City of Hope®

2022 - 2025

Implementation Strategy

Contents

Executive Summary

The service area of City of Hope is richly diverse in language, culture, religion, race 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, language spoken at home, racism and cultural biases — can increase or decrease the risk of preventing and treating potentially life-threatening illness. Serving our community and providing programs and services to our residents designed to reduce risk and improve access to health care are paramount to our success as a nonprofit hospital. One way to ensure we do this is by developing a strategy to address the main opportunities identified in our 2022 Community Health Needs Assessment (CHNA).

The Internal Revenue Service, through its 1969 Revenue Ruling 69-545, describes the Community Benefit Standard for charitable tax-exempt hospitals as helping the community in a way that relieved a governmental burden and promoted general welfare. In addition, the 1994 California Community Benefit Legislation (SB 697) required private nonprofit hospitals to assume a social obligation to provide community benefits in the public interest in exchange for their tax-exempt status. As part of this obligation, tax-exempt hospitals are directed to conduct a CHNA and develop an implementation strategy every three years. City of Hope has undertaken a CHNA as required. The CHNA is a primary tool used by City of Hope to determine our community benefit plan, which outlines how we will give back to the community in the form of health care and other services that address unmet community health needs. This assessment incorporates components of primary data collection and secondary data analysis that focus on the health and social needs of the community benefit service area.

For this recent CHNA, City of Hope collected primary data from focus groups, interviews and surveys. Secondary data was collected on the leading causes of death, illness, social determinants of health and deeper causes of health inequality. Our Community Benefit team took this data to community stakeholders and asked them, “What does this mean to you? How do you believe that these issues are impacting you and your community? What ideas for solutions do you have for addressing these concerns?” The stakeholders engaged in lively discussion and then prioritized the issues as follows:

1. **Social Determinants of Health – (for example: housing, food, economic insecurity) Addressing the root causes of poor health outcomes and disparities that are often systemic**
2. **Health Access – Removing inherent biases that prevent people from seeking and receiving quality care**
3. **Mental Health – Supporting emotional health to create resiliency and improved well-being**
4. **Cancer – Creating a safe and trusting bridge to cancer education, prevention and treatment services/care from diagnosis to treatment**

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

We encourage you to take your time reading this plan. Should you have any questions regarding how we plan to implement it, please feel free to contact our Community Benefit Department. We can be reached at CommunityBenefit@coh.org.

Who We Are and Whom We Serve

City of Hope is a world-renowned comprehensive cancer center and independent biomedical research institution near Los Angeles that offers a unique blend of compassionate care and research innovation that simply can't be found anywhere else. Here, doctors' partner with scientists to transform laboratory breakthroughs into treatments that outsmart cancer, diabetes and other life-threatening diseases. Compassion is at the heart of our approach. We care for the whole person, not just the body, so life after cancer can be rich and rewarding.

We have a rich history that is unparalleled. From two canvas cottages in a desert to a comprehensive cancer center in 100 years, our technology has led to the development of numerous breakthrough drugs, including the four most widely used cancer treatments — Herceptin, Erbitux, Rituxan and Avastin. Additionally, City of Hope researchers pioneered the application of gene therapy and blood stem cell transplants to treat patients with HIV and AIDS-related lymphoma. City of Hope has three manufacturing facilities on campus that meet strict GMP (good manufacturing practice) standards and help turn breakthrough discoveries into lifesaving therapies. Last year, City of Hope conducted more than 800 clinical trials, enrolling more than 5,000 patients. And City of Hope holds more than 450 patent portfolios and submits nearly 50 applications per year to the Food and Drug Administration for investigational new therapies.

Service Area

City of Hope's main campus is in Duarte. City of Hope's primary service area are portions of Los Angeles, Orange, Riverside, San Bernardino and Ventura counties. Most of our patients come from Los Angeles County, and in particular, communities within Service Planning Area 3 (SPA3). City of Hope itself is situated in this Service Planning Area, which is included in its primary service area (Please see Figure 1 below). SPA 3 includes 34 cities including Alhambra, Altadena, Arcadia, Azusa, Baldwin Park, Claremont, Covina, Diamond Bar, Duarte, El Monte, Glendora, Irwindale, Monrovia, Monterey Park, Pasadena, Pomona, San Dimas, San Gabriel, San Marino, Temple City, Walnut and West Covina, among others.

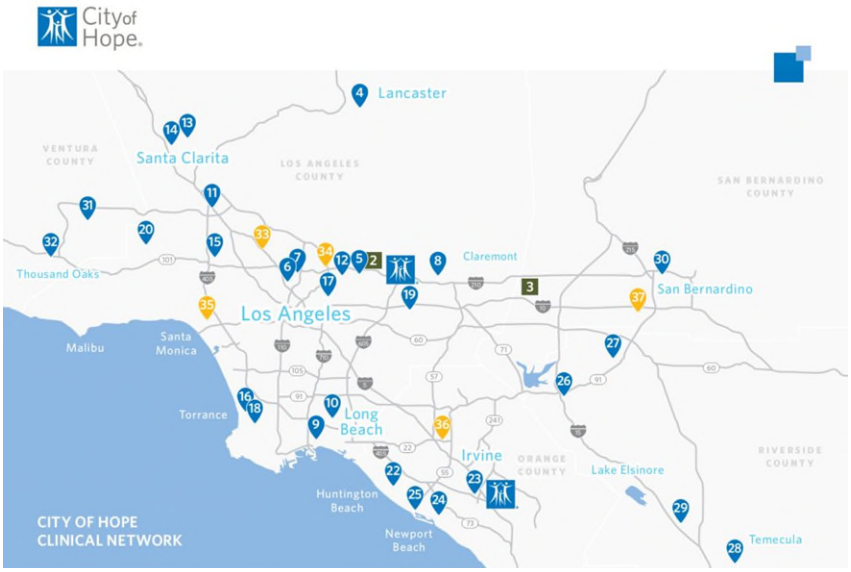


Figure 1. Service Area

Community Health Needs Assessment Findings

Secondary data analysis yielded 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.

The following criteria were used to identify significant health needs:

1. Size of the problem (relative portion of population afflicted by the problem)
2. Seriousness of the problem (impact on individuals, families and communities)

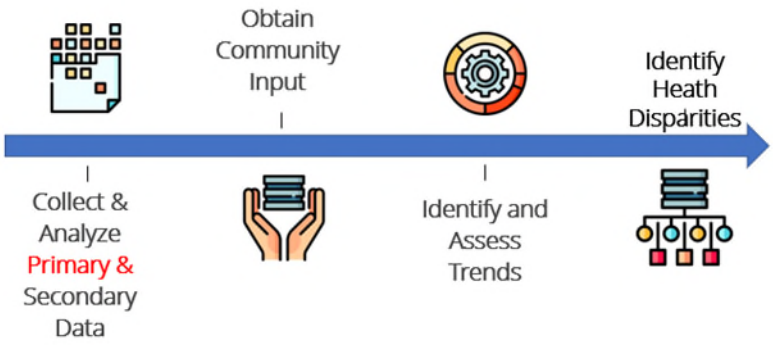
To determine size and seriousness, health indicators identified in the secondary data collection were measured against benchmark data, specifically California rates and Healthy People 2030 objectives, whenever available. Health indicators that performed poorly against one or more of these benchmarks 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

Based in the secondary data collection, 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 2022 CHNA report available on City of Hope's Community Benefit website. This year, between July and October 2022, we conducted a total of 4 focus groups (38 participants) and 38 key informant interviews with stakeholders, who either serve or represent the community, and wove them into the secondary data.



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.

Prioritization of Needs

The significant health needs identified in the process were prioritized with input from the community using the following criteria:

- Perceived severity of a health issue or health factor/driver as it affects the health and lives of community residents
- The level of importance City of Hope should place on addressing the issue

For this CHNA, we obtained primary data through focus groups, a community survey and interviews with key community stakeholders, public health and service providers, members of the medically underserved, low income, minority populations in the community, and individuals or organizations servicing or representing the interests of such populations.

City of Hope conducted 38 telephone interviews, which were completed during July to October 2022. Interview participants included a broad range of stakeholders concerned with health and well-being in the Greater Pasadena Area and in SPA 3 of the San Gabriel Valley who spoke to issues and needs in the community.

Stakeholder Validation of Prioritized Needs

CBAC member prioritizing health needs

Fourteen of our Community Benefit Advisory Council (CBAC) members met on December 7, 2022, 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 relation to seriousness, size of the problem (number of people impacted), trends, equity, feasibility, value, consequences of inaction, social determinants/root causes and effective strategies to address the 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 2023 Implementation Strategy.

The results were as follows:

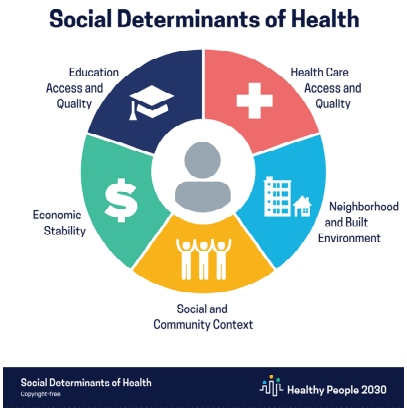
2022 Stakeholder Prioritized Health Needs

Rank	Health Needs
1	Social Determinants of Health
2	Health Access
3	Mental Health
4	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. According to the Healthy People 2030 definition of

Social Determinants of Health (SDOH), they "are the conditions in the environments where people are born, live, learn, work, play, worship and age that affects a wide range of health, functioning, and quality-of-life outcomes and risks."[1]. Our advisory council members emphasized that we need to "*look at the intersections of the SDOH risk factors in order to create solutions and make an impact in our vulnerable communities.*" With this being said, we cannot simply address one issue. Our strategy for the next several years will be to find those intersections, integrate the work, work more deeply with cross-disciplinary partners and create tangible deliverables. While the reader sees only four priority areas, with our work through the intersections, we are, in fact, addressing all eight. As one CBAC member suggested, "The *intersections are where the magic happens*."

No. 1: Social Determinants of Health (for example: housing food economic insecurity) – Addressing the root causes of poor health outcomes and disparities that are often systemic



COVID-19 shined a light on the disparities in a way that demonstrated not only the severity of the challenges our community members are facing but also the relationship between having an SDOH issue and poorer health. For example, the CHNA demonstrated that lower-income residents and communities of color in LA County had a disproportionate rate of death from COVID-19. Community members and leaders shared that during the COVID-19 pandemic, physical activity was limited. As one community leader explained, "Many people live in multigenerational homes, and there is not enough space for physical activity and getting outside. Many youth sports activities were canceled." Area residents also voiced frustration with limited safe "walkable spaces and parks" for physical exercise. The intersection here is the relationship between exercise and chronic disease.

Intersections

Looking at the intersections to effectively address the SDOH challenges of our most vulnerable communities, the CBAC members suggested:

[1] Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [date graphic was accessed], from https://health.gov/healthypeople/objectives-and-data/social-determinants-health. Retrieved 12/23/22.

- "Let's partner, partner, partner and do not reinvent or work in silos. We need a network of safety to meet basic needs. Include in the partnership a collaboration with a specialized care provider."
- "Reflect on what was exposed, e.g. isolation, lack of access, mental health, food insecurity, unaffordable living…put measures in place to say that we have learned and are prepared as we look ahead."
- "Partner with agencies that can help families navigate access to financial resources. For example, provide a space on a school campus for a person from an agency to help with educating famiilies about resources and helping them to apply for those resources."

No. 2: Health Access – Removing inherent biases that prevent people from seeking and receiving quality care

In the last CHNA, Health Access was the No. 1 issues that our stakeholders wanted us to focus on. More specifically the institutional racism and unconscious biases preventing people from seeking care. As you can see, the issues surrounding people seeking and receiving quality care still have roots in racism and unconscious bias. Many community leaders spoke about the need for medical professionals to be trained in culturally appropriate "bedside manner." Additionally, all materials and paperwork should be made available in multiple languages and with terms and vocabulary that are culturally relevant. The emphasis on providing high-quality, culturally appropriate services in many languages relieves the burden on family members who often do not know how to accurately translate medical terms. Community members and leaders emphasized the need for providers who understand and are known by the community. Cultural mistrust of medical systems can also contribute to reluctance to access health care for many communities.

Community members commented on the impact of social stigma and bias in accessing medical care. Residents fear mistreatment in medical settings based on race, sexuality, body type and weight, and gender expression. As one service provider shared, "Implicit bias and racist systems are something that health systems need to grapple with. "These concerns were prevalent for members of the LGBTAI+ community seeking gender-affirming care and facing the stigma associated with the 2022 Monkey Pox outbreaks. Community members and leaders shared concern for particularly vulnerable populations who have traditionally experienced challenges accessing health care, specifically Hispanic/Latino, African American/Black, and API individuals, immigrants (especially those who are undocumented), people with disabilities, LGBTQ

community, indigenous people, seniors, refugees, people experiencing homelessness and transition-aged youth.

Community members, particularly nonprofit leaders, voiced concerns and challenges with medical, vision and dental insurance plans for the most vulnerable populations in the service area. As one service provider shared, “In honesty, the Medi-Cal families are taken care of, but the families who have inadequate insurance through their jobs – that is where they have a harder time.” Community members and leaders shared the many barriers faced in accessing health care. These challenges include long waitlists for appointments, challenges accessing specialists, access issues and discomfort with telehealth, cost, and inability to take sick time or time away from work for appointments, resulting in missed screenings or immunizations. Many community leaders voiced concerns that the COVID-19 pandemic has aggravated these barriers. One service provider shared, "I think that they [doctor's offices] were always tight in their scheduling, but now it is worse." Community residents often wait two to three months to see a doctor. The prevalence of telehealth has expanded access for residents but has disadvantaged vulnerable populations, such as seniors and people experiencing homelessness, who may not have access to technology and Wi-Fi. As one community leader said, "The San Gabriel Valley is a tale of two cities, with pockets of wealth and pockets of poverty."

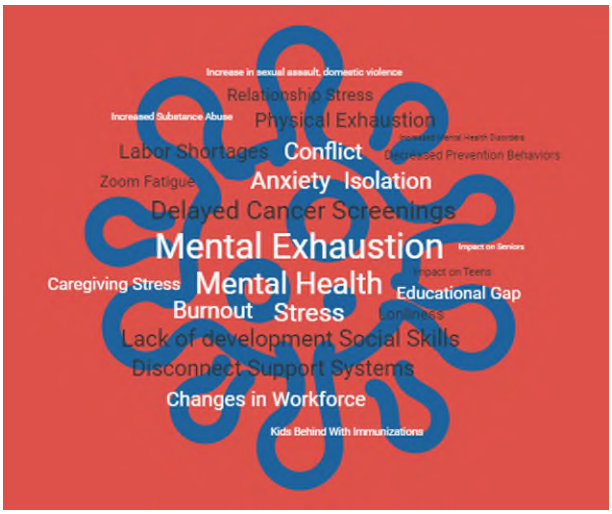
Intersections

Looking at the intersections to effectively address the Health Access challenges of our most vulnerable communities, the CBAC members suggested:

- Engage patient navigators, community health workers to help assure access to what is covered, while engaging with advocacy groups to effect change at the policy level.
- Need improved systems or access to specialty care, especially for seniors
- Increase contact with clients, especially vulnerable clients, to increase access.
- Pipeline programs (long-term), training (short-term) that is informed by the community
- Promotora programming in multiple languages and in the AA community.

No. 3: Mental Health

The COVID-19 pandemic had lasting effects on the mental health of community members in City of Hope's service area. Members mentioned the cumulative effects of the pandemic exacerbating impacts on mental health, feelings of isolation and a disconnect from systems and support, mental and physical exhaustion and general burnout, labor shortages, changes in the workforce and an educational gap for school-aged children. Some of these impacts were felt disproportionately among certain populations.



The strain on mental health was felt particularly because of social isolation, increased relationship and caregiving stress, and exhaustion or "Zoom fatigue" with increased reliance on technology. Community members and leaders voiced concerns about the long-term effects of social isolation on vulnerable groups, such as teenagers and seniors. Educators shared that for school-aged children, teenagers, and college students, the isolation of COVID-19, compounded with a lack of development of social skills due to school closures during the pandemic, has resulted in increased feelings of stress, anxiety and conflict. As one community leader said, "The physical impact [of COVID-19 quarantines] is yet to be determined, but the mental health impact is very apparent. Seniors faced challenges with social isolation compounded with challenges accessing services that moved online. One leader of a community-based organization shared, "COVID has still not gone away, and seniors are still a vulnerable population. Many seniors are still scared to leave their homes and suffer from loneliness. They are nervous when they go to the market or even the senior center because most people are not wearing masks anymore."

There are cultural considerations in seeking care for mental health concerns. In focus groups, residents who identify as Hispanic/Latino shared that many felt that the hesitancy comes from the culture of "suck it up and get over it" for mental health issues. Community leaders who work with API community members shared that the language used to speak about mental health and suicide is not always culturally appropriate and that resources need to be created in partnership with the community to be effective. The political climate has particularly affected members of the LGBTQAI+ community. As one community leader shared, "The mental health of LGBTQ+ individuals really suffered in SPA 3, especially among young people. There is a part of SPA 3 that is very conservative, and we have seen an uptick in young people who are experiencing bullying, harassment, and familial abuse." Many community members and leaders spoke about the challenges of finding adequate mental health care and the limited options within SPA 3. Service

> Mental health was the most frequent health concern shared by community members and leaders

providers specifically mentioned the need for a referral system, group therapy and culturally appropriate care.

Intersections

Many of our CBAC members felt that mental health was a connector between so many of the issues faced. If you are mentally unstable, are you able to obtain and sustain employement? Mental health is a driver for our abilitities. People need to have resilience and have good social well-being so that they can function. Looking for the intersections to effectively address the mental health challenges of our most vulnerable communities, the CBAC members suggested:

- Advocate for the use of a mental health response rather than a police response to mental health crisis.
- Advocate for increased mobile social work teams to visit people in crisis.
- We need integrated models and social connectivity programs.
- Psychiatric ER in SPA3

No. 4: Cancer – Create a safe and trusting bridge to cancer education, prevention and treatment services/care from diagnosis to treatment

As a National Cancer Institute comprehensive cancer center, City of Hope will continue to address cancer prevention. In doing so, it was not difficult to see how COVID-19, the issues surrounding economic, housing, and food insecurity and mental health have impacted access to care and influenced prevention/screening behaviors. Still, ALL cancers remain the leading cause of death across all five of the local counties and the State of California. When you dive deeper into the data, viewing each cancer individually, that changes. Good the news is that many of the cancers have dropped from the top 10 lists across all racial and ethnic groups. Breast cancer, for example, is still the leading cause of death among Hispanic/Latinos, Asians, Native Hawaiian and Pacific Islanders. Prostate cancer is still the leading cause of premature death for Black men and is interesting to note, Hawaiian and Samoan men. Prevention behaviors have also changed, and the intersection with the SDOH is how poverty level continues to be an indicator of whether a person will get a cancer screening. The high the poverty level, the least likely they are to get screened.

Intersections

Our advisory council members want to create a pathway, right at the intersection of SDOH and racial disparities by taking our services to the people. Here they suggest:

- Culturally competent education about cancer screenings
- Provide childcare at locations that provide cancer screenings

- Extend hours for cancer screening locations
- Engage more diverse community partners to help in gathering more granular data
- Focus on ethnicity and cancer rates in all health education and resources
- Outreach to increase access to clinical trials
- Advocate for laws, such as SB987, to be implemented nationally
- Reframe health/cancer screening as an investment in yourself or self-care

No one wants to get cancer. As a world-renowned cancer research institution, we can help deliver the cancer education, screening and treatment programs that ultimately save lives.

Community Benefit Advisory Council members who prioritized the 2022 CHNA results in-person. There were seven more via Zoom.

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" (Figure 2). 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 residents.

Figure 2. Five Core Principles

Collaborations

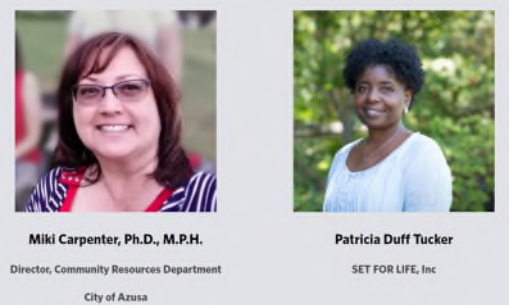
City of Hope is an institution that is overflowing with compassionate individuals. To address the needs of our community, we will leverage these rich resources to design interventions that specifically target the identified issues within our service areas. Internal teams are already trained to change the way they see their work, from looking through a marketing lens to using a community benefit lens that focuses on how the program will impact the health of a targeted group.

Externally, City of Hope will call on the diverse relationships it has nurtured with local organizations, schools/universities, governments, other nonprofit hospitals and the multitude of passionate souls that serve the vulnerable. By collaborating with our local communities, we can create systems-level approaches that 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 a shared vision. This provides a strong foundation for programs that will survive and thrive within the community we serve.

Oversight

To guarantee City of Hope's reportable community benefit programs and services are targeting identified needs and are being seen through the lens of the Five Core Principles, our CBAC will meet at least four times a year.

To ensure council members represent local vulnerable populations or are experts in issues important to vulnerable communities, we sought individuals with the following areas of expertise:



Community Benefit Advisory Council Co-Chairs

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

The Community Benefit Department 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, develop new data collection tools and learn about City of Hope's processes for ensuring programs address priorities outlined in the Implementation Strategy. Additionally, this group has an internal website that provides links to resources, community benefit best practices, and internal tools for sharing and building collaborations that strengthen the quality of staff contributions.

Anticipated Impacts on Health Needs

When we look at the four 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. To make the work meaningful, we will draw from the Healthy People 2030 Objectives and suggestions from our community. As an institution, we will aim our programs and services at our residents, focusing on the intersections where needs meet:

1. **Social Determinants of Health – (for example: housing, food, economic insecurity) Addressing the root causes of poor health outcomes and disparities that are often systemic**

   Healthy People 2030 Strategies

   1.1 Reduce the proportion of adolescents and young adults who aren't in school or working. (AH-09)
   1.2 Increase employment in working-age people. (SDOH-02)
   1.3 Reduce household food insecurity and hunger. (NWS-01)

1.4 Eliminate very low food security in children. (NWS-02)
1.5 Increase the proportion of schools with policies and practices that promote health and safety. (EH-D01)
1.6 Increase the proportion of adults with broadband internet. (HC/HIT-05)

Community Driven Strategies

1.7 Educate the public about the different types of people who fall into housing insecurity and homelessness, to help ameliorate the stigma around "homelessness."
1.8 Progressive communal living spaces
1.9 Increase availability of short-term, emergency and Section 8 housing.
1.10 Provide job training and financial literacy for free to families.
1.11 Increase affordable, quality childcare options and availability of affordable, quality early childhood education and development services.
1.12 Build relationships between wealthier communities and low-income communities, so there are stronger social ties and greater buy-in around the need to solve these issues collectively.
1.13 Build a collective understanding of the factors that make it so difficult to move out of poverty.
1.14 Increase the number of food pantries in communities.
1.15 Services and support directed toward foster youth and transitional age youth as preventive intervention
1.16 Community organizing and community self-advocacy training, plus inclusion of low-income residents at policy decision-making tables
1.17 Provide affordable, integrated health care that connects individuals to providers specializing in mental health care, substance use disorders and physical health care.

2. Health Access – Removing inherent biases that prevent people from seeking and receiving quality care

Healthy People 2030 Strategies

2.1 Reduce the proportion of people who can't get medical care when they need it. (AHS-04)
2.2 Increase the use of telehealth to improve access to health services. (AHS-R02)

Community Driven Strategies

2.3 Integrate patient experience into health/health insurance policy decision-making.
2.4 Increase cultural competency and anti-bias training among service providers.
2.5 Increase trauma-informed care trainings among service providers.
  2.5.1 Particularly care informed by an understanding of racial trauma
2.6 Increase the number of service providers that share the cultural backgrounds and languages of clients.
2.7 Increase patient retention in health care treatment programs by building more services that are rooted in cultural values and traditions.
2.8 Increase patient understanding of how to best communicate with health care providers.
2.9 Improve messaging indicating that providers are safe spaces for immigrants, LGBTQ individuals and other sensitive populations/communities.
2.10 Collaborative relationships that increase access to free or affordable preventive care
2.11 Policies changes that impact:

2.11.1 Paid sick time for hourly workers
2.11.2 Medi-Cal eligibility
2.11.3 Reimbursement rates for providers serving Medi-Cal and Medicare populations

3. Mental Health – Supporting emotional health to create resiliency and improved well-being

Healthy People 2030 Strategies

3.1 Increase the proportion of public schools with a counselor, social worker and psychologist. (AH-R09)
3.2 Reduce anxiety and depression in family caregivers of people with disabilities. (DH-D01)
3.3 Reduce suicide attempts by adolescents. (MHMD-02)

Community-Driven Strategies

3.4 Increase access to integrated care.
3.5 Increase cultural competency training and anti-bias training among mental and behavioral health care providers.
3.6 Form parent/client advisory councils for mental/behavioral health care providers.
3.7 Provide trauma-informed care, and particularly care informed by an understanding of racial trauma.
3.8 Provide training for youth/adults around how to prevent and respond to violence (including relationship violence).
3.9 Incorporate social emotional literacy into youth development programs.
3.10 Work through schools to destigmatize mental health issues and mental health care services.
3.11 Train mental health and behavioral health care providers to recognize the signs of homelessness and provide resources to respond.
3.12 Bring services to workplaces and schools and make them available in the evenings and on weekends.

4. Cancer – Creating a safe and trusting bridge to cancer education, prevention and treatment services/care from diagnosis to treatment

Healthy People 2030 Strategies

4.1 Increase the proportion of females who get screened for breast cancer. (C-05)
4.2 Increase the proportion of adults who get screened for colorectal cancer. (C-07)
4.3 Reduce prostate cancer death rate. (C-08)

Community-Driven Strategies

4.4 Improve messaging indicating that providers are safe spaces for immigrants, LGBTQ individuals and other sensitive populations/communities.
4.5 Increase cultural competency and anti-bias training among service providers.
4.6 Increase trauma-informed care trainings among service providers.
4.6.1 Particularly care informed by an understanding of racial trauma

4.7 Increase the number of service providers that share the cultural backgrounds and languages of clients.
4.8 Increase access to cancer prevention and screening services in communities disproportionately impacted by cancer morbidity and mortality.

Moving forward, City of Hope will align its efforts to 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.

Conclusion

There are many opportunities for City of Hope to be a good steward of the community we serve. Much like the spoke-and-hub approach to investments, City of Hope's community benefit process allows each department that provides community benefit programs and services to manage its own planning and delivery. The Community Benefit Department will be the central collection point for all reportable work. Throughout the year, the Community Benefit Department will provide structure and guidance in the planning and delivery of programs and services. At the end of the fiscal year, the Community Benefit Department will compile the yearly report for the community.

As an institution, City of Hope is looking forward to strengthening our relationships with community partners. We will continue to seek out ways to meet the needs of our vulnerable residents and explore the intersections that maximize collaborations and build sustainable change. We believe this will provide the most positive contributions to the collective impact of the other hospitals, organizations, schools, churches and government entities in our service area.

We hope that you have enjoyed reading our 2023-2025 Implementation Strategy. Should you have any questions, please feel free to contact our Community Benefit Department at CommunityBenefit@coh.org.

Appendix

Community Resources

Community stakeholders identified resources potentially available to address the identified community needs. This is not a comprehensive list of all available resources. For additional resources refer to:

Los Angeles County – www.211la.org

Orange County – www.unitedwayoc.org/how-we-are-doing-more/get-help-211

Riverside County and San Bernardino County – inlandsocaluw.org/211

Ventura County – 211ventura.org

Significant Health Needs	Community Resources
Access to Care	• 211 • Greater SGV Hospital Collaborative • Health Consortium of San Gabriel Valley • Lions Clubs International • Pregnancy Health Center of San Gabriel Valley • Pasadena/Altadena Coalition of Transformative Leaders PACTL • Pasadena Partnership Healthcare Committee • Pomona Wellness Community • San Bernardino Free Clinic • 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. • YWCA of SGV Senior Services - Duarte Senior Center • City of Hope Health Fair • Planned Parenthood Pasadena and San Gabriel Valley • Hear Center • Community Health Alliance of Pasadena • Herald Christian Health Center • Tzu Chi Foundation • Good Samaritan Hospital • Parish Nurses offers screenings with referrals for more services. • El Monte School District • 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

Significant Health Needs	Community Resources
	• Hispanic/Latinos for Hope (City of Hope group) goes out into the community and inform/educate about what's available. • El Proyecto del Barrio Certified Enrollment Counselors help patients understand eligibility and enrollment and to help keep them on their programs to maintain their benefits. • East Valley Community Health Center • Garfield Health Center • San Gabriel Japanese Community Center • Asian Pacific Resource Center • Asian Youth Center • Chinese Culture Development Center • Kaiser Permanente • Huntington Hospital • City of Pasadena Public Health Department • Chinatown Service Center • Wesley Health Centers • Crisis Pregnancy Center of Monrovia • A Women's Care Center • Center for Integrated Family and Health Services
Cancer	• Clínica Médica Familiár (Family Medical Clinic) has clinics twice a year. • City of Hope offers cancer screenings at health fairs. • UCLA Health Alhambra Cancer Care • Covina Cancer Care Medical Center • Huntington Cancer Center • Set for Life offers mammograms. • Children's Hospital Los Angeles • Southern California Health Conference at Pasadena Civic Center • El Monte Comprehensive Health Center • East Valley Community Health Centers • American Cancer Society has resources that can help with transportation and navigation assistance. • My Health LA patients provides emergency Medi-Cal for women 40+ with breast cancer, and for women of any age with cervical cancer through Every Woman Counts program. • MEMAH (Men Educating Men About Health) annual conference • Garfield Health Center provides mammograms and colorectal cancer screening. • Covering with Care • East SGV Health Neighborhood • Herald Cancer Association offers support, consultation, answers questions, and provides written information and links to websites. • Alzheimer's Association
Chronic Disease	• Save the Heartbeat • ChapCare • Day One

Significant Health Needs	Community Resources
	• American Heart Association • Pasadena Partnership Healthcare • Curbside CPR classes offered by the fire department. • Pasadena/Altadena Coalition of Transformative Leaders • Children's Hospital Los Angeles • Los Angeles County Department of Public Health Service • City of Azusa has a Wellness Center • Young & Healthy • 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. • Pomona Wellness Community • Pasadena Partnership Healthcare • Health plans provide educational materials about foods to eat and foods to avoid. Some have been translated by health plans.
COVID-19	• Los Angeles County Public Health Department • East San Gabriel Valley Health Center • Community Health Alliance of Pasadena • Wesley Health Centers • Barrios Action Youth and Family Center • CHIRLA The Coalition for Human Immigrant Rights • First African Methodist Episcopal Church • Pasadena Partnership Healthcare Committee • Pasadena Tournament of Roses • Queens Care • Seventh Day Adventist Church in Altadena • Young & Healthy • El Sol Neighborhood Educational Center
Economic Insecurity, Housing Insecurity and Homelessness	• Pasadena Continuum of Care Network • California Department of Social Services • San Bernardino County Cash Assistance Program for Immigrants • Sahaba Initiative • Time for Change Foundation • Southern California Edison – Energy Assistance Fund • Los Angeles County Development of Public Social Services • Teamster Union Local 63 • Community Action Partnership of San Bernardino County • Village HOPE • Legal Aid Foundation Los Angeles - Government Benefits Unit • Community Health Alliance Pasadena • Pasadena Senior Center

Significant Health Needs	Community Resources
	• St. Louise Resource Services • Youth Moving On • Union Station Homeless Services • Inland Valley Hope Partners • Project Room Key • Lutheran Social Services of Southern California • Our Savior Center • Bienestar provides assistance to persons living with HIV/AIDS who are homeless. • Salvation Army • Glenkirk Church offers Open Arms Program to serve those who are currently experiencing homelessness. • Door of Hope • Hope of the Valley • City of Hope Navigator Program • Friends in Deed • Our Savior Center - Our Homeless Family Motel Voucher Program • Ft Knox Supportive Housing for the Homeless Veterans • East San Gabriel Valley Coalition for the Homeless • D&R Turning Point • Jackie Robinson Community Center • Los Angeles Homeless Services Authority • Elizabeth House • Family Promise of San Gabriel Valley • A Meaningful Goal Housing Shelter • Foothill Family Shelter • mRelief
Food Insecurity	• Shepherd's Pantry • Seeds of Hope • Project Angel Food • SN Gabriel Valley Food Recovery Program • Catholic Charities of Los Angeles • Tzu Chi Foundation • La Casa De San Gabriel Valley Community Center • Mission San Gabriel Arc Angel • Foothill Unity Center • Centro Maravilla Service Center • Tabernacle Faith Church • Eastmont Community Center • Our Saviour Center • Elim Community Food Pantry • Second Baptist Church of Monrovia • Dream Center • Community Resource Center Pomona • God's Pantry Covina • New Song Church

Significant Health Needs	Community Resources
	• Sowing Seeds for Life
Mental Health	• San Gabriel Valley Grief Resource and Training Center • No Mind Left Behind • NAMI Pomona Valley • Universal Stress Free Zones • Comforting Hearts • Supportlink, promoting independent living for persons with disabilities • Olive Tree Children's Counseling Home • Beyond Spectrum Supportive Services • Alma Family Services • SPIRITT 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 • Whittier Hospital Medical Center has a lot of free classes • School districts. Duarte School District has partnerships with providers (Foothill Family Services and D'Veal) to come into the schools and provide services. • Pacific Clinics/Asian Pacific Family Center • Foothill Family Services • D'Veal Family & Youth Services • 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 site in El Monte • 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	• Chapcare Medical and Dental Health Center • Families Forward Learning Center • San Gabriel Valley Service Centers • Women, Infant and Children offers nutrition classes. • Community centers offer exercise programs, such as Zumba and walking. • Senior centers, such as the Azusa Senior Center. Duarte Senior Center offers referrals and some free services, including a hiking club.

Significant Health Needs	Community Resources
	• Pomona Wellness Community • 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.

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