City of Hope®

2025 Community Benefit Report

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EXECUTIVE SUMMARY

City of Hope is pleased to present the Fiscal Year 2025 Community Benefit Executive Summary, marking the culmination of the three-year reporting period accountable to the 2022–2025 Community Health Needs Assessment (CHNA) and Implementation Strategy. Throughout this cycle, City of Hope has remained steadfast in its commitment to improving health equity, advancing cancer prevention, and addressing the social and structural conditions that shape health across our diverse service area. Guided by the priorities identified through extensive community engagement City of Hope invested **$536,316,697** in quantifiable community benefit in FY2025, reflecting the scale, consistency, and impact of our mission-driven work over this three-year period. This investment reflects our mission to reduce disparities, expand access, and strengthen community capacity through programs that reach vulnerable populations across Los Angeles, Orange, Riverside, San Bernardino, and Ventura counties.

Throughout FY2025, City of Hope advanced a wide portfolio of community benefit initiatives centered on four priority areas: Social Determinants of Health, Health Access, Mental Health, and Cancer Prevention. Our Healthy Living, Community Building and Health Equity Grants continued to uplift community-based organizations working to reduce cancer risk and support wellness, while our expanded food access programs—including Produce for Patients, the inpatient Food Bag Program, and Seed to Supper—addressed the pressing challenge of food insecurity for patients and families. Strengthened social needs screening and navigation further connected patients to resources in housing, financial stability, transportation, and mental health, demonstrating our commitment to whole-person care.

City of Hope deepened its engagement with regional partners, including the Health Consortium of Greater San Gabriel Valley and Healthy San Gabriel Valley, helping advance cross-sector strategies that support chronic disease prevention, environmental health, food access, and community-led wellness initiatives. These partnerships reflect our long-standing belief that sustainable progress requires strong, trusting relationships and shared ownership with community stakeholders.

FY2025 also marked important progress in community benefit governance and systemwide capacity building. City of Hope completed the 2025 CHNA and 2025–2028 Implementation Strategy, developed

with extensive community input and adopted by the NMC Board. Additionally, we supported our City of Hope locations in Chicago, Atlanta, and Phoenix in standing up their own Community Benefit Advisory Councils and building internal capacity in community benefit reporting, transparency, and community engagement standards.

As we conclude FY2025, City of Hope remains steadfast in its commitment to advancing health equity across our service area. Through deep partnership, data-informed planning, and investments that reflect both fiscal responsibility and compassionate action, we continue to honor our legacy of service while building a healthier, more just future for the communities we serve.

For more information about this report and any of the City of Hope initiatives describe in this report, please reach out to the Department of Community Benefit: CommunityBenefit@coh.org.

Members of our Veterans for Hope Inclusion Resource Group the Boots on the Ground Alliance participating in the Welcome Home Parade and Ceremony for Vietnam Veterans in Lancaster.

WHO WE ARE: CITY OF HOPE

Founded in 1913, City of Hope is a national leader in cancer care and diabetes. 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 stage and for common or rare types of cancer. City of Hope is also proud to be a founding member of the National Comprehensive Cancer Network (NCCN), reflecting our national leadership in advancing research and treatment. NCCN member institutions are recognized for their world-renowned expertise and for treating complex, rare and aggressive forms of cancer. Most importantly, we firmly believe in providing value across the entire patient journey. At City of Hope, this is measured by the experiences and outcomes that our treatments and dedicated teams provide. Our goal is to care for the whole person, so that life during treatment and after cancer can be rich and rewarding.

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

Compassion and discovery are at the heart of our approach. Thanks to the expertise and dedication of our physicians and staff, we can treat rare complex cancers and diabetes. 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 cells and the use of advanced imaging techniques to more precisely deliver radiation therapy. Our support also extends to our community through our network of clinical locations. We work with our patients and their families at each step of the journey, providing interdisciplinary supportive services, including psychology, patient education, and support groups, such as Couples Coping with Cancer, social work, physical and occupational therapy and nutritional and financial counseling. Foundational to this

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

approach is our focus on innovation as we strive to turn tomorrow's treatments into today's therapies. We are committed to delivering the most leading-edge treatment options to our patients and discovering new ways to combat a wide variety of cancers.

Delivering Optimal Outcomes for Our Patients

NCI-designated comprehensive cancer centers like City of Hope are the reason that cancer mortality rates have fallen over the past four decades. Our patients recognize our commitment and our ability to provide life-changing outcomes.

Why Our Research and Innovation Matters

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

- Clinical trial participation is a critical aspect of care for many patients living with cancer. Our patients have access to more than 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 world and nearly 80 clinical trials either in process or completed, targeting various hematologic and solid tumors, including brain tumors.

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

are an integral part of our mission. These partnerships allow us to focus on health equity not just for City of Hope patients, but for everyone regardless of zip code. Through the Cancer Care Is Different and Cancer Care Equity Act that Governor Gavin Newsom signed into law effective on January 1, 2023, more people will have access to lifesaving cancer care at any designated cancer center in California.

Mission Statement

To make hope a reality for all touched by cancer and diabetes.

Statement of Corporate Social Responsibility

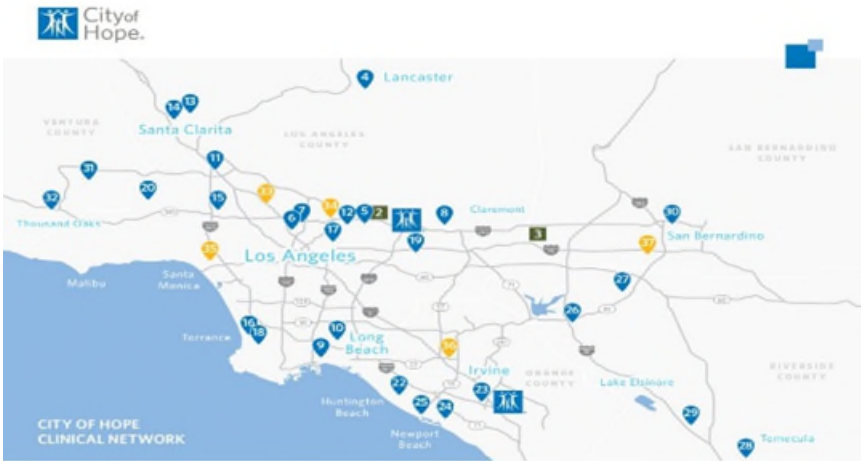
Built by the passion of volunteers determined to improve the health of their community, City of Hope has a legacy of over 100 years of caring — both caring about and caring for our people, our patients, our community and even our planet.

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

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. Most 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 others. Our service area map (right) shows our clinical network sites across five counties. In the service area, 46.7% of the population identifies as Hispanic or Latino, and non-Hispanic White residents comprise 29.1% of the service area population. Non-Hispanic Asian residents make up 13.8% of the population, 6.1% of the population identifies as Black or African American, and 3.4% identify as non-Hispanic multiracial. 0.5% of the hospital service area population identifies as some race or ethnicity other than those listed, 0.2% identify as Native Hawaiian or Pacific Islander (NHPI) and 0.2% as American Indian or Alaska Native (AIAN).

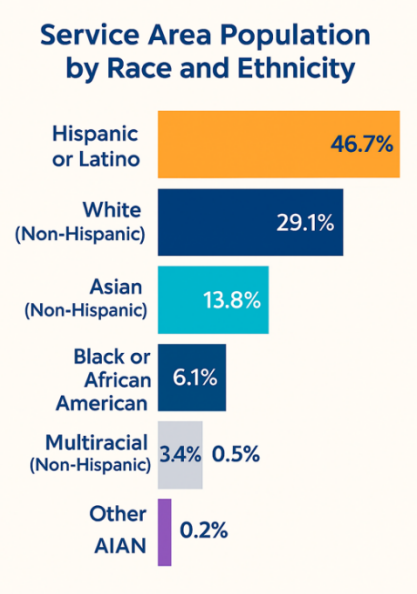


City of Hope – Service Area including clinical network locations.

Population, by Race and Ethnicity

	Los Angeles County	Orange County	Riverside County	San Bernardino County	Ventura County	COH Service Area
Hispanic or Latino	48.3%	34.1%	50.6%	54.6%	43.8%	46.7%
White	25.2%	37.7%	32.0%	25.6%	42.9%	29.1%
Asian	14.8%	21.7%	6.8%	7.9%	7.1%	13.8%
Black or African American	7.5%	1.5%	6.1%	7.6%	1.7%	6.1%
Multiracial	3.3%	4.1%	3.4%	3.3%	3.8%	3.4%
Some other race	0.6%	0.4%	0.5%	0.5%	0.5%	0.5%
Native Hawaiian or Pacific Islander	0.2%	0.3%	0.3%	0.3%	0.2%	0.2%
American Indian or Alaska Native	0.2%	0.1%	0.3%	0.3%	0.2%	0.2%

Source: U.S. Census Bureau, American Community Survey, 2019-2023, DP05. https://data.census.gov/



When race and ethnicity is examined by SPA 3 community, 92.3% of the population of Irwindale, and 84.7% of the population of South San Jose Hills identify as Hispanic or Latino. South San Gabriel has the highest percentage of Asian residents (69.5%) in the service area, followed by San Marino (68.9%). Sierra Madre (55.7%) has the highest percentage of White residents in the service area, followed by Claremont (46.3%). Altadena has the highest percentage of Black or African American residents in the service area (17.6%), followed by Charter Oak (9.1%).

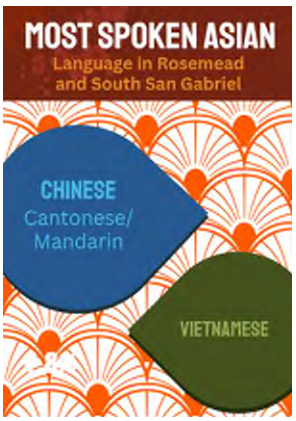
Language

In the service area, English-only is spoken at home among 50.3% of the population. Spanish is spoken in the home among 34.4% of the population, 4.4% speak an Indo-European language other than Spanish or English, and 9.8% of the population speaks an Asian or Pacific Islander language at home. 1.2% of the population speak a language 'other' than those listed.

Language Spoken at Home, Ages 5 Years and Older

	Los Angeles County	Orange County	Riverside County	San Bernardino County	Ventura County	COH Service Area
Population, aged 5+	9,329,609	2,993,848	2,304,643	2,045,415	793,373	17,466,888
English only	44.9%	54.1%	58.2%	56.4%	61.6%	50.3%
Speaks Spanish	37.7%	24.3%	34.5%	35.3%	30.2%	34.4%
Speaks Asian or Pacific Islander language	10.7%	15.5%	4.3%	5.6%	4.2%	9.8%
Speaks Other Indo-European language	5.6%	4.8%	2.0%	1.5%	3.0%	4.4%
Speaks other language	1.2%	1.3%	0.9%	1.1%	1.0%	1.2%

Source: U.S. Census Bureau, American Community Survey, 2019-2023, DP02. https://data.census.gov/



U.S. Census Bureau (2019-2023). Language Spoken at Home for the Population 5 Years and Over American Community Survey.

In the SPA 3 communities, Sierra Madre (80.9%) and La Verne (74.9%) have the highest percentage of speakers of English-only in the home. South San Jose Hills (69.1%) and La Puente (63.7%) have the highest percentage of Spanish-speakers in the service area. Rosemead (57%) has the highest percentage of people speaking an Asian or Pacific Islander language in the home, followed by South San Gabriel (53.6%), Walnut (53.4%) and San Marino (53.1%). The highest percentage of speakers of an Indo-European language other than Spanish or English at home in the service area is 7.7%, found in both Altadena and Bradbury (where it represents just 59 individuals).

Linguistic Isolation

Linguistic isolation is defined as the population, ages five and older, who speaks English "less than very well." In the service area, 19.8% of the population is linguistically isolated, with the highest rate found in Los Angeles County (23.2%). With nearly a fifth of the service area population linguistically isolated, any planning around programs and services need to be mindful to include linguistic diversity so as not to unintentionally exclude large segments of the population. Providing materials and services in multiple languages ensures equitable access and fosters trust in institutions.

Linguistic isolation impacts:

- Access to information
- Services
- Opportunities

Social and Economic Factors Ranking

The County Health Rankings rank-order counties according to a variety of health factors. Social and economic indicators are examined as a contributor to the health of a county's residents. This ranking examines: high school graduation rates, unemployment, children in poverty, social support, and others. California's 58 counties were ranked according to social and economic factors with one indicating the county with the best factors to 58 for the county with the poorest factors. With a ranking of 11, Orange County is in the top quartile of California counties, while Ventura County is in the second quartile, with a rank of 16th. The remaining three counties are in the third quartile, with Los Angeles County ranked the lowest of the area counties (37th).

Social and Economic Factors Ranking

	Los Angeles County	Orange County	Riverside County	San Bernardino County	Ventura County
County Ranking (out of 58)	37	11	30	32	16

Source: County Health Rankings, 2023. www.countyhealthrankings.org

Understanding Poverty and Its Broader Implications

Poverty is often narrowly defined by income thresholds, yet its true impact is far beyond financial limitations. In communities across the service area, poverty intersects with housing instability, food insecurity, unemployment, limited access to public benefits, and disparities in health and education. Vulnerable populations—including children, seniors, female-headed households, and immigrant families—face compounded challenges that shape their daily lives and long-term opportunities. Understanding poverty through this broader lens reveals the structural and social barriers that prevent individuals and families from thriving, and underscores the need for holistic, community-informed solutions.

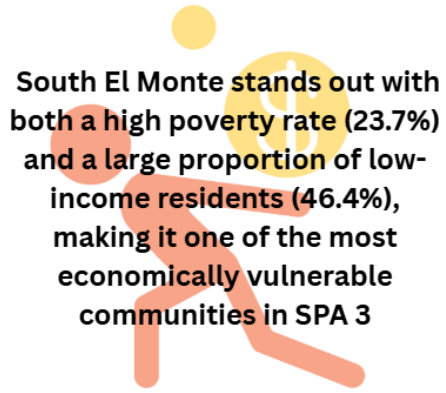
The Census Bureau annually updates official poverty population statistics. For 2023, the Federal Poverty Level (FPL) was set at an annual income of $15,480 for one person and $30,900 for a family of four. 12.4% of service area residents had incomes <100% of the Federal Poverty Level, and 29.1% of service area residents are considered low-income (below 200% of poverty). Los Angeles and San Bernardino Counties have the highest levels of poverty (both 13.6% of residents) and San Bernardino County has the highest rate of low-income residents (32.8%), followed by Los Angeles County (31.1%). Orange (9.5%) and Ventura (9%) Counties have the lowest rates of poverty-level and low-income residents (22.5% for Orange County and 22.6% for Ventura County).

Poverty Level of Residents, <100% FPL and <200% FPL

	Los Angeles County	Orange County	Riverside County	San Bernardino County	Ventura County	COH Service Area	California
Below 100% Poverty	13.6%	9.5%	11.1%	13.6%	9.0%	12.4%	12.0%
Below 200% Poverty	31.1%	22.5%	28.3%	32.8%	22.6%	29.1%	27.5%

Source: U.S. Census Bureau, American Community Survey, 2019-2023, S1701. https://data.census.gov

In the SPA 3 communities, the highest rate of poverty is found in South El Monte (23.7% of residents), followed by El Monte (17.2%). The highest level of low-income residents (55.8% of residents) is found in the city of Industry (where it represents just 63 individuals), followed by 46.4% of the residents of South El Monte and 42.3% of the residents of El Monte. The lowest rate of poverty (4.7%) is found in Bradbury, where it represents just 37 residents, followed by Sierra Madre (4.8%). The lowest rate of low-income residents is found in Bradbury (7.9%), followed by San Marino (8.9%).

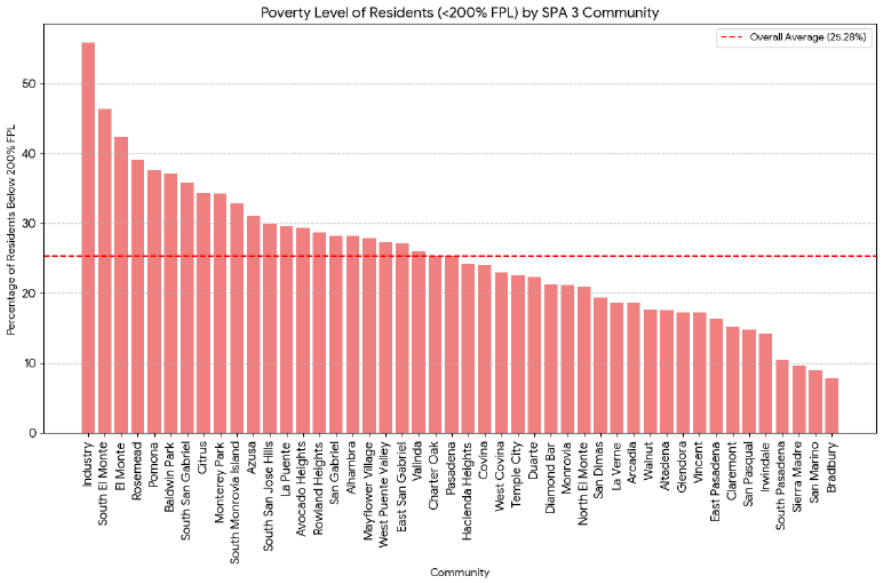


South El Monte stands out with both a high poverty rate (23.7%) and a large proportion of low-income residents (46.4%), making it one of the most economically vulnerable communities in SPA 3. This dual burden suggests that a significant portion of the population may face compounded challenges related to housing, food access, and health equity.

Poverty Level of Residents, <100% FPL and <200% FPL, by SPA 3 Community

	Below 100% Poverty	Below 200% Poverty
South El Monte	23.7%	46.4%
El Monte	17.2%	42.3%
Industry	16.8%	55.8%
Pomona	14.2%	37.6%
Rosemead	14.1%	39.0%
SPA 3 Averages	11.2%	27.4%

Source: U.S. Census Bureau, American Community Survey, 2019-2023, S1701. https://data.census.gov



Source: U.S. Census Bureau, American Community Survey, 2019-2023, S1701. https://data.census.gov

San Bernardino County has the highest rate of poverty among children (18.2%) in the service area, followed by Los Angeles County (17.7%). Among senior adults, ages 65 and older, Los Angeles County has the highest rate of poverty (14.2%), followed by San Bernardino County (12.3%). Among female heads-of-household (HoH), living with related children under age 18, 31.9% in San Bernardino County are living in poverty, while 29.3% in Los Angeles County and 29% in Riverside County are.

Educational Attainment

Understanding the educational landscape within the hospital service area is critical, as disparities in academic achievement not only mirror broader systemic inequities but also shape long-term health outcomes and economic mobility. While education is a known determinant of health, the hospital service area faces notable gaps in both high school and college attainment compared to state averages, with some counties standing out for particularly low levels of educational achievement. In the hospital service area, 17.5% of adults, ages 25 and older, lack a high school diploma, which is higher than the state (15.4%) rate. 34.1% of service area adults have a bachelor's degree or higher degree, which is lower than the state (36.5%) rate. All area counties have a lower percentage of the population that lack a high school diploma than the service area average, except Los Angeles County, where 19.3% of the population 25 and older do not have a diploma. Only San Bernardino (22.9%) and Riverside (25.1%) Counties have a lower percentage of the population with a college degree than the service area average.

Educational Attainment

	Los Angeles County	Orange County	Riverside County	San Bernardino County	Ventura County	COH Service Area
Population, 25 years and older	6,911,969	2,205,127	1,622,575	1,407,239	578,196	12,725,106
Less than 9th grade	11.6%	7.3%	8.8%	8.3%	8.8%	10.0%
9th to 12th grade, no diploma	7.7%	5.8%	7.9%	9.6%	5.9%	7.5%
High school graduate	20.3%	17.2%	26.3%	27.8%	19.5%	21.3%
Some college, no degree	17.9%	18.7%	23.4%	22.9%	20.4%	19.4%
Associate's degree	7.0%	7.7%	8.5%	8.4%	9.8%	7.6%
Bachelor's degree	22.8%	27.3%	16.0%	14.7%	22.2%	21.8%
Graduate/professional degree	12.7%	16.1%	9.1%	8.2%	13.5%	12.4%

Source: U.S. Census Bureau, American Community Survey, 2019-2023, DP02. https://data.census.gov/

High school graduation rates are determined by dividing the number of graduates for the school year by the number of freshmen enrolled four years earlier. The high school graduation rate for area counties ranges from 86.2% in San Bernardino to 92.4% in Riverside County. The Healthy People 2030 high school graduation objective is 90.7%, which San Bernardino, Los Angeles, and Ventura Counties do not meet.

High School Graduation Rates, Four-Year Cohorts, 2023-2024

	Los Angeles County	Orange County	Riverside County	San Bernardino County	Ventura County	California
Graduation rate	86.7%	91.8%	92.4%	86.2%	89.3%	86.4%

Source: California Department of Education, 2024. https://data1.cde.ca.gov/dataquest/

Differences are seen in rates of high school graduation when looked at by race or ethnicity of the students, with African American and American Indian or Alaska Native (AIAN) students having the lowest four-year graduation rates at the state level, and in all area counties, with the exception of Ventura County, where the 20 AIAN students had the second-highest graduation rate, and Pacific Islander and Hispanic or Latino students tied for the second-lowest (87%) graduation rate. Filipino and Asian students have the highest graduation rates at the state level and in all area counties, with the aforementioned exception of Ventura County's AIAN students.

High School Graduation Rates, Four-Year Cohorts, by Race and Ethnicity, 2023-2024

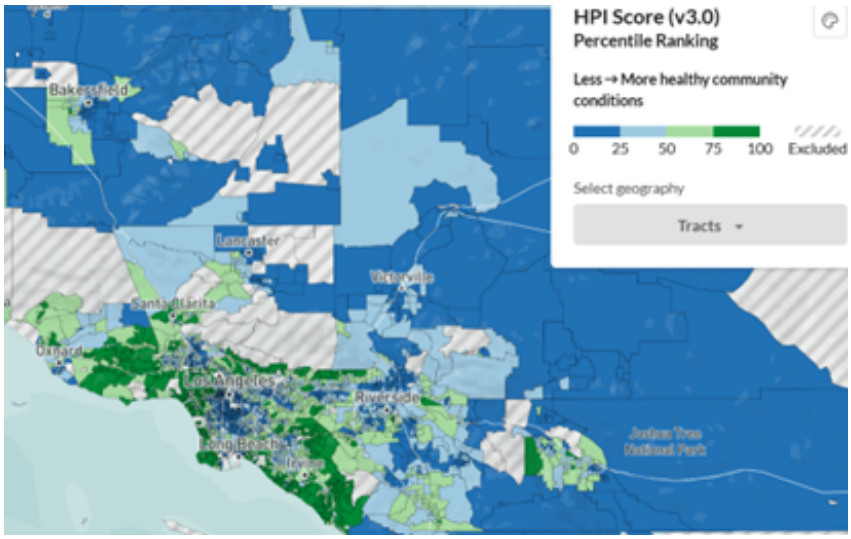
	Los Angeles County	Orange County	Riverside County	San Bernardino County	Ventura County	California
Filipino	94.8%	97.0%	96.8%	97.2%	98.3%	95.2%
Asian	94.6%	95.4%	95.1%	93.3%	94.7%	92.2%
White	89.8%	93.5%	93.9%	87.8%	93.2%	89.0%
Multiracial	90.4%	92.6%	92.9%	83.8%	92.7%	88.2%
Hispanic or Latino	85.6%	89.7%	91.9%	86.2%	87.0%	84.9%
Pacific Islander	84.0%	91.3%	92.8%	86.2%	87.0%	82.8%
American Indian or Alaska Native	83.6%	83.1%	86.6%	77.7%	95.0%	79.6%
African American	80.7%	86.8%	90.4%	79.8%	81.1%	78.4%

Source: California Department of Education, 2024. https://data1.cde.ca.gov/dataquest/

These disparities highlight the need for targeted support for African American, American Indian or Alaska Native, Pacific Islander, and Hispanic or Latino students, who continue to face systemic barriers to educational attainment across most counties.

California Healthy Places Index

The California Healthy Places Index (HPI) is a measure of socioeconomic need that is correlated with poor health outcomes. It combines 25 community characteristics into a single indexed HPI score available at the Census Tract level or aggregated for larger areas. In addition to the overall score, the index also contains eight sub-scores for each of the Policy Action Areas: economic, education, social, transportation, neighborhood, housing, clean environment, and health care access. The index was created using statistical modeling techniques that evaluated the relationship between these Policy Action Areas and life



expectancy at birth and was designed to maximize the ability of the HPI to identify healthy communities and quantify the factors that shape health. The California Healthy Places Index is a vital tool for understanding how social and environmental conditions shape health outcomes, making it essential for identifying communities with the greatest need and guiding equitable policy and resource allocation. The HPI map below displays the City of Hope Hospital Service Area and surrounding areas. The data are presented in colored quartiles (dark blue, light blue, light green and dark green). The dark blue shading indicates the census tracts with the least healthy conditions and the dark green shading shows census tracts with the healthiest conditions. (The gray hatched sections represent missing data.)

The service area counties, pooled, have an overall HPI score that is better than 55.2% of California counties. The service area has better housing conditions than just 3.4% of other California Counties, based on five criteria: homeownership, housing habitability, homeowner and renter severe housing cost burdens, and crowded housing conditions. It also has a cleaner environment than less than one-sixth (15.5%) of other California ZIP Codes, based on air pollution (particulate matter and ozone levels), and drinking water contaminants. Also low in this area (22.4%) relative to other California counties is healthcare access, based on percent insured, and neighborhood conditions (24.9%), based on park access, retail density (jobs per acre) and tree canopy.

It is clear from the map, though, at the Census tract level, scores are lowest in the eastern portion of the service area, including areas to the east which are not shown. Other Census tracts in the bottom quartile include areas in and around Perris, Moreno Valley, Riverside, San Bernardino, Hesperia, Victorville, Fontana, Ontario, Pomona, Jurupa Valley, Corona, Anaheim, Santa Ana, Long Beach, Compton, Paramount, Lynwood, South Gate, Huntington Park, Los Angeles, La Puente, El Monte, Glendale, Burbank, Simi Valley, San Fernando, Palmdale, Lancaster, Piru, Santa Paula, and Oxnard.

Unhoused

A point-in-time (PIT) count of homeless people is conducted annually in every county in every state, with unsheltered counts conducted at least every two years. These counts take place during the last 10 days of January, weather permitting. California is divided up into 44 Continuums-of-Care (CoCs), including eight in the City of Hope service area, one for each of the five counties, and an additional CoC for each of the following cities, which conduct their own counts: Long Beach, Pasadena, and Glendale.
In 2024, in the eight CoCs in the service area, there were an estimated 93,492 homeless individuals, 67.9% of whom were unsheltered. The highest number of homeless people counted was in the Los Angeles City and County CoC. See More information below.

Unhoused, 2024

	Total Number of Homeless Persons	Percent Sheltered	Percent Unsheltered
Los Angeles City and County CoC	71,201	30.5%	69.5%
Glendale CoC	175	54.3%	45.7%
Long Beach CoC	3,376	27.3%	72.7%
Pasadena CoC	556	42.3%	57.7%
Santa Ana, Anaheim/Orange County Coc	7,322	43.0%	57.0%
Riverside City and County CoC	4,249	42.6%	57.4%
San Bernardino City and County CoC	4,255	28.2%	71.8%
Oxnard, San Buenaventura/Ventura County CoC	2,358	39.2%	60.8%
Total for service area	93,492	32.1%	67.9%

Source: U.S. Department of Housing and Urban Development (HUD), 2024 CoC Homeless Populations and Subpopulations Reports. https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports/

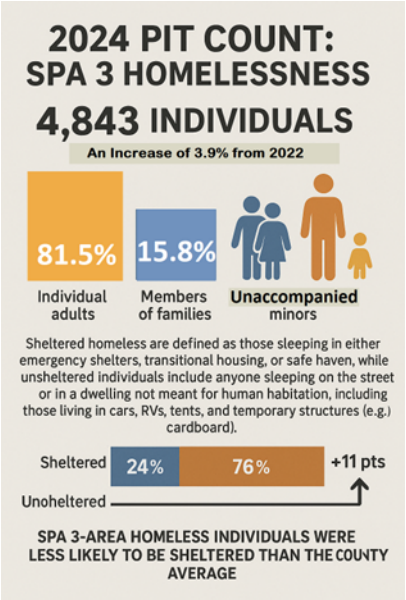
For the 2024 PIT Count, SPA 3 had an estimated 4,843 individuals who were homeless, an increase of 3.9% from 2022. 81.5% of those experiencing homelessness in SPA 3 were individual adults, 15.8% were members of families experiencing homelessness, and seven individuals (0.1%) were unaccompanied minors. Sheltered homeless are defined as those sleeping in either emergency shelters, transitional housing, or safe havens, while unsheltered individuals include anyone sleeping on the street or in a dwelling not meant for human habitation, including those living in cars, RVs, tents, and temporary structures (e.g., cardboard). The percentage of homeless people who were unsheltered increased by 11 percentage points from 2022 to 2024, and SPA-area homeless individuals were less likely to be sheltered than the county average.

Unhoused Population, 2022-2024 Comparison*

	SPA 3		Los Angeles City and County CoC*	
	2022	2024	2022	2024
Total homeless	4,661	4,843	65,111	71,201
Sheltered	36.0%	25.0%	29.5%	30.5%
Unsheltered	64.0%	75.0%	70.5%	69.5%
Individual adults, aged 25+	81.6%	81.5%	80.5%	81.6%
Individual youth, aged 18-24	4.0%	2.6%	3.0%	3.2%
Unaccompanied minors (<18)	0.02%	0.1%	0.2%	0.1%
Families/family members	14.4%	15.8%	16.3%	15.0%

Source: Los Angeles Homeless Service Authority, 2022 and 2024 Greater Los Angeles Homeless Count.
**These data represent the homeless counts from the Los Angeles County Continuum of Care, which does not include Glendale, Long Beach, and Pasadena homeless counts.*
https://www.lahsa.org/news?article=895-lahsa-releases-2022-great-los-angeles-homeless-count-results-released and https://www.lahsa.org/news?article=976-2024-greater-los-angeles-homeless-count-data&ref=hc

Chronic homelessness is defined by the U.S. Department of Housing and Urban Development – HUD – as being homeless for at least a year, or on at least four separate occasions totaling at least 12 months in the prior three years, as well as the individual or head of household (HoH) having a disability, including: a diagnosable substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability.



Among people experiencing homelessness in 2024 in SPA 3, 44.4% were chronically homeless individuals, an increase from 2022's 31% rate. Homelessness rates fell locally for veterans, individuals with a serious mental illness, and/or people with a developmental disability (people can be members of numerous sub-groups), but rose for chronically homeless family members, persons with HIV/AIDS, persons with a physical disability, and rose significantly for those with those with domestic violence experience and those who are homeless due to fleeing domestic violence, and/or those with a substance use disorder.

Food Insecurity in Los Angeles County

In 2024, 25% of Los Angeles County residents remained food insecure, including 41% of low-income residents.
(USC Dornsife Understanding America Study)

Food insecurity is an economic and social indicator of the health of a community. The U.S. Department of Agriculture (USDA) defines food insecurity as a lack of consistent access to enough food for an active, healthy life. While 22.6% of households in SPA 3 reported food insecurity, rates were higher in the Pomona (25.1%) and El Monte (30.2%) Health Districts, with the latter's rate being higher than the county average (25.4%).

Food Insecure Households

	Alhambra Health District	El Monte Health District	Foothill Health District	Pasadena Health District	Pomona Health District	SPA 3	Los Angeles County
Food insecure households	20.5%	30.2%	18.2%	13.0%	25.1%	22.6%	25.4%

Source: Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology, Los Angeles County Health Survey, 2023; http://www.publichealth.lacounty.gov/ha/LACHSDataTopics2023.htm

Mental Health

Mental health includes emotional, psychological, and social well-being. It affects how individuals think, feel, and act. It also helps determine how individuals handle stress, relate to others, and make choices. Among adults in the service area, 24% said that there had been a time in the past 12 months when they thought they might need to see a professional because of emotional/mental health problems or alcohol/drug use. Of those who sought help in the past 12 months, 46% said that they were unable to receive treatment. The Healthy People 2030 objective is for 68.8% of adults with a serious mental disorder to receive treatment (a maximum of 31.2% who do not receive treatment).

Mental Health Access and Utilization, Past Year, Adults

	Needed help for emotional/mental health problems and/or use of alcohol/drug issues	Sought help and received treatment	Sought help but did not receive treatment
SPA 3	20.6%	52.1%	47.9%
Los Angeles County	25.1%	54.2%	45.8%
Orange County	23.4%	55.3%	44.7%
Riverside County	21.1%	54.2%	45.8%

San Bernardino County	22.7%	49.3%	50.7%
Ventura County	24.9%	54.7%	45.3%
COH Service Area	24.0%	54.0%	46.0%
California	25.0%	56.4%	43.6%

Source: California Health Interview Survey, 2021-2023, pooled. http://ask.chis.ucla.edu/

Among service area teens, 33.3% felt they needed help with emotional or mental health problems (feeling sad, anxious, or nervous) in the past 12 months. Only 17.2% of service area teens have received psychological or emotional counseling in the past year.

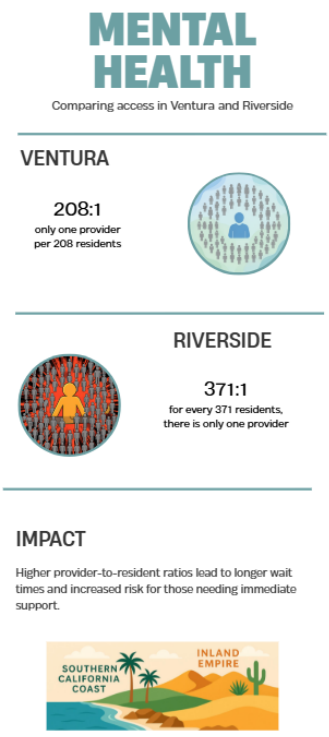
Mental Health Access and Utilization, Past Year, Teens

	Needed help for emotional/ mental health problems	Received psychological/ emotional counseling
SPA 3	27.9%	16.1%
Los Angeles County	32.0%	16.4%
Orange County	39.5%	20.8%
Riverside County	31.9%	13.7%
San Bernardino County	29.2%	19.8%
Ventura County	43.6%	16.9%
COH Service Area	33.3%	17.2%
California	32.7%	18.7%

Source: California Health Interview Survey, 2020-2023, pooled. http://ask.chis.ucla.edu/

Mental Health Providers

Mental health providers include psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists who meet specific qualifications and certifications. However, access to these professionals is significantly constrained in many areas. In Ventura County, there are 208 residents for every one mental health provider, and in Riverside County the gap widens to 371 residents per provider. These high ratios translate into fewer available appointments, longer wait times, and reduced access to essential mental health support for those who need it most.



Among adults in SPA 3, 9.1% tested as being at risk for major depression, and 11.2% reported that they have been diagnosed with depression and are either currently in treatment or having symptoms. Note that currently receiving treatment for depression may reduce a respondent's likelihood of testing as 'at-risk'. Among

area health districts, the at-risk rate was highest in the Pomona Health District (11.7%), while the rate of current Depression was highest in the Foothill (13.3%) and Pasadena (14.4%) Health Districts.

Mental Health Indicators, During the Past Year

	Adults who had serious psychological distress	Adults who took prescription medicine at least 2 weeks for emotional/ mental health issue	Teens who had serious psychological distress
SPA 3	12.9%	9.1%	33.6%
Los Angeles County	15.5%	10.9%	31.2%
Orange County	14.4%	11.7%	29.9%
Riverside County	13.2%	11.1%	26.8%
San Bernardino County	17.9%	11.3%	24.6%
Ventura County	16.0%	14.5%	31.9%
COH Service Area	15.3%	11.3%	29.5%
California	15.7%	12.2%	30.1%

Source: California Health Interview Survey, 2021-2023. http://ask.chis.ucla.edu/

Why Descriptive Data Matters

The challenges outlined in this description of the places we serve underscore the deep connections between social determinants of health—such as housing, food security, education, and mental health—and the overall well-being of our communities. When families struggle to meet basic needs, mental health often becomes an unaddressed crisis, further exacerbated by environmental stressors like recent wildfires. At City of Hope, we recognize that these issues do not exist in isolation. Our commitment is to work collaboratively with partners, leverage resources, and advocate for equitable solutions that expand access to care, strengthen community resilience, and ensure that every individual can thrive.

Community Benefit Advisory Council Members at a Healthy Living Grant Site Visit.

ORGANIZATIONAL COMMITMENT

Oversight and Management of Community Benefit Activities

Community health improvement is central to City of Hope's mission. Employees across multiple departments contribute to the planning and delivery of community benefit programs. To coordinate these efforts, the Department of Community Benefit operates within the Division of Health Equity and Community Enrichment and is led by Vice President and Chief Health Access and Community Enrichment Officer, Loretta Erhunmwunsee, MD. This structure enables City of Hope to bring together expertise and resources from across the National Medical Center and the broader City of Hope system, fostering strong internal collaboration.

Loretta Erhunmwunsee, M.D
Thoracic Surgeon; Vice President, Chief Health Access and Community Enrichment Officer

Oversight of community benefit activities is further strengthened by the Community Benefit Advisory Council (CBAC). Established in November 2014, the CBAC includes representatives from community organizations and health care partners. During Fiscal Year 2025, its membership reflected a diverse array of stakeholders who provide essential insight and guidance to ensure City of Hope's programs effectively meet community needs.

- 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 the council reflects and advocates for the most vulnerable members of our community, we engaged individuals with experience and expertise that align with today's evolving health equity landscape. Members were selected for their:

- Lived experience in communities facing disproportionate and unmet health needs, ensuring authentic representation of local challenges.
- Specialized knowledge in primary disease prevention, including strategies that reduce risk and promote long-term wellness.
- Hands-on experience partnering with local nonprofit and community-based organizations, bringing practical insight into on-the-ground service delivery.
- Expertise in epidemiology, supporting data-informed decision-making and interpretation of complex health trends.
- Proficiency in analyzing service utilization and population health data, to help guide planning, evaluation, and resource allocation.
- Deep understanding of the needs of disadvantaged populations, informed by years of direct engagement and advocacy.

CBAC Co-Chairs: Jasmine Ting, MPH: Area Administrator, Community and Field Services, SPA 3 LA County Department of Public Health; Patricia Duff Tucker, Set for Life, Inc.; Miki Carpenter, Director of Community Resources, City of Azusa.

Miki Carpenter and Patricia Duff Tucker were elected to serve an additional two-year term as co-chairs of the Community Benefit Advisory Council (CBAC), and Jasmine Ting was elected to serve her first two-year term. Throughout Fiscal Year 2025, the CBAC convened four times—twice in person and twice virtually—to oversee and support City of Hope's community benefit initiatives. Over the course of the year, members advanced the strategies outlined in the 2022–2025 Implementation Strategy by reviewing and awarding Healthy Living Grants and Kindness Grants, conducting virtual and on-site visits with grantees, and contributing to the planning and implementation of the 2025 Community Health Needs Assessment (CHNA). Their input also helped shape the

prioritization process for the 2025–2028 Implementation Strategy. Nancy Clifton-Hawkins, M.P.H., M.C.H.E.S.®, serves as City of Hope's Director of Community Benefit and provides oversight of the planning, delivery, and accountability of all community benefit programs and services. She remains available for inquiries at **CommunityBenefit@coh.org**.

COMMUNITY BENEFIT PLANNING PROCESS

All City of Hope community benefit programs continue to be guided by the Public Health Institute's Five Core Principles. These principles ensure our work remains focused, equitable, and responsive to the needs of the communities we serve:

1. **Prioritizing vulnerable populations**
   We focus on residents within City of Hope's primary service area who experience disproportionate and unmet health needs. These needs are shaped by factors such as culture, race and language barriers, age, poverty, and limited educational opportunities.
2. **Emphasizing primary prevention**
   Our programs promote health education, disease prevention, and health protection, with the goal of reducing risk and improving long-term well-being.
3. **Strengthening community capacity**
   We work alongside community stakeholders as full partners—mobilizing local expertise, building shared ownership, and supporting sustainable strategies that address both immediate concerns and their underlying causes.
4. **Building a seamless continuum of care**
   We aim to strengthen the connections between community resources and systems of care to help residents manage cancer, diabetes, and related health challenges. This approach reduces gaps in services and minimizes the need for more complex medical interventions.
5. **Ensuring collaborative governance**
   We engage community members and partners in the design, implementation, and evaluation of our initiatives. Their voices are essential in shaping programs that reflect local priorities and reflect equitable, community-informed decision making.

CBAC members prioritizing health needs

After completing the 2022 Community Health Needs Assessment (CHNA) in October 2022, the Community Benefit Advisory Council (CBAC) played a central role in prioritizing the identified health needs. During a special convening in December 2022—facilitated by Nancy Clifton-Hawkins and CBAC member Maura Harrington—the council participated in a structured prioritization process that evaluated each need based on seriousness, the number of residents affected, disparities among subpopulations, feasibility of impact, and alignment with City of Hope's mission. This process established the framework for the 2022–2025 Implementation Strategy, which was formally adopted by the City of Hope

National Medical Center Board in February 2023. While this report begins to reference early planning for the 2025 CHNA and the forthcoming 2025–2028 Implementation Strategy, all programs described here remain grounded in the priorities and commitments defined in the 2022 CHNA. The following section outlines the methodology used to gather data and determine the priority health needs that continue to guide City of Hope's community benefit efforts.

2022 Community Health Needs Assessment Methodology

City of Hope's service area encompasses communities that are diverse in language, culture, religion, and ethnicity. This diversity contributes to wide variation in social and structural factors—such as educational attainment, income, and language spoken at home—that influence risk for cancer, diabetes, and other health conditions. Understanding how these sociocultural factors shape health is essential to designing programs that reduce risk and expand access to care for our most vulnerable residents.

To accurately identify community-defined needs, City of Hope partnered with the SPA 3 Hospital Collaborative—which includes Huntington Hospital, Methodist Hospital, Emanate Health, and Kaiser Permanente Baldwin Park—to conduct a comprehensive 2022 Community Health Needs Assessment (CHNA). This collaborative approach ensured broad engagement across the region and allowed hospitals to develop a shared understanding of the issues affecting residents.

The 2022 CHNA was structured to:

1. **Develop deeper insight** into the health needs and lived experiences of communities within our service area.
2. **Inform each hospital's community benefit plan**, ensuring outreach efforts and programs align with and extend existing clinical services.
3. **Strengthen disease prevention and improve overall health**, particularly for residents facing disproportionate barriers to care.

To achieve these goals, the assessment integrated both **primary data**—collected through community input such as interviews, focus groups, stakeholder engagement—and **secondary data**, including demographic, socioeconomic, health status, and health access indicators. Together, these data sources identified key health priorities, community assets, and gaps in resources that continue to guide City of Hope's work throughout the 2022–2025 Implementation Strategy.

Secondary Data

Secondary data provides valuable insight into the diseases, conditions, and social factors that affect residents across different geographic areas. These data help City of Hope and its partners identify where health needs are most significant and where programs and services can have the greatest impact.

For the 2022 CHNA, secondary data were gathered from a broad range of local, county, and state sources. These datasets included information on community demographics, social and economic conditions, COVID-19 trends, health access, health behaviors, mental health, chronic diseases, cancer, overall health status, and mortality. When relevant, indicators were compared to California statewide data to provide context and highlight disparities within the service area. Additional datasets and detailed sources are included in **Appendix A**.

All secondary data for the hospital service area were compiled into data tables accompanied by narrative summaries. Each table identifies the specific indicator, the geographic level represented, the measurement type (such as rate, number, or percentage), county and state comparison data (when available), the data source, and the year of the data. These datasets formed a foundational component of the 2022 CHNA, helping to validate community input and guide the prioritization of health needs.

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 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 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.

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

The results were as follows:

2022 Stakeholder Prioritized Health Needs

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

It is important to know that while there were eight identified areas of need, those schooled in public health language will see that the CBAC combined topics because they felt that the root causes and shared risk factors were similar and by addressing them collectively rather than individually we could have a greater impact. According to the Healthy People 2030 definition of social determinants of health (SDOH), they "are the conditions in the environments where people are born, live, learn, work, play, worship and age that affects a wide range of health, functioning and quality-of-life outcomes and risks."[1] Our advisory council members emphasized that we need to "*look at the intersections of the SDOH risk factors in order to create solutions and make an impact in our vulnerable communities.*" With this being said, we cannot simply address one issue. Our strategy for the next several years will be to find those intersections, integrate the work, work more deeply with cross-disciplinary partners and create tangible deliverables. While the reader sees only four priority areas, with our work through the intersections, we are, in fact, addressing all eight. As one CBAC member suggested, "The *intersections are where the magic happens*."

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.

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

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 services and guarantee focus remains on those communities with disproportionate unmet health needs.

Monitoring and Evaluation

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

	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	☑

Overview of Fiscal Year 2025 Programs and Services

Fiscal Year 2025 marked a renewed return to in-person community engagement. While virtual programming continues to broaden accessibility, FY2025 was defined by stronger presence across the service area—meeting patients, families, and community members where they are. City of Hope expanded programs that reduce cancer risk, support whole-person health, and address the social and economic factors that influence outcomes across the San Gabriel Valley (SGV) and beyond. Throughout this report, visual indicators highlight the strategic priorities of each initiative advances, including cancer prevention, health equity, access to care, community capacity building, and patient support.

In the sections that follow, we take a deeper look at our most impactful FY2025 initiatives—Healthy Living Grants, Food Insecurity Programs, the 340B Program, and our key community partnerships—to illustrate how these efforts collectively advance health equity across our service area.

Strengthening Community Wellness: Healthy Living, Health Equity and Community Building Grants

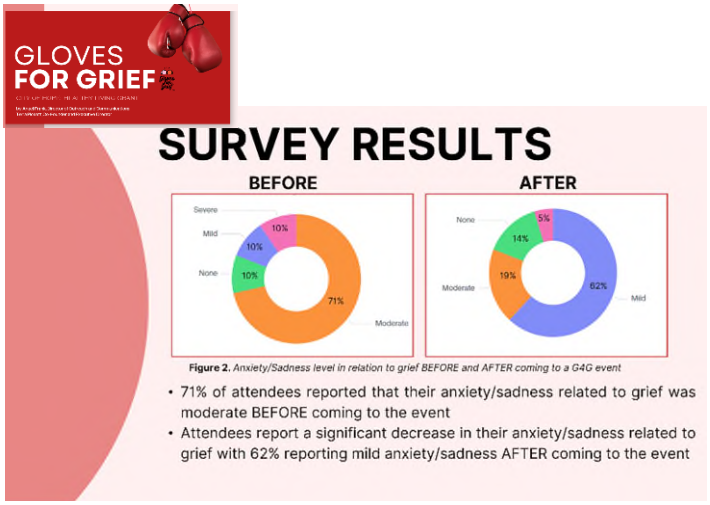
FY2025 Highlights:

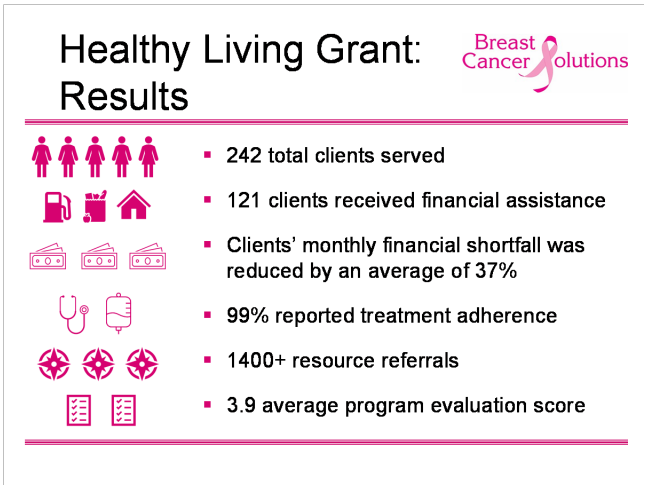
- **Supported programs focused on physical activity, nutrition, cancer risk reduction, and mental well-being.**
- **Expanded reach to communities experiencing persistent health disparities.**
- **Strengthened collaboration with grassroots and mid-sized organizations in alignment with the 2022 CHNA.**

City of Hope continued its long-standing tradition of investing in local nonprofits through the Healthy Living, Health Equity and Community grants program. These grants help organizations increase their capacity to deliver culturally responsive cancer prevention and healthy lifestyle programs. During FY2025 City of Hope shared $85,000 in grants to 14 organizations throughout the Greater Los Angeles region including Orange County.

2025 Healthy Living Grants	
YWCA – Champions for Aging Nutrition	YWCA's program empowers older adults through a 10-session cohort focused on nutrition, wellness, and advocacy, blending education with hands-on learning. It addresses food insecurity by connecting seniors to local food resources and assistance programs like CalFresh.
Manna Conejo Valley Food Distribution Center – Nourishing Health	Manna combats food insecurity in Northern Los Angeles County through a choice-based pantry model offering fresh, nutritious food tailored to clients' needs. This approach supports physical and mental well-being while reducing preventable health conditions.
Mary's Shelter – Mary's Path Equine Therapy	Mary's Path uses equine therapy to help teen moms heal from trauma, build trust, and develop emotional resilience. The program fosters nurturing relationships through caregiving roles with horses, promoting long-term behavioral health.
Boys & Girls Club of West San Gabriel Valley and Eastside – Future Hope Pharmacy	Future Hope Pharmacy provides families with access to meals, healthcare screenings, and mental health support from a community-based hub in Boyle Heights. The initiative reduces stress and promotes wellness for underserved families.
GiGi's Playhouse Orange County – GiGiFIT	GiGiFIT addresses the unique health needs of individuals with Down syndrome through adaptive fitness programs that improve physical, emotional, and social well-being. The program empowers participants to lead healthier, more independent lives.
Conejo Free Clinic – Women's Cancer Prevention and Screening Initiative	Conejo Free Clinic ensures women have access to life-saving breast and cervical cancer screenings by covering all out-of-pocket costs. This initiative promotes health equity and timely diagnosis through comprehensive patient advocacy.
Circle of Hope – Prevention with Purpose	Circle of Hope empowers Santa Clarita residents with cancer prevention education, wellness classes, and access to early detection services. Their holistic approach reduces the burden of cancer through lifestyle education and community support.
KaIND Giving – The Kindness Pantry	KaIND Giving supports cancer patients in the Antelope Valley with nutritious food tailored to their treatment needs through a collaborative distribution model. This grassroots initiative enhances health equity by integrating food support into care networks.
Hollywood Food Coalition – Community Exchange Program	The Community Exchange Program customizes food donations to meet the specific needs of small nonprofits, ensuring quality and nutritional value. It bridges gaps in L.A.'s food recovery system by connecting donors with organizations through a feedback-driven model.
Glendale Unified School District – Increasing Water Access at Roosevelt Middle School	GUSD partners with students to improve water access at Roosevelt Middle School through youth-led research and advocacy. The project installs refill stations and promotes hydration through student-designed campaigns.
2025 Health Equity Grants	
The Foundation for Transformation – Wellness Access Project	This project brings holistic wellness pop-ups to underserved neighborhoods, offering fitness, nutrition, and stress-reduction services. By meeting people where they are, it fosters inclusive, community-driven health engagement.
Shepherd's Door – Equine Therapy	Shepherd's Door provides trauma-informed equine therapy and art-based healing for domestic violence survivors. The program builds emotional resilience and trust in a peaceful, natural setting.
Better Angels United – Better Angels Resource Day	Better Angels hosts regular Resource Days to connect unhoused individuals with housing, healthcare, and economic support. This community-centered model addresses root causes of health disparities through consistent, localized outreach.
2025 Community Building Grant	
Healthy San Gabriel Valley – Accountable Communities for Health	Since 2022, Healthy San Gabriel Valley has sustained its mission through partner support, continuing to host impactful events like Roadmaps and Intersections despite limited funding. With renewed investment, HSGV aims to strengthen local collaborations, amplify systems-change data, and serve as a central hub for equitable community action.

While we celebrate our new FY2025 grantees, we also recognize the strong foundation laid by our FY2024 partners. Their conference posters, included below, illustrate the outcomes and community impact of their funded projects. To view all of the conference posters, please visit our website.

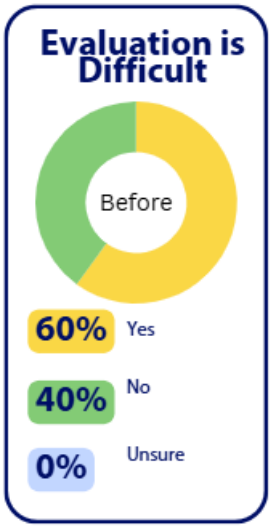


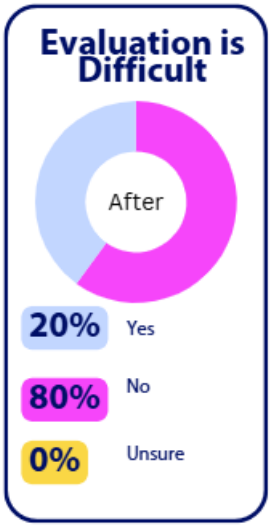


FY2025 Healthy Living Grantee Evaluation Workshop

Post-survey findings from FY2025 indicate that our programs continued to make a meaningful difference for participants, strengthening their skills and confidence in evaluation practices. While some

organizations are still building comfort in this area, many demonstrated a clear intention to integrate evaluation earlier in their program design—a critical step toward long-term effectiveness.





Over the past decade, the Healthy Living Grant Program has demonstrated the power of community-driven solutions to improve health, resilience, and well-being across our region. By supporting organizations that uplift culturally rooted wellness, expand access to prevention services, and strengthen social connections, the program has helped thousands of residents build healthier lives. These partnerships continue to show that when local leaders are equipped with the resources they need, they create meaningful change that extends far beyond a single grant cycle.

As we look ahead, this commitment to community health guides our focus toward one of the most persistent barriers to wellness: food insecurity. Building on the strengths of our Healthy Living partners,

we now turn to understanding how food access shapes health outcomes—and how collaborative, place-based strategies can ensure every family has the nourishment they need to thrive.

Food Insecurity Programs & Collaborations

Food insecurity continues to present significant barriers for patients and families undergoing cancer treatment. In FY2025, City of Hope deepened its efforts to ensure access to nutritious foods that support treatment tolerance and recovery.

Produce for Patients/Food Bag Programs

Our food insecurity programs provide compassionate, immediate support to patients and families facing hunger by connecting them with nutritious food at critical points in their care journey. Through our In-Patient Food Bag Program, 295 patients were sent home with a 25-pound bag of healthy groceries in FY2025, ensuring they had reliable nourishment during recovery. Our quarterly Produce for Patients events further expanded access to fresh foods, distributing approximately 31,479 pounds of produce to 7,200 people across our community. Over 132 employees rolled up their sleeves to support the sorting, packing and distributing the produce to our patients.

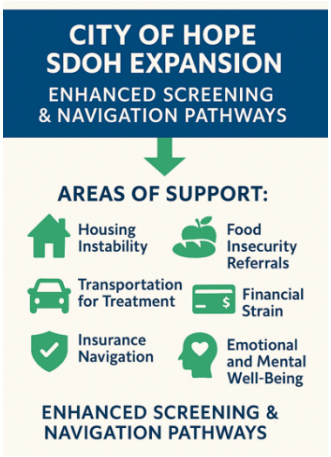
Seed to Supper (S2S)

Building on the success of our food insecurity programs, we also invested in long-term solutions that empower individuals and families to grow their own healthy food—most notably through our Seed to Supper program. In FY25, the Seed to Supper program provided a free, hands-on gardening experience that equipped novice gardeners across the San Gabriel Valley with the skills, confidence, and resources to grow a portion of their own food on a limited budget. Offered in partnership with the Pasadena Library, Duarte Senior Center, Foothill Unity Center, and other community agencies, the program strengthened participants' nutrition knowledge and improved access to fresh fruits and vegetables. Surveys showed powerful outcomes: 93% of participants learned basic

gardening skills, 100% felt confident they could grow their own food, 95% planned to continue gardening the following year, and 72% reported they would eat more vegetables contributing to healthier, more connected, and more secure communities.

Seed to Supper participants pose for a picture and tend to the garden.

Addressing Social Determinants of Health (SDOH) for Patients, Families & Caregivers



City of Hope expanded its capacity in FY2025 to identify and address the non-medical barriers that can stand between patients and the care they need. By strengthening its SDOH screening processes and enhancing navigation pathways, the organization is now better equipped to help patients move from identified social needs to stable, community-based support. Screening across six core domain-housing instability, transportation barriers to treatment, food insecurity referrals, financial strain, insurance navigation, and emotional and mental well-being—gives care teams a clearer picture of the social and environmental challenges many vulnerable patients face. The accompanying data visualization shows why this work matters so deeply. In plain English, it tells us that when a patient has even one social determinant of health (SDOH) need, such as trouble affording food or reliable housing, their chances of dying within a year increase by 20% compared to patients with no SDOH risks. Living in a more socially vulnerable neighborhood adds another layer of risk—each step up the Social Vulnerability Index increases the odds of one-year mortality by 25%. The chart also shows that, even after accounting for other factors, Black patients have a 30% higher risk, and Asian patients a 22% higher risk, of dying within a year compared to

non-Hispanic White patients. Meanwhile, Hispanic/Latino White patients do not show an increased risk in this analysis.

Together, these insights underscore why City of Hope's expanded screening and navigation approach is so critical. The data not only highlights which patients face heightened risk but also strengthens the foundation for deeper conversation with community partners and patients themselves. By proactively identifying these risks, coordinating warm handoffs, and connecting individuals to reliable resources, City of Hope is helping improve patients' stability, well-being, and long-term health outcomes.

Building Regional Capacity: Partnerships with the Health Consortium of the SGV & Healthy San Gabriel Valley

City of Hope's engagement with both the **Health Consortium of Greater San Gabriel Valley (Health Consortium)** and **Healthy San Gabriel Valley** reflects far more than participation, it represents a long-term commitment to strengthening the region's social and health infrastructure through trust, shared purpose, and sustained collaboration.

As an active Steering Committee member within the **Health Consortium**, City of Hope contributes to regional planning efforts that connect hospitals, community health centers, behavioral health agencies, and social care providers to advance equity and respond to complex community needs. This includes supporting initiatives such as the **SGV Hospital Collaborative**, **Food for All SGV**, and **cross-sector workforce development** efforts, all of which demonstrate how coordinated action can improve access to care, address social determinants of health, and build capacity across the safety-net ecosystem. These partnerships, rooted in the Consortium's history of convening diverse stakeholders and implementing community-driven strategies, reflect the shared belief that integrated, culturally responsive systems are essential to improving outcomes for underserved residents.

Through **Healthy San Gabriel Valley** and broader regional collaborations, City of Hope continues to champion **community-led approaches** that strengthen the social fabric of the SGV. The **2025 *Roadmaps: Navigating Crossroads*** convening underscored the power of connection, showcasing how community coalitions, healthcare partners, funders, and civic leaders collectively navigate the "messy and magical" work of regional transformation. City of Hope's leadership in dialogues on sustainability, innovative

funding, and resilience reflects its commitment not only to advancing cancer awareness, food access, mental health, and environmental well-being, but also to investing in the trusted relationships that make long-term progress possible.

Whether through supporting cross-sector innovation at events like the SGV Health Summit, strengthening food and nutrition security through Food for All SGV, or collaborating on systems-level solutions with local partners, City of Hope's role centers on fostering the conditions that allow vulnerable communities to thrive. These efforts affirm a shared commitment across the SGV: that sustainable futures are built through relational trust, collective action, and an unwavering focus on the wellbeing of those most at risk.

Supporting Patients Through the 340B Program

The 340B Drug Pricing Program remained essential for providing equitable access to high-quality cancer care. Savings were reinvested directly into patient support and community services in FY2025.

FY2025 340B Program Impact:

- Free oral drugs ($2M/year)
  Benefiting 25 – 27K patients per year.
- Expanding pharmacy patient care
- Provision of charity care
- Hired specialist pharmacists for clinical support
- Invested in operational improvements to ensure safety and compliance

Cross Institutional Collaborations

It is important to recognize the dedication of the many individuals whose hard work made possible more than 100 community events across our institution and throughout the vulnerable communities City of Hope serves. This year, Community Benefit collaborated closely with teams across Enterprise Growth and Innovation, Government and Community Relations, Nutrition, Rehabilitation, Health Access and Community Enrichment, our employee Inclusion Resource Groups, Nourishing Hope, Financial Services, and Nursing. A major milestone was the completion of the Community Health Needs Assessment (CHNA) and Implementation Strategies, prioritized with community input and formally adopted by the NMC Board, strengthening our commitment to transparency, accountability, and impact. In addition to

our work in California, we have been supporting our City of Hope locations in Chicago, Atlanta, and Phoenix by helping them establish their own Community Benefit Advisory Councils and providing training on community benefit reporting, standards, and compliance. We remain deeply grateful for the steadfast support of our internal colleagues and external partners and look forward to continuing our shared legacy of compassion, equity, and hope throughout our service area. If you have any questions about our community events or would like to learn more about Community Benefit at City of Hope, please contact us at **CommunityBenefit@coh.org**.

COMMUNITY BENEFIT INVESTMENTS

How Benefits Were Defined

The quantifiable community benefits provided by City of Hope in Fiscal Year 2025 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.

City of Hope employees volunteer to support Wildfire Relief in January 2025

Value of Quantifiable Benefits

Fiscal Year 2025 Community Benefit Categories	Net Benefit
CHARITY CARE[1]	48,775,631
UNPAID COSTS OF MEDI-CAL[2]	75,333,899
OTHERS FOR THE ECONOMICALLY DISADVANTAGED[3]	0
EDUCATION AND RESEARCH[4]	201,932,913
OTHER FOR THE BROADER COMMUNITY[5]	7,324,905
TOTAL COMMUNITY BENEFIT PROVIDED EXCLUDING UNPAID COSTS OF MEDICARE	333,367,349
UNPAID COSTS OF MEDICARE [2]	202,949,348
TOTAL QUANTIFIABLE COMMUNITY BENEFIT	**536,316,697**

Fiscal Year 2025 Quantifiable Community

The community benefit table reflects only those costs recognized under standard reporting definitions, but City of Hope's contributions extend well beyond what can be quantified. Our technical assistance, leadership roles, research contributions, and the long-standing relationships that strengthen community networks and capacity are critical elements of our mission, even though they are not included in operational cost reporting. These efforts exemplify how community benefit is defined not just by dollars, but by meaningful partnership and shared impact.

[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 unbilled programs, such as community health education, screenings, support groups, clinics and support services

CONCLUSION

City of Hope's Fiscal Year 2025 Community Benefit work reflects the strength of an institution deeply committed to addressing the root causes of health inequities and improving the wellbeing of the diverse communities we serve. Guided by the priorities identified in our 2022–2025 Community Health Needs Assessment and formally adopted Implementation Strategy, we continued to invest strategically in programs that expand access to care, improve social and economic conditions, and strengthen community capacity. **In total, City of Hope recorded and reinvested $536,316,697 in quantifiable community benefit during FY2025.** An extraordinary commitment that underscores the scale, depth, and seriousness of our mission-driven work. Our efforts reached across the region, advancing cancer prevention, supporting food and economic security, expanding mental health and navigation resources, and fostering collaborative initiatives such as the Healthy Living Grants, Food for All SGV, Seed to Supper, and expanded social needs screening. Collectively, these efforts demonstrate how City of Hope's mission and values translate into meaningful, measurable progress for vulnerable populations throughout our service area.

This year also marked important institutional milestones that strengthen our long-term community benefit infrastructure. We completed the 2025 Community Health Needs Assessment and the accompanying 2025–2028 Implementation Strategy, both prioritized with community input and adopted by the National Medical Center Board—affirming our commitment to transparency, governance, and community-centered decision-making. Beyond California, we supported City of Hope's cancer centers in Chicago, Atlanta, and Phoenix by helping them establish their own Community Benefit Advisory Councils and providing training on community benefit reporting, standards, and transparency. As we look forward, we remain profoundly grateful for the partners—internal and external—whose dedication makes this work possible. Together, we will continue to strengthen relationships, nurture trust, and build healthier, more resilient communities grounded in our shared legacy of compassion, equity, and hope.

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
Foothill Unity Center, Inc.	Tashera Taylor	Chief Executive Officer
Friends in Deed	Rabbi Joshua Levine Grater, M.Rb.	Executive Director

Organization	Name	Title
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?

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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

Significant Health Needs	Community Resources
	• Pasadena Partnership Health care Committee • Pomona Wellness Community • San Bernardino Free Clinic • Community Health Alliance of Pasadena (ChapCare) • Set for Life hosts health expos with health screenings. • Senior Advocacy Program, a county program for seniors primarily in nursing homes • CVS and Rite Aid offer flu shots and screenings. • Foothill Transit offers bus service from Duarte to Pasadena. • YWCA of SGV Senior Services — Duarte Senior Center • City of Hope Health Fair • Planned Parenthood Pasadena and San Gabriel Valley • Hear Center • Community Health Alliance of Pasadena • Herald Christian Health Center • Tzu Chi Foundation • Good Samaritan Hospital • Parish Nurses 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 enrollment and 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

Significant Health Needs	Community Resources
Cancer	• Clínica Médica Familiár (Family Medical Clinic) has clinics twice a year. • City of Hope offers cancer screenings at health fairs. • UCLA Health Alhambra Cancer Care • Covina Cancer Care Medical Center • Huntington Cancer Center • Set for Life offers mammograms. • Children's Hospital Los Angeles • Southern California Health Conference at Pasadena Civic Center • El Monte Comprehensive Health Center • East Valley Community Health Centers • American Cancer Society has resources that can help with transportation and navigation assistance. • My Health LA patients provides emergency Medi-Cal for women 40+ with breast cancer and for women of any age with cervical cancer through Every Woman Counts program. • MEMAH (Men Educating Men About Health) annual conference • Garfield Health Center provides mammograms and colorectal cancer screening. • Covering with Care • East SGV Health Neighborhood • Herald Cancer Association offers support, consultation, written information and links to websites and 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.

Significant Health Needs	Community Resources
COVID-19	• Los Angeles County Public Health Department • East San Gabriel Valley Health Center • Community Health Alliance of Pasadena • Wesley Health Centers • Barrios Action Youth and Family Center • CHIRLA The Coalition for Human Immigrant Rights • First African Methodist Episcopal Church • Pasadena Partnership 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

Significant Health Needs	Community Resources
	• East San Gabriel Valley Coalition for the Homeless • D&R Turning Point • Jackie Robinson Community Center • Los Angeles Homeless Services Authority • Elizabeth House • Family Promise of San Gabriel Valley • A Meaningful Goal Housing Shelter • Foothill Family Shelter • Relief
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

Significant Health Needs	Community Resources
	• Los Angeles County Department of Mental Health • Foothill Family Service offers some group services. • Whittier Hospital Medical Center has a lot of free classes. • School districts. Duarte School District has partnerships with providers (Foothill Family Services and D'Veal) to come into the schools and provide services. • Pacific Clinics/Asian Pacific Family Center • Foothill Family Services • D'Veal Family & Youth Services • Each Mind Matters, the California Mental Health movement • Mental Health Services Act • Asian Youth Center hosts a mental health day. • Health Consortium of Greater San Gabriel Valley is looking to build more connections between physical and behavioral health providers. • Healthy Neighborhoods initiative from Department of Mental Health site in El Monte • Santa Anita Family Services • Foothill Family Services • Arcadia Mental Heath • Aurora Clinic • Pacific Clinics • Asian Pacific Health Care Venture has Chinese language mental health services.
Overweight and Obesity	• Chapcare Medical and Dental Health Center • Families Forward Learning Center • San Gabriel Valley Service Centers • Women, Infant and Children offers nutrition classes. • Community centers offer exercise programs, such as Zumba and walking. • Senior centers, such as the Azusa Senior Center 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**

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.