# California Hospital Medical Center

Hospital HCAI ID: 106190125

# Community Benefit 2025 Report and 2026 Plan


## Adopted October 2025

Dignity Health
A member of CommonSpirit

## A message from

Jill Welton, President, Dignity Health California Hospital Medical Center

Dignity Health's approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments that we conduct with community input, including from the local public health department. Our initiatives to deliver community benefit include financial assistance for those unable to afford medically necessary care, a range of prevention and health improvement programs conducted by the hospital and with community partners, and investing in efforts that address social drivers of health.

California Hospital Medical Center shares a commitment with others to improve the health of our community and promote health equity, and delivers programs and services to help achieve that goal. The Community Benefit 2025 Report and 2026 Plan describes much of this work. This report meets requirements in California (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report to our community.

In fiscal year 2025 (FY25), California Hospital Medical Center provided $164,600,377 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits.

The hospital's board reviewed, approved and adopted the Community Benefit 2025 Report and 2026 Plan at its October 30, 2025 meeting.

Thank you for taking the time to review this report and plan. We welcome any questions or comments, which can be submitted using the contact information in the At-a-Glance section of this report.

Jill Welton

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President

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## At-a-Glance Summary

**Hospital HCAI ID**: 106190125

**Report Period Start Date**: July 1, 2024 **Report Period End Date**: June 30, 2025

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|---|---|
| **Community Served** | California Hospital Medical Center is located at 1401 S. Grand Ave., Los Angeles, CA, 90015. The hospital tracks ZIP Codes of origin for all patient admissions and includes all who received care without regard to insurance coverage or eligibility for financial assistance. The hospital defines its primary service area that includes 36 ZIP Codes in 10 cities within Los Angeles County, 17 of which are located in the City of Los Angeles, and 10 that are in South LA, and comprises of portions of Los Angeles County Service Planning Areas (SPAs) 4, 6, 7, and 8. CHMC serves 1,822,453 racially diverse residents. |
| **Economic Value of Community Benefit** | $164,600,377 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits<br><br>$0 in unreimbursed costs of caring for patients covered by Medicare fee-for-service, excluding Medicare reported as a part of Graduate Medical Education and subsidized health services<br><br>Community benefit expenses for services to vulnerable populations and to the broader community are listed by category in the Economic Value of Community Benefit section of this report. |
| **Significant Community Health Needs Being Addressed** | The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are:<br><br>• Mental Health<br>• Housing<br>• Diabetes<br>• Injury & Violence<br>• Substance Use<br>• Nutrition, Physical Activity & Weight<br>• Access to Health Care Services |
| **FY25 Programs and Services** | The hospital delivered several programs and services to help address identified significant community health needs. These included:<br><br>**Mental Health**<br>CA Bridge Program<br>CA Behavioral Health Clinic<br>Family Preservation Program |

Hope Street Margolis Family Center Early Head Start, Early Childhood Education Center and Youth Center
Wraparound Services Program
Welcome Baby
Frequent Utilizer Systems Engagement (FUSE) Program
Centinela Valley Mental Health Project
Emotional Wellbeing Support Group

**Housing**

Frequent Utilizer Systems Engagement (FUSE) Program
Hope Street Margolis Family Center Early Head Start and Early Childhood Education Center
LA Partnership
Community Health Improvement Grants

**Diabetes**

Diabetes Empowerment Education Program
Heart HELP (Healthy Eating Lifestyle Program)
Community Health Screenings
Cardiovascular Disease Awareness Classes

**Injury & Violence**

CA Behavioral Clinic
Family Preservation Program
Wraparound Services Program
Human Trafficking Response Task Force
Violence Prevention and Gun Safety Project
Stop the Bleed Trainings
Centinela Valley Mental Health Project
Hope Street Margolis Family Center Early Head Start, Early Childhood Education Center, Family
Welcome Baby

**Substance Use**

CA Bridge Program
Frequent Utilizer Systems Engagement (FUSE) Program

**Nutrition, Physical Activity & Weight**

Heart HELP (Healthy Eating Lifestyle Program)
Nutrition Education
Diabetes Empowerment Education Program
Community Health Screenings
Welcome Baby
Hope Street Margolis Family CenterEarly Head Start, Early Childhood Education Center, Family Childcare Network & Youth Center
Community Health Improvement Grants

| | |
|---|---|
| | **Access to Health Care Services**<br>Financial assistance<br>Para Su Salud<br>Coordinated Care Initiative<br>Frequent Utilizer Systems Engagement (FUSE) Program<br>Samaritan Project<br>Hope Street Margolis Family Center Early Head Start, Home Visitation Program<br>Navigating the Healthcare System<br>Community Health Screenings<br>St. Francis Center LA<br>Community Health Improvement Grants |
| **FY26 Planned Programs and Services**  | FY26 programs and services will continue with the exception of the following:<br>● CommonSpirit Health Community Health Improvement Grant recipients will change on March 1, 2025, when the new funding cycle begins. |

This document is publicly available online at:
https://www.dignityhealth.org/socal/locations/californiahospital/about-us/community-health-programs/community-health-needs-assessment-plan

Written comments on this report can be submitted to the California Hospital Medical Center's COMMUNITY HEALTH OFFICE, 1401 S Grand Avenue, (Leavey Hall, room 314) Los Angeles, CA 90015 or by e-mail to barbara.gonzalez@commonspirit.org.

# Our Hospital and the Community Served

## About California Hospital Medical Center

California Hospital Medical Center is a Dignity Health hospital.  Dignity Health is a member of CommonSpirit Health.

California Hospital Medical Center (CHMC) is a member of Dignity Health, which is a part of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 2,200 care sites in 24 states coast to coast, serving patients in big cities and small towns across America.

A recognized leader in excellence, innovation and community service, California Hospital Medical Center provides a full-continuum of acute care services, including a Level II Trauma Center, state-of-the-art Cardiac Catheterization Lab, Keith P. Russell Women's Birthing Center, Level III Neonatal Intensive Care Unit (NICU), seven operating suites, and a free-standing Los Angeles Center for Women's Health. With the busiest private Trauma Center in Los Angeles County and the 13th largest center for births in California, we offer a unique balance of leading technology and quality care delivered by more than 450 physicians and 1,700 employees.

Also known for our extensive community benefit programs and designation as a major teaching hospital, California Hospital is dedicated to comprehensive health and wellness.

## Our Mission

As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

## Our Vision

A healthier future for all – inspired by faith, driven by innovation, and powered by our humanity.

## Financial Assistance for Medically Necessary Care

It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay. This hospital has a financial assistance policy that describes the assistance provided to

patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.

## Description of the Community Served

California Hospital Medical Center is located at 1401 S. Grand Ave., Los Angeles, CA, 90015. The hospital tracks ZIP Codes of origin for all patient admissions and includes all who received care without regard to insurance coverage or eligibility for financial assistance. The hospital defines its primary service area that includes 36 ZIP Codes in 10 cities within Los Angeles County, 17 of which are located in the City of Los Angeles, and 10 that are in South LA, and comprises of portions of Los Angeles County Service Planning Areas (SPAs) 4, 6, 7, and 8.


### Core Demographic Summary

| | Service Area |
|---|---|
| Urbanization | Urban |
| Total Population Size | 1,822,453 |
| Race & Ethnicity *Hispanic* | 67.3% |
| *Black* | 16.1% |
| *Asian* | 7.1% |
| *White* | 6.8% |
| *American Indian or Alaska Native* | 0.2% |
| *Native Hawaiian/Pacific Islander* | 0.1% |
| Average Household Income | $84,783 |
| Percent of Population Living in Poverty (Below 100% FPL) | 21.4% |
| Unemployment Rate (December 2024) | 5.7% |
| Percent of People Age 5 and Older Who are Non-English Speaking | 34.2% |
| Percent of People <65 Without Health Insurance | 9.4% |
| Percent of People with Medicaid | 52.4% |
| Health Professional Shortage Areas | Primary Care, Dental Health, Mental Health |
| Medically Underserved Areas/Populations | Yes |
| Medically Underserved, Low Income, or Minority Populations | Yes |
| Number of Other Hospitals Serving the Community | 9 |

The population of the CHMC service area is 1,822,453. Children and youth ages 0-17, make up 23.65% of the population, 65.5% are adults, ages 18-64, and 10.76% of the population is seniors, ages 65 and older. The largest portion of the population in the service area identifies as Hispanic/Latino (67.3%), 16.1% of the population identifies as Black/African American, 7.1% as Asian, 6.8% as White. Approximately 15.43% of the population identifies as multiracial (two or more races), 0.2% are American Indian/Alaskan Native and 0.1% are Native Hawaiian/Pacific Islander. In the service area, 34.2% of the population, 5 years and older, speak only English in the home. Among the service area population, 9.4% of people <65 and older do not have health insurance and 52.4% of the people have medicaid. Approximately, 21.4% of people are below the 100% federal poverty level.

## Community Assessment and Significant Needs

The hospital engages in multiple activities to conduct its community health improvement planning process. These include, but are not limited, to conducting a Community Health Needs Assessment with community input at least every three years, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

### Community Health Needs Assessment

The health issues that form the basis of the hospital's community benefit plan and programs were identified in the most recent CHNA report, which was adopted in June 2025. The hospital makes the CHNA report widely available to the public online and a written copy is available upon request.

**CHNA web address**:
https://www.dignityhealth.org/content/dam/dignity-health/pdfs/chna/2025/2025-CHNA-CaliforniaHospitalMedicalCenter.pdf

The CHNA contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods;
- Presentation of data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

**Community Groups that Attended or Engaged with the CHNA**:

- 1010 Development Corporation

- Bienestar
- California Health Collaborative - Every Woman Counts
- California Hospital Medical Center
- Cancer Support Community Los Angeles
- Catholic Charities of Los Angeles, Inc.
- Children's Institute
- Citizens Business Bank
- Claris Health
- Create Now
- District 65
- Downtown Women's Center
- East Side Riders Bike Club, Watts Leadership Institute Affiliate
- Eisner Health
- El Nido Family Centers
- Gastroenterology Group L.A.
- Housing Works
- Iris Cantor UCLA Women’s Health Center
- Journey Out
- Koreatown Youth and Community  Center
- Los Angeles Center for Ear, Nose, Throat and Allergy
- Los Angeles County Department of Public Health
- Maternal and Child Health Access
- MLK Community Healthcare
- National Health Foundation
- New Haven
- Para Los Ninos
- Safe Parking LA
- Streets Are For Everyone (SAFE)
- SHIELDS for Families
- SISTAHFRIENDS
- South Park Neighborhood Association
- Southern California Crossroads
- Southside Coalition of Community Health Centers
- St. Francis Center
- St. John's Community Health
- St. John's Well Child and Family Center
- The Salvation Army
- To Help Everyone Health and Wellness Centers
- UCLA Luskin Social Justice Research
- Partnership, Watts Leadership Institute
- USC
- USC Street Medicine Team
- Vision y Compromiso
- Voices of Impact
- Watts Healthcare Corporation
- Wellnest

- Worksite Wellness LA
- YouthBuild Charter School of California

**Vulnerable Populations Represented by These Groups**:

- Black/African American
- Hispanic/Latino origin, including Mexican, Mexican Americans, Chicanos, Salvadorans, Guatemalan, Cubans, and Puerto Ricans.
- Socially disadvantaged groups, including the following:
    - The unhoused
    - Community with inadequate access to clean air and safe drinking water, as defined by an environmental California Healthy Places Index score of 50% or lower
    - People with disabilities
    - People identifying as lesbian, gay, bisexual, transgender, or queer
    - Individuals with limited English proficiency

This community benefit report also includes programs delivered during fiscal year 2025 that were responsive to needs prioritized in the hospital's previous CHNA report.

## Significant Health Needs

The CHNA identified the significant needs in the table below, which also indicates which needs the hospital intends to address. Identified needs may include specific health conditions, behaviors and health care services, and also health-related social needs that have an impact on health and well-being.

| Significant Health Need | Description | Intend to Address? |
|---|---|---|
| Mental Health | Mental health is not simply the absence of a mental health condition—it is also about the presence of well-being and the ability to thrive. Many factors influence our ability to thrive and experience optimal well-being, such as family and community relationships, access to opportunities, and environmental circumstances. For example, depression increases the risk for many types of physical, long-lasting (chronic) conditions. | ☑ |
| Housing | A lack of housing, encompassing both the absence of a stable home and unaffordable, poor-quality housing, negatively impacts community health by increasing physical and mental illness, fostering instability, and limiting access to basic needs. | ☑ |
| Diabetes | Diabetes is a chronic health condition where the body struggles to regulate blood sugar (glucose) because of insufficient insulin production or | ☑ |

| Significant Health Need | Description | Intend to Address? |
|---|---|---|
| | ineffective insulin use. This leads to high blood sugar levels over time, which can cause serious complications like heart disease, vision loss, and kidney disease. | |
| Injury & Violence | Violent crimes include homicide, rape, robbery and assault. Property crimes include burglary, larceny and motor vehicle theft. Injuries are caused by accidents, falls, hits, and weapons, among other causes. | ☑ |
| Substance Use | Substance use is the use of tobacco products, illegal drugs, prescription or over-the-counter drugs, or alcohol. Excessive use of these substances, or use for purposes other than those for which they are meant to be used, can lead to physical, social or emotional harm. | ☑ |
| Nutrition, Physical Activity & Weight | Poor nutrition and physical inactivity increase the risk of chronic conditions like obesity, depression, type 2 diabetes, heart disease, and some cancers—which can lead to disability and premature death. | ☑ |
| Access to Health Care Services | Access to health care refers to the availability of primary care and specialty care services. Health insurance coverage is considered a key component to ensure access to health care. Barriers to care can include lack of transportation, language and cultural issues. | ☑ |

## 2025 Report and 2026 Plan

This section presents strategies and program activities the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It summarizes actions taken in FY25 and planned activities for FY26, with statements on impacts and community collaboration. Program Highlights provide additional detail on select programs.

Planned activities are consistent with current significant needs and the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.

### Creating the Community Benefit Plan

The hospital is dedicated to improving community health and delivering community benefits with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

CHMC's community health programs involve departments beyond Community Health and Mission in their planning and operation. Hospital and health system participants included CHMC Senior Leadership Team, leadership of Hope Street Margolis Family Center (HSFC) and all of its programs and services, leadership of LA Best Babies Network, leadership of Emergency and Trauma Services, leadership of Business Development and Strategic Planning, leadership of Obstetric and NICU services, leadership of Frequent Utilizers Systems Engagement, leadership of CommonSpirit Health Violence/Human Trafficking Response and CHMC Community Health Advisory Committee.

Community input or contributions to this community benefit plan included input during the CHNA process from leaders and representatives of medically underserved, low-income, and minority populations, or local health or other departments or agencies that have current data or other information relevant to the health needs of the community served by the hospital facility.

The programs and initiatives described here were selected on the basis of the following criteria:

- Existing Infrastructure: There are programs, systems, staff and support resources in place to address the issue.
- Established Relationships: There are established relationships with community partners to address the issue.
- Ongoing Investment: Existing resources are committed to the issue. Staff time and financial resources for this issue are counted as part of our community benefit effort.
- Focus Area: the hospital has acknowledged competencies and expertise to address the issue and the issue fits with the organizational mission.

## Community Health Core Strategies

The hospital intends that program activities to help address significant community health needs reflect a strategic use of resources. CommonSpirit Health has established three community health improvement core strategies to help ensure that program activities overall address strategic aims while meeting locally-identified needs.

- Extend the care continuum by aligning and integrating clinical and community-based interventions.
- Implement and sustain evidence-based health improvement program initiatives.
- Strengthen community capacity to achieve equitable health and well-being.

## Report and Plan by Health Need

The tables below present strategies and program activities the hospital has delivered or intends to deliver to help address significant health needs identified in the community health needs assessment. They are organized by health need and include statements of goals and anticipated impact, and any collaboration with other organizations in their delivery.

**Health Need: Mental Health**

| Strategy or Program | Summary Description | Active FY25 | Planned FY26 |
|---|---|---|---|
| CA Bridge Program | Supports the emergency department as a primary access point for the treatment of substance use disorders and co-occurring mental health conditions. by identifying patients who would benefit from initiating medication for addiction treatment (MAT) or mental health services. | ☒ | ☒ |
| CA Behavioral Health Clinic | Supports the emotional and psychological well-being of children and their families by providing individual, family, and group psychotherapy, psychiatric and case management services. | ☒ | ☒ |
| Family Preservation Program | Screens parents for depression/anxiety and IPV. Screens children for adverse childhood experiences (ACEs) and mental health or behavioral issues and provides referrals. | ☒ | ☒ |
| HSFC Early Head Start, Early Childhood Education Center and Youth Center | Screens parents for depression, anxiety and IPV. Screens children and youth for mental health and behavioral issues and provides referrals to community resources. | ☒ | ☒ |
| Wraparound Services | Wraparound Program provides community-based support and individualized planning for children, including those with severe emotional and behavioral disorders and their families. | ☒ | ☒ |
| Welcome Baby | Home visitors screen for perinatal mood and anxiety disorders (PMADs), Intimate Partner Violence (IPV) and substance use disorders, and refers individuals needing treatment to community resources. | ☒ | ☒ |

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|---|---|---|---|
| Frequent Utilizer Systems Engagement (FUSE) Program | This project connects the top 10% of the highest cost, highest need chronically homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental and behavioral health care services through a collaboration with Housing Works, and JWCH, Inc. | ☒ | ☒ |
| Centinela Valley Mental Health Project | CHMC is working in partnership with Providence Health will increase the capacity of local community organizations, community members, youth organizations and schools in the Centinela Valley to identify mental health distress and/or suicidality, and to respond appropriately. | ☒ | ☒ |
| Emotional Wellbeing Support Group | Community Health Promoters deliver mental health workshops and provide community resources. | ☒ | ☒ |
| **Goal and Impact**: The hospital's initiatives to address behavioral health are anticipated to result in increased access to mental health and substance use services in the community, and improved screening and identification of mental health substance use needs. | | | |
| **Collaborators**: Key partners include schools and school districts, community and faith-based organizations, UniHealth Foundation, Dignity Health Southern California Hospitals, Providence Health and LA County agencies. The hospital will provide mental health care providers, case managers, health educators, social workers, philanthropic cash grants, outreach communications, and program management support for these initiatives. | | | |

## Health Need: **Housing**

| Strategy or Program | Summary Description | Active FY25 | Planned FY26 |
|---|---|---|---|
| Frequent Utilizer Systems Engagement | This project connects the top 10% of highest cost, highest need, chronically homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services. | ☒ | ☒ |
| Hope Street Margolis Family Center (HSMFC)Early Head Start, Early Childhood | Enrolls homeless pregnant women and/or parenting women with children, ages 0-3. Outreaches to families in shelters to help them access | ☒ | ☒ |

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|---|---|---|---|
| Education Center and Youth Center | permanent affordable housing. At The Nest, priority enrollment will be given to children, ages 0-5, experiencing homelessness. | | |
| LA Partnership | The LA Partnership is composed of community health directors of nonprofit hospitals and health systems in LA County who have agreed to collaborate on housing insecurity and homelessness in their overlapping service areas. | ☒ | ☒ |

**Goal and Impact**: The hospital's initiatives to address housing insecurity and homelessness are anticipated to result in: improved health care delivery to persons experiencing homelessness and increased access to community-based services and supports for persons experiencing homelessness.

**Collaborators**: Key partners include Housing Works, JWCH, Inc., LA Partnership, Samaritan, city and county agencies, faith & community based organizations, community clinics, community-based, other nonprofit hospitals and homeless service providers. The hospital will provide social workers, health care providers, case managers, philanthropic cash grants, outreach communications, and program management for these initiatives.

## Health Need: Diabetes

| Strategy or Program | Summary Description | Active FY25 | Planned FY26 |
|---|---|---|---|
| Diabetes Empowerment Education Program (DEEP) | Participants with pre-diabetes & diabetes learn tools and techniques to prevent and manage diabetes. Participants are provided resources. | ☒ | ☒ |
| Heart HELP (Healthy Eating Lifestyle Program) | Five-week curriculum to help minimize risk for cardiovascular disease through healthy eating and cooking, maintaining an active lifestyle, and addressing risk factors such as overweight/obesity, hypertension, and cholesterol. Refers participants who are food insecure to CalFresh, WIC and other food assistance programs as appropriate. | ☒ | ☒ |
| Community Health Screenings | The hospital lab provides free health screenings including cholesterol, glucose, A1c, blood pressure, and BMI, education and referrals. | ☒ | ☒ |

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|---|---|---|---|
| Cardiovascular Disease Awareness Classes | A presentation about CVD risk factors is given and participants are invited to lifestyle workshops to positively influence modifiable risk factors in their lives. | ☒ | ☒ |
| **Goal and Impact**: The hospital's initiatives to address diabetes are anticipated to result in: increased identification and treatment of diabetes, increased compliance with disease prevention recommendations (screenings, and lifestyle and behavior changes), and improved healthy eating and active living. | | | |
| **Collaborators**: Key partners include: Schools, FQHCs, Southside Coalition of Community Health Centers, LA County Department of Public Health, youth organizations, faith-based groups, senior centers, and community-based organizations. The hospital will provide health care providers, hospital lab technicians, community health promoters, patient navigators, philanthropic cash grants, outreach communications, and program management support for these initiatives. | | | |

## Health Need: Injury & Violence

| Strategy or Program | Summary Description | Active FY25 | Planned FY26 |
|---|---|---|---|
| CA Behavioral Clinic | Children ages 0-21, with Medi-Cal receive mental health services. Parents may receive dyadic care with their child. | ☒ | ☒ |
| Family Preservation Program | Family preservation services are short-term, family-focused services to assist families in crisis by improving parenting and family functioning while keeping children safe. | ☒ | ☒ |
| Wraparound Services Program | Provides community-based support and individualized planning for children, including those with severe emotional and behavioral disorders and their families.<br>The Wraparound Team implements an intensive family preservation plan that supports keeping the child at home with his/her family. | ☒ | ☒ |
| Human Trafficking Response Task Force | The Human Trafficking Response Task Force provides training to identify potential victims of sex and/or labor trafficking in the ED and other hospital units. | ☒ | ☒ |

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|---|---|---|---|
| Violence Prevention and Gun Safety Program | The program aims to provide violence prevention efforts in community and workplace violence.<br>The gun safety program provides gun safety education to community members in Los Angeles County and healthcare professionals. | ☒ | ☒ |
| Stop the Bleed | Stop the Bleed trains, equips and empowers the public to help in a bleeding emergency before professional help arrives. | ☒ | ☒ |
| Centinela Valley Mental Health Project | CHMC is working in partnership with Providence Health will increase the capacity of local community organizations, community members, youth organizations and schools in the Centinela Valley to identify mental health distress and/or suicidality, and to respond appropriately. | ☒ | ☒ |
| Hope Street Margolis Family Center (HSMFC)Early Head Start, ECE, Family Childcare Network, and Youth Center | Screens parents for depression/anxiety and intimate partner violence (IPV). Screens children for mental health and behavioral issues. Refers parents and children who need treatment to community resources. | ☒ | ☒ |
| Welcome Baby | Parents learn the importance of responsive caregiving and keeping their children safe.<br>Participants are routinely screened for IPV and referred for counseling and support as needed. | ☒ | ☒ |

**Goal and Impact**: The hospital's initiative to address violence and injury prevention are anticipated to result in: increased access to programs in the community that focus on reduced violence and injury prevention.

**Collaborators**: Key partners include Cast, Journey Out, Safe Haven Medical Clinic, faith community, community-based organizations, public safety agencies, city agencies, schools and school districts, community health centers, Providence Health, and youth organizations. The hospital will provide case managers, health care providers, health educators, social workers, philanthropic cash grants and outreach communications in support of this initiative.

## Health Need: Substance Use

| Strategy or Program | Summary Description | Active FY25 | Planned FY26 |
|---|---|---|---|

| | | | |
|---|---|---|---|
| California Bridge Program | Supports the emergency department as a primary access point for the treatment of substance use disorders and co-occurring mental health conditions.<br>Utilizes a trained navigator to identify patients who would benefit from initiating medication for addiction treatment or mental health services. | ☒ | ☒ |
| Frequent Utilizer Systems Engagement (FUSE) Program | This project connects the top 10% of the highest cost, highest need chronically homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental and behavioral health care services. | ☒ | ☒ |
| **Goal and Impact**: The hospital's initiatives to address substance use are anticipated to result in: early identification and treatment of substance use; It seeks to achieve this by integrating evidence-based addiction treatment, particularly medication for addiction treatment (MAT), into standard medical practices, especially in hospital emergency departments. | | | |
| **Collaborators**: Key partners include community clinics, FQHCs, community-based organizations, faith groups, public health, city agencies and homeless services organizations. The hospital will provide health care providers, substance use navigators, community health educators, case managers, philanthropic cash grants, outreach communications, and program management support for these initiatives. | | | |

**Health Need: Nutrition, Physical Activity and Weight**

| Strategy or Program | Summary Description | Active FY25 | Planned FY26 |
|---|---|---|---|
| Heart HELP (Healthy Eating Lifestyle Program) | Five-week curriculum to help minimize risk for cardiovascular disease, cholesterol, and diabetes through healthy eating and cooking, maintaining an active lifestyle, and addressing risk factors such as overweight/obesity, hypertension, and cholesterol. Referrals provided. | ☒ | ☒ |
| Nutrition Education | Participants receive one-time nutrition classes to empower individuals to make informed choices about food and nutrition to adopt and maintain, improve overall health, and reduce the risk of chronic diseases. | ☒ | ☒ |

| | | | |
|---|---|---|---|
| Diabetes Empowerment Education Program | Participants with pre-diabetes & diabetes learn tools and techniques to prevent and manage diabetes. Participants are provided resources. | ☒ | ☒ |
| Community Health Screenings | The hospital lab provides free health screenings including cholesterol, glucose, A1c, blood pressure, and BMI. | ☒ | ☒ |
| Welcome Baby | Families learn about child development milestones. Assess baby and mom for nutrition and access to food. Referrals provided as needed. | ☒ | ☒ |
| Hope Street Margolis Family Center (HSMFC)Early Head Start, Family Childcare Network, & Youth Center | Hope Street Margolis Family Center (HSMFC)Early Head Start programs provide comprehensive health and nutrition services, which include nutrition education for both children and their families, promoting healthy eating habits. | ☒ | ☒ |
| **Goal and Impact**: The hospital's initiatives to address nutrition, physical activity and weight are anticipated to result in: knowledge about how to increase knowledge of healthy eating, active living through healthy recommendations (screenings, and lifestyle and behavior changes), and provide resources to address food access. | | | |
| **Collaborators**: The hospital will partner with local schools, community based organizations, faith based organizations, community health advocates, and department of public health. | | | |

**Health Need: Access to Health Care Services**

| Strategy or Program | Summary Description | Active FY25 | Planned FY26 |
|---|---|---|---|
| Financial Assistance | California Hospital Medical Center provides financial assistance to those who have health care needs and are uninsured, underinsured, ineligible for government programs or otherwise unable to pay. | ☒ | ☒ |
| Para Su Salud | Enrollment assistance to individuals and families to sign up for health and dental health insurance benefits. | ☒ | ☒ |

| | | | |
|---|---|---|---|
| Coordinated Care Initiative | The goal of the project is to ensure patients follow up with their primary care doctor following a hospitalization or a visit to the ER. | ☒ | ☒ |
| Frequent Utilizers Systems Engagement Program | The project supports the top 10% highest cost, highest need chronically homeless individuals seen at CHMC to intensive case management, supportive housing, mental, and behavioral health care services. | ☒ | ☒ |
| Hope Street Margolis Family Center (HSMFC)Early Head Start, Family Childcare Network, & Youth Center | Assists families in accessing health and dental health insurance coverage.<br>Assists families in establishing a medical home for each family member. | ☒ | ☒ |
| Navigating the Healthcare System | A curriculum for navigating the healthcare system focuses on empowering our patients to understand health insurance, access various types of care, communicate with providers and utilize electronic health records, and manage their own health. Curriculum provided at bedside. | ☒ | ☐ |
| Health Screenings | The hospital lab provides free health screenings including cholesterol, glucose, A1c, blood pressure, and BMI. | ☒ | ☒ |

**Goal and Impact**: The hospital's initiatives to address access to care are anticipated to result in increased access to health care for the medically underserved, reduced barriers to care, and increase access to primary and specialty care services.

**Collaborators**: Key partners include community clinics, FQHCs, CBOs, faith organizations, public health, city agencies and homeless services organizations. The hospital will provide health care providers, lab technician, enrollment counselors, community health educators, case managers, philanthropic cash grants, outreach communications, and program management support for these initiatives.

## Community Health Improvement Grants Program

One important way the hospital helps to address community health needs is by awarding restricted financial grants to non-profit organizations working to improve health status and quality of life. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations related to CHNA priorities.

In FY25, the hospital awarded the grants below totaling $290,000. Some projects also may be described elsewhere in this report.

| Grant Recipient | Project Name | Health Needs Addressed | Amount |
|---|---|---|---|
| Cancer Support Community LA | Healing Equitably through Action, Resilience & Teamwork (HEART) Initiative | Behavioral Health<br>Chronic Diseases | $85,000 |
| St. Francis Center | St. Francis Center | Access to Care<br>Housing | $85,000 |
| Ketchum YMCA | Los Angeles YMCA: The Center for Community Wellbeing | Access to Care | $85,000 |
| Safe Parking LA | Safe Parking LA 2024-2025 Figueroa Program | Housing<br>Access to Care | $35,000 |

## Program Highlights

The following pages describe a sampling of programs and initiatives listed above in additional detail, illustrating the work undertaken to help address significant community health needs.

### Centinela Valley Mental Health Project

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| Significant Health Needs Addressed | • Mental Health<br>• Access to Care |
| Program Description | • California Hospital Medical Center working in partnership with Providence Health will increase the capacity of local community organizations, community members, youth organizations and schools in the |

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| | Centinela Valley to identify mental health distress and/or suicidality, and to respond appropriately.<br>● Community Health Promoters will deliver Mental Health First Aid training and Mind Matters workshops primarily to organizations and community members of the Centinela Valley. |
| Population Served | ● The main audience is residents of the Centinela Valley in South Los Angeles<br>● 90% of program participants must come from a long list of specific zip codes in that region. Some of these zip codes include 90001, 90002, 90003, 90008, 90011, 90016, 90018, 90037, 90043, 90044, 90045, 90047, 90059, 90061, 90062, 90220, 90249, 90250, 90260, 90301, 90302, 90303, 90304, and 90305<br>● The program focuses on children and adults in these communities, especially those who face disparities in access to health care, including immigrant populations. |
| Program Goal / Anticipated Impact | The Centinela Valley Mental Health Project seeks to reduce health disparities and expand equitable access to mental health and related health services for residents of South Los Angeles Centinela Valley. By fostering collaboration among hospitals, clinics, and community organizations, the program aims to integrate behavioral, and social supports to improve overall wellbeing.<br>● Increase Access to Services<br>● Improve Community capacity<br>● Reduction in Barriers to Care |
| FY 2025 Report | |
| **Activities Summary** | The Centinela Valley Mental Health Project engaged community members through a combination of education and advocacy. Principal activities included providing mental health education and trainings such as Mind Matters and Mental Health First Aid to reduce stigma and build local capacity for early intervention. Partnerships with schools, clinics, and community-based organizations strengthened coordination of care and resources, while capacity-building efforts equipped local organizations and leaders with tools to identify and respond to mental health needs. |
| **Performance / Impact** | During FY25, the Centinela Valley Mental Health Project delivered a total of 103 Community classes, reaching 1440 participants across priority zip codes in South Los Angeles. Through workshops such as Mind Matters and Mental Health First Aid, participants gained tools to recognize signs of stress, trauma, and mental health challenges, and to connect peers and family members with appropriate resources. |

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| | These activities directly supported the program's goal of expanding access to mental health education and reducing barriers to care in the Centinela Valley. The reach of over 1400 residents trained and engaged reflects measurable progress in building community capacity to identify mental health needs earlier and link individuals to culturally competent services. Collaborative partnerships with schools, clinics, and community-based organizations further amplified the impact by extending these resources to families, youth, and vulnerable populations throughout the region. |
| FY 2026 Plan | |
| **Program Goal / Anticipated Impact** | The Centinela Valley Mental Health Project aims to increase access to mental health education, reduce stigma, and strengthen community capacity for early intervention in South Los Angeles Centinela Valley.<br><br>Through classes such as Mind Matters and Mental Health First Aid, the program anticipates that:<br>● At least 1,000 residents annually will participate in workshops that build knowledge of mental health and stress management<br>● Over 100 classes per year will be conducted in partnership with schools, clinics, and community-based organizations to expand the reach of mental health education.<br>● 90% of participants will report increased awareness of mental health resources or improved confidence in recognizing signs of mental distress.<br>● Community organizations and leaders engaged through the program will demonstrate increased capacity to connect residents to services and advocate for equitable access to care. |
| **Planned Activities** | No planned changes in program activities. |

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| Frequent Utilizers Systems Engagement (FUSE) Program | |
| Significant Health Needs Addressed | ● Housing<br>● Access to Care |
| Program Description | ● A Homeless Health Initiative funded project connects the top 10% highest cost, highest need chronically homeless individuals seen at CHMC to intensive case |

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| | management, supportive housing, and appropriate physical, mental, and behavioral health care services through a collaboration with Corporation for Supportive Housing, Housing Works, and JWCH, Inc. |
| Population Served | Chronically homeless individuals. |
| Program Goal / Anticipated Impact | Improve the health of patients who are experiencing chronic homelessness who meet the criteria as belonging in the 10th Decile, increase their housing stability, and reduce their avoidable ED visits.<br>● Reduce avoidable ED visits/hospitalizations among FUSE patients (measured at 6 and 12 months post discharge.<br>● Improve health and housing stability among 30% or more of patients enrolled in FUSE.<br>● Achieve financial sustainability to ensure FUSE program outcomes continue beyond the grant period. |
| FY 2025 Report | |
| Activities Summary | ● Patient identification: Patients in the ED and inpatient are screened for eligibility into the program.<br>● Screening, Referrals + Connection: Eligible patients are referred for ongoing case management. Ineligible patients are connected to other services like primary & behavioral health care.<br>● Ongoing case management: Patients receive housing navigation and case management with a goal towards permanent housing. |
| Performance / Impact | ● Permanently housed 6 individuals (49 total since 2020)<br>● Referred 132 individuals to Enhanced Care Management at John Wesley Community Health (JWCH)<br>● Enrolled 10 individuals in Community Supports at Housing Works |
| Hospital's Contribution / Program Expense | $510,272.00. This included personnel, staff development and training, mileage/transportation, software, equipment, interim housing, and move-in expenses. |
| FY 2026 Plan | |
| Program Goal / Anticipated Impact | The program goal and anticipated impacts for FY2026 remains the same as the previous year - to continue to provide chronically homeless patients, who are assessed in the hospital and eligible for the program, with intensive case management, housing navigation, and linkage to community-based primary and behavioral health care. The focus of the program is to |

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| | improve both the health of our patients and their housing stability. More specifically, the program works to enhance cross-sector care coordination to improve outcomes around patient care, reduce avoidable ED visits and hospitalizations, and decrease health care costs. |
| **Planned Activities** | No planned changes in program activities. |

| Welcome Baby | |
|---|---|
| Significant Health Needs Addressed | • Access to Care<br>• Nutrition, Physical Activity<br>• Injury and Violence |
| Program Description | • Welcome Baby provides pregnant women and new moms with information, support, and a trusted partner to help them through the journey of pregnancy and early parenthood. This program is grant-funded by First 5 LA in partnership with Maternal & Child Health Access. |
| Population Served | Pregnant women and new moms in the Metro LA community. |
| Program Goal / Anticipated Impact | The goals of the Welcome Baby program at CHMC are:<br>• Support pregnant women to receive needed mental health, dental services and other needed services<br>• Achieve as safe and healthy of a home environment as possible<br>• Increase breastfeeding initiation, exclusivity and duration rates<br>• Provide education and support services for families at postpartum visits<br>• Promote healthy physical and emotional development<br>• Create or enhance existing linkages with social services, educational and health care agencies to obtain needed services |
| FY 2025 Report | |
| **Activities Summary** | This free and voluntary program at CHMC offered the following during pregnancy and throughout the baby's first nine months:<br>• An in-hospital visit where they receive assistance with breastfeeding and information about bonding and attachment, taking care of your baby, and resources their family may need<br>• A personal Parent Coach who meets with the mother and their family in the comfort and convenience of their home |

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| | • Information and support on breastfeeding, home safety and other topics<br>• An in-home appointment with a nurse within the first few days after delivering at the hospital<br>• Referrals to additional resources to help the mother and baby |
| **Performance / Impact** | From July 2024 to June 2025, the Welcome Baby program served 922 women |
| **Hospital's Contribution / Program Expense** | This is a grant-funded program with funding from First 5 LA and offered in partnership with Maternal and Child Health Access. The hospital liaisons that conduct the in-hospital visits are CHMC employees. CHMC provides office space, computers, printers and office support for this program. |
| FY 2026 Plan | |
| **Program Goal / Anticipated Impact** | The goals of the Welcome Baby program for FY 2026 remain the same:<br>• Support pregnant women to receive needed mental health, dental services and other needed services<br>• Achieve as safe and healthy of a home environment as possible<br>• Increase breastfeeding initiation, exclusivity and duration rates<br>• Provide education and support services for families at postpartum visits<br>• Promote healthy physical and emotional development in 100% of infants visited<br>• Create or enhance existing linkages with social services, educational and health care agencies to obtain needed services |
| **Planned Activities** | No planned changes in program activities. |

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| Hope Street Margolis Family Center | |
| Significant Health Needs Addressed | • Mental Health<br>• Housing<br>• Diabetes<br>• Injury and Violence<br>• Substance Use<br>• Nutrition, Physical Activity & Weight<br>• Access to Health Care Services |
| Program Description | Hope Street Margolis Family Center (Hope Street) was established in 1992 as a collaboration between UCLA and |

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| | California Hospital Medical Center. Its mission is to educate children, strengthen families, and transform the community. HSFC empowers and strengthens families by addressing the social determinants of health through a continuum of care that includes health screenings, mental health, literacy, early childhood education, early intervention, child welfare, youth and social services. Programs and services include Early Head Start (EHS), Child Development Centers, Family Childcare Network, Family Literacy, School Readiness, Youth Center, Family Preservation, Wraparound Services, California Behavioral Clinic, and Home Visitation. |
| Population Served | HSFC focuses its efforts on some of the poorest and most densely populated areas in Los Angeles County. HSFC programs serve children, youth, parents and families. |
| Program Goal / Anticipated Impact | The goals of Hope Street Margolis Family Center continuum of whole child and family programs are:<br>● Enhance the capacity of parents and families to nurture and care for their children<br>● Promote children's overall health, mental health, development, school readiness, and academic achievement<br>● Strengthen existing service delivery networks and foster community partnerships<br>● Develop services that are accessible and responsive to our local community |
| FY 2025 Report | |
| Activities Summary | ● Early Head Start (EHS) offered comprehensive child development and family support services for children 0-3 years old.<br>● Early Childhood Education Centers: four licensed child development centers served children from 0-5 years old through four licensed centers.<br>● Family Childcare Network offered developmentally enriched childcare for infants, toddlers, and preschool aged children through a network of licensed family child care providers.<br>● Family Literacy provided parents with literacy training, English as a Second Language, GED and other adult education as well as parenting education.<br>● School Readiness prepared children and their families' successful transition to kindergarten through full day education and case management.<br>● The Youth Center provided academic support, health and wellness activities, sports and recreation, and arts programming for elementary, middle and high school students. Summer of Science program is offered every |

year and aims to inspire students to explore STEAM subjects and careers. College prep and career development activities are also offered.
- Family Preservation provided weekly home-based counseling and case management, care coordination, parenting classes, support groups and multi-disciplinary care to families whose children are at risk of abuse, neglect, and exploitation.
- Wraparound Services provided home-based permanency support to meet the complex needs of children with mental health and behavioral concerns who are involved in the child welfare system.
- California Behavioral Clinic provided individual, family and group psychotherapy, psychiatric and case management services to support the emotional and psychological well-being of children and their families.
- Home Visitation program provided support, education and resources for mothers through in-home prenatal and early childhood nurse visits.

**Performance / Impact**

Below are the number of children and families served by Hope Street Margolis Family Center by program by quarter in FY 2025:

| Program | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|---|
| Early Head Start | 1,472 | 1,348 | 1,700 | 1,664 |
| Family Child Care | 198 | 172 | 172 | 180 |
| Youth Center | 423 | 423 | 410 | 416 |
| Family Preservation | 324 | 351 | 293 | 248 |
| Behavioral Health | 1,283 | 1,193 | 1,103 | 999 |
| Center-Based | 964 | 784 | 792 | 704 |

**Hospital's Contribution / Program Expense**

Hope Street Margolis Family Center is housed in a customized 4-story building (30,000 sq. ft.) built by California Hospital Medical Center. It has attached play areas for young children as well as a full-sized basketball court for older youth and teens. All services are supported by grants and philanthropy,

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| | total program expense of $19,024,96. All Hope Street Margolis Family Center (HSMFC)staff are California Hospital Medical Center employees. |
| FY 2026 Plan | |
| **Program Goal / Anticipated Impact** | The goals of Hope Street Margolis Family Center's continuum of whole child and family programs are:<br>• Enhance the capacity of parents and families to nurture and care for their children.<br>• Promote children's overall health, mental health, development, school readiness, and academic achievement.<br>• Strengthen existing service delivery networks and foster community partnerships.<br>• Develop services that are accessible and responsive to our local community. |
| **Planned Activities** | No change in program activities from last year. |

| Ca Bridge Program | |
|---|---|
| Significant Health Needs Addressed | • Access to Care<br>• Substance Use<br>• Mental Health |
| Program Description | • The CA Bridge program at California Hospital Medical Center provides help for substance use disorders (SUD) and co-occurring behavioral health conditions.<br>• The CA Bridge program supports clinicians to make medication for addiction treatment (MAT) accessible as the standard of care.<br>• The model includes three core elements: rapid access to low-barrier treatment, navigation to on-going care, and a culture of harm reduction. |
| Population Served | Patients with substance use disorders |
| Program Goal / Anticipated Impact | • Number of referrals received through the ED and inpatient units<br>• Number of ED/hospital encounters where a patient was seen by the navigator for any reason<br>• Number of ED/hospital encounters where a patient was discharged with a follow up appointment with a SUD provider<br>• Number of ED/hospital encounters where a patient was treated with buprenorphine |

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| | • Number of ED/hospital encounters where a patient was diagnosed with overdose and seen by the Navigator<br>• Number of naloxone distributed |
| FY 2025 Report | |
| Activities Summary | Patients in the ED or inpatient units who have issues with opioids, alcohol, methamphetamines or any illicit or illicit drugs or who ask for help with substance use are referred to the Substance Use Navigator. Depending on the situation, a clinician may provide a dose of Buprenorphine. Buprenorphine is a safe drug that can help relieve withdrawal symptoms. CHMC's Substance Use Navigator will help patients link to services or treatment programs outside of the hospital setting. |
| Performance / Impact | 278 patients were seen by a Substance Use Navigator. |
| Hospital's Contribution / Program Expense | Total program expense is $146,527 with grant funding of $97,038. CHMC contributes office space, computers, printers and office equipment. |
| FY 2026 Plan | |
| Program Goal / Anticipated Impact | The program goal and anticipated impacts for FY2026 remains the same as the previous year - to connect patients to addiction treatment and address social and behavioral health needs with the support of the Substance Use Navigator. |
| Planned Activities | No planned changes in program activities. |

| Heart HELP (Healthy Eating Lifestyle Program) and Cardiovascular Disease Classes | |
|---|---|
| Significant Health Needs Addressed | • Nutrition, Physical Activity and Weight |
| Program Description | • The Heart HELP (Healthy Eating Lifestyle Program). and Cardiovascular Disease Awareness workshops are a series of weekly workshops for adults suffering from or at risk for cardiovascular diseases such as hypertension, hypercholesterolemia, myocardial infarction, stroke, or congestive heart failure.<br>• Participants learn about reducing risk factors which includes good nutrition, physical activity and weight management. |
| Population Served | Adults living in the service area of California Hospital Medical Center, parents whose children attend schools in the service |

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| | area, parents of children served by Hope Street Margolis Family Center. |
| Program Goal / Anticipated Impact | The overall goal of the Heart HELP (Healthy Eating Lifestyle Program)and Cardiovascular Disease Awareness workshops is for participants to:<br>● Meet the recommended guidelines for BMI<br>● Decrease saturated fat consumption and sodium intake<br>● Increase physical activity<br>● Increase the number of participants whose blood pressure is under control<br>● Increase medication compliance among those with prescribed medication<br>● Increase the proportion of adults who are aware of the symptoms and know to respond to a heart attack or stroke |
| FY 2025 Report | |
| Activities Summary | A California Hospital Medical CenterCommunity Health Promoter taught the Heart HELP classes and CVD Awareness workshops at 25 different locations in Los Angeles. They were taught at schools, churches, and community partner sites. |
| Performance / Impact | A total of 25 Heart HELP series were offered – one in English and 24 in Spanish. A total of 381 individuals enrolled in the Heart HELP series. Eight CVD Awareness classes were offered with a total of 44 participants. |
| Hospital's Contribution / Program Expense | The overall program expense for the Heart HELP and CVD Awareness Classes is $1,083,875 which include Director Community Health Outreach, Manager of Community Health, Community Health Promoter and Community Health RN (currently vacant). California Hospital Medical Center also provides a spacious office, office furniture, supplies, screening supplies, DPH licenses, computers and printers. |
| FY 2026 Plan | |
| Program Goal / Anticipated Impact | The overall goals of the Heart HELP and CVD Awareness workshops are:<br>● Meet the recommended guidelines for BMI<br>● Decrease saturated fat consumption and sodium intake<br>● Increase physical activity<br>● Increase the number of participants whose blood pressure is under control<br>● Increase medication compliance among those with prescribed medication<br>● Increase the proportion of adults who are aware of the symptoms and know to respond to a heart attack or stroke. |
| Planned Activities | No planned changes in program activities. |

| Para Su Salud | |
|---|---|
| Significant Health Needs Addressed | • Access to Care<br>• Nutrition |
| Program Description | • Para Su Salud helps navigate the application process for Medi-Cal, Covered California and other health access and public benefit programs.<br>• Community Health Specialists assess each individual to determine eligibility for health insurance and other public benefit programs and assist with enrollment.<br>• They also assist with annual redetermination renewals. This is a grant-funded program. |
| Population Served | Persons who need assistance with health insurance coverage and annual renewals. |
| Program Goal / Anticipated Impact | The overall program goal is to enroll uninsured individuals into the health insurance program s/he qualifies for. Specific outcomes include:<br>• Number of persons reached through outreach.<br>• Number of persons enrolled in health insurance.<br>• Number of six-month re-certifications completed. |
| FY 2025 Report | |
| **Activities Summary** | As more meetings and events opened up and were held in-person, the Community Health Specialists were able to participate in community outreach events and do presentations with community partners in person. They were also able to meet with and assist participants in person. |
| **Performance / Impact** | From July 2024 to June 2025, Para Su Salud assisted a total of 113 persons. |
| **Hospital's Contribution / Program Expense** | Total program expense is $198,702, with a restricted grant of $53,037. The program is staffed by CHMC employees composed of a Project Supervisor, Community Health Specialists, Utilization/Determination Specialist and Administrative Assistant. CHMC also contributes office space, computers, printers and office equipment. |
| FY 2026 Plan | |
| **Program Goal / Anticipated Impact** | The program goal is to provide enrollment assistance and redetermination assistance. Para Su Salud staff will continue to track the number of people they outreach to, number enrolled, number of re-certifications completed. |

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| Planned Activities | No planned changes in program activities. However, there is only one staff member on the team. |

## Other Community Health and Community Building Programs

The hospital delivers community programs, services and non-quantifiable benefits in addition to those described elsewhere in this report. Like those programs and initiatives, the ones below are a reflection of the hospital's mission and its commitment to improving community health and well-being.

**Dignity Health Community Investment Program: Active Loans near CHMC**

Abode Communities (Abode)
A partner of Dignity Health since 2010, Abode is considered a thought leader in the affordable housing industry and since 2012, has placed in service 500 affordable housing units within the County of Los Angeles, with another 900 affordable units currently under construction and expected to be placed in service over the next several years.

Art Share Los Angeles Inc. (Art Share)
In 2015, CommonSpirit approved a 5-year $500,000 loan to Art Share, a community arts center and affordable housing complex for low-income artists in downtown Los Angeles.

Everytable, PBC
Everytable, PBC, is a for-profit "public benefit corporation" founded in 2015 with the purpose of making healthy food affordable, convenient, and accessible for all.

Genesis LA Economic Growth Corporation
Founded in 1998, Genesis LA Economic Growth Corporation (Genesis) is a Community Development Financial Institution (CDFI) with over $42 million in total assets, making it the fourth largest CDFI headquartered in Los Angeles (LA) County.

Los Angeles Community Health Centers (LACHC)
In 2017 Dignity Health approved a 7-year $5,000,000 participation loan with Nonprofit Finance Fund to help LACHC construct a new FQHC in the Skid Row neighborhood of downtown Los Angeles.

United Way of Greater Los Angeles
United Way of Greater Los Angeles is a Los Angeles, California, nonprofit organization whose mission is to permanently break the cycle of poverty for the most vulnerable individuals, supporting low-income families, students, veterans, and people experiencing homelessness.

Corporation for Supportive Housing (CSH)

In June 2016 Dignity Health approved a 7-year $3,000,000 loan to CSH to further this CDFI's work in creating supportive housing geared toward preventing and ending homelessness.

## Economic Value of Community Benefit

The economic value of all community benefit is reported at cost. Patient financial assistance (charity care) reported here is as reported to the Department of Health Care Access and Information in Hospital Annual Financial Disclosure Reports, as required by Assembly Bill 204. The community benefit of Medicaid, other means-tested programs and Medicare is calculated using a cost-to-charge ratio to determine costs, minus revenue received for providing that care. Medicare reported here is fee-for-service only and excludes Medicare reported as a part of Graduate Medical Education and subsidized health services.

Other net community benefit expenses are calculated using a cost accounting methodology. Restricted offsetting revenue for a given activity, where applicable, is subtracted from total expenses to determine net benefit in dollars.

| Financial Assistance and Means-Tested Government Programs | Vulnerable Population | Broader Community | Total |
|---|---|---|---|
| Traditional Charity Care | $17,588,474 | | $17,588,474 |
| Medi-Cal | $133,491,908 | | $133,491,908 |
| Other Means-Tested Government (Indigent Care) | $0 | | $0 |
| **Sum Financial Assistance and Means-Tested Government Programs** | **$151,080,382** | | **$151,080,382** |
| | | | |
| **Other Benefits** | | | |
| Community Health Improvement Services | $3,858,929 | $88,456 | $3,947,385 |
| Community Benefit Operations | $1,083,875 | $18,375 | $1,102,250 |
| Health Professions Education | $0 | $6,083,265 | $6,083,265 |
| Subsidized Health Services | $836,505 | $0 | $836,505 |
| Research | $0 | $0 | $0 |
| Cash and In-Kind Contributions for Community Benefit | $1,550,590 | $0 | $1,550,590 |
| Other Community Benefits | $0 | $0 | $0 |
| **Total Other Benefits** | **$7,329,899** | **$6,190,096** | **$13,519,995** |
| | | | |
| **Community Benefits Spending** | | | |
| **Total Community Benefits** | **$158,410,281** | **$6,190,096** | **$164,600,377** |
| Medicare | $0 | | $0 |
| **Total Community Benefits with Medicare** | **$158,410,281** | **$6,190,096** | **$164,600,377** |