LA Regional Food Bank and Seeds of Hope, Health Consortium of the San Gabriel Valley and the SPA3 Hospitals collaborative for their incredible support of bringing programming, like this, to people in need.



EPIC integration of the two Hunger Vital Signs Food Insecurity questions.

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 Community Benefit Advisory Council (CBAC) members review all the applications and make the selections for both the Healthy Living and Kindness grant programs. Council members also conduct site visits of Healthy Living grantees. Not only is it rewarding to help local organizations, but these groups provide City of Hope with more insight into the needs of vulnerable local populations. They also teach City of Hope about ways to support community efforts that tackle health disparities in culturally appropriate and specific ways. Throughout the funding period, City of Hope continues to support these organizations by providing technical assistance and networking opportunities. To learn more about the Healthy Living Grants click here.

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

Healthy Living Grant

During Fiscal Year 2021, 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 2021 Healthy Living Cohort included a diverse slate of awardees that spanned the Greater Los Angeles and Orange County regions. These impressive organizations are: Rainbow Labs, Glendale Unified School District, Orange County Buddhist

Church, El Monte Union High School District, National Coalition fo 100 Black Women – Los Angeles Chapter,

Promotors for Better Health, and the Global Federation of Chinese Businesswomen – Greater LA Chapter.

Their programs are described below:

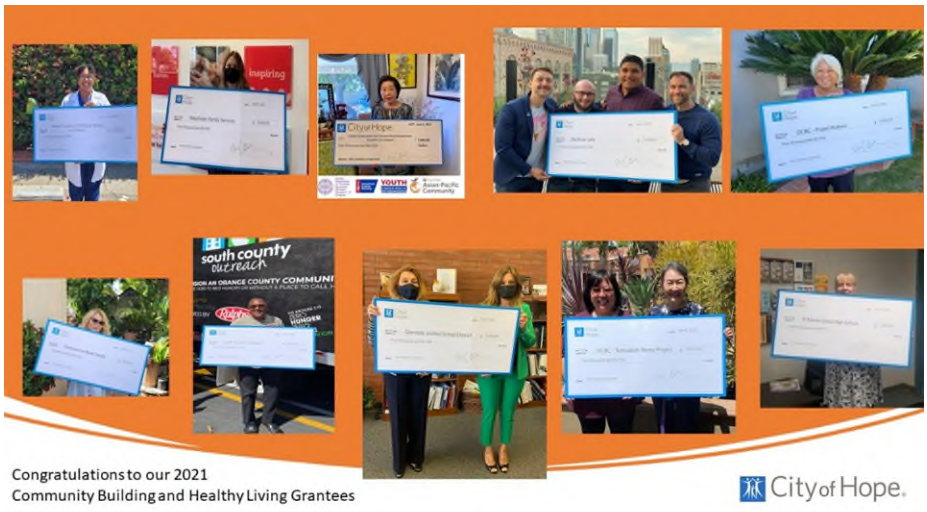
Rainbow Labs**. Summer Mentoring Program for LGBTQ+ Youth** will be acting on the power of mentors to address mental health. They are launching a nine-week pilot program starting June 2021. 50 LGBTQ+ youth pair with 10 mentors for a summer-long afterschool program. Youth will meet weekly with their peers and a mentor for formal activities, such as utilizing their storytelling power and an accelerator program offering opportunities for youth to engage with LGBTQ+ professionals. Mentors will also offer informal time for one-on- one support to the unique needs of their mentees. All of those selected to mentor will undergo extensive trauma-informed, youth development, and LGBTQ affirming training.

Glendale Unified School District**. GUSD Student Wellness Services** are focused on increasing the emotional and physical well-being of GUSD students and their families though the implementation of supportive mental-health and wellness topics/counseling via remote programming. Recognizing the intersections between hunger and mental health, GUSD School Wellness Services will also provide food and food resources to the students who enter their program.

Orange County Buddhist Church. **Project Kokoro Senior Crafts Class** will address issues that are prevalent with the Japanese American senior community such as, isolation, decreased stimulation and decrease in personal interaction outside of their homes. Through the craft classes they will encourage hand/eye coordination, problem solving, creating express and project completion. Additionally, they will provide discussions on topics of concern to the seniors, as well as current issues that will increase socialization and sharing of stories. To stay active, physically, they will offer gentle exercise and movement activities. Ultimately this will result in reduced social isolation, increased interpersonal interaction and the promotion of critical thinking skills.

El Monte Union High School District**. Burger Swap** will encourage students to change their burger eating habits by providing a plant-based burger choice in their cafeteria. Students will participate in the awareness by developing a social media campaign, via PSAs, to will convince teens that plant-based burger options are an easy swap for their favorite beef patty meals. Students will also showcase the benefits of meatless burgers beyond saving the world and reducing their carbon footprint, or capitalizing on some student's interests in health eating, environmental sustainability and humane treatment of animals.

National Coalition of 100 Black Women – Los Angeles Chapter**. Cancer Health Disparities Against Black Women** recognizes that access to cancer treatment and prevention programs has not been equal for African Americans living in urban areas. This program will reach out to Black women, living in LA District 10, providing them educational materials, programming and support needed inform and empower while on, and after, their cancer journey.



Promotors for Better Health**. HPV + COVID-19 Vaccine Program** will use a combination of a promotora model and the co-design process to create health education materials that will increase HPV and COVID-19 vaccination rates in the Latino communities in Los Angeles and the Inland Empire. The promotora model utilizes lay community health workers to target often hard-to-reach populations, traditionally excluded racial/ethnic groups and other medically underserved communities. The co-design process stresses the importance of community input and review and aims to draw on diverse perspectives by actively engaging people with lived experience in program design.

Orange County Buddhist Church**. Tomodachi Bento Project** will address three main goals: food insecurity, mental health and healthy living of socially isolated/homebound Japanese senior citizens residing in Orange County. To address the food insecurity, meal packages that require only microwaving or boiling water will be delivered with each bento lunch. The meal packages can provide four to five additional meals for approximately 70 seniors. The social isolation that often leads to loneliness, anxiety and depression among seniors will be mitigated through the 10-20-minute weekly in-person visits and monthly check in calls. Participants will also be invited to participate in a weekly senior program called, Stretch and Munch, giving them an opportunity to engage with others and to take part in a gentle exercise program.

Global Federation of Chinese Businesswomen – Greater LA Chapter**. Recovery, Resilience and Reconnection for Hope** will focus on increasing prioritization of cancer health awareness to empower and support communities during and after the pandemic through an Asian symposium and youth conference. An array of creative approaches will be used to reach their targeted community, which will include: simulcast translation in Chinese, Korean and Vietnamese, Youth cancer health ambassadors who will provide first-hand accounts regarding their cancer journeys, conference will be broadcast via Zoom, YouTube and Facebook, ACS Youth Cancer Health Ambassadors will lead the efforts to create social media public health and engagement campaigns, care team navigators will connect participants with needed community health resources and classes.

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.

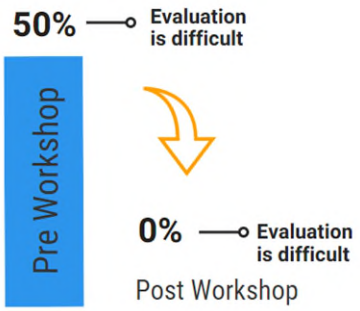
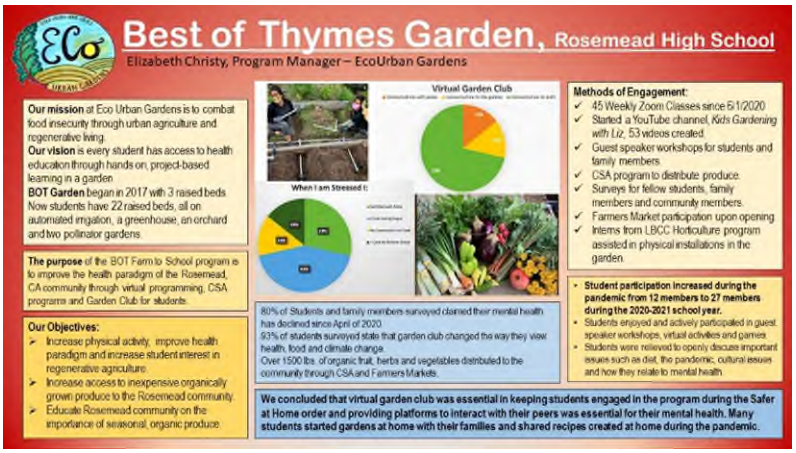


Figure 13. Changed belief in difficulty in conducting program evaluation. February 2022, Evaluation Workshop.

City of Hope's CBAC members will conduct site visits later in the year for each grantee and provide feedback where necessary. Ultimately, this grant program is about building community and capacity around efforts that support health and wellness in our service area. Our grantees overwhelmingly raised their own belief in their ability to conduct program evaluation. 50% did not believe that evaluation was difficult at the onset of the training. By the end, minds were cultivated and strengthened, and not one participant felt that evaluation was difficult (Figure 13). This is a testimony to the work we do to build their capacity and to ultimately tell their story as a means to leverage future support and to sustain the changes that they sparked in their own communities.

At the end of the funding cycle when new grants were awarded, the 2020 grantees participated in a half-day conference, where they shared their program results with the community and acted as mentors to the new round of Healthy Living Grant recipients. In June 2021, the eight 2020 healthy living grantees shared their findings after a year of implementing programs during a virtual conference. All 2020 grantees made 15-minute

presentations and held a virtual poster session. While the programs varied from cancer support to community gardening to building resilience during COVID-19, all shared a common theme: to improve the lives of the vulnerable living throughout our region. You can access their virtual poster session via our [Community Benefit webpage](). Below is an example of one particular program that has revolutionized their school, the Best of Thymes Garden at Rosemead High School. Breathe SoCal showed that even in COVID-19 restrictions you could deliver important lifesaving info for our community members with lung disease.



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

Community Capacity Building Grants

During the grant review process, the CBAC members found that some proposals did not fit the critiera for a one-year project, yet these proposals are worthy as they meet the specific needs of the local vulnerable community. To address this, the council created a new funding category called the, "Community Capacity Building Grant." City of Hope also awarded **Community Building** grants for organizations whose work reflects and identified need but do not fit the parameters of the Healthy Living Grant. This year we are pleased to announce the **2021 City of Hope Community Building** grant recipients:

South County Outreach. Their Hunger Prevention (food pantry) program boasts a "Client Choice" model, whereby clients are able to "shop" the market's shelves as they would a typical grocery store. However, due to COVID-19, they have temporarily amended this model, allowing for clients to preselect foods based on preference and dietary restrictions, and staff and volunteers shop the market for each client individually. This allows clients to remain in their vehicles and retrieve food curbside, as they might at any local grocer or chain store. This model helps prevent food waste and increases dignity among the clients—remaining sensitive to the cultural food preferences in which many of our clients have expressed interest. Every household can visit monthly for a week's worth of free groceries for every member of the household.

Wayfinder Family Services**.** Wayfinder Family Service's Special Education School is one of the only state-certified, nonpublic schools in Southern California to teach individualized curricula to elementary and high school age youth (5-22) with severe disabilities, including vision loss, autism, hearing impairment, Down syndrome, seizure disorders and cognitive delays. The Capacity Building Grant will support Wayfinder Family Services in creating COVID-19 classroom structures that will continue to deliver important programming related to life skills, positive self-image and increased independence.

COVID-19 has become a major factor in the community's ability to thrive during these uncertain times. Both **South County Outreach** and **Wayfinder Family Services** has received the $5,000 grant to live out their vision and serve communities that are especially vulnerable because of the impact of COVID-19.

COVID-19 Relief Community Building Funds

Much like FY2020, as FY2021 progressed, we realized that we would, again, have a surplus of funds given

many of our programs went online. This virtual transition provided us with more dollars available for giving. We identified a savings of $30,000 that we could use to address important needs of local organizations who were serving the vulnerable. The following represent seven organizations that the CBAC selected to receive COVID-19 Relief Community Building Funds:

1. **Community Resource Center for Aging**

   The Community Resource Center for Aging is a free, community-based resource for community members who may require or be interested in referrals, resource guidance or in some instances, basic case management services, in order to navigate myriad of aging-related circumstances. This supports the funding of additional additional language ability, such as Armenian- and Spanish-speaking resource specialists to address the diverse needs of their local communities.

2. **American Cancer Society**

   ACS are partnering with health systems across their target counties in 2021 to:
   - Provide technical assistance and resources to rapidly increase HPV vaccinations and breast, lung and colorectal cancer screening rates.
   - Address disparities and reduce barriers to screening exacerbated by the pandemic.
   - Implement evidence-based interventions.
   - Create learning communities to foster best practice sharing.
   - Use data to drive all aspects of the project.
   - Execute sustainable and meaningful process improvement.

   The COVID-19 pandemic created devastating disruptions in cancer screenings, and it is our aim to restore or even improve prepandemic cancer screening routines and prevent later stage cancer diagnoses.

3. **Azusa Rotary Club**

   Support the Azusa Rotary's Interact Clubs. The Interact Clubs extend Rotary's mission to young people ages 12-18, helping them to develop leadership skills and discover the power of *Service Above Self.* Rotary Club members serve as mentors and guide Interactors as they carry out community projects. Launching Interact Clubs at the two high schools is of particular importance as youth programs need to expand in the City of Azusa.

4. **Alta Med Health Services**

   Support the creation of their new initiative, the Youth Organizing Institute (YOI). As part of the Youth Community Action Program within AltaMed's Institute for Health Equity, a youth organizing group of approximately 20 youth of color recently conducted a community-based participatory research project and found different structural barriers and systemic inequities in accessing mental health resources. In addition, the war on drugs disproportionately impacted youth of color; indeed, its impacts are still felt today. Instead of having mental health and social services, our youth of color are criminalized. Given the findings of this youth-led project and the receptiveness of the participants for this work, AltaMed is embarking on the creation of the YOI. The YOI will serve as a vehicle for long-term youth engagement in Los Angeles.

5. **San Gabriel Consortium on Homelessness**

   Funding will support the convening of homeless services providers in the San Gabriel Valley. The consortium includes nearly 400 participating agencies. The consortium has plans for continued growth as the broker of services and information relating to homelessness in the San Gabriel Valley.

6. **Seven Generations – United American Indian Involvement, Inc.**

United American Indian Involvement Inc. is the largest provider of human and health services for American Indians/ Alaskan Natives (AI/AN) living in the County of Los Angeles. Funding supported their Annual American Indian Day on September 11, 2021. This is an annual gathering of the indigenous community where there will be cultural and health programming. They will have extensive COVID-19 prevention as well as vaccination education.

7. **Illumination Foundation – Orange County**

Funding to support ongoing recuperative care services for the unhoused in Orange County. Illumination Foundation has innovated a unique program designed specifically to care for homeless patients who do not have a place to recuperate after ER or hospital discharge. This program ensures that patients will have a place to stay off of the streets to properly recover and prevent a return to the emergency room. As a result, the Illumination Foundation Recuperative Care Program greatly reduces the cost to hospitals by taking homeless clients from hospital beds and into their care. This effective model of care shows outcomes with 50% fewer readmissions within 90 days of being discharged to Recuperative Care than patients who are discharged to their own care.

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 2021, two employee resource groups and one individual employee were awarded grants to support their amazing ideas that will continue to resonant in the lives of every person who has been touched by their work.

Women in Stem VirtualForum

Women's Professional Network

Women's Professional Network (WPN) connected young women to women currently in STEM (science, technology, engineering, mathematics) careers. Promoting opportunities that exist in the STEM field to underserved communities specifically discussing the disparities with young women of color from the surrounding areas. There was open dialogue about how they can assist and change their communities by perusing these fields and giving back. WPN promoted the event to female high school students within the San Gabriel valley neighboring cities of Duarte, Monrovia, South El Monte, Baldwin Park and Pasadena. Figure 14 shows how the program impacted participants confidence to pursue a career in STEM.

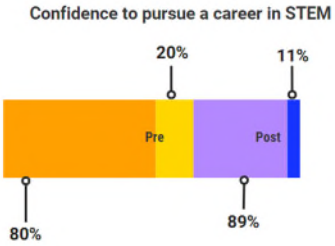


Figure 14. WPN Pre/Post Test Results: Confidence to pursue a career in STEM

Mental Health Virtual Juneteenth Celebration
Connecting People of African Descent for Hope

Mental health has become more recognized as a disease instead of a stigma. Many factors contribute to include poverty and socioeconomic status. As African Americans are more likely to live in poverty, they are twice as likely to report psychological distress and are overall 20% more likely to suffer from mental illness. (US HHS OMH, 2020; ADAA, 2020). Effects of COVID-19 have magnified factors that have an already increasing impact on mental illness and wellness among Blacks Americans (ADAAA, 2020). Some of these factors include socioeconomic status, health disparities, and racial injustice. The Juneteenth Celebration provided awareness and real-life tools for enhancing the mental health and wellness of the black community at City of Hope and the catchment area. It is also designed to bring awareness of the burdens African Americans carry and challenges faced daily, both in and out of the workplace, while simultaneously celebrating heritage and culture.

Little Free Library
Maribel Diaz

The "Little Free Library" model is self-sustaining — the premise is general literacy promotion by having a forum where community members have a place where they can take a book for free but also donate literature. While the intent is to commit, via this grant, to sustain the promotion of health and awareness literature to address chronic disease (specifically diabetes and cancer), the Little Free Library will remain in existence inperpetuity since the infrastructure and model is already set. After one year of the Little Free Library existence, Maribel Diaz will continue to collaborate with City ofHope Physician Relations Liaisons and Community Outreach Team, Center of Community Alliance for Research & Education and the SFS Library if they are willing (and interested) to continue to donate literature/education material for the effort. What this Little Free Library did is bigger than erecting a little house for books. This Little Free Library built community. Community members share their thoughts below.

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, Endocrinology & Metabolism to Enterprise Support Services to 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 engaged in during Fiscal Year 2021.

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

Savoring Hope Cooking Classes

One such collaboration are the Savoring Hope cooking classes. These interactive classes are led by City of Hope's Executive Chef Christian Eggerling and Dr. Susan Nyanzi, Dr.Ph., MCHES® our nutrition educator. During the Fiscal Year 2021, 1,556 community members (both City of Hope staff and members of our global community) participated in 18 different online cooking demonstration classes. 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 recreating healthy meals (Figures 15,16,17). We know that when you build a person's confidence, it can change their belief and result in behavior change.

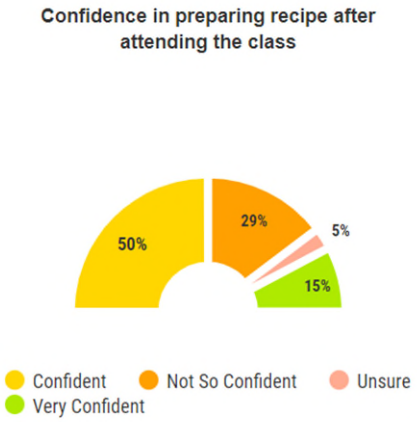


Figure 15. Confidence in preparing recipe

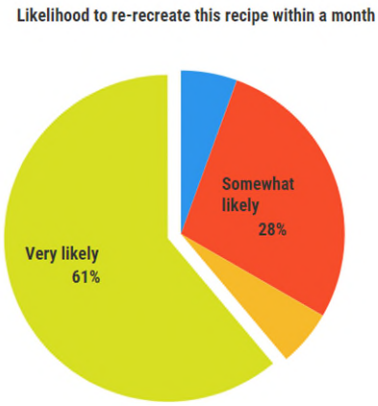


Figure 16. Likelihood to re-create recipe

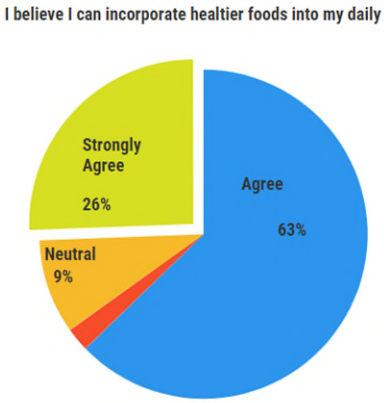
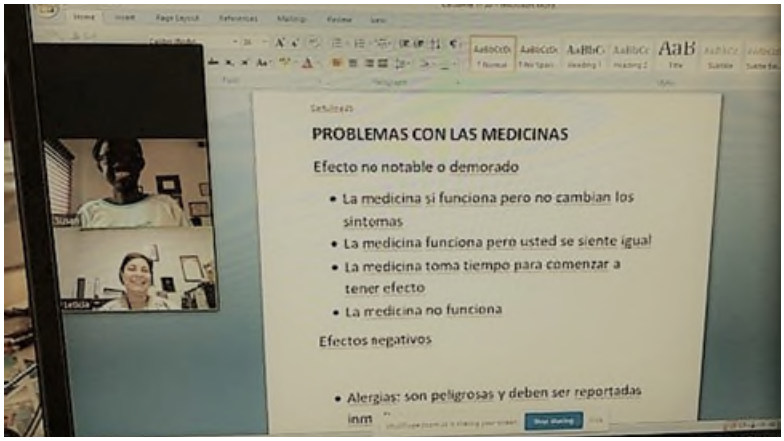


Figure 16. Belief in incorporating healthier foods in to diet

Healthy Lifestyles

Launched in 2019, Nutrition for Healthy Lifestyles specifically target those living with chronic disease to help manage their conditions, including cancer prevention strategies. These participants require ongoing support for improved physical and mental health. Six community organizations were trained in FY 2020 to deliver Lifestyles program curriculum. The intent has been for each trained leader to implement the program in their respective communities, and doing so with the proper cultural context and languages. During FY 2021 the program was delivered virtually by the Montclair Clinic and Set



Montclair Clinic Virtual Healthy Lifestyle Class. City of Hope hosted the virtual platform.

for Life Inc. Montclair clinic services a monolingual Spanish speaking clientele. Set for Life Inc. is a stand alone nonprofit connected to the largest and oldest African American church in Monrovia. Between October 1, 2020, to September 30, 2021, 20 community members completed the six-week educational program. While many focus on the total numbers that participated in the program, we look at the qualitative impact that the content and facilitators had on the partcipants. Below are some comments that the incredible community members had to say:

- *I have Diabetes and my blood sugar drop from 400 last week to 300 this week*
- *Amazing class.*
- *Every time I listen to the class, I learn something new*
- *We appreciate you*
- *I like that we can open up and talk*
- *Feels like we are somewhere else*

Garden of Hope

This second year of COVID-19 did nothing to dampen the spirits of all who participated in the events and programs at the Garden of Hope. Something incredible happens when you stick your hands in the ground and plant things. Many of the lessons we learn in life are exemplified in a gardener's experience. When you plant a seed of hope or a sunflower, you need to cultivate it by watering and nourishing it. You have to protect it and rely on the support of others to help with its continued growth. Our Garden of Hope has continued to be a gathering place for the community, both internal and external to City of Hope. While we saw fewer patients this year, we did see more City of Hope employees, patient caregivers and community members stop by. While COVID-19 did keep us from hosting in-person programs, we were still

able to allow a limited number of Garden Sprouts in to maintain the joy our garden provides. On most weekends during the summer of 2021, you would find at least eight people working in the garden. It was amazing. When asked why they would be there, they said it was because it helped them out to be able to connect with the community in an outdoor setting. The connection between good mental health and gardening has been well established for years and we are delighted to be able to contribute to the health and wellness of our closeknit community. As mentioned earlier, while we were not able to hold our larger educational events in person, our AmeriCORPS volunteer, Alan Melgoza Calderon, created amazing programs that allowed people to continue to learn and grow in their knowledge of urban farming. Our Garden Sprouts were nourished with age old wisdom regarding pollination and pollinators, composting, and seeding. We are all so proud of the work that goes on in the Garden of Hope and the community we have built because of it. Stop by for a visit, it is open 24/7.

Roots of Hope

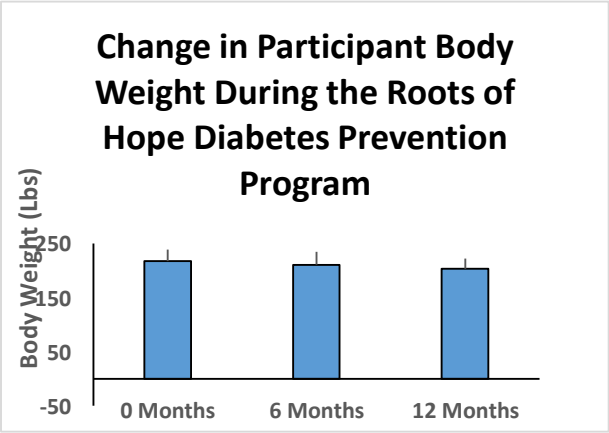
Through our partnership with Seeds of Hope, a ministry of the Episcopal Diocese of Los Angeles, Roots of Hope educates church members with prediabetes and those at risk for type 2 diabetes on what they can do to lower their risk. Evidence suggests that people with diabetes have significantly higher risk for many forms of cancer, with type 2 diabetes and cancer sharing many risk factors, including poor diet and lack of exercise. Thus, Roots of Hope's nationally Centers for Disease Control -certified Diabetes Prevention Program (DPP) encourages participants to adopt sustainable behavior modifications that include healthy eating and physical activity. **Despite the challenges of COVID-19 this past year, we transitioned to delivering much of the program virtually, expanding from 15 participants across two sites to 212 participants across seven sites by March 2021**. This is extraordinary growth during an unprecedented year and while technology enabled us to expand our reach through virtual sessions, this growth can largely be attributed to the groundwork laid in recent years to expand enrollment through mutually beneficial community partnerships.

Diabetes Prevention Program (DPP) grocery shopping field trip.

We continue to build capacity by looking beyond the episcopal community. **This past year, we established a new partnership with Claremont Graduate University to build a regional approach and secular branch of the program.** This collaboration will increase the number of lifestyle coaches and locations to which the

program will be delivered as CGU covers the Inland Empire, Riverside, and San Bernardino; City of Hope is largely focused on the westside and downtown LA, and will soon expand to south LA. CGU brings expertise in evaluating the program not only from a medical standpoint, but in looking at how social determinants of health determine participant engagement and their understanding from the sessions. It is often challenging to evaluate outcomes in lifestyle modification programs due to a number of external factors, such as finances, social support and safe spaces, to name a few. CGU will help us explore these potential influences that may affect why someone may eat healthier.

The outcomes for this intervential program are significant, too (Figures 17,18, 19). The pandemic clearly created barriers to success in the program and little improvement was seen in the four cohorts that were run predominantly in 2020/2021. However, it is very likely that participation in the program minimized some of the adverse effects of the pandemic on weight gain, emotional eating and other risk factors for type 2 diabetes like stress/adequate sleep. Few of the participants experienced significant weight gain so it is possible that the DPP helped these individuals to remain at a stable weight, despite the anxiety and other challenges of the pandemic.



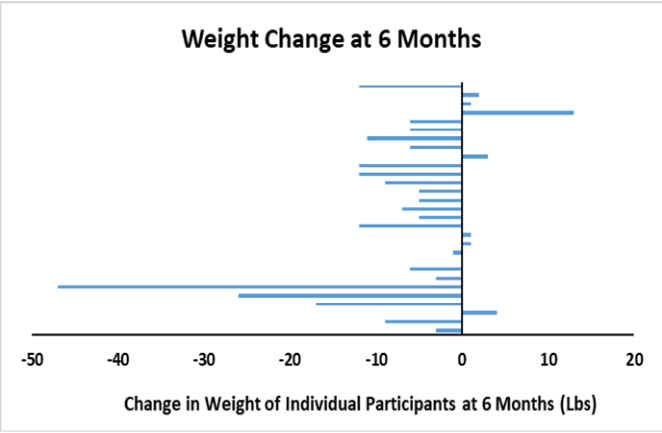


Figure 17 and Figure 18 DPP Outcomes for FY 2021

There were slight decreases in the HbAlC over the pandemic participants, too.

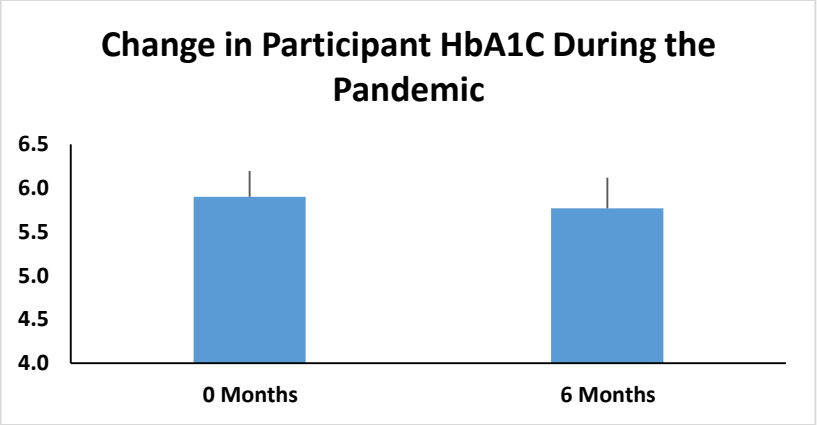


Figure 19. DPP Outcomes for blood sugar levels. FY2021

Cancer Care Is Different Advocacy

Providing health care for cancer is different than for any other disease. Cancer is now recognized not as one condition, but as multiple conditions. With the emergence of genomic sequencing technology, cancer may soon be viewed as potentially hundreds of conditions. That means that cancer is a highly personal disease that differs from individual to individual. However, hospitals and physician groups have widely varying levels of experience in diagnosing and treating the various types of cancer, much less how those types may manifest uniquely in individuals. Community oncologists can see up to 30 patients in a day, each with a different kind of cancer. It is simply impossible to keep up with the pace of innovation across the entire cancer care spectrum. Expertise matters, too, as narrow networks assume that for each cancer patient, the needed expertise is ubiquitous. This may be the case for some common, early stage cancers. But, for other rare or complex cancers, such as acute leukemia or other blood cancers that require highly specialized interventions, a limited network may deny a patient access to the expertise

"The need for access to the proper expertise is heightened by the reality that cancer is a rapidly evolving field, one that requires ongoing access to the most recent therapeutics and technology. The consequences of limited or delayed access to state-of-the-art diagnostics are significant, leading to misdiagnoses that can often mean unnecessary exposure to toxic chemotherapy agents, suffering or avoidable death," said Joseph Alvarnas, M.D., a hematologist-oncologist who serves as vice president for government affairs at City of Hope.

available at a comprehensive cancer center. Many of these patients lose their lives or live a shorter lifetime of chronic illness, pain and suffering. When it comes to cancer survival, access to specialists may be everything. When patients with rare or complex cancers have access to care at a comprehensive cancer center, they often experience better outcomes at lower costs. Research has documented significant differences in outcomes, including survival, if a patient is seen at a community hospital versus a National Cancer Institute-designated comprehensive cancer center.

City of Hope, along with their partners in advocacy: American Cancer Society – Cancer Action Network, International Myeloma Foundation, California Chronic Care Coalition, and the North Bay Cancer Alliance, are ensuring access to promising new innovations, experts specializing in various cancer types and advances in personalized, precision cancer treatments, which are all critical components in improving outcomes and saving lives. The Cancer Patients Bill of Rights outlines six key principles, proclaiming that cancer patients have a right to:

- Understand fully their diagnosis and be informed about treatment options in culturally appropriate and understandable languages
- Transparent and timely processes that ensure access to contracting oncology specialists, diagnostic testing and accurate interpretations of those tests
- Contracting cancer subspecialists who have expertise in the treatment of their subtypes of cancer when complex decisions are needed
- Medical treatments for pain management and other services that support their overall health
- Contracting National Cancer Institute-designated comprehensive cancer centers and leading academic medical centers for the management of complex cancers that require multiple experts or high-risk or emerging therapies
- Relevant clinical trials, medical research and cutting-edge innovation, including evidence-supported precision medicine

In August 2021, the California State Legislature adopted this first-in-the-nation Cancer Patient Bill of Rights.

Internal Partnerships

It is important to recognize the participation of the hardworking individuals who contributed to over 158 community education and support group events across this institution and in the vulnerable communities City of Hope serves. Because COVID-19 has shed a light on the disparities within our communities, there has been an incredible shift in the way City of Hope views it's responsibility to address equitably address those disparities. In January 2021, we welcomed our first-ever Chief Diversity, Equity and Inclusion Officer, **Angela L. Talton**. Talton leads the development of a vision and strategy for advancing DE+I and ensuring measureable accountability and commitment across the enterprise. She established City of Hope's DE+I strategy, mission and Strategic Implementation Roadmap in collaboration with administrative, research and clinical staff. City of Hope's diversity efforts include the establishment of a Diversity, Equity & Inclusion Governance Council. The Council of nine senior executives, were commissioned by President and CEO Robert Stone, in the fall of 2020, and is tasked with providing guidance and alignment on initiative recommendations regarding advancing contributions to health equity and community outreach, increasing the diversity of its workforce and suppliers, and ensuring an inclusive experience with supporting systems, policies and procedures. The council has been instrumental in providing forums and listening sessions to hear the voice of City of Hope staff and use that input to ideate multiple programs, initiatives and best practices to further City of Hope's diversity, equity and inclusion efforts. City of Hope has also brought greater diversity, representation and accountability, and a broader range of perspectives and ideas, to its executive leadership. The institution is working to expand its focus on leadership development, conscious inclusion, community outreach, education and engagement regarding diversity, equity and inclusion.

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

COMMUNITY BENEFIT INVESTMENTS

How Benefits Were Defined

The quantifiable community benefits provided by City of Hope in Fiscal Year 2021 are listed in Table 1. 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[10]	8,745,000
UNPAID COSTS OF MEDI-CAL[11]	72,304,756
OTHERS FOR THE ECONOMICALLY DISADVANTAGED[12]	0
EDUCATION AND RESEARCH[13]	126,193,358
OTHER FOR THE BROADER COMMUNITY[14]	4,261,008
TOTAL COMMUNITY BENEFIT PROVIDED EXCLUDING UNPAID COSTS OF MEDICARE	150,804,490
UNPAID COSTS OF MEDICARE[11]	155,728,167
TOTAL QUANTIFIABLE COMMUNITY BENEFIT	**306,532,657**

Table 1. Fiscal Year 2021 Quanitifiable Community Benefit

City of Hope also provided a wide range of benefits to our communities that is not reflected in Table 1 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.

[10] Charity Care includes traditional charity care write-offs to eligible patients at reduced or no cost based on the individual patient's financial situation
[11] 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
[12] Includes other payors for which the hospital receives little or no reimbursement (County indigent)
[13] Costs related to the medical education programs and medical research that the hospital sponsors
[14] Includes nonbilled 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 2021 investment of **$306,532,657** and reported on the strategies prioritized in our 2018 to 2021 Implementation Strategy Plan. The main focus areas of our Fiscal Year 2021 community benefit programs and services: **COVID-19 Responding to the Community Call for Vaccine Access; Food Insecurity; Healthy Living, Community Capacity Building, and Kindness Grants; Greater San Gabriel Valley Hospital Collaborative; Cancer Care Is Different/Cancer Patient Bill of Rights** 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. Our hiring of a chief diversity, equity and inclusion officer will assist us in being intentional when planning programs and involving a more diverse group of individuals in delivering community benefit programs and services.

Community Building Grant recipient in support of the 20th Annual American Indian Day, September 2021

This document represents our efforts at addressing the community prioritized 2021-2023 Implementation Strategy during the FY2021. The designation of the Department of Community Benefit as an institutional priority and placing it within the Office of Diversity, Equity and Inclusion, has heightened the

sense of urgency to create strong, useful programs that meet the needs of the vulnerable populations in our service area. We will continue to view existing and future programs through a lens that places vulnerable populations at the forefront of the planning process. We are confident this institutional commitment will foster more collaboration among City of Hope employees and our community stakeholders. Prioritizing Community Benefit allows for a more strategic focus on issues that are critical to our service area, while creating pathways for health and healing.

Appendix A
2019 Needs Assessment Tools

Primary Data Collection Participants

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

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

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

Primary Stakeholder Interview Questions

Interview Questions and Notes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

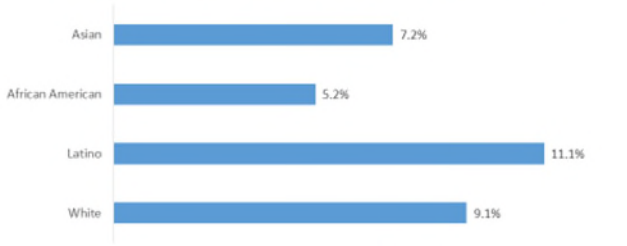
5. Would you like to add any additional information?

Community Voice Summary

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

Increasing concern about mental health

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



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

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

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

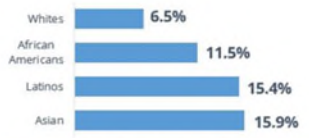
Stress and depression can be exacerbated by...
- Economic instability
- Social isolation

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

Health Care is increasingly unaffordable and inaccessible

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

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



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

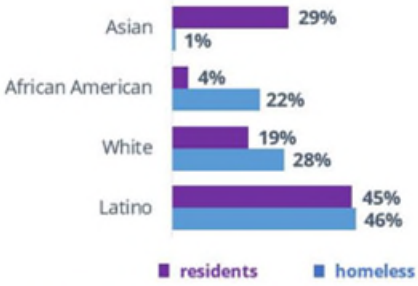
% of SPA 3 residents who did not have a usual place to go when sick or needing health advice in 2018[10]

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

Housing insecurity and homelessness are at crisis levels

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

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



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

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

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

Economic and food insecurity are straining families and systems

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

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

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

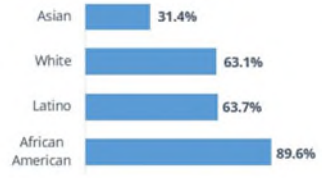
"I see the communities with a tremendous financial strain – working class families and seniors on fixed incomes."

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

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

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

Overweight or Obese in SPA 3 in 2018[18]



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

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

Deepening understanding of the role of social and environmental determinants.

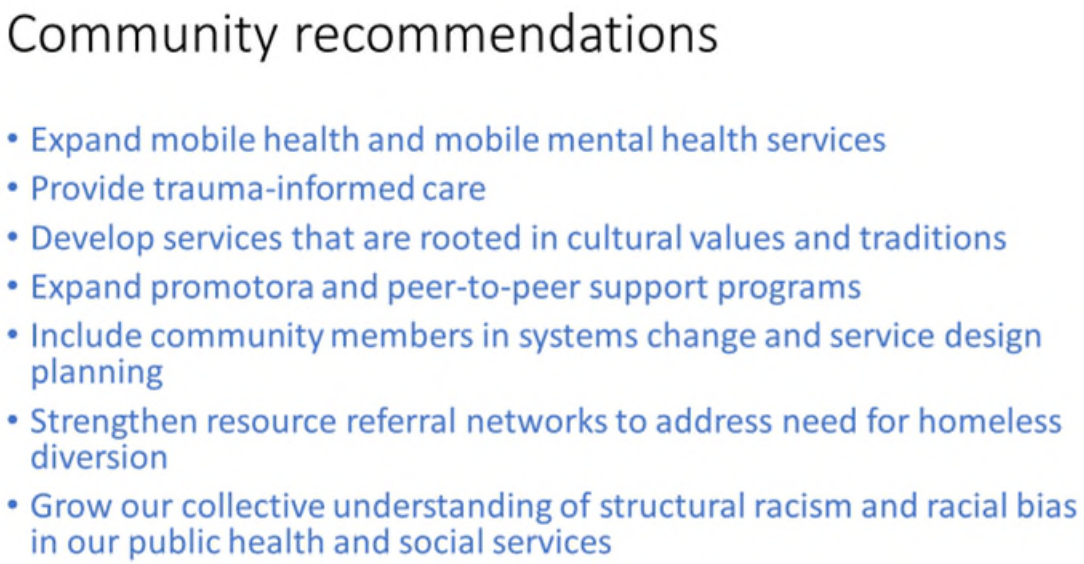
Emerging efforts are looking at disparities and equity issues.

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

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

Some populations are especially vulnerable

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



Community Resources

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

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

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

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

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

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

Appendix B
Financial Assistance Policy

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

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

City of Hope

Provision of Patient Assistance Items to Patients Who Demonstrate Financial Need

I. PURPOSE / BACKGROUND

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

II. POLICY

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

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

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

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

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

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

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

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

G. Assistance will not be reported as charity care.

III. PROCEDURE

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

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

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

Related Policy:
1. Charity Care

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

Appendix C
Charity Care Policy

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

City of Hope

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

Charity Care Policy

I. PURPOSE / BACKGROUND

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

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

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

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

II. POLICY

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

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

8/7/2019 10:52 AM

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

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

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

F. **Income Eligibility:**

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

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

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

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

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

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

1. **Guiding Principles:**

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

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

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

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

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

2. **Patient Application Process:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. **Public Awareness:**

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

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

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

O. **Collections:**

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

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

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

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

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

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

P. **Oversight and Board Responsibilities:**

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

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

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

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

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

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

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

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

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Attachment A

CITY OF HOPE
CHARITY CARE ASSISTANCE
FPL GUIDELINES

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

2019 FPL GUIDELINES

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

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

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Attachment B

City of Hope Charity Care: Methodology for Identifying LEP Populations

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

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

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

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

1. Spanish
2. Traditional Chinese

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

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Attachment C

City of Hope Charity Care Policy: List of Providers

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

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

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

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