City of Hope

2023

Community Benefit Report

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EXECUTIVE SUMMARY

City of Hope® is pleased to submit a report of our community benefit activities for Fiscal Year 2023 (from October 1, 2022, to September 30, 2023). 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.

Benefits for the Broader Community
$8,291,747

Health Research, Education and Training Programs
$173,038,034

Medical Care Services
(Including Medicare Shortfall)
$353,643,341

FY2023 Total Investment
$534,973,122

Fiscal Year 2023 Commmunity Benefit Investments

This report is intended to share the progress City of Hope – Los Angeles, has made in addressing the health needs in the 2019 Community Health Needs Assessment and subsequent 2021-2023 Implementation Strategy. Throughout this document, we will demonstrate an understanding of the diverse needs of the multicultural communities we serve and a commitment to the creation of the infrastructure necessary to carry out an extensive array of community projects. Our traditional community education efforts in cancer prevention and cancer risk reduction are also reflected. The total value of our community benefit investments during the Fiscal Year 2023 was **$534,973,122.** This represents a $169,403,334 increase over Fiscal Year 2022.

While we continue to update guidance regarding COVID-19 safety parameters, we are seeing more and more engagement from our hospital teams with our community partners. Our relationships with community stakeholders are stronger than ever, and we clearly see the importance that these trusting relationships have on our ability to identify community needs and where we can make the most impact. We will continue to look for the intersections between health and health equity as we progress our Community Health Needs Assessment (CHNA) strategies. 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 which along with our implementation strategy is available for download on our website via CityofHope.org/community-benefit . We welcome you to share your comments with us by emailing CommunityBenefit@coh.org.

City of Hope Nurses, assemble burritos for anyone who is hungry in Downtown Los Angeles. October 2023

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 56 National Cancer Institute (NCI)-designated comprehensive cancer centers in the U.S. The NCI designation recognizes excellence in treatment, research and expertise to address the many features of the disease, whether in early or late stage, and for common or rare types of cancer. City of Hope is also proud to be a founding member of the National Comprehensive Cancer Network (NCCN), reflecting our national leadership in advancing research and treatment. NCCN member institutions are recognized for their world-renowned expertise and for treating complex, rare and aggressive forms of cancer. Most importantly, we firmly believe in providing value across the entire patient journey. At City of Hope, this is measured by the experiences and outcomes that our treatments and dedicated teams 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. Our scientists, clinicians and specialists work under one roof, meaning that each patient receives coordinated care from a team of doctors. City of Hope patients benefit from our extraordinary capabilities and leading-edge technological advances, such as the application of robotics to remove the disease and use 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. Foundational to this approach is our focus on innovation as we strive to turning tomorrow's treatments into today's 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. 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 more than 850 clinical trials investigating potentially groundbreaking treatments. City of Hope enrolled 1 in 4 patients in clinical trials in 2021, including nearly 80 clinical trials in breast cancer alone. These trials provide unique treatment options to City of Hope patients and pave the way for important breakthrough therapies.
- City of Hope is a pioneer in bone marrow and stem cell transplants. As one of the largest and most successful programs of its kind in the U.S., our program attracts patients from across the nation and around the world.
- Numerous breakthrough cancer drugs, including Herceptin, Erbitux, Rituxan and Avastin, are based on technology pioneered by City of Hope.
- City of Hope is at the leading edge of an immunotherapy called chimeric antigen receptor therapy — also known as CAR T cell therapy — with one of the most comprehensive programs in the world, and nearly 80 clinical trials either in process or completed, targeting various hematologic and solid tumors, including brain tumors.

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

Mission Statement

City of Hope is transforming the future of health. Every day we turn science into practical benefit. We turn hope into reality. We accomplish this through exquisite care, innovative research, and vital education focused on eliminating cancer and diabetes. ©2012 City of Hope

Statement of Corporate Social Responsibility

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

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

Our Diversity, Equity and Inclusion Belief Statement

We believe diversity, equity and inclusion are 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.

City of Hope is committed to respecting and reflecting the diversity of our patients, their families and caregivers, and the community without regard to race, color, religion, gender, gender identity or expression, sexual orientation, national origin, genetics, disability status, age, marital status, veteran status or any other protected class.

Communities We Serve

City of Hope primary service area

City of Hope, Los Angeles, 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 over 30 clinical network locations . The majority of our patients come from Los Angeles County, specifically from communities within Service Planning Area 3 (SPA 3). City of Hope itself is within SPA 3, which includes 34 cities, such as Alhambra, Altadena, Arcadia, Azusa, Baldwin Park, Claremont, Covina, Diamond Bar, El Monte, Glendora, Irwindale, Monrovia, Monterey Park, Pasadena, Pomona, San Dimas, San Gabriel, San Marino, Temple City, Walnut and West Covina.

Race/Ethnicity[1]

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

[1] U.S. Census 2020 Redistricting Data

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

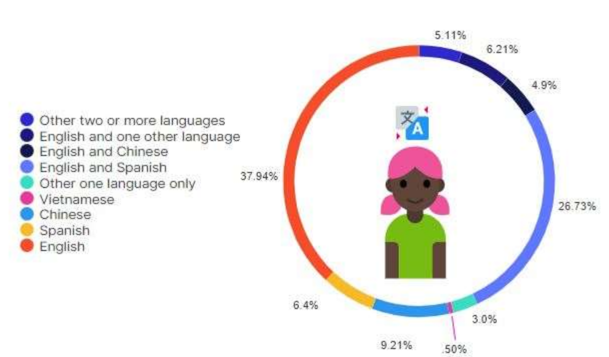
The previous chart illustrates the low and high range proportions of ethnic groups by SPA 3 city. In 2017, Irwindale, La Puente and South El Monte had the highest concentration of the Latino population, with a rate of 93.3%, 84.7% and 82% respectively. In 2020, the three cities remained home to the highest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

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

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

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

Language[2]



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

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

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

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

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

Social Determinants of Health

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

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

Poverty

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

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

Educational Attainment

One of the key drivers of health is educational attainment — low levels of education are often linked to poverty and poor health[5]. In SPA 3, 14 cities rank below the state level in the rate of college educated adults,

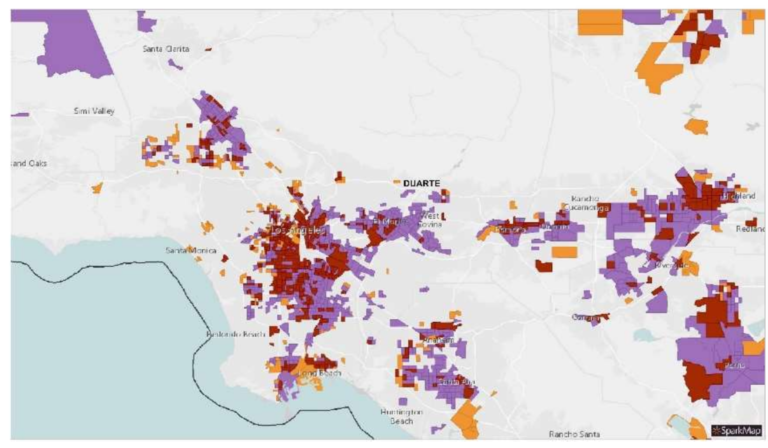
[3] Annual Update of the HHS Poverty Guidelines https://www.federalregister.gov/documents/2022/01/21/2022-01166/annual-update-of-the-hhs-poverty-guidelines. Accessed (January 28, 2022)
[4] "Making Ends Meet: How Much Does It Cost to Support a Family in California?" (December, 2017). California Budget and Policy Center. Available at https://calbudgetcenter.org/wp-content/uploads/Making-Ends-Meet-12072017.pdf Accessed [June 13, 2019]
[5] Raghupathi, V., Raghupathi, W. The influence of education on health: an empirical assessment of OECD countries for the period 1995–2015. Arch Public Health 78, 20 (2020). https://doi.org/10.1186/s13690-020-00402- AND Zajacova A, Lawrence EM. The Relationship Between Education and Health: Reducing Disparities Through a Contextual Approach. Annu Rev Public Health. 2018 Apr 1;39:273-289. doi: 10.1146/annurev-publhealth-031816-044628. Epub 2018 Jan 12. PMID: 29328865; PMCID: PMC5880718.

ages 25 and older. South El Monte (7.7%) and La Puente (9.1%) have the lowest rates of college graduates in SPA 3.

South El Monte and El Monte have the highest percentage of those with no high school education, 29.1% and 24.5% respectively. The highest percentage of residents with a high school diploma are found in Baldwin Park (29.5%), Industry, (34.8%), La Puente (30.6%) and Valinda (30.4%). Walnut (38.4%) and San Marino (40.1%) have the highest percentage of college-educated adults over the age of 25. San Marino also has the second-highest household median income at $164,423. Though South El Monte has the lowest percentage of college graduates and the highest percentage of residents with no high school education, they have a higher percentage of high school graduates (27.3%) than the state (20.4%).

Vulnerable Populations

Poverty and educational attainment are predictive of at-risk or vulnerable populations. As depicted in the map[6], City of Hope's service area is home to many vulnerable communities. Communities with residents at 200% below the poverty threshold are shown in this map. The purple areas demonstrate communities where residents have less than a high school education. The mustard-colored areas are where people live below the federal poverty level. The reddish brown is illustrative of communities where residents have both less than a high school education and live below the federal poverty level. The unique composition of these five counties makes them vulnerable on many levels and reinforces the need for community benefit programs. From our 2022 Community Health Needs Assessment we learned:



COVID-19 Lived Experience by SPA3 and County

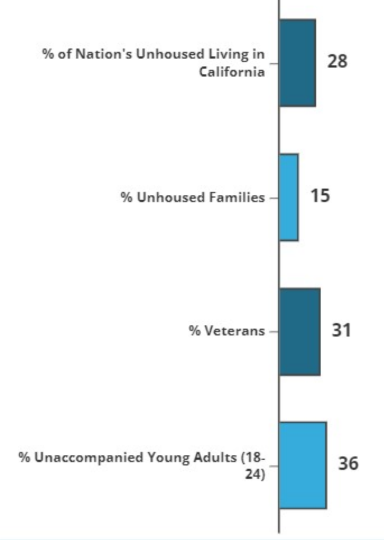
[6] Source: Community Commons. Vulnerable Populations Footprint Tools. https://sparkmap.org. Retrieved on 11/27/23.

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

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

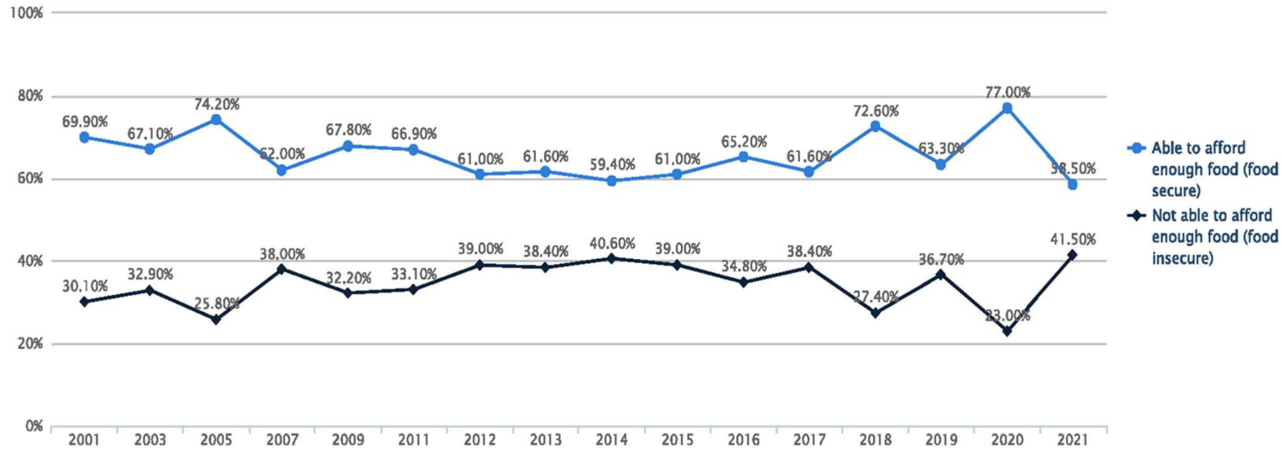
The Unhoused

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



Food Insecurity

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



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

Mental Health

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

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

Impairment Due to Poor Mental Health in the Past 12 Months

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

Source: California Health Interview Survey, 2020

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

ORGANIZATIONAL COMMITMENT

Oversight and Management of Community Benefit Activities

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

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

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

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

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

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

COMMUNITY BENEFIT PLANNING PROCESS

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

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

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

Miki Carpenter and Patricia Duff Tucker serve as the co-chairs of CBAC. Throughout Fiscal Year 2023, CBAC met four times (twice in person and twice virtually). During the course of this year, our CBAC worked toward achieving strategies identified in the 2021-2023 Implementation Strategy. Members reviewed and awarded the Healthy Living Grants and Kindness Grants, conducted virtual and on-site visits with the grantees, participated in the in-person Healthy Living Grant Conference and provided guidance as we completed our 2022 Community Health Needs Assessment and shared the findings with our community. 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.

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 CBAC assisted in the prioritization of the CHNA during a special meeting held in December 2019. The process was facilitated by both 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.

2022-2025 Community Benefit Advisory Council members.

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 is paramount to our success as a nonprofit hospital. The best way to learn about our community's needs is to simply ask them. That is exactly what we did. In partnership with our SPA 3 Hospital Collaborative, Huntington Hospital, Methodist, Emanate Health, and Kaiser Permanente – Baldwin Park, City of Hope embarked on a comprehensive journey to discover how our collective community believes they are doing and what they believe they need to be healthy.

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

Secondary Data

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

Primary Data

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

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

Focus Groups

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

Interviews

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

Summary of 2019 Community Health Needs Assessment Results

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

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

Significant Health Needs

The following significant health needs were determined:

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

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

Resources to Address Significant Needs

Through the focus groups, surveys and interviews, community stakeholders and residents identified community resources that can help address 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, the consequence 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 2021 Implementation Strategy. Results were as follows:

CBAC members prioritizing health needs

2019 Stakeholder Prioritized Health Needs

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

Rank	Health Needs
4	Chronic Disease
5	Cancer Prevention

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

Plan to Address Needs

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

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

CBAC members who prioritized the 2019 CHNA results

Collaborations

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

Oversight

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

Anticipated Impacts on Health Needs

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

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

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

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

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

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

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

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

Needs Not Addressed

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

Monitoring and Evaluation

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

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

COMMUNITY BENEFIT INITIATIVES

Overview of Fiscal Year 2023 Programs and Services

Fiscal Year 2023 saw an emergence from the isolation of COVID-19. While teams continued to deliver important events via a virtual environment, there was an increase of in-person events. Our reach was greater and a wide variety of people from throughout the service area were able to participate in our programs. What follows is a reflection of our work during Fiscal Year 2023. Each initiative has specific goals that benefit the community. Many initiatives have been thriving for years, while others are new based on the Fiscal Year 2019 Community Health Needs Assessment. Some are organization-wide, while others are conducted by a specific department. The grid here provides a quick overview of our Fiscal Year 2023 programs and services.

	Core Principles				Strategic Priorities				
Program Activity *Beckman Research Center	Vulnerable Populations	Primary Prevention	Seamless Continuum of Care	Community Capacity Building	Access to Care	Mental Health	Economic and Housing Insecurity	Chronic Disease Prev. – Healthy Living	Cancer Prevention
Workforce Development									
• Student Mentoring/Interns • Train, Educate and Accelerate Careers in Healthcare • YES2Success – Summer Youth Program*	x	X		x	x			x	x
Community Health Awareness/Healthy Living (Screening, Lectures/Classes Support Groups)									
• Community Nutrition, Smoking Cessation, and Cancer Prevention Classes • Community Health Fairs • Healthy Living – Community Building Grants • Kindness Grants • Community Gardens/Garden of Hope • 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 – Social Determinants of Health Support									
• Patient Resources Coordination • Transportation • Village Stays • Food Insecurity	x	x	x		x	x	x	x	x
Seamless Continuum of Care									
• Community Nutrition, Diabetes and Cancer Prevention Classes • Community Health Fairs • Cancer Care is Different	x	x	x	x	x		x	x	x
Medical Professional Education									
• Pharmacy • Nutrition • Rehabilitation • Nursing • Social Work • Health Education	x	x	x	x	x			x	x

Fiscal Year 2023 Strategic Priority

Key Community Benefit Initiatives

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

What follows is a status report on the main focus areas of our Fiscal Year 2023 community benefit programs and services: Healthy Living, Community Capacity Building and Kindness Grants; Food Insecurity Programs and Collaborations, and Addressing the Social Health Needs (SDOH) of Patients/ Families/Caregivers.

To help you see the connection between the priority areas and our programs, look at the colorful boxes in each section. 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	✔

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.

Healthy Living Grant

During Fiscal Year 2023, the funding for the **Healthy Living Community Grant** program continued to grow and we were excited to provide $105,000 to 15 organizations that demonstrated a creative, yet sustainable, approach to promoting healthy living via our priority areas in the colored box. Budget-wise, this was a 50% increase in funding over the year before. The 2023 Healthy Living Cohort included a diverse slate of awardees that spanned the Greater Los Angeles and Orange County regions. These impressive organizations are: Mental Health Advocacy Services, Breast Cancer Angels, Pediatric Adolescent Diabetes Research and Education Foundation, Duarte High School Environmental Club, Hollywood Food Coalition, Growing Hope Gardens, AV-Boots on the Ground, City of San Gabriel – HEAR Commission, Rainbow Labs, Montclair community Foundation, LYTE Foundation, Inc.. Their programs are described below:

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

Mental Health Advocacy Services

Mental Health Trainings: Mental Health and Homelessness. Provide trainings that support mental and behavioral health providers to understand the mental health challenges of the unhoused.

Breast Cancer Angels

One Family At A Time. Sustainably supporting the social health needs of breast cancer patients from Orange County to Riverside.

Pediatric Adolescent Diabetes Research and Education Foundation

Accepting. Advancing. Amazing. Type 1 Diabetes Education and Support Program. Education-based program to support disadvantaged teens diagnosed with type1 diabetes. They offer year-round support, education and treatment assistance to teens and their families. They also work directly with teens and their families (support systems) to increase competence, control and confidence in their ability to control their diabetes.

Duarte High School Environmental Club

School Garden. Link environmental learning and therapeutic gardening into a school-based garden. Students design and build the garden. They also infuse gardening into the culture at the school.

Hollywood Food Coalition

Community Exchange. Through their innovative food rescue program, they rescue, sort and distribute 2.4 million pounds of rescued food with their network of over 140 fellow nonprofits.

Growing Hope Gardens

Urban Resident Food Garden. Through community collaborations, Growing Hope Gardens serve residents of a permanent supportive housing community. They engage the residents through a series of leadership and skill building workshops that provide access to food, enhance wholeness at the individual and community level, and build a sustainable program through community engagement that fosters ownership.

AV-Boots on the Ground

Fight for Veterans Health Benefits. Addresses the gap in veteran engagement at community events that link them to social care and health services through targeted approaches that build trust.

City of San Gabriel—HEAR Commission

Mental Wellness. Seek to normalize discussion around mental illness and treatment. Provide local residents with the opportunity to meet and connect with mental health services providers in their community.

"Bigger Ask" Healthy Living Grants

Beginning in 2022 we created the "Bigger Ask" Healthy Living Grant. This is an opportunity for handpicked previous grantees, who have created significan and innovative impact, to apply for either a $10,000 or $25,000 grant. We established this new category because we believe these organizations have what it takes to change the narrative around health and equity, in the communities they serve. The 2023 Bigger Ask recipients are below:

Rainbow Labs 10K

Leveraging the Power of LGBTQ+ Volunteers as Mentors for LGBTQ+ Youth. Responding to their 2021 focus groups with LGBTQ youth, they will strengthen a mentoring infrastructure that will provide youth with the caring and consistent adults in their lives, that they indicated that they needed.

Montclair Community Foundation 10K

Cultivating Wellness in Montclair. The Montclair Community Foundation will assist the efforts of Healthy Montclair's promotoras and by expanding the Montclair Community Garden as a resource for increasing access to organic fruits and vegetables and improving physical activity through gardening.

LYTE Foundation, Inc. 25K

Living Your Truth Empowered Charter Program. Will offer free coaching and programming through community-based, locally tailored charters for breast cancer survivors immediately following treatment.

The important message to take home from the Healthy Living Grant Program is that "small is beautiful". Local organizations can benefit from smaller grants, that increase their productivity, allow them to scale previous efforts and/or launch a pilot program without making a large investment.

Fiscal Year 2023 Healthy Living Grant Cohort

Healthy Living Grant Outcomes Fiscal Year 22/23 Grantees

Grantees sharing program outcomes during the poster session

At the end of the funding cycle, when new grants were awarded, the 2022 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 2023, the 2022 Healthy Living grantees shared their findings after a year of implementing programs during our in-person conference. All grantees made 15-minute presentations and held a poster session. While the programs varied from HPV vaccinations to working with foster youth, all shared a common theme: to improve the lives of the people living in the communities they serve. Below are a select few posters. To learn more about these program and to see the others' outcomes, we invite you to visit our [Healthy Living Grant website].

Boys and Girls Club of Metro LA – 2023 Healthy Living Conference Poster

VOLUNTEER CORPS: BUILDING VOLUNTEER SUPPORT

Our mission at Eco Urban Gardens is to combat food insecurity through urban agriculture and regenerative living.
Our vision is every student has access to health education through hands on, project-based learning in a Farm to School Program.
Volunteer Corps builds sustainable and reliable volunteer support from communities surrounding the Farm to School program.

The Goals of the Volunteer Corps are to develop leadership within the communities where Farm to School programs exist and support the community outreach and engagement for maximum impact.

Our Objectives:

1) Outreach to potential volunteers
2) Create training manual for volunteers
3) Develop High Value Volunteers
4) Engage New Community Partners
5) Develop systems for feedback and improvement of programs.

The Urban Farmer Handbook will be used for training volunteers as well as future staff. Since we began outreach, we developed 5 Volunteer Corps members who have shown dedication and passion and executed tasks in a timely manner.

Events since new V. Corps members were onboarded have gone more smoothly and have a better turn out!

Corps members are currently helping with outreach with grassroots campaigning and SMM.

Developed "Urban Farmer Handbook" → Identified Target Demographics → Outreach to Community → 3 Weekend Training Workshops → Delegate tasks to new Corps members → Review content with input from new Corps members

EcoUrban Gardens – 2023 Healthy Living Conference Poster

City of Hope.

2023 Healthy Living Conference – City of Hope
Optimist Youth Homes and Family Services
Fostering Optimism: Housing Units for Homeless College Students

Morgan Paden, Development Director, Grants

ABSTRACT

The overarching goal of the Fostering Optimist: Housing Units for College Students Experiencing Homelessness Program is to provide comfortable and supportive transitional housing for community college students who are homeless or at-risk of being homeless.

INTRODUCTION

In partnership with the Los Angeles Community College District, Optimist provides housing at our Highland Park Campus to create a supportive environment for high-risk community college students, including former foster youth. In addition to providing housing for these students, Optimist has the existing infrastructure for a holistic approach to provide these youth with mental health services, career and educational advocacy, mentors, food services, and recreational activities. This funding has supported housing, school supplies, and materials to assist residents.

CONCLUSION

- In 2022, LACCD and OYHFS entered an agreement to provide housing to 13 unhoused community college students
- The available rooms filled quickly and there remains a waitlist with 30+ applicants hoping for housing.
- Approximately 50% of the LACCD students who sought housing were also former foster youth and many have requested supportive services such as therapy and educational support which Optimist provides onsite.

THE CHALLENGE

In Los Angeles County, 35-60% of youth aging out of foster care have no safe, affordable housing available. In 2020, the Los Angeles Homeless Services Authority (LAHSA) reported the number of homeless youth in Los Angeles County increased more than 18.5% over the previous year. Homeless youth with a history of foster care report an average duration of 36.6 months, which designates them as chronically homeless.

For youth transitioning out of the fractured foster care system, successful educational attainment is key to self-sufficiency in adulthood. However, foster youth have significantly worse educational outcomes. Only 65% of youth in foster care complete high school or earn a GED by age 21, and less than 11% go on to earn a college degree.

Many community college students in the U.S. are experiencing homelessness. Youth, desperate for an education, are living in their cars at night as they attend class during the day. This is even truer for former foster youth who have few family supports to rely on. Optimist aims to remove barriers to student success and create stability for students who are at risk of homelessness.

"Our view is that foster youth are not defined by what has happened to them; they are only limited by access to supports and resources to achieve their dreams."

Dr. Todd Sosna, Chief Executive Officer, Optimist Youth Homes & Family Services

Resident Stories

STUDENT A
After completing core coursework at LACCD, she was accepted to USC. Optimist staff helped her find new affordable housing close to USC's campus.

STUDENT B
Optimist supported her during her pregnancy and the birth of her child. She and her infant still live in Optimist housing. This has allowed her to continue her schooling while being a new mom.

STUDENT C
He found therapy helpful but could not continue treatment due to the hurdles of couch surfing and school. Now that he has secured housing and counseling is onsite, he goes to therapy again and reports that his mental health has improved.

STUDENT D
She plays on the basketball team at Pierce College and will enroll in a nursing program at a four-year University this fall.

Stated vs Actual Outcomes

80% | 100%
Students receiving mental health services will show improved emotional wellness

80% | 100%
Students will maintain good standing at their college

100% | 100%
Students will have positive social support systems

100% | 100%
Students will meet with an advisor to discuss career and employment plans

80% | 100%
Students will reenroll for the following semester

100% | 100%
Students will be offered mental health support

Meet Carolina:
A previously unhoused Mother and College Student. Now an Optimist Resident

"I had an apartment with roommates, but it became so expensive that **I found myself living in my car.** My daughter went to live with her father because I did not want her to see me like this. I would visit her and pretend like everything was ok, but really **it was a bad situation.**"

"When I scheduled a tour, I was greeted by their staff. Everyone was so nice, welcoming, and supportive. I told them I had a support animal and a child. While **other places would have turned me away** at that point, Optimist made extra accommodations to make sure we were all safe, off the streets, and in a comfortable apartment that I'm proud to call home. **We love living here!**"

Optimist Youth Homes and Family Services – 2023 Healthy Living Conference Poster

2023 Community Building Grants

During the grant review process, the CBAC members found that some proposals did not fit the critiera for a one-year project, yet these proposals are worthy as they meet the specific needs of the local vulnerable community. To address this, the council created a new funding category called the Community Capacity Building Grant. City of Hope also awarded **Community Building** grants for organizations whose work reflects an identified need, but do not fit the parameters of the Healthy Living Grant. This year, we are pleased to announce the **2023 City of Hope Community Building** grant recipients:

Orange County Buddhist Church

Tomodachi Bento — Addressing Social Isolation Among Elderly Japanese Americans. Just as a physician treats the mind, body and soul of a patient, Tomodachi Bento, through its Social Isolation and Engagement Plan, seeks to engage seniors, caregivers and the community similarly though Lunch and Learn, Dining Out and culturally sensitive programs.

Conejo Free Clinic

Breast Cancer Screening & Diagnostics for Low-Income Women. Provides breast cancer screenings and/or diagnostic tests for vulnerable refugee populations in Ventura County.

Asian American Senior Citizen Service Center

Mental Health Café. The Asian American Senior Citizen Service Center hosts mental health café sessions within the API community utilizing an integrative approach of peer/professional co-facilitation.

2023 Health Equity Grant

Created several years ago, our Advisory Council wanted to have an avenue to recognize and support organizations that are on the forefront of addressing long standing health inequities in their communities. Recognizing the higher mortality rate for Black/African Americans led to 1.63 million excess deaths between 1999 to 2020 compared with White Americans, according to a new JAMA study. Clyde Yancy, an author of the study and chief of cardiology at Northwestern University's Feinberg School of Medicine, said that “the high mortality rates have more to do with the United States history of discrimination than with genetics”, adding that it is "very clear that we have an uneven distribution of health." In our effort to raise more visibility and importance of Black/African American infant and mom’s health, we awarded the 2023 Health Equity grant to:

[Mighty Little Giants, Inc.](#)
NICU Family Support. Addressing the inequities that Black and Indigenous women face when birthing, Mighty Little Giants will partner with the Antelope Valley Hospital to provide a safe space for postpartum support and healing.

We Build Community Capacity

Many of our grantees have either no or limited experience in supporting a program of evaluation. To help them in gaining these skills we host a virtual evaluation workshop. During this time, grantees learnas a cohort, in a judgment free zone, and practice using the evaluation tools that will help them tell their story at the annual conference.

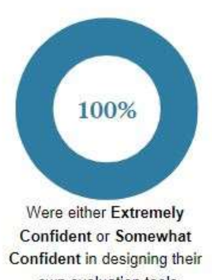
Evaluation Design Needs To Be:

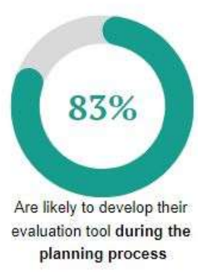
- **Organized** from start to achieve specific agreed-upon uses
- **Have a clear purpose** that is focused on the utility of what is learned
- **Storytelling component** to help those who carry out the evaluation to know who will do what with the findings

2023 Cohort Evaluation Workshop Post Survey Results

We believe from postsurvey results that we positively impacted those in attendance. While some held back in confidence, their resolve to integrate evaluation earlier into their program planning is important.

Ultimately, this grant program is about building community and capacity around efforts that support health and wellness in our service area. This is a testimony to the work we do to build their capacity and ultimately tell their story as a means to leverage future support and to sustain the changes that they sparked in their own communities.





It was empowering and I learned a lot.

Your workshop was really helpful and wonderful. My concerns are only my own ability to focus and retain new information during this busy year. But . . . I do feel you gave me a great head start.

Very valuable information, great support by Nancy and her team. Breakout sessions allowed for peer sharing and individualized support.

Kindness Grants

The Kindness Grant program was designed to support City of Hope team members who want to do good in their communities. Over the years, we have funded a variety of programs that addressed issues across the

spectrum from essential oils for pain reduction in cancer patients to forums on Black/African American hair care and its link to cancer. The programs were creative, insightful, and truly impacted their audiences at a visceral level.

During FY2023, we awarded nine grants to City of Hope employees in support of their ideas. Many chose to design programs that addressed not just one of our priority areas but often times two or three. To learn and follow the inspirational, visionary concepts of our City of Hope employees, see below:

Mental Health Benefits of DIY Gifts **Submitted by: Lingqui Fink** **Corporate Accounting** **Total awarded: $500** **Strategy Addressed:** Mental Health	**Creative Approach:** During the Pandemic, my teenage daughter started making and gifting her family and friends cute small gift boxes made with greeting cards. The process of making these gift boxes, the thought that goes into it, the personalization, and uniqueness of each box, and the time spent making it, made her happy. DIY gifts offer a range of mental health benefits that are associated with crafting something special. She wants to show others how to make them and gift them as she does. We will partner with local children's hospitals, senior residents living facilities, public libraries, and children's daycare facilities to spread joy on celebrations such as Christmas, Valentine's Day, Easter, Mother's Day, and Father's Day.The gift boxes are made of greeting cards, each with its unique design and personalization. Participants may bring their own greeting cards they received from their loved ones. They are environmentally friendly, as re-used greeting cards work for this project. They are amazingly beautiful. We have sample images to share upon request.
Adopt a Senior Nursing Class **Submitted by: Diego Rodriguez** **Nursing Leadership Admin/Pride in the City – Employee Resource Group** **Total awarded: $2,500** **Strategies Addressed:** Mental Health, Economic and Housing Insecurity	**Creative Approach:** Most of the team members working on this project are nurses. We know firsthand how difficult it is to complete the nursing program. There is plenty of evidence to support the shortage of nurses in the USA. In addition, the focus on minorities is to provide hope to those who may face systemic barriers because of their background or sexual orientation. Some students are first-generation migrants and the first to complete higher education. Others struggle with poverty, live in their cars, and barely have access to balanced meals. Our project will benefit students who might think they can't cross that finish line. It will contribute to the nursing shortage, and COH is willing to open its doors and provide opportunities and support to newly graduated nurses through the NRP.
Orange County Jewish Cancer Education Initiative **Submitted by: Joshua Cohen, M.D.** **Department of Surgery** **Total awarded: $5,000** **Strategy Addressed:** Cancer	**Creative Approach:** Partnering with Sharsheret, a nationally recognized organization in this field, is a surefire way to engage the Jewish community in a much-needed educational conversation around hereditary cancer risk in Jewish families, while also spotlighting City of Hope's new facility and exceptional medical care. Sharsheret will recruit and guide Orange County-based Jewish organizational partners to plan 2 in-person community-wide programs and one virtual community-wide program that focus on the increased risk of hereditary breast and ovarian cancer among Jewish families, healthy living, disease prevention, and Sharsheret's support services. These experiential events for men and women, will be held in OC synagogues/ community centers, and might include a pink challah bake/panel discussion around survivorship/healthy living, a nutrition presentation with a registered dietitian, and/or an exercise event let by an oncology fitness expert. Featured specialists will be from City of Hope. To encourage participation of local organizations/synagogues, as part of this City of Hope grant, we **will offer partners financial stipends** to: 1) help offset costs of hosting, including security, refreshments and required materials,

	and 2) encourage non-hosting partners to market the programs to their congregations and encourage member' participation. I believe that by offering expense coverage and removing the financial barrier, community organizations will be motivated to participate in this much needed education and awareness. Additionally, having these opportunities to connect with medical professionals and ask questions in a casual and engaging environment allows community members to feel connected to both Sharsheret and City of Hope, while also learning essential information.
Empowering Women's Cancer Prevention through Genetic Awareness **Submitted by: Alexandra Capasso – Center for Precision Medicine** **Total awarded: $1,500** **Strategies Addressed:** Access to Care, Chronic Disease, Cancer	**Creative Approach:** We have partnered with the Downtown Women's Center and will be providing an educational event on cancer prevention and the utility of genetic services. Instead of the conventional method of educating individuals through a presentation or seminar, we are going to make our education more approachable by providing a less structured, more informal environment. This will allow individuals to ask questions, gather information, and discuss their concerns with us over light refreshments. It will provide an opportunity for individuals to ask more personalized questions that they wouldn't otherwise ask in front of a larger audience.
Dysphagia Food Bank **Submitted by: Mercedes Mendoza – Speech Language Pathology** **Total awarded: $2,000** **Strategies Addressed:** Access to Care, Cancer, Economic and Housing Insecurity	**Creative Approach:** Collaboration with a local food bank and local chapters of NSSHLA (National Student Speech Hearing Language Association) to create a network for safe and affordable access to necessary dysphagia supplies for patients with swallowing disorders who are prone to food insecurity. Mercedes will provide awareness to the local chapters via in-service at recurring meetings in addition to the development of promotional flyers for local food banks/COH to promote the programming in the community.
Caregiver Support Group in Spanish "¡Cuidadores con esperanza, poder, y conexión!" **Submitted by: Mariela Gallo Department of Supportive Care Medicine** **Total awarded: $2,180** **Strategy Addressed:** Access to Care, Mental Health, Cancer	**Creative Approach:** A caregiver support group in Spanish will be offered twice a year at City of Hope, in Duarte CA beginning with the first offering from January thru April and the second offering from May thru August. These dates are broken up into eight sessions per group. Registration will be open to both City of Hope and non-City of Hope caregivers from all cancer diagnoses in active treatment. Participants will be asked to commit to attending all sessions. Groups will be composed of a total of twelve participants. The caregiver support group in Spanish will provide culturally competent intervention modalities including exploring areas of distress for caregivers throughout the caregiver journey, learning how to manage unmet needs, providing empowerment through education and tools, and understanding and communicating about prognosis. This program will also provide crucial information about the unique needs of Hispanic caregivers. There is a deficit in research and culturally and linguistically competent resources for Hispanic caregivers of cancer patients. Thus, we will be able to gain exploratory information related to distress and the overall needs of Hispanic caregivers. This will be done in a safe and therapeutic environment. All sessions will be led by one of our leading psychiatrists in the field of psycho-oncology to provide interventional therapeutic support and appropriate referrals and communication with the multidisciplinary team when needed. Each session will be co-led by a clinical social worker who will provide supportive counseling and assistance with concrete needs including transportation, community resources, and financial assistance when needed.
Growing Hope Gardens **Submitted by: Megan French – Office of Philanthropy**	**Creative Approach:** I will work with Carolyn Day, the executive director and founder of Growing Hope Gardens (GHG) and a Master Gardener, as she evaluates the needs at Community Corp-owned affordable housing communities gardens, where GHG has an MOU, and

Total awarded: $3,420 **Strategies Addressed:** Economic and Housing Insecurity, Chronic Disease	designs the layout and plants seedlings to accommodate the needs of the residents and maximize space. It is crucial to engage community members in the process of maintaining their gardens, so they understand how to best utilize the produce and to help ensure long-term sustainability. Growing Hope Gardens visits the gardens bi-monthly for maintenance. The funds from City of Hope's Kindness Grant will be used to host seven Community Wellness Garden events. These are two-hour workshops with three GHG Garden Team Engagement Specialists. The Garden Team Engagement Specialists distribute free, locally sourced produce, along with harvesting the produce grown in the resident gardens. The workshops are open to all ages, residents, and their friends and families. Participants learn techniques to harvest different crops, increase nutritional awareness, how to use a spinner, kid-safe knife and prepare each vegetable, and share the garden-fresh dishes. Participants also learn to plant seeds and seedlings, and how to transplant and water them.
Increasing Access to Free Mindfulness-Based Mental Health Counseling Program **Submitted by: Pooja Sathyanarayanan – Department of Systems Biology** **Total awarded: $4,000** **Strategy Addressed:** Access to Care, Mental Health	**Creative Approach:** A format consisting solely of individual counseling sessions (with no hybrid group/ individual counseling format), with flexible scheduling was found by program leadership to be more aligned with the community need. However, this is currently not cost effective for the organization. This project will help pilot a new format that can reduce the barriers to access. The project will also devote resources toward outreach, which the organization has a need but no available funding for, through targeted Google Ads and creation of outreach logs.
Breast Cancer Awareness & Education Is Power: Together we Can Make a Difference **Submitted by: Victoria Taylor-McKinley – Office of the Chief Financial Officer** **Total awarded: $3,900** **Strategies Addressed:** Access to Care, Chronic Disease, Cancer	**Creative Approach:** The creative approach to accomplish the strategy is to create a program where the expert speakers are people of color who will discuss the statistics on breast cancer for people of color, the importance of early screening through mammograms and self-breast exams, prevention through healthy living, diet and exercise. There will also be a discussion on using certain products that contain endocrine-disrupting chemicals linked to an increased risk of breast cancer in women of color and to educate the attendees on clinical trials. This will be an interactive program where polls will be conducted to reinforce the information, the audience can ask the experts questions and gift card giveaways for active participants. The audience will leave with information on breast cancer, how to do self-breast checks, low and no cost mammograms, healthy diet and exercise and clinical trials.

The Employee Kindness Grant program is designed to encourage City of Hope employees to engage with the community. Utilizing the same approach as the Healthy Living Grants, we provide the parameters for the strategies and allow applicants to submit their ideas for how to address an identified need. Not only are we supporting employees to do good in their communities, we are also providing them skills and courage to tackle critical social health issues.

Food Insecurity — Greater San Gabriel Valley Hospital Collaborative, Produce for Patients, Garden of Hope and Kid Run Farmers Markets

Greater San Gabriel Valley Hospital Collaborative, Community Health Needs Assessment and Food for All Initiative

The Hospital Collaborative is an initiative of and facilitated by the Health Consortium of Greater San Gabriel Valley (Health Consortium) and began meeting in mid-2018. The mission of the Health Consortium is to strengthen the health care safety net and optimize seamless access to high quality physical health, mental health and substance use disorder services in the Greater San Gabriel Valley. This area includes both the San Gabriel and Pomona Valleys, stretching from Pasadena to Pomona and incorporating the geographic area defined by Los Angeles County as Service Planning Area (SPA) 3. The Greater San Gabriel Valley Hospital Collaborative, funded in part by the UniHealth Foundation, serves to (a) work collaboratively to streamline and coordinate data collection for the community health needs assessments 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 - the L.A. County Department of Public Health and the Pasadena Public Health Department. As a direct result of this partnership, the hospitals committed to identifying high-confidence social determinants of health and worked on strategies to resolve those issues.

SPA 3 Hospital Collaborative partners

2022 Community Health Needs Assessment Rollout (CHNA) to Community

In April 2023, we marked the second coordinated rollout of the CHNA to the community. City of Hope hosted the event in Cooper Auditorium on the Duarte campus. Attendees represented organizations across the San Gabriel Valley and presented a myriad of topics. The session provided an overview of the major trending health issues and social health issues that impact equity in the cities we serve. Audience members were given an opportunity to ask for clarification of the data presented and provide insight from their

Audience participation at the 2023 Health Trends in SGV event.

perspective. At the end the hospital partners made another commitment to continue to work collaboratively on issues that impact the residents in our region. To learn more about our 2022 CHNA, click here.

Food for All Initiative

In June 2021, the UniHealth Foundation funded the Hospital Collaborative to coordinate a regional project, the *Greater San Gabriel Valley Food for All Initiative,* to reduce food insecurity among economically and medically vulnerable hospital patients at participant hospitals. Primary project participants include five of the six Hospital Collaborative members: Huntington Hospital, Methodist Hospital, City of Hope, Kaiser Permanente Baldwin Park and Emanate Health. These partners currently engage in food insecurity work at different levels, and this initiative would facilitate each to progress accordingly. Initiative components include:

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 for emergency food services and/or to Project Angel Food for delivery of medically tailored meals, both selected due to their expertise and services. Seeds of Hope 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. Project Angel Food's mission is to prepare and deliver healthy meals to feed people impacted by serious illness and can accommodate 39 different medically tailored meal 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 of community benefit serves as the co-chair of this effort. Data from the last fiscal year are as follows:

Seeds of Hope

Insights	Referrals with Food4All Designation					All referrals to date by Hospitals to Food Partner with or without program designation[c]	Program vs. Nonprogram Count Differential
Seeds of Hope	2022-23 [a]	2023-2024					
Hospital Referrals	Total	Q1	Oct-23	Total	% to Goal		
City of Hope	55	2	3	60		80	20
Emanate Health	11	2	1	14		14	0
USC Arcadia	50	7	3	60		78	18
Kaiser Permanente BP	19	0	2	21		-	0
Huntington[b]	66	53	25	144		-	0
Totals	201	64	34	299			38
Target thru 10.31.23				896	33.4%		

(a) 2022--23 program period runs from 2/1/2022 to 6/30/2023. Not all hospitals referred patients to the program in the first 8 months of implementation given the long onboarding process for some hospitals that ran through September, 2022. Referal start dates on Unite Us platformwere Kaiser 2/2022, City of Hope 4/2022, USC Arcadia 6/2022, Emanate 9/2022

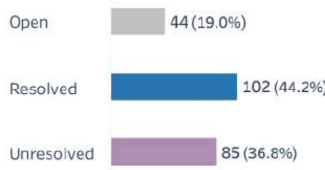
(b) All referrals from Huntington (no program designation available)

(c) This column inlcudes all referrals Null, Food4all and Out of network, except for KP BP where only Food4All designation applies.

Project Angel Food

PAF reported client:	Cohort 1	Cohort 2	Cohort 3	Cohort 4	Cohort 5	Cohort 6	Cohort 7	Total	
USC Arcadia Hospita	5	4	2	4	4	2	1	22	
City of Hope	3	2	0	2	0	1	0	8	
Emanate Health	0	2	14	8	10	17	2	53	
KP Baldwin Park	0	0	1	2	0	2	1	6	
Huntington Hospital	0	8	3	3	0	0	1	15	
Seeds of Hope	2	0	0	0	2	2	4	10	
Total	**10**	**16**	**20**	**19**	**16**	**24**	**9**	**114**	**90.5%**
Cohort target	**18**	**18**	**18**	**18**	**18**	**18**	**18**	**126**	

Managed Case Resolution (through 9.30.2023) PAF and SOH
Total managed cases: 231



Service Types and Case Outcomes
187 managed cases (resolved + unresolved)

Food Assistance	Managed Cases	Resolved Cases	Unresolved Cases	%
Received Services	51	51		27%
Enrolled	1	1		1%
Referred Out of Network	2	2		1%
Received Prepared Meals	12	12		6%
Received List of Local Food Pantries/Banks	6	6		3%
Received Supplemental Food from Food Pantries	6	6		3%
Received Gift Cards/Financial Assistance to Purchase Food	4	4		2%
Client Self Resolved	3	3		2%
Unable to Contact	52		52	28%
Client Declined Services	21		21	11%
Other	29	17	12	16%
Totals	**187**	**102**	**85**	
		55%	**45%**	

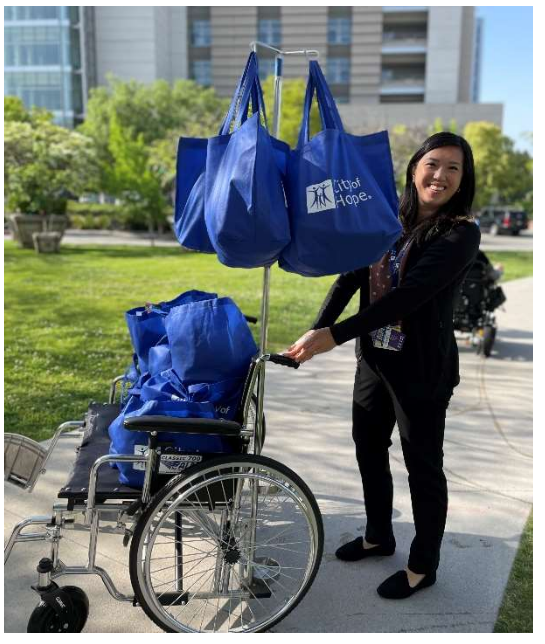
We have learned a great deal during the implementation of this program. Among the most impactful is that even if patients are identified as in need of food, it is still very difficult to connect them to a food source. Food delivery programs seem to be the most accepted and sustainable. Programs where we provide patients with food resources are not as well received. Collectively there is much work to be accomplished. We value this incredible collaboration with the local hospitals and we all are committed to sustaining these efforts now and in the future.

City of Hope Food InSecurity Programs

In addition to supporting the Food for All collaborative, City of Hope created a multidisciplinary team with representation from our clinical and administrative staff to address food insecurity of our most vulnerable patients. During Fiscal Year 2023, we continued to provide produce to patients who responded yes t our inquiry of whether they were food insecure. Thos patients were able to request a 20 lb bag of food upon discharge from our Helford Hospital. Between October 2022 and September 2023, we were able to provide 49 bags of food to patients. We also purchased a refrigerator and freezer so that when patients are discharged to Hope Village, and are food insecure, they can have food stored and delivered to them.. Additionally, we have created a special food resource guide that will be provided to all patients. Those identified with food insecurity will receive extra support from the patient resource coordinators and the team at Hope Village. They will walk the patient through the guide and teach them how to access the local food resources.

Produce for Patients

Between October 2022 and September 2023, City of Hope employees and a handful of local community members sorted and passed out over 26,000 lbs of food delivered by our partner Seeds of Hope. We would not be able to deliver such incredible services without the support of our own organization. During a work day, City of Hope encouraged employees to give back to our community by lending a hand to the quarterly Produce for Patients. From sorting the thousands of pounds of produce from the LA Regional Food Bank, delivered via our community partner, Seeds of Hope, to spinning signs and delivering food to the patient's hands, our committed employees happily serve the community with a smile on their faces and warmth in their hearts.



Total Volunteers in 2023: 123
Total Hours Freely Given: 369 Hours
Total In-Kind $: $24,000

Garden of Hope

Celebrating five years, in September 2023, the Garden of Hope has evolved into a space where hope is felt and where everyone is welcome. Dena Brummer, our AmeriCorps Volunteer from Fiscal Year 2022, extended for another year. This has allowed us to not only provide a great volunteering experience for our master gardener, we have been able to grow our volunteer and programming efforts, too. This year, we have held monthly lunch and learns around gardening knowledge and sustainability. We have participated in enterprise-wide events that promoted awareness surrounding racial/ethnic affinity groups. We participated in community events where we provided demonstrations on garden to table cooking. Our monthly volunteer events bring out community members and City of Hope staff to support the maintenance needs of the garden as well as learning valuable gardening skills. The bounty from the garden is shared with community members, patients and local food banks.

Garden of Hope volunteers and Dena Brummer (center) garden manager supporting the 2023 Martin Luther King Jr. Day event.

Kid Run Farmers Markets

After a couple of years the Kid's Run Farmers Markets is sustainable. With a minimal $350 investment from

four farmers markets, the schools are now able to sustain the program on their own. The challenge is to find that right schools willing to provide the staff support to oversee the program. Over the last several years of working with the La Primeria Elementary School in El Monte, two teachers, along with our team (of two) engage the children in the end-to-end program that trains the students to order produce, sort it and stage the market. During Fiscal Year 2023 we funded two markets at La Primeria and were energized by the children and community. This past year the children hosting the markets were third graders. What we learned is that children this age need more support, but they are just as capable of hosting these markets with the right training and mentors. This incredible program was well received and we look forward to opportunities, like this, to transform school fundraising and connect children to real food.

La Primaria students and community at their Kid Run Farmer's Market

Social Determinants of Health

The Social Determinants of Health (SDOH) are defined as conditions that exist where a person lives, works and plays. An example could be, a neighborhood that is impacted by violence and poor infrastructure (roads, street lights, etc.) that could create barriers for a person trying to go to school or get to a job. For patients, these social health issues can greatly determine whether they can seek treatment, recover and experience an sustainable healthy life. This last year, City of Hope has been focused on creating the necessary pathways to identify patients with social health needs and direct them into community resources that can help them. Earlier in this report, we introduced you to the food security programs that were created to expand access to food. What we have found is that patients who experience food insecurity also experience transportation, financial and housing volatility, too. We have invested in the UniteUs database where patients with identified social health needs can be referred directly to a community resource near where they live. An inter-disciplinary group has been established with a monthly meeting cadence to address the SDOH needs of our patients at both a workgroup and a steering committee level. One key initiative for this group was to implement tracking of SDOH questions within our hospital's EPIC system. Our EPIC team has successfully implemented the SDOH questions into the system, and staff have been trained on how to ask these questions. QR codes with links to 211.org or FindHelp.org are provided on all patient after visit summaries. Should a patient have needs outside of their clinic visits, they are able to access resources near their homes and can do so 24 hours a day, seven days a week. We are continuing to work across the institutition to build pathways that will be supportive of all patients, their families and caregivers.

Cancer Care Is Different Advocacy

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

The California Cancer Care Equity Act (SB 987) went into effect Jan. 1, 2023. This bill expands access to specialized cancer care for Medi-Cal patients who receive a complex cancer diagnosis.

Backed by City of Hope since the beginning, the bill was introduced by Sen. Anthony Portantino (SD-25) in April 2022 and passed by both chambers of the California Legislature unanimously. SB 987 represents a critical first step in delivering on the promise of the California Cancer Patients Bill of Rights resolution, which recognizes that cancer patients should receive appropriate, timely and equitable access to expert cancer care and was adopted by the Legislature in 2021. Throughout Fiscal Year 2023, City of Hope's Government and

Community Relations team continued to advocate for this effort. To learn more about all of the Cancer Care is Different effort click here.

Cross Institution Collaborations

It is important to recognize the participation of the hardworking individuals who contributed to over 180 community events across this institution and in the vulnerable communities City of Hope serves. To do this work, Community Benefit collaborated most notably with teams in Enterprise Growth and Innovation, Government and Community Relations, Nutrition, Rehabilitation, Diversity, Equity and Inclusion, the employee resource groups, Nourishing Hope, Financial Services, and Nursing. It has been another amazing year and we are full of gratitude for all of our generous friends, collaborators and community members who have supported us and helped us to serve those in need. Should you have any questions about our community events or want to learn more about Community Benefit at City of Hope, please send us a note at: CommunityBenefit@coh.org.

COMMUNITY BENEFIT INVESTMENTS

How Benefits Were Defined

The quantifiable community benefits provided by City of Hope in Fiscal Year 2023 are listed in the table below. Consistent with community benefit standards, only activities funded by City of Hope National Medical Center (versus Beckman Research Institute of City of Hope, City of Hope Medical Foundation or Philanthropy) are included.

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

Methods Used to Collect Data and Derive Values

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

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

City of Hope employees donating Garden of Hope produce to Shepherd's Pantry

Value of Quantifiable Benefits

FY23 Community Benefit Categories	FY22 Net Benefit
CHARITY CARE[1]	38,243,361
UNPAID COSTS OF MEDI-CAL[2]	92,067,810
OTHERS FOR THE ECONOMICALLY DISADVANTAGED[3]	0
EDUCATION AND RESEARCH[4]	173,038,034
OTHER FOR THE BROADER COMMUNITY[5]	8,291,747
TOTAL COMMUNITY BENEFIT PROVIDED EXCLUDING UNPAID COSTS OF MEDICARE	311,091,952
UNPAID COSTS OF MEDICARE[2]	223,332,170
TOTAL QUANTIFIABLE COMMUNITY BENEFIT	**534,973,122**

Fiscal Year 2023 Quanitifiable Community

[1] Charity Care includes traditional charity care write-offs to eligible patients at reduced or no cost based on the individual patient's financial situation.
[2] Unpaid costs of public programs include the difference between costs to provide a service and the rate at which the hospital is reimbursed. Estimated costs are based on the overall hospital cost to charge ratio. This total includes the revenue and expense associated with the state Quality Assurance Program. City of Hope recognized net revenue from the Quality Assurance Program, which is recorded as $0 Medi-Cal shortfall.

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

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

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

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

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 2023 investment of $**534,973,122** and reported on the strategies prioritized in our 2021-2023 Implementation Strategy Plan. The main focus areas of our Fiscal Year 2023 community benefit programs and services: Healthy Living, Community Capacity Building and Kindness Grants, Food Insecurity - Greater San Gabriel Valley Hospital Collaborative, Food for All Initiative, Garden of Hope and Produce for Patients, Social Determinants of Health, and the Cancer Care Patient Equity Bill have been described in detail. We also had an incredible amount of cross-institutional collaborations that have utilized the lens of health disparities and the social determinants of health to create new partnerships and leverage current relationships to deliver services to our most diverse and vulnerable communities. With the pandemic still in our minds,we have begun to do more in-person interactions with our community. We have learned that we can extend our reach to the communities we serve by continuing our online programming.

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

Appendix A
2019 Needs Assessment Tools

Primary Data Collection Participants

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

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

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

Primary Stakeholder Interview Questions

Interview Questions and Notes

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

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

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

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

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

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

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

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

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

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

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

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

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

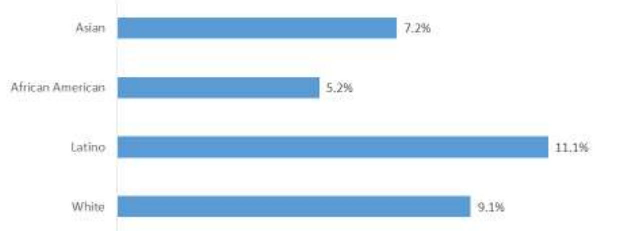
4. What are the differences in health-care needs and health-care outcomes between first and second generation Latinos. First generation being foreign born and second being U.S. born.

5. Would you like to add any additional information?

Community Voice Summary

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

Increasing concern about mental health



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

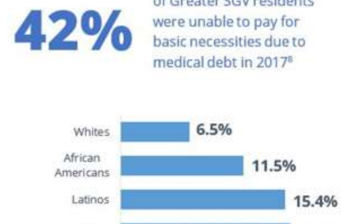
Some groups…
- Are more impacted
- Have less access to resources

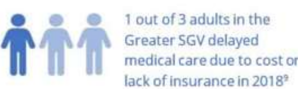
"Do you feel stressed? No, sick! You feel feo. Alone, like you don't know where to go. The stress of not being able to find a place to live is too much for a person."

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





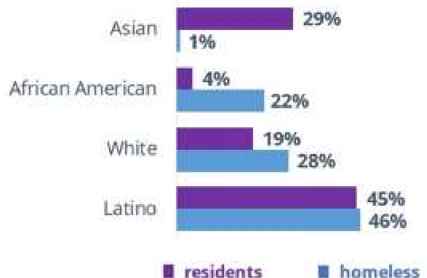
"In our area, I don't know what is happening, I don't know if the doctors are already booked or have total capacity for the Medical patients but they are full, and the patients get referred to places outside of the area, which is very difficult because they don't have transportation."

% 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

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]

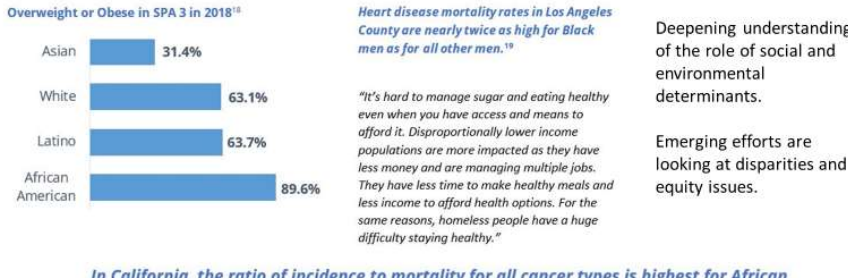
In a 2018 survey, 49% of Latinos in the Greater SGV report being able to afford enough food each month, 67% of Whites and 88% of Asians[17]

"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…



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 recommendations

- Expand mobile health and mobile mental health services
- Provide trauma-informed care
- Develop services that are rooted in cultural values and traditions
- Expand promotora and peer-to-peer support programs
- Include community members in systems change and service design planning
- Strengthen resource referral networks to address need for homeless diversion
- Grow our collective understanding of structural racism and racial bias in our public health and social services

Community Resources

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

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

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

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

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

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

Appendix B
Financial Assistance Policy

Status **Active** PolicyStat ID **13165549**

Origination	11/1/2005	Owner	Kristina Johnson
Last Approved	4/3/2023	Area	Administrative - Institutional
Effective	4/3/2023	Scopes	Foundation, Medical Center
Last Revised	4/3/2023		
Next Review	4/2/2026		

Financial Assistance Policy

I. PURPOSE / BACKGROUND

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The purpose of this Financial Assistance Policy (the "Policy") at City of Hope (COH) is to promote and facilitate access to high quality healthcare consistent with the COH mission and its Code of Conduct. COH seeks to improve the quality of health care and ensure that care is accessible to the maximum number of people possible within the resources available at COH. Meeting the needs of uninsured and underinsured patients is an important element in COH's commitment to the community.

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

II. POLICY

A. **Patients Who May Apply:** An individual may apply for Financial Assistance (free care) at COH if the individual meets all of the following conditions:

1. The individual meets the criteria for care at COH for a primary diagnosis of cancer, diabetes, HIV/AIDS, hematologic disease or for treatment with hematopoietic cell transplantation; and
2. The individual meets the income eligibility criteria set forth in this policy and the *Financial Assistance Guidelines Table* (Appendix A); and
3. The individual is a US Resident or has received care from COH within the past year regardless of residency; and the individual is not a participant of the COH International Medicine Program or have a patient status of "International Patient." Please refer to Appendix One for the definition of an International Patient.

B. **Account Types Covered:** The following account types are covered by this policy:

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1. Self pay services where a patient has no insurance that covers the services at issue, and
2. Insured patients where the patient has limited or has fully exhausted their medical benefits, and
3. Insured patients who are unable to pay patient liabilities e.g., deductibles, co-insurance, or copays, as required by third party coverage, including Medicare deductible or coinsurance and Medi-Cal Share of Cost.

C. **Services Covered:** This policy covers all medically necessary services that COH 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.

1. This policy covers services billed by the COH National Medical Center and the COH Medical Foundation.
2. This policy covers services billed by COH Retail Pharmacies, including specialty and non-specialty medications.
3. For purposes of this policy, questions or issues about medical necessity will be resolved by COH's Chief Medical Officer, or their designee.

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D. **Financial Assistance Provided:** If a patient qualifies for financial assistance, the patient will receive the financial assistance necessary to ensure that services provided by COH covered under this policy and received during the eligible time period are free to the patient for medically necessary care. There is no sliding discount scale associated with the provision of financial assistance. Once a patient at COH qualifies for financial assistance, the patient receives all services with no out-of-pocket cost.

E. **Amounts Generally Billed:** In providing financial assistance, COH is required by law to consider and disclose the method for calculating the amounts generally billed ("Amounts Generally Billed" or "AGB") *when applicable* to individuals who have insurance covering emergency or other medically necessary care, and to guarantee that patients accepted for financial assistance will not be charged more than the AGB.

1. AGB is not applicable. COH patients who qualify for financial assistance will receive services (including emergency or other medically necessary care) at no out-of-pocket cost.
2. COH will not charge patients as care is provided at no out-of-pocket cost. Therefore, patients will not be charged more than AGB for emergency or other medically necessary services.
3. COH uses the Prospective Medicare method for calculating AGB.

F. **Duration of time for which financial assistance is approved:** A patient will be accepted for financial assistance for a period of one year. If a longer period of financial assistance is

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required and requested, the patient will be re-evaluated, using the same criteria as were initially applied and outlined within this policy.

G. **Financial Assistance Income and Asset Criteria:** Patients are evaluated for qualification based on income and patient assets.

   1. **Financial Assistance Guidelines Table:** The *Financial Assistance Guidelines Table* (Appendix 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 *Financial Assistance Guidelines Table* will be updated annually by the Vice President of Revenue Cycle based on updates to the FPL.

   2. **Income Below 600% of FPL:** An individual will be considered for financial assistance if their Income (or family's Income) is less than 600% of FPL, as provided in the *Financial Assistance Guidelines Table*. An individual will also be considered for financial assistance if that individual or their estate has declared bankruptcy.

   3. **Patient Assets:** Consistent with COH's mission and the proper stewardship of COH funds, all monetary assets of the patient or patient's legal guardian may be considered in reviewing a financial assistance 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.

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H. **Nondiscrimination:** In making decisions regarding the provision of financial assistance pursuant to this policy, COH does not discriminate on the basis of age, sex, gender, gender identity, race, religion, creed, disability, sexual orientation, or national origin.

   1. All determinations regarding patient financial obligation are based solely on financial need and patients may be considered for financial assistance at any time that the inability to pay becomes evident to the patient or COH, regardless of any prior determinations under this policy.

   2. A patient may apply for financial assistance at any time.

   3. COH renders financial assistance on a uniform and consistent basis according to this policy.

I. **Patient Application Process and COH Review of Applications:**

   1. **Identification of patients who may be eligible for assistance under this policy:**

      a. Identification of patients who are eligible for financial assistance can take place at any time, including before services are scheduled, while the patient is receiving services, or during the billing and collection process.

      b. Patients may apply for financial assistance or be identified as potential financial assistance applicants by COH staff at multiple points in the continuum of care, such as Patient Referral Services, Scheduling, Financial Counseling, inpatient and outpatient admitting, and registration. All front line administrative and clinical staff, including COH affiliated physicians,

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Clinical Social Work staff, Patient Advocates and Research Operations are encouraged to identify patients and refer them to Financial Clearance (FC), a division of Patient Access.

c. 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.

d. This policy does not change COH's existing policies allowing COH to:

   i. Redirect patients who are out-of-network to an in-network provider, or

   ii. Determine whether to accept patients from outside facilities who seek transfer to COH. For additional information, see *Transfer Into or Out of COHNMC* and *Patient Admissions Policies*.

2. **Patient Application Process:**

a. Applicants are responsible for cooperating fully with the application process, including the provision of information requested on the *Financial Assistance Evaluation Form*.

   i. Patients or prospective 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. If a patient's financial circumstances have changed since their last W-2 or previous income tax return, the last four paycheck stubs will be used to determine proof of income.

   ii. FC counselors may assist patients in completing financial assistance applications to provide maximum consistency.

b. If it appears that the patient might be eligible for Medi-Cal or another state health program, FC refers the patient to a vendor who can assist the patient with Medi-Cal and Medicare Part B applications. It is the responsibility of the patient or their family to apply for such coverage with assistance from COH's application vendor, and proof of a completed application must be provided to COH.

c. Patients who do not qualify for Financial Assistance under this policy may be eligible for other assistance through the COH policies noted in the Related Policies section at the end of this policy, or through outside pharmaceutical assistance programs.

d. COH may also gather the necessary information via an automated tool to assess whether the individual is eligible for Presumptive Financial Assistance.

3. **COH Review Process:**

a. Financial assistance applications will be reviewed by FC to determine if the patient meets the eligibility criteria in this policy.

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b. The applications will then be approved or denied by the following COH designated individuals based on annual estimated patient liability:
   i. Up to $10,000: Financial Counselor, Financial Clearance
   ii. $10,001 to $25,000: Manager, Financial Clearance
   iii. $25,001 to $50,000: Sr. Manager, Patient Financial Services
   iv. $50,001 to $100,000: Director, Patient Financial Services
   v. $100,101 to $500,000: VP, Revenue Cycle
   vi. $500,001 and greater: Chief Medical Officer, Chief Financial Officer, and Chief Operating Officer or their designee(s)

c. These estimated financial liability amounts are calculated based on the patient's proposed patient treatment plan, taking into account insurance coverage and any discounts available under other COH policies as noted below.

d. The annual calculation will be based on the date of service, rather than calendar year.

e. It may be difficult to quantify the dollar amount described above for patients whose primary residence is outside of the areas that COH generally serves. Those individuals will be connected with Supportive Care for an assessment of their access to transportation to and from COH for necessary care, a discussion of the caregiving resources available to them near their primary residence, and an analysis of their insurance plan and its coverage, if any, for services at COH. If necessary, the applications for these patients may be reviewed by the Financial Assistance Committee.

f. It may also be difficult to quantify the dollar amount described above for patients who are eligible to participate in a clinical trial. Those individuals will be connected with the appropriate research staff and Financial Clearance for an assessment of their potential responsibility for standard of care services, a review of the potentially applicable clinical trials, and an analysis of their insurance plan and its coverage, if any, for services at COH. If necessary, the applications for these patients may be reviewed by the Committee.

g. As needed, any of the reviewers above may consult with COH clinical staff, as well as COH administration, Financial Clearance, Case Management, Patient Access, Research Operations and Clinical Research Services, and the Ethics and Compliance Department.

h. Following receipt of completed application and financial qualifications verified by FC, a "Financial Assistance 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.

4. **Exceptions to the Policy:** A Financial Assistance Committee ("the Committee") may

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approve patients for Financial Assistance who do not meet all of the eligibility criteria specified in this Policy.

a. The Committee is comprised of the Chief Medical Officer or his/her designee, representatives from each clinical program at COH (including the Chair or designee from Hematology/Hematopoietic Cell Transplantation, Medical Oncology, Surgery, Pediatrics), Revenue Cycle, Financial Clearance, Supportive Care Medicine, a member of the Patient Rights and Organizational Ethics Committee, and a community/patient representative. The Committee may invite other individuals to present cases to the Committee, including the patient's treating physician.

b. The Committee will meet bi-weekly, or as needed, to review applications that do not meet the eligibility criteria in this policy. The Committee may be called on an ad hoc basis for time sensitive applications.

c. For example, 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:

    i. Expired Breast and Cervical Cancer Treatment Program Restricted coverage

    ii. Conditions of participation requiring the patient to have a Primary Care Physician (PCP) in the community

    iii. Treatment/services that are restricted in the community

    iv. Existing COH patients converting to non-contracted Managed Care Plans (including commercial, Medicare and Medi-Cal managed care plans) when a COH Physician reviews and determines that patient's safety and survival will be comprised from interruption of ongoing treatment at COH.

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5. **Annual Review:** COH may reevaluate patients designated as eligible for financial assistance at any time and will reevaluate each patient's eligibility at least annually.

J. **Patient Notification:** Applicants for financial assistance are notified of decisions in writing.

K. **Patient Right to Appeal:** Each patient denied financial assistance will be given the right to appeal. If a patient is denied financial assistance, all reasons for denial are included in the notice provided and the patient is informed of their appeal rights and the appeal rights procedures.

1. 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.

2. Within 14 days of receiving an appeal from a patient who has been denied financial assistance, the patient and FC 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 COH respects the confidentiality and privacy of those who

seek financial assistance.

1. FC 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 COH 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. **Communication of Financial Assistance Process to Patients and Community:**

1. **Public Awareness:**
    a. COH is committed to building awareness of the Financial Assistance Policy through a variety of mechanisms including but not limited to: (i) visible signage within COH (such as posters or notices in key admitting and registration areas, point of service brochures in waiting areas); (ii) COH's website; (iii) in routine, written notification given at the time of admission to COH, and (iv) in bill statements showing outstanding patient self-pay balances. All notices will include a toll-free number and information explaining how to access an FC counselor. COH will also provide a paper or electronic copy of the "Financial Assistance Policy" upon request.
    b. COH is committed to using the primary languages of the major ethnic and cultural communities who utilize COH in all materials used in connection with the "Financial Assistance Policy." Printed information will be available in English, Spanish, and Traditional Chinese languages. Translators in COH'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 "Financial Assistance Policy" and are updated periodically regarding changes. Detailed materials for training are prepared and maintained by Patient Financial Services. Materials include information on how to access financial assistance, standards of cultural sensitivity and how to preserve confidentiality, including best practices and practices not tolerated by COH. All employees are made aware of the availability of financial assistance as part of employee orientation.

N. **Collections and Regulatory Compliance:**

1. COH will apply this policy before outstanding accounts are sent to collection. COH does not advance outstanding accounts to collection while a patient is undergoing financial counseling, attempting to qualify for financial assistance, or attempting in good faith to settle payment.
2. Neither COH 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

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financial assitance under this policy.

a. ECA is not utilized in connection with this policy. Although COH does not use ECA, COH is committed to adherence with all laws governing its financial services transactions in addition to those that govern the use of ECA, meaning that 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 COH makes widely available to the public by posting it on the COH website.

3. All agencies used for collection are advised of COH policy in writing, and the "Financial Assistance Policy" is incorporated by reference in collection contracts with such agency(ies). COH receives written assurances from agency(ies) that they will adhere to COH financial services standards.
4. COH is compliant with AB1020 regarding the consumer debt collection process and debt assignment.
5. COH is compliant with the No Surprise Billing Act and ensures that good faith estimates for self-pay and uninsured patients include appropriate percentage discounts.

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O. **Oversight and Board Responsibilities:** To ensure proper oversight, COH has implemented several layers of program management and review:

1. Senior management reviews detailed reports on COH's provision of financial assistance on a quarterly basis.
2. The Board of Directors is responsible for balancing the critical need for patient financial assistance with the sustainability of COH's resources and its financial integrity in order to serve the broader community. To this end, the Board will receive an annual report informing them of total financial assistance and community benefits provided to our patients.
3. To be an effective steward of COH's resources, the Board of Directors ("the Board") strives to preserve the financial health of COH. 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.

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Related Policies

1. Center for International Medicine: Financial and Patient Payment Policy
2. Code of Conduct
3. Collections Policy
4. New Patient Application and Acceptance
5. Patient Admissions
6. Patient Discounts and Free Services
7. Patient Financial Services: COBRA Assistance
8. Prescription Assistance
9. Professional Courtesy Discounts
10. Provision of Patient Assistance Items to Patients Who Demonstrate Financial Need
11. Transfer Into and Out of COHNMC

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

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1. **Charity Care Policy** – The Financial Assistance policy replaces the Charity Care policy.
2. **City of Hope (COH)** – City of Hope National Medical Center (COHNMC) and City of Hope Medical Foundation (COHMF or Foundation)
3. Extraordinary Collection Actions ECA – are defined as actions taken by a hospital facility against an individual related to obtaining care covered under the hospital facility's FAP (Financial Assistance Policy).
4. **Financial Assistance** – Free or partially subsidized health care services, including retail pharmacy services, provided by COHNMC and COHMF to eligible individuals who meet the criteria set forth in Section II.A of this Policy.
5. **Income** – Gross income from all sources.
6. **International Patient** – Pursuant to the Center for International Medicine: Financial and Patient Payment Policy, an international patient may include but is not limited to the patient circumstances described below: A patient:
    a. Who is a foreign national and resides outside of the USA; or
    b. Who resides in a USA territory (Puerto Rico, Guam, St. Thomas, St. John, Water Island, North Mariana Islands, American Samoa); or
    c. Who is a foreign national currently inside of the USA temporarily and is not using U.S. federal or state governmental program funds or benefits to pay for medical services. These patients
        - May be receiving care at another hospital and looking to transfer care to COH;
        - May have been diagnosed and/or have begun/completed treatment in

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another country; or

- May be staying with family, or on vacation

d. Who has a home in the USA but primarily resides in their country of citizenship (For Example: a Canadian patient with a winter home in Phoenix, AZ); or

e. Who is a USA citizen living outside of the USA or is permanently residing in another country; or

f. Who is a USA citizen in another country on a work or student visa, or who is a missionary; or

g. Who is a USA military service member stationed outside of the USA and looking to come back to the USA for care.

7. **Medically Necessary Services** – Inpatient or outpatient services deemed medically necessary by a COH medical staff member.
8. **Presumptive Financial Assistance** – COH recognizes that a portion of the uninsured or underinsured patient population may not engage in the traditional financial assistance (FA) application process. If the required information is not provided by the patient, COH may utilize an automated, predictive scoring tool to qualify patients for Financial Assistance; the tool predicts the likelihood of a patient to qualify for Financial Assistance based on publicly available data sources. The tool will provide estimates of the patient's likely socio-economic standing, as well as the patient's household income and size.
9. **Self-Pay Balance** – The outstanding balance of a COH 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 Financial Assistance Policy. (Guarantor refers to the individual assuming financial responsibility for services received by the patient.)
10. **Standard of Care Services** – Treatment that is accepted by medical experts as a proper treatment for a certain type of disease and that is widely used by healthcare professionals. Also called best practice, standard medical care, and standard therapy. (see NIH Dictionary of Cancer Terms)
11. **US Resident** – Individual who has lived in the United States for more than 6 months within the last 12 months.

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Appendix A: City of Hope Financial Assistance FPL Guidelines

The following Financial Assistance Eligibility Guidelines are based on the Federal Poverty Guidelines effective **January 1, 2023**. This schedule delineates the household income thresholds according to the FPL.

2023 FPL GUIDELINES

Number in household	Annual 100%	Annual 600%	600% Monthly
1	$ 14,580.00	$ 87,480.00	$ 7,290.00

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2	$	19,720.00	$	118,320.00	$	9,860.00
3	$	24,860.00	$	149,160.00	$	12,430.00
4	$	30,000.00	$	180,000.00	$	15,000.00
5	$	35,140.00	$	210,840.00	$	17,570.00
6	$	40,280.00	$	241,680.00	$	20,140.00
7	$	45,420.00	$	272,520.00	$	22,710.00
8	$	50,560.00	$	303,360.00	$	25,280.00
Each additional person, add	$	5,140.00				

Source: detailed-guidelines-2023.pdf (hhs.gov)

Appendix B: City of Hope Financial Assistance Policy: 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 COH'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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Appendix C: City of Hope Financial Assistance Policy: List of Providers

- City of Hope Medical Group physicians (when services are provided at COH*)

* For more information, see *Financial Assistance Policy*. For questions, please contact Financial Clearance Services at (844) 936-4673.

Approval Signatures

Step Description	Approver	Date

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