City of Hope®

2024

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 2024 (from October 1, 2023, to September 30, 2024). The State of California's Community Benefit law (SB697) requires nonprofit hospitals to address the needs of their communities through programs designed to help prevent diseases and improve the health status of its citizens.

Fiscal Year 2024
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 2022-2025 Community Health Needs Assessment and subsequent 2022-2025 Implementation Strategy. Throughout this document, we will demonstrate an understanding of the diverse needs of the multicultural communities we serve and a commitment to the creation of the infrastructure necessary to carry out an extensive array of community projects. Our traditional community education efforts in cancer prevention and cancer risk reduction are also reflected. The total value of our community benefit investments during Fiscal Year 2024 was $440,640,996.

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 everand 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 that, along with our implementation strategy, is available for download on our website via www.cityofhope.org/community-benefit. We welcome you to share your comments with us by emailing CommunityBenefit@coh.org.

City of Hope nurses collect items to distribute to Project Ropa in Downtown Los Angeles, 2024

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 57 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 stageand 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 reengineered white cells to target and attack a patient's cancer cellsand 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 therapyand nutritional and financial counseling. Foundational to this approach is our focus on innovation as we strive to turn tomorrow's

Longtime employee, Thomas Brown, supporting the quarterly Produce for Patients program

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 730 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 worldand 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 researchand vital education focused on eliminating cancer and diabetes. ©2012 City of Hope

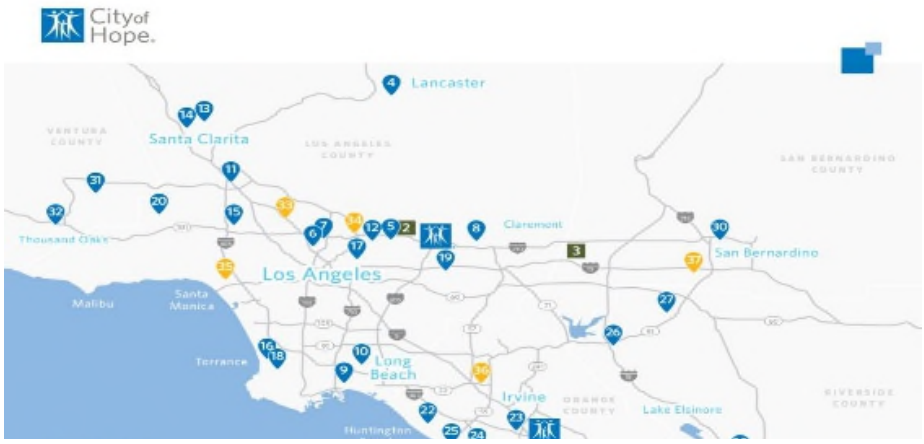
Statement of Corporate Social Responsibility

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 lifestylesand 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.

Communities We Serve

City of Hope's main campus is located at 1500 East Duarte Road in Duarte, California. City of Hope’s primary service area includes portions of Los Angeles, Orange, Riverside, San Bernardino and Ventura counties. The majority of our patients come from Los Angeles County and, in particular, communities within Service Planning Area 3 (SPA 3). SPA 3 includes 34 cities, including Alhambra, Altadena, Arcadia, Azusa, Baldwin Park, Claremont, Covina, Diamond Bar, Duarte, El Monte, Glendora, Irwindale, Monrovia, Monterey Park, Pasadena, Pomona, San Dimas, San Gabriel, San Marino, Temple City, Walnut and West Covina, among



City of Hope – Service Area including clinical network locations.

others. Our service area map (below) shows our clinical network sites across five counties.

Race/Ethnicity[1]

The five-county service area represents 47% of the population in California. These counties make up 56% of the Latino population in the state, 38% of the white population, 45% of the Asian population and 52% of the Black population. All counties but Orange County have a higher proportion of Latinos compared to the state. The white population is proportionately higher in Ventura (42.7%) and Orange (37.6%) counties. The Asian population is proportionately highest in Orange (20.9%) and Los Angeles (14.9%) counties. The Black/African American population is higher in San Bernardino County (8.1%), Los Angeles County (7.5%) and Riverside County (6.5%). In SPA 3, the highest population of Latinos is in Pomona and El Monte. Altadena and Pasadena have the highest concentration of Black individuals. 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 chart above illustrates the low and high range proportions of ethnic groups by SPA 3 city. In 2017, Irwindale, La Puente and South El Monte had the highest concentration of the Latino population, with a rate of 93.3%, 84.7% and 82% respectively. In 2020, the three cities remained home to the highest concentration of the Latino population with 90.8% in Irwindale, 81.7% in La Puente and 79.6% in South El Monte.

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

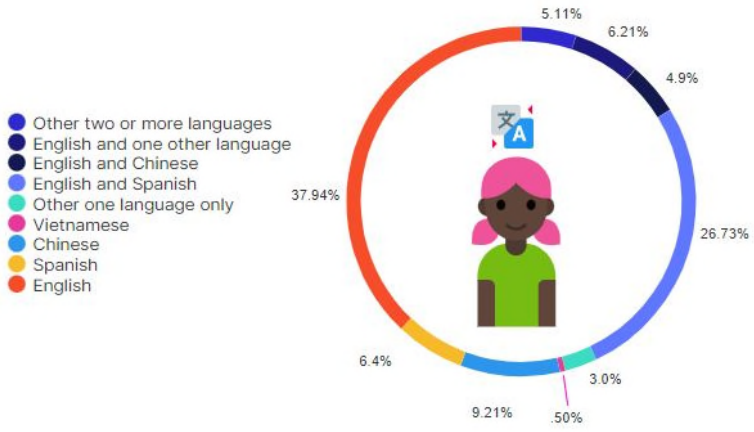
The highest population of Asians reside in Walnut (67.1%) and Monterey Park (66%). The 2020 Census also shows Asian populations comprising over 60% of the population in numerous other cities, including Arcadia (64.6%), Rosemead (64%), Temple City (63.5%), San Gabriel (63.4%), Rowland Heights (61.3%)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

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 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.



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

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

Language	City
English Only	Sierra Madre (80.8%), La Verne (77.2%), Claremont (74.8%)
Spanish Only	South El Monte (66.3%), La Puente (65.6%), Baldwin Park (61.8%)
Other Indo European	Altadena (9.3%), Bradbury (7.3%), Pasadena (6.0%)
Asian/Pacific Islander	Rosemead (58.4%), Rowland Heights (57.4%) San Gabriel (56.6%)
Other	Bradbury (6.7%), Glendora (2.9%), San Dimas (1.8%)

Language Spoken at Home, SPA3 Cities With the Highest Rates. Source: U.S. Census, American Community Survey, 2020

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 vulernability affects people.

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 2024, the Federal Poverty Level for an individual stood at annual income of $15,060 (in 2022 $13,590) while for a family of four it was $31,200[3] (in 2022 $27,750). 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]

[3] Annual Update of the HHS Poverty Guidelines https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines Accessed (December 19,2024)

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

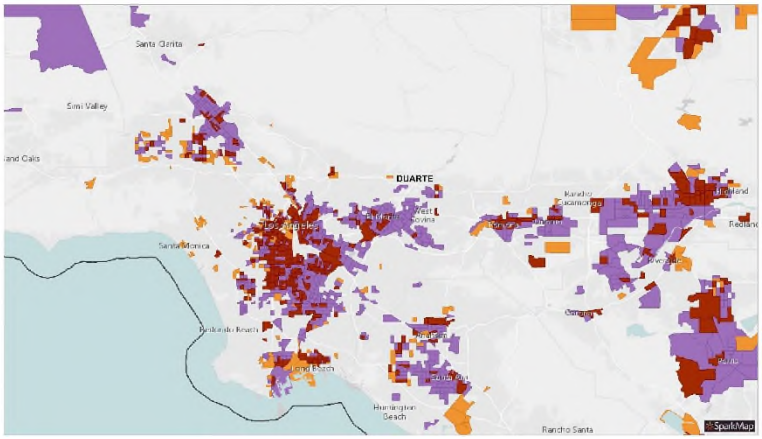
Educational Attainment

One of the key drivers of health is educational attainment — low levels of education are often linked to poverty and poor health[5]. In SPA 3, 14 cities rank below the state level in the rate of college educated adults, ages 25 and older. South El Monte (7.7%) and La Puente (9.1%) have the lowest rates of college graduates in SPA 3.

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

Vulnerable Populations

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 represent communities where residents have less than a high school education. The mustard-colored areas indicate regions where people live below the Federal Poverty Level. The reddish brown areas illustrate communities where residents have both less than a high school education and live below the Federal Poverty Level. The unique makeup of these five counties makes them vulnerable and highlights the need for community benefit programs.



[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.

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

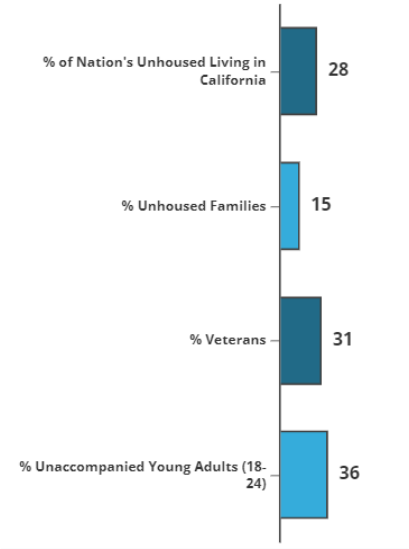
COVID-19 Lived Experience by SPA3 and County

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

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

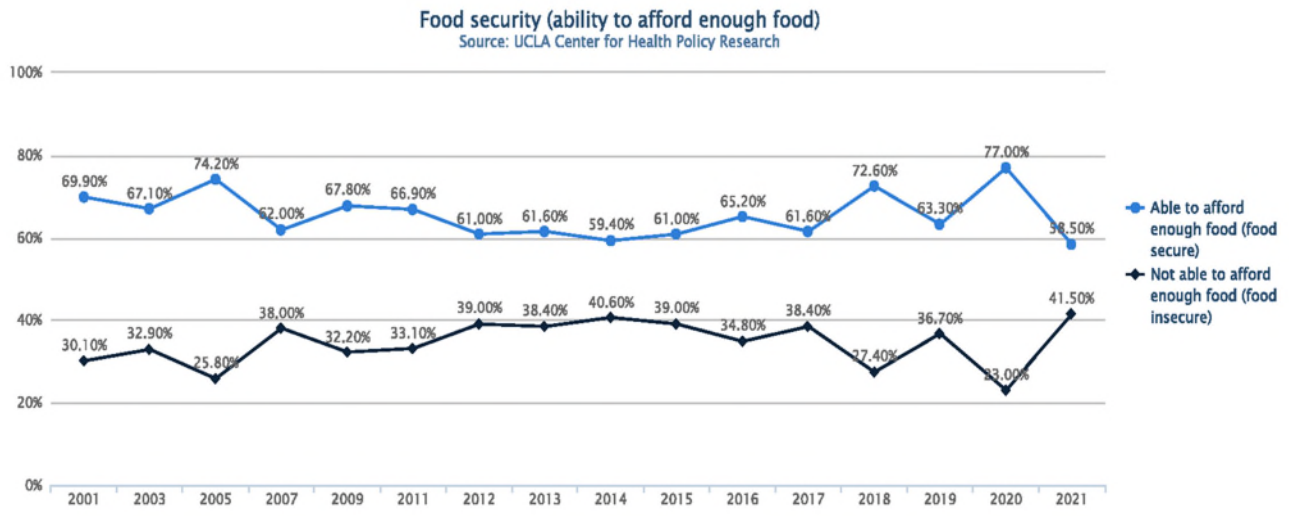
The Unhoused

In Los Angeles County, the total unhoused count rose by 18.7% to 67,198 from 2017 to 2020, creating a public health crisis. The unsheltered count increased by 24.4% to 51,092. Between 2020 and 2022, the rate of increase slowed to 4%, with the total count reaching 69,144. About 12% experience chronic homelessness, and over two-thirds are male. Among adults, 1 in 4 face substance abuse or mental illness. Most unhoused individuals are Latino/Hispanic (56%), White (25%), and Black/African American (17%). In SPA 3, the rate 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 during Fiscal Year 2024 membership of the council had representation from the 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
- MaryKnoll Sisters
- Planned Parenthood Pasadena and San Gabriel Valley
- San Gabriel Valley Economic Partnership
- 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

Miki Carpenter and Patricia Duff Tucker serve as the co-chairs of the CBAC. Throughout Fiscal Year 2024, the 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 2022-2025 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 CHNA 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.

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

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

COMMUNITY BENEFIT PLANNING PROCESS

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

1. Emphasis on 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 futureand often more complex medical care

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

After the review of the results in the 2022 CHNA in October 2022, the CBAC assisted in the prioritization of the CHNA during a special meeting held in December 2022. The process was facilitated by both Clifton-Hawkins and CBAC member Maura Harrington. The framework for the design of the 2022 to 2025 Implementation Strategy was set during this convening. The strategy can be downloaded and reviewed by clicking here. Completion of the 2022 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 2022-2025 Implementation Strategy was officially adopted by the City of Hope National Medical Center Board during their February 2023 meeting. Next, you will find the methodology used to gather data and prioritize health needs in that 2022 assessment.

CBAC members prioritizing health needs

COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS AND RESULTS

2022 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 2022 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 servicesand (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 can pinpoint diseases and conditions that impact citizens at different geographic levels. This data can help an organization target programs and services directly to communities that are impacted the most. Secondary data was collected from a variety of local, county and state sources to present community demographics, social and economic factors, COVID-19, health access, health behaviors, mental health, chronic diseases, cancer and health statusand mortality. When pertinent, these data sets are presented in the context of the State of California, framing the scope of an issue as it relates to the broader community. Additional data sets can be found in Appendix A.

Secondary datasets for the hospital service area were 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 and data year.

Primary Data

Primary data asks community stakeholders, including residents, service providers and representatives across sectors, how a particular health or social issue impacts them. Primary data can be gathered directly through focus groups, interviews and/or targeted surveys. When an organization can address the most pressing issues — the root causes of health inequities — the path to preventing or eliminating a leading cause of death becomes clearer.

Interviews

In total, 38 telephone interviews were completed during July to October 2022. Interview participants included a broad range of stakeholders concerned with health and well-being in the Greater Pasadena area and in SPA 3 of the San Gabriel Valley who spoke to issues and needs in the community. Interview participants and their organizational affiliations are included in Appendix B.

The interviews were structured to obtain greater depth and richness of information on health needs identified as priorities through a review of health data and needs conducted prior to the interviews. First, interview participants were asked to describe, from their perspective, some of the major health issues impacting the community, as well as populations who were not regularly accessing health care.

During the interviews, participants were asked to share their perspectives on the issues, challenges and barriers relative to the identified health needs (What makes each health need a significant issue in the community? What are the challenges people face in addressing these needs?).

Focus Groups

For this CHNA, primary data were collected through four focus groups that reached 37 persons. The focus groups took place from July to October 2022. City of Hope partnered with community-based organizations to assist with outreach and recruitment of participants. The organizations engaged residents to participate in the focus groups by using the method they knew to be most effective.

Summary of 2022 CHNA 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:

- Health access, including general access to care, preventive care and bias in systems
- Cancer
- Chronic disease
- Economic insecurity
- Housing insecurity and homelessness
- Mental health
- Overweight and obesity
- Food insecurity
- COVID-19

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

Fourteen of our CBAC members met on December 7, 2022, to identify the top health needs to be prioritized over the next three years. Based on findings from the primary and secondary data collections, participants learned about the identified health needs within City of Hope's community service areas. After the data presentation, everyone was instructed to rate these leading indicators in relation to seriousness, size of the problem (number of people impacted), trends, equity, feasibility, value, consequences of inaction, social determinants/root causes and effective strategies to address the problem. Then they were

CBAC members who prioritized the 2022 CHNA results in-person. There were seven more via Zoom.

instructed to represent their priorities by placing colored dots on the charts. Red #1, Blue #2, Green #3 and Yellow #4. People were also invited to elaborate on their prioritized issues with comments that can help us shape the overall strategies for the 2023 Implementation Strategy.

The results were as follows:

2022 Stakeholder Prioritized Health Needs

Rank	Health Needs
1	Social Determinants of Health
2	Health Access
3	Mental Health
4	Cancer Prevention

It is important to know that while there were eight identified areas of need, those schooled in public health language will see that the CBAC combined topics because they felt that the root causes and shared risk factors were similarand by addressing them collectively rather than individually we could have a greater impact. According to the Healthy People 2030 definition of social determinants of health (SDOH), they "are the conditions in the environments where people are born, live, learn, work, play, worship and age that affects a wide range of health, functioningand quality-of-life outcomes and risks."[7] Our advisory council members emphasized that we need to "*look at the intersections of the SDOH risk factors in order to create solutions and make an impact in our vulnerable communities.*" With this being said, we cannot simply address one issue. Our strategy for the next several years will be to find those intersections, integrate the work, work more deeply with cross-disciplinary partners and create tangible deliverables. While the reader sees only four priority areas, with our work through the intersections, we are, in fact, addressing all eight. As one CBAC member suggested, "The *intersections are where the magic happens*."

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

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.

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 2022 needs assessment, the CBAC will convene four times per year to review progress and budgeting related to the 2022-2025 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. **Social Determinants of Health** – (for example: housing, food, economic insecurity) Addressing the root causes of poor health outcomes and disparities that are often systemic
2. **Health Access** – Removing inherent biases that prevent people from seeking and receiving quality care
3. **Mental Health** – Supporting emotional health to create resiliency and improved well-being
4. **Cancer** – Creating a safe and trusting bridge to cancer education, prevention and treatment services/care from diagnosis to treatment

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 servicesand 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 2024 Programs and Services

Fiscal Year 2024 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 2024. 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 2022 CHNA. Some are organization-wide, while others are conducted by a specific department. The grid here provides a quick overview of our Fiscal Year 2024 programs and services.

	Core Principles				Strategic Priorities			
Program Activity *Beckman Research Center	Vulnerable Populations	Primary Prevention	Seamless Continuum of Care	Community Capacity Building	SDOH	Health Access	Mental Health	Cancer Prevention
Workforce Development								
• Student Mentoring/Interns • Train, Educate and Accelerate Careers in Healthcare • YES2Success – Summer Youth Program*	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
Diversity Initiatives								
• Inclusion 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/Staff	x	x		x	x		x	x
Health Care Support Services – Social Determinants of Health Support								
• Patient Resources Coordination • Transportation • Village Stays • Food Insecurity • Patient Prescription Assistance Program	x	x	x		x	x	x	x
Seamless Continuum of Care								
• Mobile Cancer Screenings • Community Prostate Cancer Screening	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

Fiscal Year 2024 Strategic Priority Programming

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 2024 community benefit programs and services: **Healthy Living, Community Capacity Building and Kindness Grants; Food Insecurity Programs and Collaborationsand 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	Social Determinants of Health	✔
	Health Access	✔
	Mental Health	✔
	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 grants, in Fiscal Year 2018, we created a special grant category to encourage our employees, who have good ideas, to do something great for their community, called Kindness Grants. Our CBAC members review all the applications and make the selections for both the Healthy Living and Kindness grant programs. Council members also conduct site visits of Healthy Living grantees. Not only is it rewarding to help local organizations, but these groups provide City of Hope with more insight into the needs of vulnerable local populations. They also teach City of Hope about ways to support community efforts that tackle health 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. During FY2024 City of Hope awarded $105,000 to local

organizations committed to delivering programs and services to our communities.

Healthy Living Grants

During Fiscal Year 2024, the funding for the Healthy Living Community Grant program continued to grow in the reach throughout the regionand we were excited to provide $90,000 to 13 organizations that demonstrated a creative, yet sustainable, approach to promoting healthy living via our priority areas in the colored box. The 2024 Healthy Living Cohort included a diverse slate of awardees that spanned the Greater Los Angeles and Orange County regions. These impressive organizations are: Altadena Meals on Wheels, April Parker Foundation, Breast Cancer Solution, Gloves4Grief, Marzette's House, OneGeneration, Pelvic Sanctuary Team, Health Bridges, San Gabriel High School, Therapeutic Play Foundation, Unlimited Possibilities, Pomona Hope and Set for Life Inc.Their programs are described below:

1. Altadena Meals on Wheels Meals for Alta Dena Seniors ($5,000)	Altadena Meals on Wheels, a volunteer-run nonprofit, has been serving hot meals to residents since 1973, focusing on compassion, dignity and nutritional excellence. This grant will support efforts at increasing awareness and visibility of the program as it builds its volunteer base, recruits new board members who can contribute to the growth of the serviceand provide meal supplementation to local recipients.
2. April Parker Foundation Futures First: Peer Community Health Worker ($5,000)	Established in 2018, the April Parker Foundation supports and empowers vulnerable groups in Los Angeles, Orange and San Diego counties, focusing on youth and young adults aged 16-24. Our mission is to serve marginalized BIPOC populations facing systemic challenges, by developing initiatives that promote lasting well-being and equity. The "Futures First: Peer Community Health Workers" program addresses critical health issues like mental health, chronic disease prevention, nutrition and social determinants of health, empowering youth to become community health workers who enhance community health navigation and promote mental well-being.
3. Breast Cancer Solutions Eliminating Financial Barriers for Underserved Breast Cancer Patients ($5,000)	In 1997, a homeless woman with breast cancer sought help from county social services, which led to the founding of Breast Cancer Solutions (BCS) in 1998 to address financial barriers to treatment. BCS assists clients with high needs who face obstacles like unstable housing, lack of transportation, poor nutrition and unaffordable medical expenses. By providing financial support for living and treatment costs, as well as community resource navigation and mental health support, BCS ensures access to care and promotes treatment adherence.
4. Gloves 4 Grief Gloves for Grief: Mind, Body, Soul Sellness Event ($5,000)	Gloves4Grief, a nonprofit founded a year ago, emerged from personal pain and loss with a mission to aid individuals and families on their grief journey. Through holistic programs focused on mind, body and soul, we aim to guide people through their pain, fostering inner strength and resilience. Our approach addresses mental health within the context of grief, offering tailored pathways to resilience and improved well-being through affordable wellness events like boxing, yoga and art therapy.
5. Marzette's House Project Healthy Hearts and Mind	Established in 2010, Marzette's House provides services to individuals experiencing homelessness, foster youth and families, aiming to empower socioeconomically disadvantaged communities in the Antelope Valley. Our health initiatives focus on the

($5,000)	benefits of nutritious foods and habits that promote mental and physical well-being through interactive workshops, a community cookbook and educational walking trips to grocery stores. Participants also have the opportunity to cultivate plots in a community garden or use indoor gardening kits, engaging in self-reflection through journaling to track their progress toward healthier lifestyles.
6. One Generation ONEgeneration's Senior Enrichment Center Mental Health and Wellness Program ($5,000)	Founded in 1978, ONEgeneration is committed to enhancing the quality of life for seniors, families and communities by addressing their diverse and complex needs. The COVID-19 pandemic intensified challenges for vulnerable populations, making it crucial to expand access to free mental health care to support frail older adults, adults with disabilities and family caregivers. Our Reseda Senior Enrichment Center's Mental Health and Wellness program offers daily clinician access, biweekly support groups, counseling, mindfulness workshopsand the Buried in Treasures training for those struggling with hoarding, ensuring culturally and linguistically appropriate services to foster resilience and well-being.
7. Pelvic Sanctuary Team Inclusive Pelvic Health Pop Up: Engaging Communities through Education ($5,000)	Pelvic Sanctuary is dedicated to transforming pelvic health education by offering accessible, inclusiveand culturally sensitive resources, particularly addressing the challenges faced by marginalized and stigmatized communities like LGBTQIA+ individuals and sex workers. To revolutionize pelvic health education, we utilize creative and artistic approaches, including interactive pop-up stands at community events, high-quality promotional materialsand strategic partnerships with queer artists in Los Angeles to engage diverse communities and raise awareness. Through educational resources, workshopsand multimedia content, we aim to empower individuals, foster dignity and confidenceand combat health care disparities, envisioning a future where pelvic health is prioritized by everyone regardless of gender, race, sexual orientation, or socioeconomic status.
8. Health Bridges Health Bridges – Holistic Health Initiative ($5,000)	Health Bridges, a student-led initiative at Pomona College's Draper Center for Community Partnerships, aims to improve health outcomes for adolescents and low-income, underinsuredand LEP patients in San Bernardino and Los Angeles counties. Our goal is to ensure everyone has equitable access to quality health care, regardless of language, income, or immigration status. PHEY will offer a series of 13 workshops covering mental health, physical wellnessand nutritional health for local youth, culminating in a community recipe archive project. PSNRN involves Health Bridges volunteers identifying and addressing patients' social health needs through internal referrals to ParkTree staff and external referrals to local organizations, supplemented by follow-up support.
9. San Gabriel High School Addressing the Mental Health Needs of Our Community ($5,000)	San Gabriel High school, part of the Alhambra Unified School District in California, has a predominantly minority student body with 94% of students being Asian (55%) or Latinx (36%)and 76% qualifying for free or reduced-price lunches. During the COVID-19 pandemic, we launched the SGHS Virtual Calming Room, featuring sounds, music, visual aids, guided meditation, journaling, puzzles, games, yoga and links to mindfulness apps, which received positive feedback from students and teachers. Recognizing the ongoing mental health challenges post-pandemic, we established a physical calming room on campus and plan to promote it through a PSA video, aiming to support emotional well-being and address the high number of mental health referrals and assessments among students.

10. Therapeutic Play Foundation Community Health Access ($5,000)	Therapeutic Play Foundation, Inc. (TPF), founded in 2015 by Nakeya T. Fields, LCSW, PPSE, is driven by her experiences as a Black mother, aiming to address disparities in access to safety, resourcesand health care within Black communities. TPF's mission is to employ innovative strategies for community-based outreach, offering diverse behavioral health services for youth and families in Los Angeles County, particularly in underserved areas. To overcome barriers such as transportation and childcare responsibilities, TPF provides reduced-rate services and stipends, with grant funding supporting initiatives to enhance access to essential mental health services and foster community engagement in economically disadvantaged areas.
11. Unlimited Possibilities Access to Care Program ($5,000)	In 1953, United Cerebral Palsy of Orange County (UCP-OC) was established to support and enhance the lives of individuals with cerebral palsy, both children and adults. We respectfully seek a $5,000 grant from City of Hope to support our Access to Care program, which provides essential early intervention and pediatric therapy to 380 uninsured and under-insured children with disabilities. Our program addresses a critical need in Orange County, where the demand for children's disability services has surged by 28% between 2013 and 2022and local providers often shy away from treating low-income children due to inadequate reimbursement rates from state-sponsored insurance.

"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 significant and innovative impact, to apply for either a $10,000 or $25,000 grant. They still must compete against others and are reviewedand scored, by the CBAC members. 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 2024 Bigger Ask recipients are below:

Set for Life Building a Future for SFL ($25,000)	SET for LIFE (Social Equity Training for Living Informed Futures Everyday) has operated as a federally recognized 501(c)3 charitable nonprofit since 2004, dedicated to providing free resources and education to underserved communities. Our main goal is to address mental health disparities among African Americans and marginalized groups, which are often exacerbated by systemic racism and limited health care access. To achieve this, we focus on improving economic stability and empowering individuals through job training opportunities, facilitated by partnerships with minority-owned businesses and local youth organizations.
Pomona Hope After School and Summer Enrichment with Pomona Hope ($10,000)	Pomona Hope is dedicated to fostering a healthy community through workshops and a communal garden, addressing challenges like stress and limited access to nutritious foods and recreational areas. Enrichment workshops offer activities like gym games and art sessions, aiming to enhance emotional expression and social skills among participants, alongside providing nutritious meals. The community garden provides a valuable outdoor space for gardening and workshops on nutrition and environmental topics, promoting a sense of community and well-being.

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.

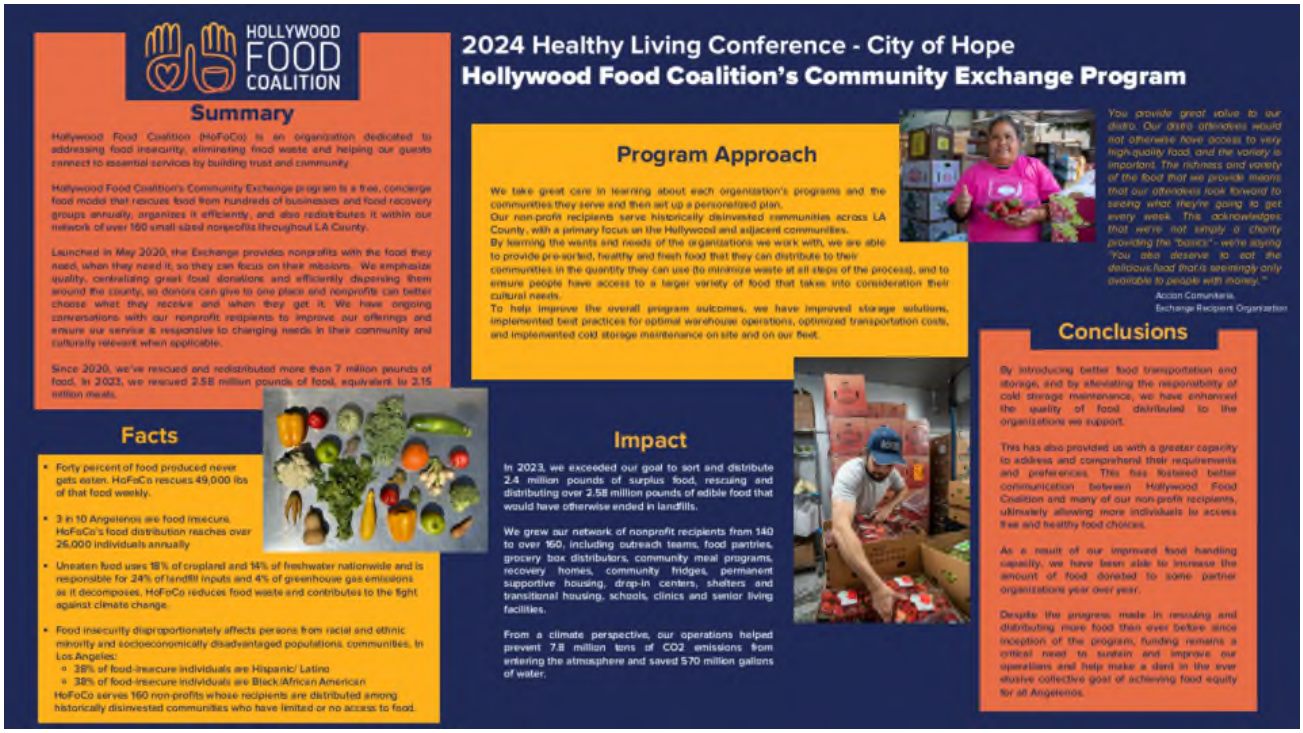
Fiscal Year 2024 Healthy Living Grant Cohort

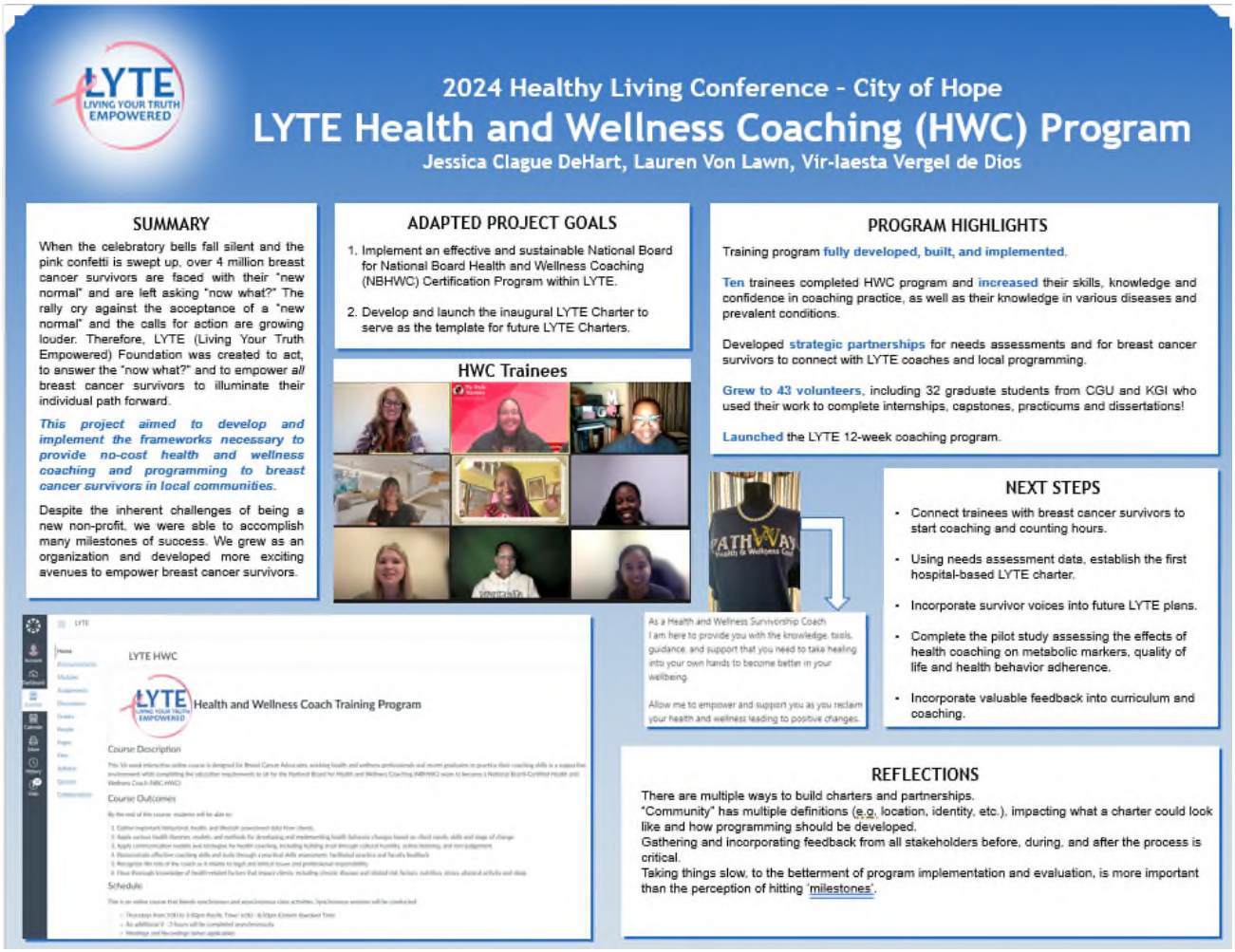
Healthy Living Grant Outcomes FY2024 Grantees

Grantees sharing program outcomes during the poster session

At the end of the funding cycle, when new grants were awarded, the 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 2024, the 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.


RAINBOW LABS
LEVERAGING THE POWER OF LGBTQ+ VOLUNTEERS AS MENTORS FOR LGBTQ+ YOUTH
HEALTHY LIVING CONFERENCE
Championing the mental health of LGBTQ+ youth through transformative mentoring relationships
According to the The Trevor Project's 2022 National Survey on LGBTQ Youth Mental Health, LGBTQ+ youth who had at least one accepting adult were 40% less likely to report a suicide attempt in the past year compared to those who did not have a supportive adult in their life.
GRANT GOALS
BUILD POSITIVE MENTOR/MENTEE RELATIONSHIPS
In post-program surveys from our Spring 2024 programming, _% of mentees and _% of mentors reported having a positive relationship with their mentor/mentee.
INCREASE MENTOR OUTREACH
From November 2023-May 2024, we recruited _ mentors from within the LGBTQ+ community across Los Angeles County.
INCREASE ORGANIZATIONAL EFFICACY IN VOLUNTEER PROGRAMMING
Our volunteer management contractor, new volunteer manager, and program staff collaborated to generate a new Volunteer Management Plan!
With the support from the City of Hope Healthy Living Grant, we have been able to dedicate staff focus to reimagining our mentor training process.
This has paved the way for generative, important discussions about culturally responsive and trauma-informed mentoring practices.
TRAUMA informed MENTORING
The Healthy Living Grant has also allowed us to direct more focus and planning toward lasting forms of volunteer appreciation, celebration, and community-building.
VOLUNTEER CULTURE
APPRECIATION
WWW.RAINBOWLABS.ORG


HOLLYWOOD FOOD COALITION
2024 Healthy Living Conference - City of Hope
Hollywood Food Coalition's Community Exchange Program
Summary
Hollywood Food Coalition (HoFoCo) is an organization dedicated to addressing food insecurity, eliminating food waste and helping our guests connect to essential services by building trust and community
Hollywood Food Coalition's Community Exchange program is a free, concierge food model that rescues food from hundreds of businesses and food recovery groups annually, organizes it efficiently, and also redistributes it within our network of over 160 small sized nonprofits throughout LA County.
Launched in May 2020, the Exchange provides nonprofits with the food they need, when they need it, so they can focus on their missions. We emphasize quality, centralizing great food donations and efficiently dispersing them around the county, so donors can give to one place and nonprofits can better choose what they receive and when they get it. We have ongoing conversations with our nonprofit recipients to improve our offerings and ensure our service is responsive to changing needs in their community and culturally relevant when applicable.
Since 2020, we've rescued and redistributed more than 7 million pounds of food. In 2023, we rescued 2.58 million pounds of food, equivalent to 2.15 million meals.
Facts
Forty percent of food produced never gets eaten. HoFoCo rescues 49,000 lbs of that food weekly.
3 in 10 Angelenos are food insecure. HoFoCo's food distribution reaches over 26,000 individuals annually
Uneaten food uses 18% of cropland and 14% of freshwater nationwide and is responsible for 24% of landfill inputs and 4% of greenhouse gas emissions as it decomposes. HoFoCo reduces food waste and contributes to the fight against climate change.
Food insecurity disproportionately affects persons from racial and ethnic minority and socioeconomically disadvantaged populations communities. In Los Angeles:
38% of food-insecure individuals are Hispanic/ Latino
38% of food-insecure individuals are Black/African American
HoFoCo serves 160 non-profits whose recipients are distributed among historically disinvested communities who have limited or no access to food.
Program Approach
We take great care in learning about each organization's programs and the communities they serve and then set up a personalized plan.
Our non-profit recipients serve historically disinvested communities across LA County, with a primary focus on the Hollywood and adjacent communities.
By learning the wants and needs of the organizations we work with, we are able to provide pre-sorted, healthy and fresh food that they can distribute to their communities in the quantity they can use (to minimize waste at all steps of the process), and to ensure people have access to a larger variety of food that takes into consideration their cultural needs.
To help improve the overall program outcomes, we have improved storage solutions, implemented best practices for optimal warehouse operations, optimized transportation costs, and implemented cold storage maintenance on site and on our fleet.
You provide great value to our diets. Our dear attendees would not otherwise have access to very high-quality food and the variety is important. The richness and variety of the food that we provide means that our attendees look forward to seeing what they're going to get every week. This acknowledges that we're not simply a charity providing the "basics" - we're saying "You also deserve to eat the delicious food that is seemingly only available to people with money."
Acción Comunitaria,
Exchange Recipient Organization
Impact
In 2023, we exceeded our goal to sort and distribute 2.4 million pounds of surplus food, rescuing and distributing over 2.58 million pounds of edible food that would have otherwise ended in landfills.
We grew our network of nonprofit recipients from 140 to over 160, including outreach teams, food pantries, grocery box distributors, community meal programs, recovery homes, community fridges, permanent supportive housing, drop-in centers, shelters and transitional housing, schools, clinics and senior living facilities.
From a climate perspective, our operations helped prevent 7.8 million tons of CO2 emissions from entering the atmosphere and saved 570 million gallons of water.
Conclusions
By introducing better food transportation and storage, and by alleviating the responsibility of cold storage maintenance, we have enhanced the quality of food distributed to the organizations we support.
This has also provided us with a greater capacity to address and comprehend their requirements and preferences. This has fostered better communication between Hollywood Food Coalition and many of our non-profit recipients, ultimately allowing more individuals to access free and healthy food choices.
As a result of our improved food handling capacity, we have been able to increase the amount of food donated to some partner organizations year over year.
Despite the progress made in rescuing and distributing more food than ever before since inception of the program, funding remains a critical need to sustain and improve our operations and help make a dent in the ever elusive collective goal of achieving food equity for all Angelenos.



2024 Community Building/Health Equity Grants

During the grant review process, the CBAC members found that some proposals did not fit the criteria for a one-year project, yet these proposals are worthy as they meet the specific needs of the local vulnerable community. To address this, the council created a new funding category called the Community Capacity Building Grant. City of Hope also awarded 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 2024 City of Hope Community Building/Health Equity grant recipients:

YWCA Addressing the SDOH for the Black Community in SGV ($5,000)	The YWCA of San Gabriel Valley (YWCA-SGV) is committed to social change in the region, addressing issues like racism, sexism and gender-based violence through systemic change and shared impact initiatives. Partnering with the Los Angeles County Anti-Racism, Diversityand Inclusion Initiative, YWCA-SGV organized a listening session in response to the State of Black Los Angeles County report, attracting leaders from the Black community and related organizations in SGV. Inspired by this session, YWCA-SGV plans to collaborate with Black organizations to engage the 3% Black population in SGV, hosting gatherings to foster ongoing dialogue and developing a

strategic plan for social and systemic change, supported by hiring a facilitator and consultant.

Adventures to Dream Planting Positive Seeds and Nourishing Young Minds ($5,000)

At Adventures to Dreams Enrichment (AtDE), our goal is to empower young individuals aged 5 to 16 through enriching activities, safe learning environments, food cultivation and mentorship opportunities, particularly focusing on the 90813 zip code in LA County, which faces economic challenges and community issues. Founded in 2015 by Ms. Sheila G., a breast cancer survivor treated at City of Hope, AtDE originated from her experience as a preschool teacher in Los Angeles' housing projects, aiming to provide a safe haven for children to engage in constructive activities on Saturdays. Through initiatives like our garden project and partnerships with the City of Long Beach, we address health disparities by promoting access to education, fresh produce and physical activity opportunities, with a focus on ongoing monitoring and evaluation to ensure program effectiveness and sustainability.

Mark Kepple High School Aztec Amigos Community ($5,000)

Launched in the 2023-24 school year at Mark Keppel High School, the Aztec Amigos Community is a unique club that brings together Severely Disabled students and general education students to promote inclusion and understanding. Through meetings and events focused on inclusion and awareness, the club aims to foster empathy and compassion among students of diverse abilities, encouraging interactions across various campus settings. To support the emotional well-being of students with disabilities and nurture empathy among general education students, the club organizes activities like dance parties, baking and operating a staff coffee cart, while also raising awareness about disabilities within the campus community through events like a disability awareness fair.

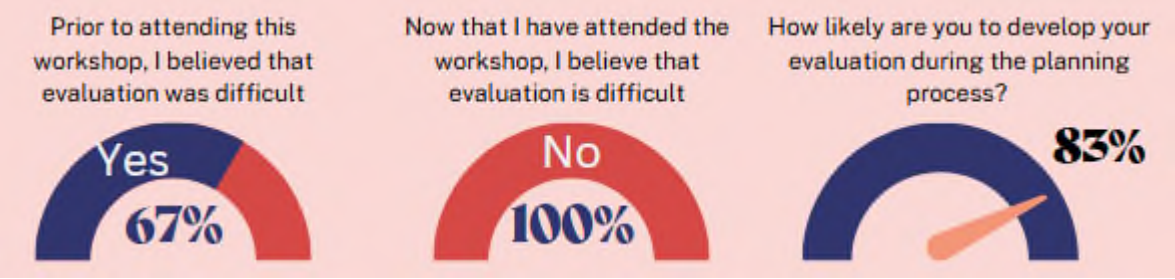
We Build Community Capacity

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 learn as a cohort in a judgment free zoneand practice using the evaluation tools that will help them tell their story at the annual conference.

2024 Cohort Evaluation Workshop Postsurvey 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.



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, insightfuland truly impacted their audiences at a visceral level.

During Fiscal Year2024, 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 oftentimes two or three. To learn and follow the inspirational, visionary concepts of our City of Hope employees, see below:

Preventing Homelessness and Food Insecurity Among Low-Income Chinatown Seniors **Submitted by: Sue Chang Pathology** **Awarded $4,200**	Partnering with SEACA significantly benefited low-income and disabled seniors in Chinatown. SEACA's 20+ years of community work enabled the distribution of fresh produce and public health resources since 2020. This partnership helped address food and housing insecurity among seniors, many of whom live on fixed incomes and face language barriers. By providing financial stipends to local organizations and businesses, we ensured the successful hosting of events and distribution of necessary materials. This initiative not only supported the immediate needs of the seniors but also fostered a sense of community and collaboration among local partners. SEACA's efforts in training and organizing local youth, residentsand stakeholders on economic and environmental justice further strengthened the community. Their long-term goal of developing future leaders ensures the sustainability and continued positive impact on the community.
Exide Community Film Screenings and Health Resource Fairs **Submitted by: David Martinez Volunteer Services Department** **Awarded $4,200**	Partnering with Communities for a Better Environment (CBE) had a significant positive impact on South East Los Angeles. Our collaboration raised awareness about lead contamination from the closed Exide Technologies plant, which had polluted the area for over three decades. Through film screenings and health fairs, we informed residents about the ongoing clean-up efforts and the health risks associated with lead exposure. This initiative helped residents understand the importance of soil testing and clean-up enrollment, addressing the root causes of poor health outcomes. By providing up-to-date information and resources, we empowered the community to take action and advocate for their health and well-being.

	CBE's long-standing commitment to environmental justice and community organizing ensured that our efforts were effective and sustainable. Their expertise in mobilizing local youth, residentsand stakeholders created a strong network of support, fostering resilience and improved health outcomes for the community. Overall, our project not only addressed immediate health concerns but also built a foundation for ongoing community engagement and advocacy, ensuring a healthier future for South East Los Angeles.
Advancing Cancer Prevention and Care Across Asian Pacific American Communities **Submitted by: Sophia Yeung** **Asian Pacific Community ERG** **Awarded $4,000**	City of Hope Asian Pacific Community (APC) supported Asian-American Pacific community members through community events, promoting diversity, equity and inclusion. As a cancer survivor and committee leader aimed to create a compassionate and supportive network for the Asian American community, cancer patients, survivorsand families. APC's mission was to bridge City of Hope with diverse Asian American communities, enhancing access to cancer health services and education. They focused on addressing cancer, the leading cause of death among Asian Americans, by providing tailored education and resources to overcome health disparities and cultural barriers. They organized the Asian American Cancer Health Symposium, featuring expert speakers and simultaneous interpretation in multiple languages. The symposium, livestreamed on various platforms, included a Healthy Living Cancer Health Ambassador training. Participants received certificates and became ambassadors, sharing knowledge within their communities. Community partners like the Lion's Club and the American Cancer Society played crucial roles in promoting the symposium and engaging diverse groups. The symposium successfully raised awareness, with 71% of participants likely to recommend it and 98% planning to pursue cancer-preventive measures. Their efforts built a foundation for ongoing community engagement, ensuring continued support and education for the Asian American community.
Prostate Cancer Education, Awareness and Screening: Serving our African American and Hispanic/Latino Communities **Submitted by: Greisha L. Ortiz Hernandez** **Population Sciences** **Awarded $3,072**	These events aimed to raise awareness and educate underserved communities about prostate cancer. African American and Hispanic/Latino men have higher rates of advanced prostate cancer due to limited access to early screening and other risk factors. They set up informational booths and provided free PSA screenings. Educational materials and health talks by

City of Hope doctors were also part of the events. Our efforts addressed health disparities and promoted early detection, crucial for improving health outcomes.
Community partners like "Vision y Compromiso" and Culver City Foshay Lodge No. 467 helped organize the events and recruit participants. Internal partners, including graduate students and health care professionals, assisted with logistics and screenings. The success of these events was measured by increased screening rates and improved knowledge about prostate cancer among participants. Our initiative fostered community engagement and built a foundation for ongoing health education and support.
At these events, they setup two stations. One station is for educational purposes and the other station is for PSA screening. The station for educational purposes is used to provide educational materials regarding prostate cancer. The station for screening will be equipped with serological materials proper equipment and reagents for blood specimen collection. A certified nurse oversees collecting and storing biospecimen. The biospecimen will be sent to a certified laboratory for free PSA measurement. They will then follow up with the participants and provide suggestions according to their PSA results. During these events, they coordinated services for community members, have City of Hope doctors speak and educate attendees on testicular health (includes self-examinations), the importance of PCa screeningsand provide education on wellness and healthy eating.

A Roaming Farmer's Market to Improve the Health of Seniors by Addressing Food Insecurity and Mental Health Stigma

Submitted by: Cristal Resto
Department of Pop Sciences - Division of Biomarkers of Early Detection and Prevention

Awarded $1,900

Cristal Resto, a proud Latina from Baldwin Park, California, began her journey at City of Hope as an intern and advanced to a clinical research assistant II. Her work with the Eat, Move, Live study highlighted how tailored programs can reduce barriers for underserved communities, inspiring her mission to increase access to fruits and vegetables and provide nutrition and mental health education.
Cristal organized a mobile farmer's market project to build community and empower seniors through access to fresh produce and education. This initiative addressed mental health, social determinants of health and health access.
A 2022 community health assessment revealed high rates of mental health issues and poverty in Baldwin Park. This project aimed to address these issues by providing fresh produce and education.
She collaborated with the Mayor of Baldwin Park and the YWCA of San Gabriel Valley to implement this project. The YWCA provided a mental health toolkitand Dr. Victoria Seewaldt and Dr. Christopher Sistrunk advised on project implementation and survey design.

Success was measured through pre/post surveys assessing changes in knowledge, attitudes and behaviors related to mental health and nutrition. The project aimed to create a sense of community and empower individuals to share their knowledge with others, ensuring sustainability and long-term impact.

YPN Hope in the Community
Submitted by: Yuddy Jesus
Young Professional Network (YPN)

Awarded $3,500

In August 2022, YPN held the first "Hope in the Community" event, providing information on early screening, healthy eating and mental health. The positive response from the community underscored the need for continued efforts.
The proposal aimed to build on the previous event by collaborating with partners to offer screenings and more information on clinical trials. The event addressed cancer education, health access and mental health support.
South Central Los Angeles, an underserved community, faced high cancer death rates and distrust in the health care system. The event aimed to bridge this gap by providing trusted health information and resources. The event featured interactive activities and booths with information on diabetes, cancer and other health topics. Community partners, including local churches and health care organizations, played crucial roles in planning and execution.
Success was measured through surveys and engagement activities, ensuring continuous improvement and community impact. The initiative aimed to create a sustainable model for health education and support in the community.

Up in Smoke: The short and long term effects of smoking

Submitted by: Victoria Taylor-McKinley
Office of CFO

Awarded $4,200

Victoria Taylor-McKinley worked at City of Hope for nearly 11 years, serving African American communities in San Gabriel Valley and South Los Angeles. She aimed to address the disproportionate advertising and sale of tobacco and cannabis products in these communities, exacerbated by the glamorization of smoking by hip-hop celebrities.
In 2021, 8.2% of Black youth used tobacco products, with higher mortality rates from smoking-related diseases compared to other groups. Taylor-McKinley organized a forum to educate African American youth (ages 13-21) on the short-term and long-term effects of smoking.
The event featured African American health professionals, a former tobacco executive and a hip-hop entertainer. It included a general session, panel discussion and breakout sessions, with lunch and transportation provided.
Community partners included the Church of Christ in San Gabriel Valley and South Los Angeles, City of Hope and UCLA physicians, a USC researcher, a mental health professional and the American Heart Association. The event was hosted at the South Los Angeles Church of Christ, which provided transportation, volunteersand lunch.
Success was measured through pre- and post-event surveys and interactive activities. The initiative aimed to create a sustainable impact by following up with participants and providing ongoing information on smoking.

Cancer Support Community - Self-Care Bundles
Submitted by: Lesley Han

The Nursing Workforce Committee to supported the Cancer Support Community (CSC) during the holidays. They aimed to create self-care bundles for oncology patients to support their mental health during cancer treatments.

Nursing Workforce Committee

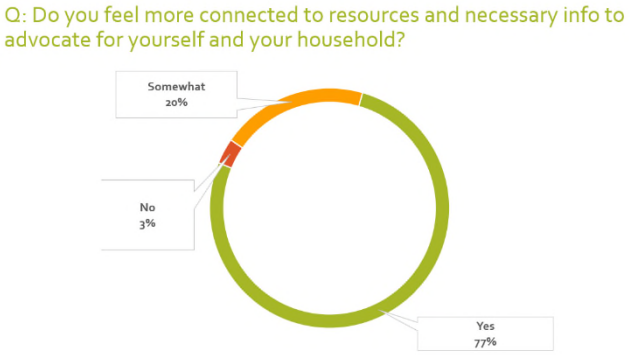
Awarded $500

Partnering with CSC, they coordinated the collection of self-care items through donation bins around the Duarte campus, seeking a $500 Kindness Grant to meet their goal of 50 bundles. Each bundle included personalized notes from City of Hope nurses.
The project addressed mental health by supporting emotional resilience and well-being. CSC served thousands of oncology patients in the San Gabriel Valley, offering services like yoga, art and support groups. The initiative aimed to affirm CSC's mission that "Community is stronger than cancer."
Donations were collected from hospital staffand the bundles were distributed through CSC, spreading love and encouragement. Community partners included the Nursing Workforce Committee and CSC.
Success was measured by increased participation in CSC's orientation sessions, with a goal of a 25% increase. The project aimed for sustainability by holding annual donation drives and exploring further collaboration opportunities with CSC.

Downey Community Blood Pressure Screening
Submitted by: Julissa Forte, R.N.
Savannah Forte, PCA
3C Outpatient and 3West Pediatrics

Awarded $170

Julissa Forte, a nurse and Savannah Forte, a nurse assistant, recognized the need for better health access at their local senior center. They initiated free monthly blood pressure screenings, educating attendees on the importance of regular checks and healthy lifestyle choices. This project, supported by City of Hope health care volunteers and the Barbara J. Riley Community & Senior Center, aimed to empower older adults with knowledge and tools for better health. The initiative measured success through attendance and surveys, ensuring sustainability through dedicated funding and volunteer support. Their efforts significantly enhanced community health awareness and encouraged proactive health management.



Exide Community Film Screening Evaluation Results

Community members participating in the Kindness Grant Exide Community Film Screening

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.


FY2024 Kindness Grant Recipients

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

Greater San Gabriel Valley Hospital Collaborative

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. The Health Consortium recently received further funding to sustain the work on the Food for All initiative and expand effort to improve access to food via our hospital network. The findings for the end of the initiative is provided below:

SPA 3 Hospital Collaborative partners

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 levelsand 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.

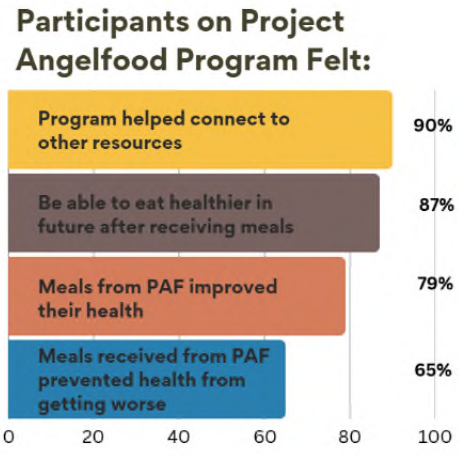
2) Partnerships With Local Community Based Organizations (CBOs): All patients identified as food insecure will be linked with Seeds of Hope for emergency food services and/or to Project Angel Food for delivery of medically tailored meals, both selected due to their expertise and services. Seeds of Hope 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 below is cumulative and includes Fiscal Year 2024.

Total Number of Hospital Referrals to Seeds of Hope & Project Angel Food * March 1, 2022 – June 30, 2024		
	Referrals to SOH	**Referrals to PAF**
From Unite US platform:		
City of Hope	71	37
Emanate Health	18	138
USC Arcadia Hospital	95	66
Kaiser Permanente Baldwin Park	29	17
From findhelp platform:		
Huntington Health	247	85
From Hospitals Via Seeds of Hope:		38
Total Hospital Referrals	**460**	**381**
Referrals from: Unite Us and findhelp dashboards		

Hospital Clients Served by Project Angel Food in Cohorts 1-9 March 2022 – June 2024		
Referring Program Partner	**Number Referred**	**Total Number Served**
City of Hope	37	17
Emanate Health	138	69
USC Arcadia Hospital	66	31
Kaiser Permanente Baldwin Park	17	11
Huntington Health	85	36
SUB-TOTAL	**343**	**164**
Seeds of Hope	38	22
TOTAL	**381**	**186**



PAF participants who completed the post-assessment survey reported significantly lower rates at all levels of food insecurity on the scale. In fact, self-reported high ratings of 4 or 5 on the 5-point Likert scale were cut in half for all six levels of food insecurity, meaning that fewer patients felt food insecure after participating in the Project Angel Food cohort.

Sustainability planning was a key focus for the SGV Hospital Collaborative and Food4All SGV workgroup in the final year of the program (Year 3). Three of the four participating hospitals have committed to provide financial support for the Food4All SGV program moving forward as part of their overall commitment to supporting movement from the Food4All SGV program as a pilot to a core Health Consortium program (the fourth is still considering it). The SGV Hospital Collaborative has confirmed its interest in continuing to focus on food insecurity and is looking also to build on the work of this program to expand the food insecurity focus to encompass other social determinants of health (SDOHs) as well, ensuring that patients who are screened with SDOH needs are linked to the appropriate services and resources.

The hospitals are working on determining the longer-term opportunities that will be outgrowths of the Food4All SGV program successes. As noted above, the SGV Hospital Collaborative is considering options for program continuity, including sustainability of the Food4All SGV program as well as building on this program to address additional SDOH needs.

This program made in-roads to addressing needs beyond food insecurity, tackling not only food insecurity but other SDOH needs as well. It became clear to all participants that that individuals experiencing food insecurity were also likely to experience other needs associated with income insecurity, such as housing, transportation and utility payments. The program fostered extensive internal collaboration within hospitals, encouraging open discussions across various departments and helping to break down silos. One observer noted, “It was impressive how the program assessed additional psychosocial needs, which proved very beneficial.” At City of Hope, the program helped dismantle departmental silos by consolidating various groups into a unified structure with a governing council. This approach facilitated a more coordinated effort to address SDOH across the entire hospital system.

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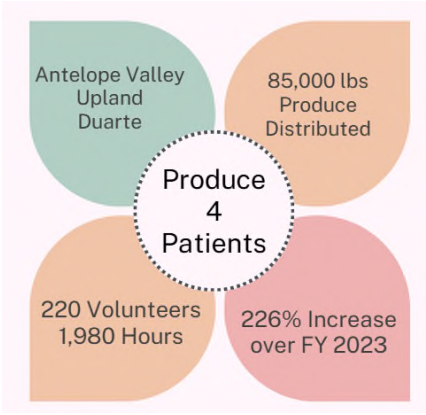
This project started before the Joint Commission and Centers for Medicaid Services mandated that all hospitals screen patients for SDOH risks. By being ahead of the curve, this program has also set the hospitals up for success in rolling out the larger SDOH programming, essentially bringing all the hospitals into partial compliance prior to the deadlines for implementation and with lessons learned to help guide next steps and future processes.

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 2024, we continued to provide produce to patients who responded yes to our inquiry of whether they were food insecure. Those patients were able to request a 20 lb bag of food upon discharge from our City of Hope Helford Clinical Research Hospital. Between October 2023 and September 2024, we were able to provide 151 bags of food to patients. This is a 208% increase over FY2023. This significant change can be due to the work to institutionalize the referral process and the screening for social determinants of health.

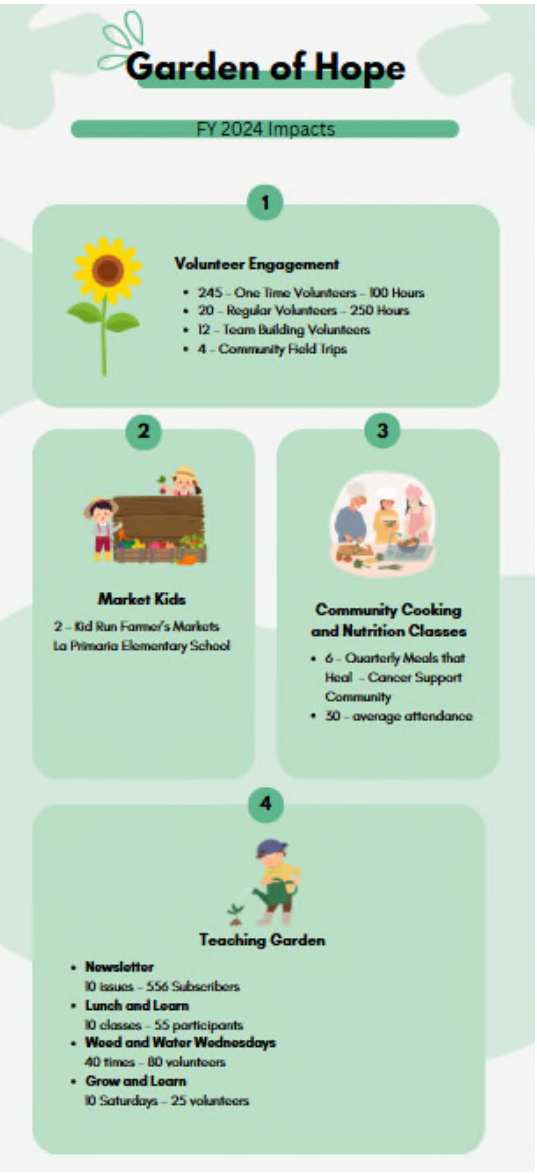
Produce for Patients



Between October 2023 and September 2024, City of Hope employees and a handful of local community members sorted and passed out over 85,000 lbs of produce delivered by our community food partners. This number represents 226% increase in total food distributed over FY2023! We would not be able to deliver such incredible services without the support of our own organization. In total 220 volunteers gave 1,980 hours of service to this project. They sorted the thousands of pounds of produce from the LA Regional Food Bank, delivered via our community partners, Seeds of Hope, Antelope Valley Parterns in Health and Inland Valley Hope Partners. Volunteers also provided traffic control, wayfinding and delivered food to the patient's cars or hand. We are grateful to have employees that embody our value of compassion.

Behind the scenes at July 2024 Produce for Patients

Garden of Hope



The Garden of Hope continues to thrive, expanding its programs each year to combat food insecurity through education and community engagement. In Fiscal Year 2024, we have strengthened partnerships and built essential infrastructure to support our mission.

A key part of our success has been the expertise of master gardener and master food preserver, Dena Brummer, whose guidance has helped engage volunteers for over 350 hours this year. Much of this participation is thanks to our effective marketing and communication efforts, including a monthly newsletter reaching over 550 individuals.

By focusing on food insecurity, we have empowered our community through hands-on programs such as Lunch and Learns, Weed and Watering Wednesdaysand Grow and Learn. These initiatives equip individuals with the knowledge and skills to grow their own food, ensuring greater self-sufficiency. Additionally, our community cooking and nutrition programs teach participants how to prepare fresh, healthy meals, maximizing the benefits of homegrown produce.

Through gardening, education and shared knowledge, we are not just growing food — we are growing food security and resilience in our community.

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Local schools enjoy participating in their community service projects at the Garden of Hope in 2024.

Kids Run Farmers Markets

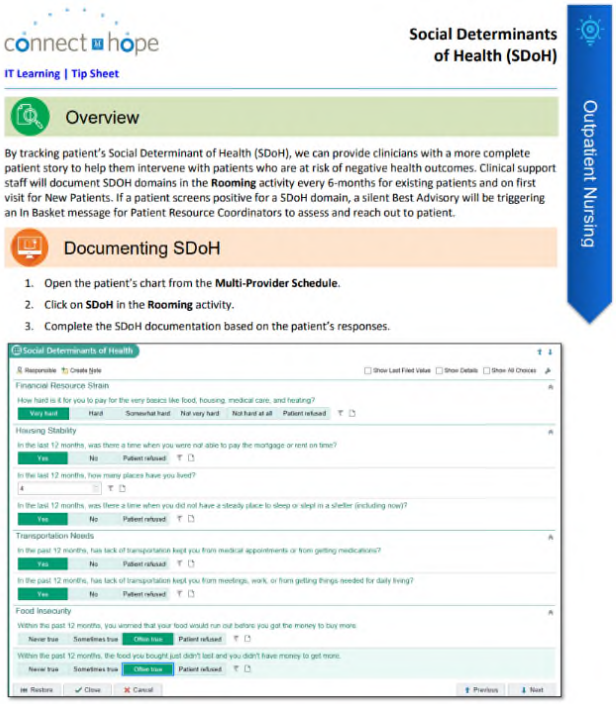
Over the past four years, the La Primaria Farmers Market has demonstrated sustained growth, reinforcing our commitment to sustainability and experiential learning for students through the **Market Kids** program. In Fiscal Year 2024, the market generated **$484 in April and $517 in May**, reflecting both increased community engagement and the development of entrepreneurial skills among participating students. All revenue is reinvested into the market, supporting expansion efforts such as **diversifying available produce** and enhancing interactive learning opportunities. Upcoming initiatives include providing students with **small clay pots to decorate and plant succulents**, which will add unique, student-created items to the market while fostering creativity, sustainability awareness and business management skills. Looking ahead, La Primaria Farmers Market will continue to evolve as a platform for hands-on learning, empowering students to develop lifelong skills in sustainability, entrepreneurship and community engagement.

The La Primaria marketing team for their Market Kids program.

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. During the first seven months of the year we continued to use the UniteUs platform. At the end of the contract and based on our Food for All, collaborative partners and our own internal stakeholders, we are moving toward the FindHelp application to continue to support and provide external resources to our patients in need. An interdisciplinary groups continue to meet monthly to address the SDOH needs of our patients at both a workgroup and a steering committee level. Over this last fiscal year, we have successfully integrated the SDOH questions into the workflow for both inpatient and outpatient interactions. We have also met as a system and established the integration of the SDOH questions into the workflows at the Chicago, Atlanta and Phoenix (CAP) locations. We continue to train staff on the workflow protocol and have also adapted this at the CAP sites too. 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 2024, 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 Institutional Collaborations

It is important to recognize the participation of the hardworking individuals who contributed to over 100 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. We have also been supporting the work at the other City of Hope cancer centers in Chicago, Atlanta and Phoenix that included: conducting the Community Health Needs Assessments in each region, prioritizing needs with local community stakeholders and completing the Implementation Strategies. It's been a fantastic yearand we can't thank our wonderful friends, collaborators and community enough for their support. They've all helped us make a real difference for 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 2024 are listed in the table on the following page. 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 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.

Fiscal Year 2024 Community Impact Day with MaryKnoll Sisters and Grow Monrovia

Value of Quantifiable Benefits

Fiscal Year 2024 Community Benefit Categories	Net Benefit
CHARITY CARE[1]	55,716,459
UNPAID COSTS OF MEDI-CAL[2]	85,936,534
OTHERS FOR THE ECONOMICALLY DISADVANTAGED[3]	0
EDUCATION AND RESEARCH[4]	172,360,514
OTHER FOR THE BROADER COMMUNITY[5]	11,109,547
TOTAL COMMUNITY BENEFIT PROVIDED EXCLUDING UNPAID COSTS OF MEDICARE	265,419,757
UNPAID COSTS OF MEDICARE[2]	176,145,328
TOTAL QUANTIFIABLE COMMUNITY BENEFIT	**440,640,996**

Fiscal Year 2024 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 2024 investment of **$440,640,996** and reported on the strategies prioritized in our 2022-2025 Implementation Strategy Plan. The main focus areas of our Fiscal Year 2024 community benefit programs and services: **Healthy Living, Community Capacity Building and Kindness Grants; Food Insecurity Programs and Collaborations, Addressing the Social Health Needs (SDOH) of Patients/ Families/Caregivers** and the **Cancer Care Patient Equity Bill** have been described in detail. We also had incredible cross-institutional collaborations that have utilized the lens of health disparities and the SDOH to create new partnerships and leverage current relationships to deliver services to our most diverse and vulnerable communities. Our teams are doing more in-person interactions with our community and extending our reach through online programming.

This document represents our efforts at addressing the community-prioritized 2022-2025 Implementation Strategy during Fiscal Year 2024. 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
2022 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:

Interview Participants

Organization	Name	Title
Alhambra Police Department	Eric Lozick	Marketing and Community Engagement
American Heart Association	Nancy Song	Community Impact Director
Asian Youth Center	Michelle Freridge, M.P.A., JD	Executive Director
Azusa Pacific University	Sally Mansour, M.S., LMFT	Director, Community Counseling Center Administrative Faculty, Department of Graduate Psychology
Azusa Senior Center	Angie Jaime, M.S.W.	Case Manager
ChapCare Medical and Dental Health Center	Steven Abramson	Chief Operations Officer
City of Azusa	Miki Carpenter	Director of Community Resources
City of Pasadena Housing Department	Diane Trejo, M.P.H.	Housing Assistance Officer
City of Pasadena Outreach Response Team	Tony Zee	Firefighter
City of Pasadena, Public Health Department	Judith Dunaway	Division Manager, Health Promotion & Policy Development
City of Pasadena, Public Health Department	Shatisha Mann	Program Coordinator, GEM Link
City of Pasadena, Public Health Department	Whitney Harrison, M.P.A.	Division Manager, Social and Mental Health
City of Pasadena, Public Health Department	Ying-Ying Goh, M.D.	Director and Health Officer
Claremont Hillel	Hannah Elkin	Rabbi/Hillel Director

Organization	Name	Title
Foothill Unity Center, Inc.	Tashera Taylor	Chief Executive Officer
Friends in Deed	Rabbi Joshua Levine Grater, M.Rb.	Executive Director
Health Consortium of Greater San Gabriel Valley	Deborah Silver	Director/Consultant
Herald Christian Health Center	Carolin Eng	Chief Operating Officer
Los Angeles County Department of Health Services, San Gabriel Valley Health Center Group	Ernest P. Espinoza	Director for the San Gabriel Valley Health Center Group
Los Angeles County Department of Public Health	Jocelyn Estiandan	Integration Unit Manager
Majestic Realty	Fran Inman	Senior Vice President
Pacific Clinics	Nina Paddock, M.P.H., RD	Comprehensive Service Manager
PALS for Health	Mireya Munoz	Project Manager
Pasadena Job Center, National Day Laborer Organizing Network (NDLON)	Julieta Aragon	Minimum Wage Coordinator
Pasadena National Association for the Advancement of Colored People (NAACP)	Allen Edson	President
Pasadena Outreach Response Team	Isaac Arreola	Union Station Homeless Services Representative
Pasadena Outreach Response Team	Nathan Press	Social Worker
Pasadena Unified School District	Ana “Ria” Apodaca, M.Ed.	Director of Health Programs
Planned Parenthood Pasadena and San Gabriel Valley	Christian Port, M.P.A.	Senior Manager of Business Development
Planned Parenthood Pasadena San Gabriel Valley	Lidia Carlton	Director of Community Education
Rose City High School, Pasadena Unified School District	Kathy Watson	Substance Abuse Intervention Specialist
San Gabriel Valley Dental Society	Lee Adishian, B.S., RDH	Executive Director
SPIRITT Family Services	Elvia Torres	Executive Director
Union Station Homeless Services and Pasadena Police Department, Homeless Outreach Psychiatric Evaluation (HOPE) Team	Erin Butler, A.S.W.	HOPE Team Street Outreach and Service Liaison
Vietnamese American Cancer Foundation	Becky Nguyen	Executive Director
Walter Lee Wilmore Foundation	Statice Wilmore	Chief Executive Officer
Young and Health Tiny Teeth Program	Mary Donnelly-Crocker, M.A.	Executive Director
YWCA of San Gabriel Valley	Debra M. Ward, M.P.H.	Chief Executive Officer

Focus Group Participants

Organization	Participants	Number of Participants
Azusa Senior Center	Community Members. Two groups: English speakers and Spanish speakers	18
Emanate Health	First 5 LA, Welcome Baby Home Visitation Program Staff	6
Emanate Health	Get Enrollment Moving (GEM) Program Staff:	6
Herald Christian Health Center	Community Members	7

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?

Resources to Address Community Needs

Community stakeholders identified resources potentially available to address the identified community needs. This is not a comprehensive list of all available resources. For additional resources refer to:
Los Angeles County — www.211la.org
Orange County — www.unitedwayoc.org/how-we-are-doing-more/get-help-211/
Riverside County and San Bernardino County — inlandsocaluw.org/211
Ventura County — 211ventura.org/

Significant Health Needs	Community Resources
Access to Care	• 211 • Greater SGV Hospital Collaborative • Health Consortium of San Gabriel Valley • Lions Clubs International • Pregnancy Health Center of San Gabriel Valley • Pasadena/Altadena Coalition of Transformative Leaders PACTL • Pasadena Partnership Health care Committee • Pomona Wellness Community

Significant Health Needs	Community Resources
	• San Bernardino Free Clinic • Community Health Alliance of Pasadena (ChapCare) • Set for Life hosts health expos with health screenings. • Senior Advocacy Program, a county program for seniors primarily in nursing homes • CVS and Rite Aid offer flu shots and screenings. • Foothill Transit offers bus service from Duarte to Pasadena. • YWCA of SGV Senior Services — Duarte Senior Center • City of Hope Health Fair • Planned Parenthood Pasadena and San Gabriel Valley • Hear Center • Community Health Alliance of Pasadena • Herald Christian Health Center • Tzu Chi Foundation • Good Samaritan Hospital • Parish Nurses offer screenings with referrals for more services. • El Monte School District • AltaMed • Western University provides dental services at two dental clinics at schools. • Duarte School District's Health Services Center focuses on getting kids access to health insurance. • Foothill Unity Center food bank • Department of Health Services clinic in El Monte • Latinos for Hope (City of Hope group) go out into the community and inform/educate about what's available. • El Proyecto del Barrio Certified Enrollment Counselors help patients understand eligibility and enrollmentand keep them on their programs to maintain their benefits. • East Valley Community Health Center • Garfield Health Center • San Gabriel Japanese Community Center • Asian Pacific Resource Center • Asian Youth Center • Chinese Culture Development Center • Kaiser Permanente • Huntington Hospital • City of Pasadena Public Health Department • Chinatown Service Center • Wesley Health Centers • Crisis Pregnancy Center of Monrovia • A Women's Care Center • Center for Integrated Family and Health Services
Cancer	• Clínica Médica Familiár (Family Medical Clinic) has clinics twice a year. • City of Hope offers cancer screenings at health fairs. • UCLA Health Alhambra Cancer Care • Covina Cancer Care Medical Center

Significant Health Needs	Community Resources
	• Huntington Cancer Center • Set for Life offers mammograms. • Children's Hospital Los Angeles • Southern California Health Conference at Pasadena Civic Center • El Monte Comprehensive Health Center • East Valley Community Health Centers • American Cancer Society has resources that can help with transportation and navigation assistance. • My Health LA patients provides emergency Medi-Cal for women 40+ with breast cancerand for women of any age with cervical cancer through the Every Woman Counts program. • MEMAH (Men Educating Men About Health) annual conference • Garfield Health Center provides mammograms and colorectal cancer screening. • Covering with Care • East SGV Health Neighborhood • Herald Cancer Association offers support, consultation, written information and links to websitesand answers questions. • Alzheimer's Association
Chronic Disease	• Save the Heartbeat • ChapCare • Day One • American Heart Association • Pasadena Partnership Health care • Curbside CPR classes offered by the Fire Department. • Pasadena/Altadena Coalition of Transformative Leaders PACTL Children's Hospital Los Angeles • Los Angeles County Department of Public Health Service • City of Azusa has a Wellness Center • Young & Healthy • El Proyecto Del Barrio does medication management and assistance. • Clinic pharmacy dispensary provides some additional medications. • Los Angeles County Department of Health Services, Healthy Choice the Easy Choice work to make healthier options more accessible, including exercise breaks in meetings, etc. • Foothill Unity Center offers a walking program and checks blood pressure. • Pomona Wellness Community • Pasadena Partnership Health care • Health plans provide educational materials about foods to eat and foods to avoid. Some have been translated by health plans.
COVID-19	• Los Angeles County Public Health Department • East San Gabriel Valley Health Center • Community Health Alliance of Pasadena • Wesley Health Centers • Barrios Action Youth and Family Center

Significant Health Needs	Community Resources
	• CHIRLA The Coalition for Human Immigrant Rights • First African Methodist Episcopal Church • Pasadena Partnership Health care Committee • Pasadena Tournament of Roses • QueensCare • Seventh Day Adventist Church in Altadena • Young & Healthy • El Sol Neighborhood Educational Center
Economic Insecurity, Housing Insecurity and Homelessness	• Pasadena Continuum of Care Network • California Department of Social Services • San Bernardino County Cash Assistance Program for Immigrants • Sahaba Initiative • Time for Change Foundation • Southern California Edison — Energy Assistance Fund • Los Angeles County Development of Public Social Services • Teamster Union Local 63 • Community Action Partnership of San Bernardino County • Village HOPE • Legal Aid Foundation Los Angeles — Government Benefits Unit • Community Health Alliance Pasadena • Pasadena Senior Center • St. Louise Resource Services • Youth Moving On • Union Station Homeless Services • Inland Valley Hope Partners • Project Roomkey • Lutheran Social Services of Southern California • Our Saviour Center • Bienestar provides assistance to Persons Living with HIV/AIDS (PLWH) who are homeless. • Salvation Army • Glenkirk Church offers Open Arms Program to serve those who are currently experiencing homelessness. • Door of Hope • Hope of the Valley • City of Hope Navigator Program • Friends in Deed • Our Savior Center — Our Homeless Family Motel Voucher Program • Ft Knox Supportive Housing for the Homeless Veterans • East San Gabriel Valley Coalition for the Homeless • D&R Turning Point • Jackie Robinson Community Center • Los Angeles Homeless Services Authority • Elizabeth House • Family Promise of San Gabriel Valley • A Meaningful Goal Housing Shelter

Significant Health Needs	Community Resources
	• Foothill Family Shelter • mRelief
Food Insecurity	• Shepherd's Pantry • Seeds of Hope • Project Angel Food • SN Gabriel Valley Food Recovery Program • Catholic Charities of Los Angeles • Tzu Chi Foundation • La Casa De San Gabriel Valley Community Center • Mission San Gabriel Arc Angel • Foothill Unity Center • Centro Maravilla Service Center • Tabernacle Faith Church • Eastmont Community Center • Our Saviour Center • Elim Community Food Pantry • Second Baptist Church of Monrovia • Dream Center • Community Resource Center Pomona • God's Pantry Covina • New Song Church • Sowing Seeds for Life
Mental Health	• San Gabriel Valley Grief Resource and Training Center • No Mind Left Behind • NAMI Pomona Valley • Universal Stress Free Zones • Comforting Hearts • Supportlink, promoting independent living for persons with disabilities • Olive Tree Children's Counseling Home • Beyond Spectrum Supportive Services • Alma Family Services • SPIRITT Family Services • Enki Mental Health Center • Foothill Unity Center provides referrals and services for families and the homeless. • National Association for the Mentally Ill • Tri-Cities Mental Health serves Pomona, La Verne and Claremont • Los Angeles County Department of Mental Health • Foothill Family Service offers some group services. • Whittier Hospital Medical Center has a lot of free classes. • School districts. Duarte School District has partnerships with providers (Foothill Family Services and D'Veal) to come into the schools and provide services. • Pacific Clinics/Asian Pacific Family Center • Foothill Family Services • D'Veal Family & Youth Services

Significant Health Needs	Community 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 site in El Monte • Santa Anita Family Services • Foothill Family Services • Arcadia Mental Heath • Aurora Clinic • Pacific Clinics • Asian Pacific Health Care Venture has Chinese language mental health services.
Overweight and Obesity	• Chapcare Medical and Dental Health Center • Families Forward Learning Center • San Gabriel Valley Service Centers • Women, Infant and Children offers nutrition classes. • Community centers offer exercise programs, such as Zumba and walking. • Senior centers, such as the Azusa Senior Center and Duarte Senior Center, offers referrals and some free services, including a hiking club. • Pomona Wellness Community • Each city has some exercise programs. • Swim programs for school-age children • Some nonprofits organize physical education and/or nutrition education/healthy snacks, such as Boys & Girls Clubs. • City of Duarte hosts a Biggest Loser contest and sponsors city walks.

Appendix B
Financial Assistance Policy

Status Active PolicyStat ID 13165549

City of Hope

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

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:

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.

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

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.

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,

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.

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

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.

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

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.

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.

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

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

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.

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

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.

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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