# California Hospital Medical Center

# 2022 Community Health Implementation Strategy

Adopted October 2022


Dignity Health
California Hospital
Medical Center

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## At-a-Glance Summary

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| **Community Served**  | Dignity Health California Hospital Medical Center (CHMC) primarily serves downtown and South Los Angeles. The hospital service area is located in Los Angeles County Service Planning Area (SPA) 4 (Metro Los Angeles) and also includes parts of SPA 6 (South), SPA 7 (East) and SPA 8 (South Bay). CHMC serves 1,942,854 racially diverse residents. The service area includes Skid Row that has the largest concentration of homeless in LA County. |
| **Significant Community Health Needs Being Addressed**  | The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are:<br>• Access to health care<br>• Behavioral health (mental health and substance use)<br>• Birth indicators<br>• Chronic diseases, including overweight and obesity and food insecurity<br>• Housing insecurity and homelessness<br>• Violence prevention |
| **Strategies and Programs to Address Needs**  | The hospital intends to take several actions and dedicate resources to these needs, including:<br><br>*Access to Health Care*<br>Financial assistance<br>*Para Su Salud* – enrollment assistance program<br>Health Ministry Program<br>HSFC Early Head Start Program and LA Best Babies Network's (LABBN) perinatal and early childhood home visitation programs<br>Navigating the Health Care System<br>10th Decile Project<br><br>*Behavioral health (substance use and mental health)*<br>CA Bridge Program<br>HSFC Early Head Start Program, Early Care and Education Centers, Wraparound Service Program, Youth Center & Early Intervention Program<br>Pico Union & South LA Family Preservation Programs<br>Cultural Trauma and Mental Health Resiliency Project<br>10th Decile Project<br>CA Behavioral Health Clinic<br>LABBN's perinatal and early childhood home visiting programs<br>Community grants program<br><br>*Birth indicators*<br>African American Infant and Maternal Mortality Initiative (AAIMM)<br>HSFC Early Head Start Program<br>Cherished Futures for Black Moms & Babies<br>LA County Perinatal and Early Childhood Home Visitation Consortium<br>LABBN's perinatal and early childhood home visiting programs |

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| | Community grants program<br><br>*Chronic diseases, including overweight and obesity and food insecurity*<br>Health Ministry Program<br>Heart HELP Program<br>Diabetes Empowerment Education Program (DEEP)<br>Chronic Disease Self-Management Program<br>Healthy Eating and Lifestyle Program<br>Women's Health Center<br>Coordinated Care Initiative<br>HSFC's Early Head Start Program, early care and education centers, family childcare network, youth center<br>LABBN's perinatal and early childhood home visiting programs<br>10th Decile Project<br>Support groups<br>Food Recovery Initiative<br>Community grants program<br><br>*Housing insecurity and homelessness*<br>Homeless Health Initiative<br>10th Decile Project<br>HSFC's Early Head Start Program, The Nest (ECE center)<br>LA Partnership<br>Community grants program<br><br>*Violence prevention*<br>HSFC Early Head Start Program, Early Care and Education Centers, Family Childcare Network, Youth Center, Early Intervention Program<br>CA Behavioral Health Clinic<br>LABBN's perinatal and early childhood home visiting programs<br>Cultural Trauma and Mental Health Resiliency Project<br>Stop the Bleed<br>Human Trafficking Response Initiative<br>Pico Union & South LA Family Preservation Programs<br>Wraparound Services Program<br>Community grants program |
| **Anticipated Impact** | The anticipated impact of these strategies and programs include:<br>• Increased access to health care and reduced barriers to care.<br>• Improved coordination of services for persons experiencing homelessness.<br>• Increased availability of and access to behavioral health services in community settings.<br>• Improved birth outcomes.<br>• Increased prevention and treatment of chronic diseases.<br>• Reduced community violence and decreased injuries.<br>• Increased access to needed services and resources through collaboration with community partners. |

**Planned Collaboration**

Key community partners include (partial listing):

- Community health centers
- Faith-based organizations
- Foundations
- Housing and homeless service agencies
- Immigrant Integration Task Force
- LA Best Babies Network partners
- Los Angeles city agencies
- Los Angeles County agencies, including public health and substance abuse prevention and control
- Mental health agencies
- Organizations serving LGBTQ populations
- Public safety agencies
- Regional collaboratives
- Schools and school districts
- Senior centers and service agencies
- Southside Coalition of Community Health Centers
- Youth organizations

This document is publicly available online at the hospital's website. Written comments on this report can be submitted to the California Hospital Foundation at 1401 S. Grand Avenue, Los Angeles, CA 90015. To send comments or questions about this report, please email Margaret Lynn Yonekura, M.D., Director, Community Health at m.l.yonekura@commonspirit.org.

# Our Hospital and the Community Served

## About the Hospital

California Hospital Medical Center is a part of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 1,000 care sites in 21 states coast to coast, serving 20 million patients in big cities and small towns across America. CHMC is located at 1401 S. Grand Avenue, Los Angeles, California 90015. It has served the greater Los Angeles community for over 130 years. The hospital facility is licensed for 318 beds and provides a full-continuum of acute care services, including a Level II Trauma Center, state-of-the-art Cardiac Catheterization Lab, Keith P. Russell Women's Birthing Center, Level III Neonatal Intensive Care Unit (NICU), seven operating suites, and a free-standing Los Angeles Center for Women's Health. CHMC has the busiest private Trauma Center in Los Angeles County and the 13th largest center for births in California.

## Our Mission

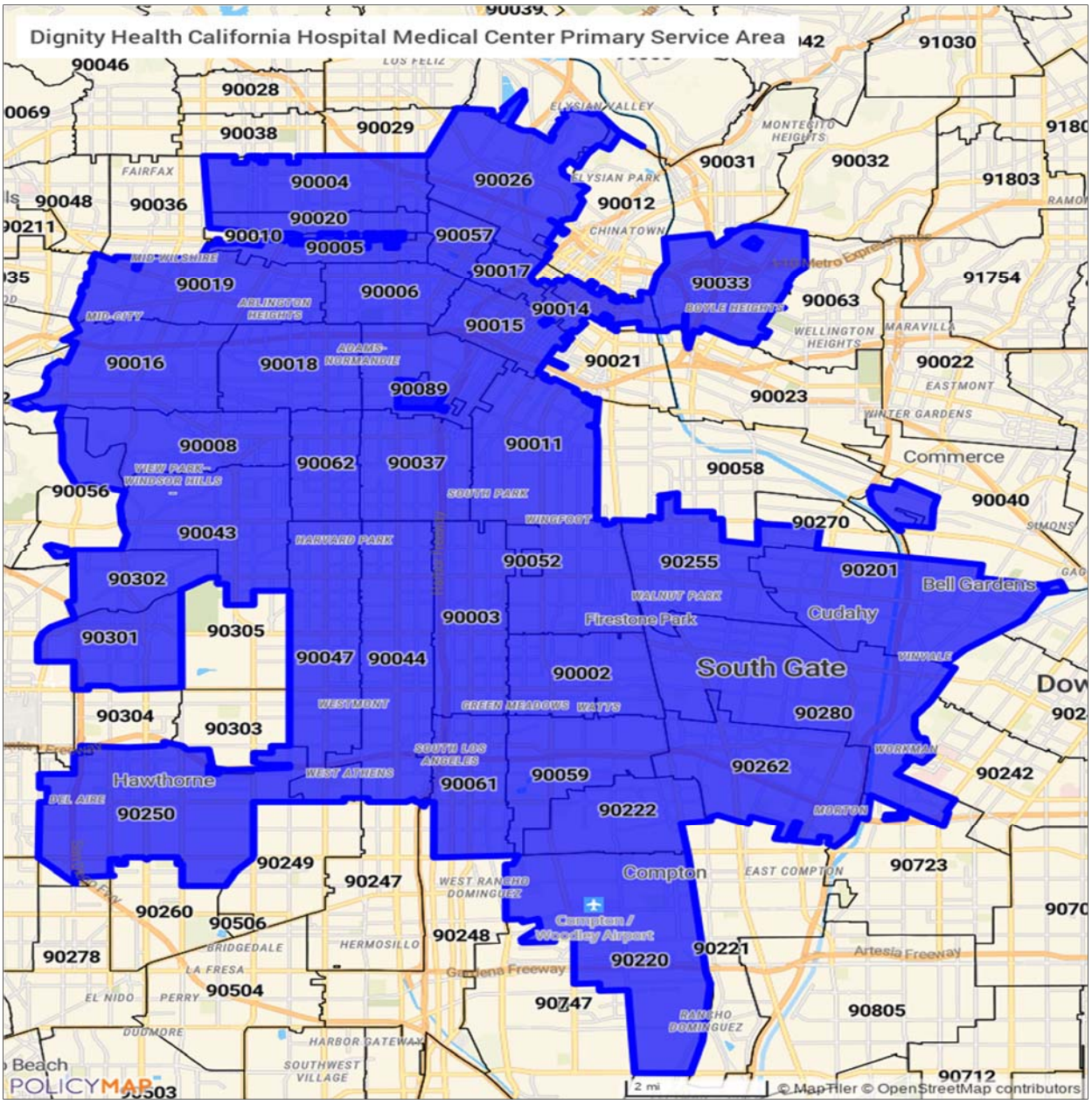
The hospital's dedication to assessing significant community health needs and helping to address them in conjunction with the community is in keeping with its mission. As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

## Financial Assistance for Medically Necessary Care

It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay. This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.


## Description of the Community Served

The hospital serves 36 ZIP Codes in 10 cities, 17 of which are located in the City of Los Angeles and 10 that are in South Los Angeles. A summary description of the community is provided below, and additional details can be found in the CHNA report online.




The population of the CHMC service area is 1,942,854. Children and youth, ages 0-17, make up 25.1% of the population, 65.1% are adults, ages 18-64, and 9.8% of the population are seniors, ages 65 and older. The largest portion of the population in the service area identifies as Hispanic/Latino (67.8%), 17.3% of the population identifies as Black/African American, 6.8% are Asian, and 6.2% are White/Caucasian. 1.3% of the population identifies as multiracial (two-or-more races), 0.2% as Native Hawaiian/Pacific Islander, and 0.2% as American Indian/Alaskan Native.

Among the residents in the service area, 24% are at or below 100% of the federal poverty level (FPL) and 52% are at 200% of FPL or below. Those who spend more than 30% of their income on housing are said

to be "cost burdened." In the service area, 56.2% of owner and renter-occupied households spend 30% or more of their income on housing. Educational attainment is a key driver of health. In the hospital service area, 36.2% of adults, ages 25 and older, lack a high school diploma, which is higher than the state rate (16.7%). 17.9% of area adults have a Bachelor's or higher degree.

## Community Assessment and Significant Needs

The health issues that form the basis of the hospital's community health Implementation Strategy and programs were identified in the most recent CHNA report, which was adopted in April 2022. The CHNA contains several key elements, including:

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

Additional details about the needs assessment process and findings can be found in the CHNA report, which is publicly available on the hospital's website or upon request from the hospital, using the contact information in the At-a-Glance Summary (page 4).

### Significant Health Needs

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

| Significant Health Need | Description | Intend to Address? |
|---|---|---|
| Access to health care | Access to health care refers to the availability of primary care and specialty care services. Health insurance coverage is considered a key component to ensure access to health care. Barriers to care can include lack of transportation, language and cultural issues. | X |
| Birth indicators | Poor pregnancy and birth outcomes include low birthweight, preterm births and infant mortality. These are associated with late or no prenatal care, unplanned pregnancy, cigarette smoking, alcohol and other drug use, being HIV positive, obesity, maternal age, and poor nutrition. | X |
| Chronic diseases | A chronic disease or condition usually lasts for three months or longer and may get worse over time. Chronic diseases can usually be controlled but not always cured. The most | X |

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| | common types of chronic diseases are cancer, heart disease, stroke, diabetes, and arthritis. | |
| COVID-19 | The Coronavirus disease (COVID-19) is an infectious disease caused by the SARS-CoV-2 virus. In the U.S., over one million persons have died as a result of contracting COVID. | |
| Economic insecurity | Economic insecurity is correlated with poor health outcomes. Persons with low incomes are more likely to have difficulty accessing health care, have poor-quality health care, and seek health care less often. | |
| Education | Educational attainment is a key driver of health. Low educational attainment is associated with self-reported poor health, shorter life expectancy, and higher rates of death, disease and disability. | |
| Food insecurity* | The USDA defines food insecurity as limited or uncertain availability of nutritionally adequate foods or an uncertain ability to acquire foods in socially-acceptable ways. | X |
| Housing and homelessness | Homelessness is known as a state of being unhoused or unsheltered and is the condition of lacking stable, safe, and adequate housing. | X |
| Mental health | Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. | X |
| Overweight and obesity* | Overweight and obesity are common conditions that are defined as the increase in size and amount of fat cells in the body. Obesity is a chronic health condition that raises the risk for heart disease and is linked to many other health problems, including type 2 diabetes and cancer. | X |
| Preventive practices | Preventive practices refer to health maintenance activities that help to prevent disease. For example, vaccines, routine health screenings (mammogram, colonoscopy, Pap smear) and injury prevention are preventive practices. | |
| Substance use | Substance use is the use of tobacco products, illegal drugs or prescription or over-the-counter drugs or alcohol. Excessive use of these substances, or use for purposes other than those for which they are meant to be used, can lead to physical, social or emotional harm. | X |
| Violence and injury | Violent crimes include homicide, rape, robbery and assault. Property crimes include burglary, larceny and motor vehicle | X |

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| | theft. Injuries are caused by accidents, falls, hits, and weapons, among other causes. | |

*These significant needs will be addressed within the scope of the chronic disease need.

### Significant Needs the Hospital Does Not Intend to Address

Taking existing hospital and community resources into consideration, CHMC will not directly address COVID-19, economic insecurity, education and preventive practices as priority health needs. Knowing that there are not sufficient resources to address all the community health needs, CHMC chose to concentrate on those health needs that can most effectively be addressed given the organization's areas of focus and expertise. The hospital has insufficient resources to effectively address all the identified needs and, in some cases, the needs are currently addressed by others in the community.

## 2022 Implementation Strategy

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years, including resources for and anticipated impacts of these activities.

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

### Creating the Implementation Strategy

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

The following criteria were used by the hospital to determine the significant health needs CHMC will address in the Implementation Strategy:

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

CHMC engaged hospital leaders to examine the identified health needs according to these criteria. The CHNA served as the resource document for the review of health needs as it provided statistical data on the severity of issues and also included community input on the health needs. As well, the community prioritization of the needs was taken into consideration. As a result of the review of needs and application of the above criteria, CHMC chose to focus on: access to care, behavioral health (mental health and substance use), birth indicators, chronic disease (including overweight and obesity and food insecurity), housing insecurity and homelessness, and violence and injury prevention. For each health need the hospital plans to address, the Implementation Strategy describes: actions the hospital intends to take,

including programs and resources it plans to commit, anticipated impacts of these actions, and planned collaboration between the hospital and other organizations. In most cases, the strategies identified to address the selected needs are based on existing programs that have evidence of success. For some strategies, CHMC is part of a larger collaborative initiative.

## Community Health Strategic Objectives

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources and engagement of participants inside and outside of the health care delivery system.

CommonSpirit Health has established four core strategic objectives for community health improvement activities. These objectives help to ensure that our program activities address strategic aims while meeting locally-identified needs.


Create robust alignment with multiple departments and programmatic integration with relevant strategic initiatives to optimize system resources for advancing community health.


Scale initiatives that complement conventional care to be proactive and community-centered, and strengthen the connection between clinical care and social health.


Work with community members and agency partners to strengthen the capacity and resiliency of local ecosystems of health, public health, and social services.


Partner, invest in and catalyze the expansion of evidence-based programs and innovative solutions that improve community health and well-being.

## Strategies and Program Activities by Health Need

| Health Need: Access to Health Care | | | | | |
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| **Anticipated Impact (Goal)** | The hospital's initiatives to address access to care are anticipated to result in: increased access to health care for the medically underserved, reduced barriers to care, and increased availability and access to primary and specialty care services. | | | | |
| **Strategy or Program** | **Summary Description** | **Strategic Objectives** | | | |
| | | Alignment & Integration | Clinical - Community Linkages | Capacity for Equitable Communities | Innovation & Impact |
| Financial assistance for the uninsured or underinsured | CHMC provides financial assistance to those who have health care needs and are uninsured, underinsured, ineligible for a government program or otherwise unable to pay. | X | | | |
| *Para Su Salud* – enrollment assistance program | Provides assistance to individuals and families to sign up for health and dental health insurance benefits. | X | X | | |
| Health Ministry Program | Parish Nurse refers those without a medical home to local FQHCs. | X | X | | |
| HSFC Early Head Start Program and LA Best Babies Network's (LABBN) perinatal and early childhood home visitation programs | Assists families in accessing health and dental health insurance coverage. Assists families in establishing a medical home for each family member. | X | X | | |
| Navigating the Health Care System | A four-unit health literacy curriculum designed by Nemours Children's Health System for use with high school students in | | X | | X |

| Health Need: Access to Health Care | | | | | |
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| | classroom or community settings. The program prepares students to be responsible for managing their own health care as they transition into adulthood. | | | | |
| 10th Decile Project | This grant-funded project connects the top 10% highest cost, highest need chronically homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services through a collaboration of Corporation for Supportive Housing, Housing Works, and JWCHI, Inc. | X | X | X | X |
| **Planned Resources** | The hospital will provide health care providers, parish nurses, enrollment counselors, community health educators, case managers, philanthropic cash grants, outreach communications, and program management support for these initiatives. | | | | |
| **Planned Collaborators** | Key partners include: community clinics, FQHCs, community-based organizations, Early Head Start, LA Best Babies Network, faith groups, public health, city agencies and homeless services agencies. | | | | |

| Health Need: Behavioral Health (Mental Health and Substance Use) | | | | | |
|---|---|---|---|---|---|
| **Anticipated Impact (Goal)** | The hospital's initiatives to address behavioral health are anticipated to result in: increased access to mental health and substance use services in the community, and improved screening and identification of mental health and substance use needs. | | | | |
| **Strategy or Program** | **Summary Description** | **Strategic Objectives** | | | |
| | | Alignment & Integration | Clinical - Community Linkages | Capacity for Equitable Communities | Innovation & Impact |
| Behavioral Health Navigator Program (CA Bridge Program) | Supports the emergency department as a primary access point for the treatment of substance use disorders and co-occurring mental health conditions. Utilizes trained navigators to identify patients who would benefit from initiating medication for addiction treatment (MAT) or mental health services. | X | X | X | X |
| HSFC Early Head Start Program, Early Care and Education Centers, Wraparound Services Program, Youth Center, Early Intervention Program | Screens parents for depression/anxiety and intimate partner violence (IPV). Screens children and youth for mental health and behavioral issues. Refers parents and children who need treatment to community resources. Wraparound Program provides community-based support and individualized planning for children, including those with severe emotional and behavioral disorders and their families | X | X | X | X |
| Pico Union and South LA Family Preservation Programs | Screens parents for depression/anxiety and IPV. Screens children for adverse childhood experiences (ACEs) and mental health or behavioral issues. Refers parents and/or children needing treatment for mental health concerns. Offers support group for women who have experienced IPV. Offers anger management | X | X | X | X |

| Health Need: Behavioral Health (Mental Health and Substance Use) | | | | | |
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| | psychoeducational group and offers a parenting psychoeducational group. | | | | |
| UniHealth Cultural Trauma and Mental Health Resiliency Project | Joint effort of the six Dignity Health hospitals in Southern California working in partnership to increase the capacity of local community organizations, community members and hospitals to identify mental distress and/or suicidality among at risk youth, and to respond appropriately. Improved access to prevention and early intervention mental health and SUD (substance use disorder) services, Identifies and funds grantees who deliver Mental Health First Aid, Youth Mental Health First Aid, and Question, Persuade, and Refer to the target population in the service area. | X | X | X | X |
| 10th Decile Project | This Homeless Health Initiative grant-funded project connects the top 10% of highest cost, highest need chronically homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services through a collaboration of Housing Works and JWCHI, Inc. | X | X | X | X |
| CA Behavioral Health Clinic | Children and youth, ages 0-21, with Medi-Cal receive mental health care services. | X | X | X | |
| LABBN's Perinatal & Early Childhood Home Visiting Programs | Home visitation screens for perinatal mood and anxiety disorders (PMADs) and IPV and refers individuals needing treatment to community resources | X | X | X | X |

| Health Need: Behavioral Health (Mental Health and Substance Use) | | | | | |
|---|---|---|---|---|---|
| Community grants program | Offers grants to nonprofit community organizations that provide mental health and substance use programs and services. | | | X | |
| **Planned Resources** | The hospital will provide mental health care providers, case managers, health educators, social workers, philanthropic cash grants, outreach communications, and program management support for these initiatives. | | | | |
| **Planned Collaborators** | Key partners include: schools and school districts, community-based organizations, the UniHealth Foundation, Dignity Health Southern California Hospitals, other non-profit hospitals and LA County agencies. | | | | |

| Health Need: Birth Indicators | | | | | |
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| **Anticipated Impact (Goal)** | The hospital's initiatives to address birth indicators are anticipated to result in: improved birth outcomes, reduced barriers to care, and increased availability and access to prenatal and perinatal services. | | | | |
| **Strategy or Program** | **Summary Description** | **Strategic Objectives** | | | |
| | | Alignment & Integration | Clinical - Community Linkages | Capacity for Equitable Communities | Innovation & Impact |
| African American Infant and Maternal Mortality Initiative (AAIMM) | Reduces black maternal and infant mortality by decreasing risk factors for maternal mortality (advanced maternal age and obesity, IPV, PMADs), prematurity, low-birth weight, and SIDS (sudden infant death syndrome). | X | X | X | X |
| HSFC Early Head Start Program | Provides prenatal home visiting services to improve birth outcomes. | X | X | X | X |
| Cherished Futures for Black Moms & Babies | A collaborative effort to reduce infant mortality and improve maternal patient experiences and safety among Black moms and babies in South LA and the Antelope Valley. Aligns with the comprehensive LA County African American Infant and Maternal Mortality (AAIMM) initiative and aims to support the legacy of local communities working to advance birth equity. The collaborative explores key interventions focusing on clinical, organizational, and community level strategies to address African American birth inequities. Increases the capacity of project partners to meet the needs of Black women and families through a series of learning opportunities on equity, root causes, and implicit bias. | X | X | X | X |

| Health Need: Birth Indicators | | | | | |
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| LA County Perinatal and Early Childhood Home Visitation Consortium | A consortium run by LABBN. Membership includes the majority of organizations providing home visiting services in LA County. Together, they work to support Los Angeles County's home visitation programs by sharing training and educational resources, researching best practice standards, supporting enhanced referral systems between programs, conducting research and collecting data on home visiting outcomes, and advocating for systems and policies that recognize the tremendous value of home visitation services. | X | X | X | X |
| LABBN's Perinatal and Early Childhood Home Visiting Programs | Offers programs by 14 hospitals and their community partners throughout LA County including CHMC. Patients experiencing their first pregnancy are enrolled in Nurse Family Partnership, which is run by LA County DPH. | X | X | X | X |
| Community grants program | Offers grants to nonprofit community organizations that provide access to prenatal and perinatal programs and services. | | | X | |
| **Planned Resources** | The hospital will provide health care providers, community health educators, case managers, philanthropic cash grants, outreach communications, and program management support for these initiatives. | | | | |
| **Planned Collaborators** | Key partners include: community clinics, community-based organizations focused on maternal-infant health, faith groups, Los Angeles County Department of Public Health and other non-profit hospitals. | | | | |

| Health Need: Chronic Disease (including Overweight and Obesity and Food Insecurity) | | | | | |
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| **Anticipated Impact (Goal)** | The hospital's initiatives to address chronic diseases are anticipated to result in: increased identification and treatment of chronic diseases, increased compliance with disease prevention recommendations (screenings and life style and behavior changes) and improved health eating and active living. | | | | |
| **Strategy or Program** | **Summary Description** | **Strategic Objectives** | | | |
| | | Alignment & Integration | Clinical - Community Linkages | Capacity for Equitable Communities | Innovation & Impact |
| Health Ministry Program | Parish Nurse screens for common chronic diseases including overweight/obesity. Refers those with abnormal results to local FQHCs if they do not already have a medical home. | X | X | X | |
| Heart HELP Program | Minimizes risk for cardiovascular disease by healthy eating and cooking, maintaining an active lifestyle and addressing risk factors such as obesity/overweight, hypertension, cholesterol, and pre-diabetes/diabetes. Refers those who are food insecure to CalFresh, WIC, and other food assistance programs for which they qualify. | X | X | | |
| Diabetes Empowerment Education Program (DEEP) | Prevents diabetes among persons with pre-diabetes. Participants with diabetes learn to manage their disease and improve their health in order to prevent complications. Refers those who are food insecure to CalFresh, WIC, and other food assistance programs for which they qualify. | X | X | | X |
| Chronic Disease Self-Management Program | In six weekly workshops, participants with chronic conditions learn to manage and improve their health. | X | X | | |
| Healthy Eating and Lifestyle | Overweight/obese children, ages 5-12, and their parents learn to | | X | | |

| Health Need: Chronic Disease (including Overweight and Obesity and Food Insecurity) | | | | | |
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| Program | decrease screen time, consumption of fast food, sugar sweetened beverages, and calorie-dense, nutrient poor food and to increase their physical activity and consumption of fresh fruits, vegetables and water. | | | | |
| Women's Health Center | Refers uninsured women to the Women's Health Center for free mammography and cervical cancer screenings. | X | X | X | |
| Coordinated Care Initiative | Patients with chronic diseases, who have their medical home at FQHCs belonging to the Southside Coalition of Community Health Centers and are inpatients at CHMC, participate in this program. Patient navigators develop care plans for enrolled patients and coordinate their post-discharge care. | X | X | X | X |
| HSFC's EHS, ECE Centers, Family Childcare Network, Youth Center | Pregnant and parenting women with children, ages 0-3, learn about the importance of: breastfeeding, healthy eating, and maintaining an active lifestyle in order to prevent obesity/overweight. Children and youth, ages 7-18, learn about healthy eating, healthy cooking, portion control, the importance of maintaining an active lifestyle and healthy coping strategies for life's stressors. They are encouraged to participate in the Youth Fitness Program. Refers those who are food insecure to CalFresh, WIC, and other food assistance programs for which they qualify. | X | X | | |
| LABBN's Perinatal & Early Childhood Home Visiting Programs | Pregnant and parenting women with children, ages 0-5, learn about the importance of breastfeeding, the consumption of fresh fruits, vegetable and water, and maintaining an active lifestyle in order to prevent obesity/overweight. Refers those who are food insecure to | X | X | X | |

| Health Need: Chronic Disease (including Overweight and Obesity and Food Insecurity) | | | | | |
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| | CalFresh, WIC, and other food assistance programs for which they qualify. | | | | |
| 10th Decile Project | This grant-funded project connects the top 10% highest cost, highest need chronically homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services through a collaboration of Corporation for Supportive Housing, Housing Works, and JWCHI, Inc. | X | X | X | X |
| Support groups | Assists persons with chronic diseases to improve their emotional well-being through mutual support, coping strategies, and psychoeducation. | | X | | |
| Food Recovery Initiative | Participates in CommonSpirit systemwide committee to address food insecurity issues in the community, including reducing barriers to accessing healthy food. | X | X | | |
| Community grants program | Offers grants to nonprofit community organizations that provide chronic disease-focused programs and services. | | | X | |
| **Planned Resources** | The hospital will provide health care providers, parish nurses, patient navigators, health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives. | | | | |
| **Planned Collaborators** | Key partners include: FQHCs, Food Finders, Southside Coalition of Community Health Centers, public health, youth organizations, faith community, senior centers, community-based organizations and other non-profit hospitals. | | | | |

| Health Need: Housing Insecurity and Homelessness | | | | | |
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| **Anticipated Impact (Goal)** | The hospital's initiative to address housing insecurity and homelessness are anticipated to result in: improved health care delivery to persons experiencing homelessness and increased access to community-based services for persons experiencing homelessness. | | | | |
| **Strategy or Program** | **Summary Description** | **Strategic Objectives** | | | |
| | | Alignment & Integration | Clinical - Community Linkages | Capacity for Equitable Communities | Innovation & Impact |
| Dignity Health Homeless Health Initiative | Provides three social workers to assist with discharge planning for homeless patients seen in the ED. | X | | X | |
| 10th Decile Project | This Homeless Health Initiative grant-funded project connects the top 10% of highest cost, highest need chronically homeless individuals seen at CHMC to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services through a collaboration of Housing Works and JWCHI, Inc. | X | X | X | X |
| HSFC's Early Head Start Program, The Nest (ECE Center) | Enrolls homeless pregnant women and/or parenting women with children, ages 0-3. Outreaches to families in shelters to help them access permanent affordable housing. At The Nest, priority enrollment will be given to children, ages 0-5, experiencing homelessness. | X | X | X | |
| LA Partnership | The LA Partnership is comprised of community health directors of nonprofit hospitals and health systems in LA County who have agreed to collaborate on housing insecurity and homelessness in | X | X | X | X |

| Health Need: Housing Insecurity and Homelessness | | | | | |
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| | their overlapping service areas. HASC's Communities Lifting Communities provides the backbone infrastructure for the Partnership. | | | | |
| Community grants program | Offers grants to nonprofit community organizations that provide housing and homelessness programs and services. | | | X | |
| **Planned Resources** | The hospital will provide social workers, health care providers, case managers, philanthropic cash grants, outreach communications, and program management for this initiative. | | | | |
| **Planned Collaborators** | Key partners include: Corporation for Supportive Housing, Housing Works, JWCHI, Inc., city and county agencies, funders, faith community, community clinics, community-based organizations, other non-profit hospitals and homeless services providers. | | | | |

| Health Need: Violence and Injury Prevention | | | | | |
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| **Anticipated Impact (Goal)** | The hospital's initiative to address violence and injury prevention are anticipated to result in: increased access to programs in the community that focus on reduced violence and injury prevention. | | | | |
| **Strategy or Program** | **Summary Description** | **Strategic Objectives** | | | |
| | | Alignment & Integration | Clinical - Community Linkages | Capacity for Equitable Communities | Innovation & Impact |
| HSFC Early Head Start Program, Early Care and Education Centers, Family Childcare Network | Screens parents for depression/anxiety and intimate partner violence (IPV). Screens children for mental health and behavioral issues. Refers parents and children who need treatment to community resources. | X | X | X | X |
| HSFC Youth Center | Youth, ages 7-18, access homework assistance, a computer learning lab, and the Youth Fitness Program at this afterschool program. Youth develop relationships with caring adults and learn healthy coping skills through yoga. | X | | | |
| HSFC Early Intervention Program | Serves families with infants or toddlers who have a developmental delay or disability or with an established risk condition likely to result in a delay. Specialists evaluate and assess infants and toddlers and provide EI and family support services for young children, ages birth to 3 years. Participants are routinely screened for IPV and referred for counseling and support as needed. | X | X | X | |
| CA Behavioral Health Clinic | Children, ages 0-21, with Medi-Cal receive mental health services. | X | X | X | |

| Health Need: Violence and Injury Prevention | | | | | |
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| LABBN's Perinatal and Early Childhood Home Visiting Programs | Home visitors teach families about milestones of child development. Parents learn the importance of responsive caregiving and keeping their children safe. Participants are routinely screened for IPV and referred for counseling and support as needed. Participating families receive First 5 LA *Kit for New Parents* that discusses safety for infants/toddlers. | X | X | X | X |
| UniHealth Cultural Trauma and Mental Health Resiliency Project | Joint effort of the six Dignity Health hospitals in Southern California working in partnership to increase the capacity of local community organizations, community members and hospitals to identify mental distress and/or suicidality among at risk youth, and to respond appropriately. Improved access to prevention and early intervention mental health and SUD services, Identifies and funds grantees who deliver Mental Health First Aid, Youth Mental Health First Aid, and Question, Persuade, and Refer to the target population in the service area. | X | X | X | X |
| Stop the Bleed Program | Stop the Bleed is a national awareness campaign and call-to-action. Trains, equips, and empowers the public to help a bleeding emergency before professional help arrives. | | X | X | X |
| Dignity Health Human Trafficking Response Initiative | The CHMC Human Trafficking Response Task Force provides training to identify potential victims of sex and/or labor trafficking in the ED and other hospital units. The survivor advocates from CAST LA and Journey Out work in the ED to assist staff in identifying potential victims and encourage potential victims to accept services. | X | X | X | |

| Health Need: Violence and Injury Prevention | | | | | |
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| Pico Union and South LA Family Preservation Programs | Family preservation services are short-term, family-focused services to assist families in crisis by improving parenting and family functioning while keeping children safe. A support group for women who are victims of IPV, an anger management group for men and women, and a parenting group for men and women is conducted in Spanish every week. | X | X | X | |
| Wraparound Services Program | Provides community-based support and individualized planning for children, including those with severe emotional and behavioral disorders and their families. The Wraparound Team implements an intensive family preservation plan that supports keeping the child at home with his/her family. | X | X | X | X |
| Community grants program | Offers grants to nonprofit community organizations that provide violence and injury prevention programs and services. | | | X | |
| **Planned Resources** | The hospital will provide case managers, health care providers, health educators, social workers, philanthropic cash grants and outreach communications in support of this initiative. | | | | |
| **Planned Collaborators** | Key partners include: community-based organizations, CAST LA, Journey Out, faith community, public safety agencies, city agencies, schools and school districts, community health centers, UniHealth Foundation and youth organizations. | | | | |

## Program Highlights

On November 2, 2021, CommonSpirit Health announced an industry-leading commitment to achieve net-zero greenhouse gas emissions by 2040 with an interim target to cut operational emissions in half by 2030. As one of the nation's largest, most diverse and leading health systems, CommonSpirit's pledge will impact the climate crisis by delivering more sustainable, resilient, and climate-smart health care across its 21-state footprint. "We believe there is an unbreakable connection between the health of our planet and the health of our people," said Lloyd H. Dean, CEO of CommonSpirit. "Our net-zero commitment supports our focus on addressing the underlying causes of health inequities, from access to clean air and safe drinking water to the effects of extreme weather, with a goal of creating healthier communities for all."

CommonSpirit's net-zero by 2040 target was shared at the UN Climate Change Conference (COP26) in Glasgow, Scotland, and is in line with US goals under the Paris Agreement, the international treaty on climate. The goals outlined in the Paris Agreement seek to hold the increase in the global average temperature to well below 2 degrees Celsius, above pre-industrial levels, and pursue efforts to limit the temperature to 1.5 degrees Celsius. Reaching these goals will prevent the worsening of the human health impacts of climate change, especially among the vulnerable.

"Urgent action is needed now to reverse climate change," said Shelly Schlenker, Executive Vice President and Chief Advocacy Officer for CommonSpirit. "We are committing to an ambitious, science-based goal that leverages advances in the pace and scale of renewable infrastructure."


For the fifth year in a row, California Hospital Medical Center won the Practice Greenhealth's Emerald Award in 2022. The Greenhealth Emerald Award recognizes outstanding hospitals from within the Partner for Change applicants. This competitive award recognizes the top 20 percent of applicants and is focused on advanced sustainability programs and exemplary scores in a range of categories. "Your leadership, ingenuity, and hard work have earned Dignity Health California Hospital this year's

Greenhealth Emerald Award. This recognizes your organization's ongoing commitment to improving its environmental performance and your efforts to build sustainability into the operations of your institution."

In addition, in 2022 CHMC won the Green Building Award. The Green Building category is presented to hospitals that have demonstrated LEED and other green building achievements over the past five years. These hospitals emphasize policies that show a commitment to or requirement for LEED-level construction standards for all major new builds or renovations. Achievements include energy and water efficiency, safer materials, regional sourcing, integration of nature and other mechanisms to create high-performance healing environments. CHMC was one of ten hospitals in the country that received this award.