

Glendale Memorial Hospital & Health Center

Community Benefit Report 2011
Community Benefit Plan 2012

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I - EXECUTIVE SUMMARY

Glendale Memorial Hospital and Health Center (GMHHC) is an acute care hospital with 234 licensed beds. Geographically, the hospital serves the city of Glendale including surrounding communities of La Crescenta, La Canada/Flintridge, portions of Burbank and northern sections of the greater Los Angeles metropolitan area. The primary and secondary service area representing approximately 80% of hospital discharges consists of 1.2 million people. Patient admissions totaled 11,368 during fiscal year 2011. Hospital staff is comprised of 1,300 employees. The medical staff consists of 530 physicians. Active volunteers total 450.

During FY11, Glendale Memorial celebrated its eighty-fifth year of providing healthcare to Glendale and the surrounding areas. Last fall, the hospital's annual Flu Vaccination program resulted in nearly 500 community members receiving flu vaccinations. These vaccinations were delivered through both our annual Drive-Thru Flue Shot Clinic, as well as a program that offered the flu vaccination to homebound seniors in local retirement communities. In addition, Glendale Memorial has also taken an active role in the Armenian bone Marrow Donor registry (ABMDR), which has achieved, or nearly achieved most of the goals set out for 2011 as outlined in the Program Digest. The Registry is expected to add 2,500 new donors by the end of the year. The hospital also offers disease management programs and supports the Glendale Healthy Kids Program.

Glendale Memorial is continually ranked (*by Healthgrades*) among the best in the entire country:

- Ranked among the top 10% in the Nation for Overall Cardiac Services
- Five Star Rated for Cardiology Services in 2012
- Five-Star Rated for Coronary Bypass Surgery
- Ranked among the top 10% in the Nation for the Treatment of Stroke
- Ranked among the top 5% in the Nation for Women's Health

Glendale Memorial Heart Center has once again in 2011 been selected to receive the "Blue Distinction Center for Cardiac Care" designation by the Blue Shield of California Cardiac Quality Initiative and Blue Cross/Blue Shield Association for meeting or exceeding certain criteria that demonstrate reliability in delivering cardiac care and better overall outcomes for its patients.

Glendale Memorial Hospital and Health Center Service Lines include:

Heart Center

- Non-invasive Diagnostic Services
- Invasive Interventional Procedures
- Surgical Services

- Cardiac Research Studies
- Cardiac Fitness Center

Spine Services

- Surgery of Cervical, Thoracic and Lumbar
- Non-surgical Treatment Options
- Aquatic Therapy

Cancer Center Services

- Prostate Cancer Support Group
- Marcia Ray Breast Center & Breast Cancer Support Group
- Cancer prevention and treatment Clinical Trials

Women's Health Services

- Newborn intensive Care Unit
- High Risk Perinatal Services
- Outpatient Perinatal Services
- Breastfeeding Education Program
- State-approved Prenatal Diagnostic Center

In fiscal year 2011, the unsponsored expense for community benefit excluding the unpaid cost of Medicare was \$39,917,089. The total unsponsored community benefit expense, including the unpaid cost of Medicare, was \$46,433,387.

II - MISSION AND STRATEGIC POSITIONING STATEMENTS

Glendale Memorial Hospital and Health Center is a member of Catholic Healthcare West (CHW) the largest health system in California. Both CHW and Glendale Memorial Hospital and Health Center are committed to furthering the healing ministry of Jesus. We dedicate our resources to: delivering compassionate, high-quality, affordable health services; serving and advocating for our sister and brothers who are poor and disenfranchised; and partnering with others in the community to improve the quality of life.

As a member of CHW, GMHHC is committed to furthering the values and vision of CHW. Our hospital strategic positioning statement is:

“With caring & compassion, we will improve the health and quality of life of the people we serve.”

Our mission provides guidance to focus our resources within the city of Glendale and surrounding communities. Our mission is also why we exist and is the primary reason why we participate in community benefit activities.

III. – ORGANIZATIONAL COMMITMENT

A. Governing Process

A Community Board, comprised of up to 22 members, that reviews and approves the annual Community Benefit Plan, governs GMHHC. The Community Board is made up of individuals who represent the communities in which we serve. Board representation includes medical staff members, community-based organization leaders, hospital and CHW staff.

The Community Board provides a community perspective and support for the Hospital President and the CHW system to achieve the mission and values of GMHHC and CHW. By assessing community health needs, the needs of the GMHHC medical staff and national trends in healthcare delivery, the Community Board assists the hospital President in developing the strategic direction of GMHHC consistent with the needs of the community. In addition, they monitor the implementation of its goals and strategic initiatives. The Community Benefit plan is developed in accordance with policies and procedures of CHW and incorporates system wide performance measures identified by the CHW Board for community benefit programs.

The Community Board supports the CHW Community Grants Program that partners with other nonprofit organizations whose programs respond to the strategic priorities identified in our hospitals' Community Health Assessments or Community Benefit Plans. Grant funds are to be used to provide services to underserved populations. Last year, over \$100,000 was allocated to support local agencies like the Glendale Healthy Kids, Glendale Free Clinic, Union Station Homeless Services, City of Glendale Fire Department and Foothill Family Services to name a few.

The Community Board provides advice and consultation concerning the annual operating and capital budgets as a part of the budget development process and receives periodic reports from management comparing actual operations to budget.

B. New Board Members FY11

Robert Gall, MD and Roberto Zarate

All Board Members – See Appendix, Attachment A

C. Glendale Memorial Hospital participates in the Catholic Healthcare West Community Grants Program by allocating a percentage of the previous year's expense to award to other not-for-profit agencies in the community that are addressing the unmet health-related needs of the community. In FY2011 grants totaling more than \$77,000 were made to the following organizations:

- American Armenian Medical Society Ladies Auxiliary
- City of Glendale Fire Department
- Foothill Family Service
- Glendale Community Free Health Clinic
- Glendale Healthy Kids

- Union Station Homeless Services

IV – COMMUNITY

A. Definition of Community

Service area for Purposes of Needs Assessment

The Glendale Memorial Hospital and Health Center (GMHHC) service area was defined by the follow ZIP Codes:

90026 (Hollywood)	
90027 (Los Feliz)	91202 (Glendale)
90029 (Hollywood)	91203 (Glendale)
90039 (Griffith Park)	91204 (Glendale)
90041 (Eagle Rock)	91205 (Glendale)
90042 (Highland Park)	91206 (Glendale)
90065 (Glassell Park)	91207 (Glendale)
90042 (Tujunga)	91208 (Glendale)
91201 (Glendale)	91214 (La Crescenta)

The 2010 population of the GMHHC service area is estimated at 591,678 persons and is considered a federally designated medically underserved area.

Age Distribution

The overall age distribution of the service area population is 26.65% (157,717) are 0 – 20 years of age, 60.87% (360,209) are 21 – 64 years of age, and 12.46% (73,704) are 65 years of age and older.

Race/Ethnicity

Overall, the GMHHC service area population (2010) estimates can be described as follows: 34.3% are White, 2.0% are Black, 15.9% are Asian/ Pacific Islander, 41.5% are Hispanic, and approximately 6.4% are of other races.

Within the Glendale ZIP Codes of 91201 to 91208, 27.7% of the population is of Armenian descent. 46.6% (209,227) of residents over the age of 18 are foreign born, and 23.8% (106,858) are not U.S. citizens.

Uninsured Population

- The number of uninsured Californians continues to rise with approximately 6.8 million people uninsured, which is more than 20% of the population under age 65. California has the sixth largest proportion of uninsured in the nation, but because of California's large population, it has the largest number of uninsured residents of any state in the nation.

- Families with yearly incomes below \$25,000 are most likely to be uninsured; however, more than one-third of California's uninsured have family incomes greater than \$50,000.
- Approximately 14% of California's uninsured are children. Fifty-seven percent of California's uninsured children are in families where the head of the household works full time, all year.
- In 2009, Whites had an 11.2% likelihood of being uninsured, Blacks had 19.4%, Asians had 18.3%, Latinos had 32.1%, and other racial/ethnic groups had a 11.67% likelihood of being uninsured. Nearly, 60% of California's uninsured are Latino.
- In the GHMMC service area, 15.4% (80,316) of the population is uninsured, which is 1.3% less percent of population than Los Angeles County.
- In the GHMMC service area, 19.3% (73,325) of adults aged 18 to 64 are uninsured, and 5.0% (7,080) of children are uninsured.

Uninsured Population

Region	Number of Persons	Percent of Population
GMHHC Service Area	80,316	15.4%
Los Angeles County	1,605,000	15.6%
California	6,600,000	21.0%

Source: 2007 Los Angeles County Health Survey; California Healthcare Almanac (2010) - California Healthcare Foundation; Nielsen Claritas Inc. created on HealthyCity.org

The community is served by Glendale Memorial Hospital, Glendale Adventist Medical Center and Verdugo Hills Hospital. A listing and map of community health assets is included in Appendix, Attachment B.

B. Community Needs and Assets Assessment Process

A Community Benefit and Health Needs assessment is conducted triennially. In 2010 FMA Community Health Consulting prepared the assessment on behalf of the three not-for-profit hospitals serving the Glendale community: Glendale Memorial Hospital and Health Center, Glendale Adventist Medical Center and Verdugo Hills Hospital. The assessment is shared with the City of Glendale and other local government agencies with the objective of achieving a more coordinated allocation of both public and private health resources in Glendale. In addition, it is hoped that the community-wide health needs assessment will also stimulate greater collaboration between and among healthcare providers, government agencies, and community organizations.

Three approaches have been integrated into the Community Benefit and Health Needs Assessment:

- Secondary data and information
- Assets mapping
- Qualitative and quantitative primary research

Secondary Data

FMA Community Health Consultants summarized key demographic, socio-economic and health status indicators for each hospital's service area. Demographic information was analyzed using published information from the 2000 and 2010 U.S. Bureau of the Census and as available through Nielsen Claritas, Inc., a private vendor of demographic and other related information, created on HealthyCity.org. Further information was obtained through:

- American Heart Association
- California Alcohol and Drug Data System
- California Department of Finance
- California Department of Health Services
- Birth Records
- Center for Health Statistics
- Death Records
- Diabetes Prevention and Control Program
- MediCal Care Statistics
- California Department of Justice: Criminal Justice Statistics Center
- California Health Interview Survey
- California Healthcare Foundation (Employee Benefit Research Institute)
- California Managed Risk Medical Insurance Board
- California Office of Statewide Health Planning and Development¹
- Healthcare Information Resource Center: Healthcare Quality and Analysis Division
- Healthcare Workforce and Community Development Division
- Centers for Disease Control: National Health Interview Survey; National Center for Health Statistics
- Centers for Medicare and Medicaid (formerly Health Care Financing Administration)
- Los Angeles County Cancer Surveillance Program, Department of Preventive Medicine, University of Southern California
- Los Angeles County Child Welfare Services; Case Management System Datamart
- Los Angeles County Department of Children and Family Services
- Los Angeles County Department of Public Health
- Data Collection and Analysis Unit
- Immunization Program
- Maternal Child and Adolescent Health Program
- Office of Health Assessment and Epidemiology

- National Center for Chronic Disease Prevention and Health Promotion: Behavioral Risk Factor Surveillance System
- Office of Statewide Health Planning and Development
- RAND California
- California Department of Education
- California Department of Justice
- Department of Alcohol and Drug Data Programs
- California Highway Patrol Statewide Integrated Traffic Records System
- U.S. Department of Health and Human Services: Health Resources and Services Administration

Inventory of Community Assets

Thirty community leaders and representatives representing 24 community-based organizations provided community insight for the Community Benefit and Health Needs Assessment by participating in a focus group. The Glendale Healthier Community Coalition generously offered to host the focus group during a regularly scheduled meeting. Participating agencies resided and provided services in both Glendale and the surrounding communities of Northeast Los Angeles. Participants represented many sectors of the community including education, philanthropic, social services, health care, faith-based organizations, and other community agencies. The following organizations participated:

Glendale Healthier Community Coalition Focus Group

- Community Foundation of the Verdugos
- CINCO
- Comprehensive Community Health Centers
- Delta Consulting
- Dreires Nursing Care Center
- Glendale Adventist Medical Center
- Glendale Community College
- Glendale Healthy Kids
- Glendale Memorial Hospital and Health Center
- Glendale News Press
- Glendale Religious Leaders Association
- Glendale SDA Church
- Glendale Unified School District
- Glendale Youth Alliance
- Los Angeles County Department of Public Health
- Neighborhood Legal Services
- Office of Assembly member Mike Gatto
- Path Achieve
- Safe Place
- Salvation Army
- Verdugo Hills Hospital
- Wellness Works
- YMCA

Health Problems

Community leaders and representatives from community organizations identified the following as the most important health problems² of Glendale and the surrounding communities:

- Risk Behaviors:
 - Smoking
 - Obesity
 - Poor nutrition and food choices
 - Lack of physical activity
 - Underlying cultural issues that affect health behaviors

- Access to Healthcare
 - Uninsured adults
 - Lack of coordination related to management of chronic diseases
 - Need for culturally sensitive, language appropriate health education
 - Access to dental care – Seniors

- Medical Conditions
 - Asthma – Children
 - Dental issues – Children
 - Stress
 - Cardiovascular disease
 - Diabetes
 - Falls – Seniors
 - Disability among seniors

Employees with Community Affiliations

VP & Chief Operating Officer	Rotary Club International, Glendale Leadership Counsel
VP of Fund Development	Glendale Kiwanis International, Glendale Healthier Community Coalition, Southern California Association of Healthcare Development Officers (SCAHD)
VP Business Development	Glendale Chamber of Commerce
VP of Human Resources	Holy Family Girls Academy, Pasadena/Foothill YWCA, Women’s Racial Justice Breakfast, Women of Excellence Speaker Series
Senior Pharmacists	Glendale Community Free Health Clinic
Director Physician Relations	American Armenian Bone Marrow Donor Registry
Director of Food and Nutrition	Glendale Healthy Kids

² Health problems are defined as those problems having the greatest impact on community health.

Manager Community Outreach	Glendale Kiwanis International, Glendale YWCA, Glendale Latino Association
Director of Mission Integration	Glendale Religious Leaders Association Southern California Ecumenical Council, Glendale Healthier Community Coalition
Manager, Volunteer services	Southern California Association of Directors of Volunteer Services, San Gabriel Area of Hospital Volunteers

C. Results of the Needs Assessment

Results

Priority setting in health can be defined as a process of determining how health care resources should be allocated among competing programs. The Health Priority Matrix is designed to assist healthcare providers in determining how to allocate their resources, by ranking and scoring medical conditions and health behaviors.

Based on data from the SB 697 Community Benefit and Health Needs Assessment, results tabulated from the Automated Health Priority Matrix demonstrate that resources should be invested in the following health conditions (listed in order of rank) for the GMHHC service area:

- **Heart Disease**
- **Mental Health**
- **Hypertension**
- **Diabetes**
- **Pneumonia and Influenza**
- **Respiratory Conditions (COPD, Asthma)**

Based on data from the SB 697 Community Benefit and Health Needs Assessment, results tabulated from the Automated Health Priority Matrix demonstrate that overall resources should be invested to address the following health behaviors (listed in order of rank):

- **Poor Nutrition – Adults**
- **Overweight and Obesity**
- **Lack of Physical Activity (Children and Adults)**
- **Poor Nutrition - Children**
- **Uninsured Status**

Discussion of Results

Three of the top health conditions listed, heart disease, hypertension and diabetes, are considered to be health conditions that could be prevented and managed through proper nutrition, exercise, and weight control.

All of the listed health conditions could be prevented, detected earlier and managed through regular contact with a medical care provider. Within the GMHHC service area, 19.8% of adults between ages 18 and 64 years did not have a regular source of health care and almost one-quarter (23.6%) reported difficulty in accessing healthcare. Nearly twelve percent of adults couldn't afford to receive treatment from a physician for an illness within the last year and 8.1% were unable to attain mental health care. More than 19% of adult residents were uninsured and 9.7% were underinsured. An additional 9.3% of insured residents reported a period of time without health insurance within the past twelve months.

All of these preventive measures are ranked in the top six health behaviors that should be addressed to decrease the risk of disease.

	Poor Nutrition Adults	Overweight and Obesity	Lack of Physical Activity (and associated factors)	Access to Health Care/ Uninsured	Excessive Alcohol Consumption	Adult Immunization
Heart Disease						
Mental Health						
Hypertension						
Diabetes						
Pneumonia/ Influenza						
Chronic Lower Respiratory Disease						

Key Findings

- The age adjusted death rate of 542.1 deaths per 100,000 people within the GMHHC service area was 7.9% lower than in 2004. The age-adjusted death rate for all causes in the GMHHC service area was 13.1% lower than Los Angeles County (624.0 per 100,000 population). Note: The 2010 Community Needs Assessment references the latest available data which in some cases is from 2007.
- The majority of deaths (75.0%) occurred among seniors age 65 and older.
- The following conditions were the leading causes of mortality in the GMHHC service area:

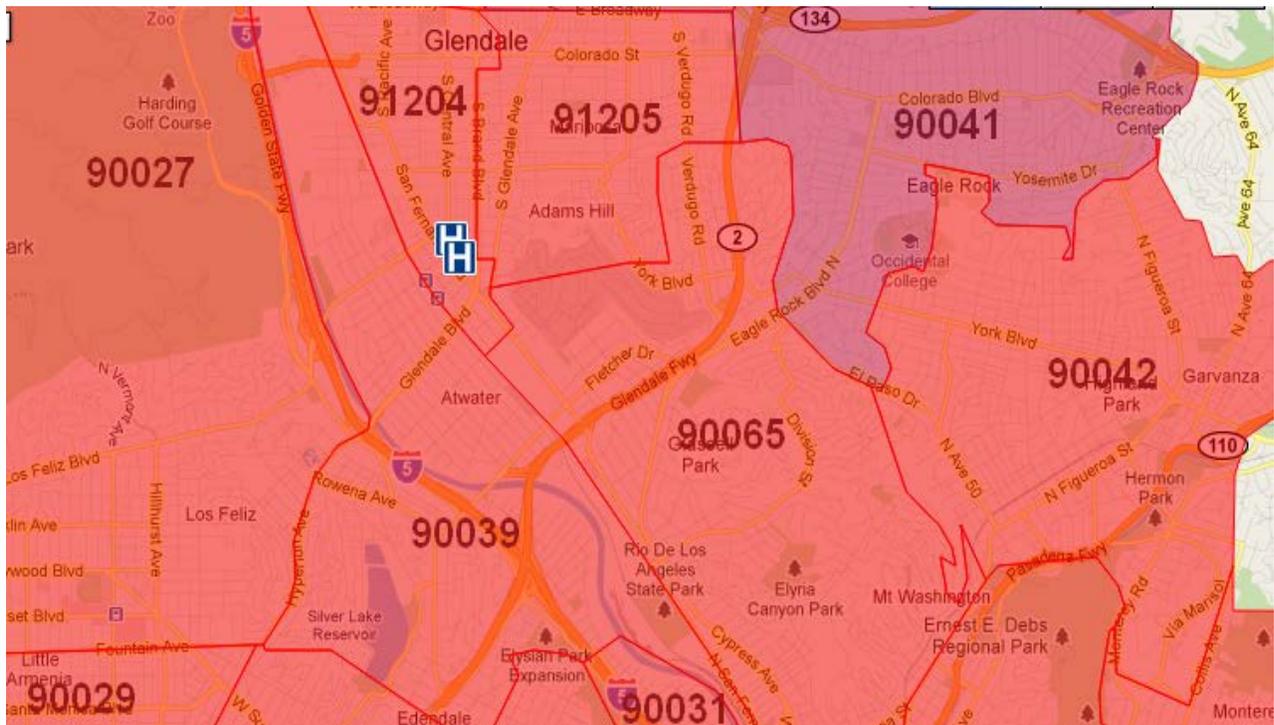
- Heart Disease – 29.3% of total deaths in the service area; age-adjusted death rate is 156.2 per 100,000 population.
 - Cancer – 23.8% of total deaths in the service area; age-adjusted death rate is 131.2 per 100,000 population. Deaths due to lung cancer had a greater age-adjusted death rate (23.6 per 100,000 population) than other types of reported cancer.
 - Stroke – 5.2% of total deaths in the service area; age-adjusted death rate is 28.3 per 100,000 population.
- The GMHHC service area's age-adjusted mortality rate was less than during 2004 in the following areas:
 - Heart Disease
 - Cerebrovascular disease (stroke)
 - Overall Cancer
 - Colon Cancer
 - Female Breast Cancer
 - Lung Cancer
 - Chronic Lower Respiratory Disease
 - Unintentional Injuries
 - Homicide
 - Suicide
 - Chronic liver disease/Cirrhosis
- The GMHHC service area's age-adjusted mortality rate increased from 2004 in the following areas:
 - Prostate Cancer
 - Pneumonia and influenza
 - Diabetes
 - Alzheimer's disease
- The GMHHC service area met the Healthy People 2010 national objectives in the following areas:
 - Coronary Heart Disease
 - Cerebrovascular Disease (Stroke)
 - Overall Cancer
 - Colon Cancer
 - Female Breast Cancer
 - Lung Cancer
 - Prostate Cancer
 - Unintentional Injuries
 - Motor Vehicle Collisions
 - Suicide
 - Diabetes

- The GMHHC service area did not meet the Healthy People 2010 national objectives in the following areas:
 - Homicide
 - Chronic Liver Disease and Cirrhosis

Community Need Index

The Map and Community Need Index from CHW highlights the highest and lowest need, based on the socio-economic barriers of the areas surrounding Glendale Memorial Hospital by zip code and population. The socio-economic barriers include: income, insurance, education, housing and culture/language. The need ranking score is lowest at 1 and the greatest need is at 5.

Glendale Memorial Hospital



Lowest Need

■ 1 - 1.7 Lowest

■ 1.8 - 2.5 2nd Lowest

■ 2.6 - 3.3 Mid

■ 3.4 - 4.1 2nd Highest

Highest Need

■ 4.2 - 5 Highest

	Zip Code	CNI Score	Population	City	County
■	91201	4.4	25240	Glendale	Los Angeles
■	91202	3.6	22771	Glendale	Los Angeles
■	91203	4.4	15217	Glendale	Los Angeles
■	91204	4.8	17402	Glendale	Los Angeles

■	91205	4.8	42988	Glendale	Los Angeles
■	91206	4	33131	Glendale	Los Angeles
■	91207	3	9690	Glendale	Los Angeles
■	91208	2.6	15779	Glendale	Los Angeles
■	91214	2.6	31350	Glendale	Los Angeles
■	90004	5	70525	Los Angeles	Los Angeles
■	90026	5	74633	Los Angeles	Los Angeles
■	90027	4.6	51079	Los Angeles	Los Angeles
■	90028	5	31576	Los Angeles	Los Angeles
■	90029	5	44380	Los Angeles	Los Angeles
■	90031	5	40555	Los Angeles	Los Angeles
■	90032	4.8	49747	Los Angeles	Los Angeles
■	90038	5	33199	Los Angeles	Los Angeles
■	90039	4.2	30473	Los Angeles	Los Angeles
■	90041	3.8	29851	Los Angeles	Los Angeles
■	90042	4.8	68221	Los Angeles	Los Angeles
■	90065	4.8	50180	Los Angeles	Los Angeles
■	91040	3.2	20256	Los Angeles	Los Angeles
■	91042	4.2	27574	Los Angeles	Los Angeles
■	91352	4.8	49357	Los Angeles	Los Angeles
■	91501	3.8	20658	Burbank	Los Angeles
■	91502	4.6	12858	Burbank	Los Angeles
■	91504	3.6	25787	Burbank	Los Angeles
■	91505	3.4	31217	Burbank	Los Angeles
■	91506	3.6	18982	Burbank	Los Angeles
■	91506	3.6	18982	Burbank	Los Angeles
■	91605	5	63647	Los Angeles	Los Angeles
■	91606	5	50265	Los Angeles	Los Angeles

V - COMMUNITY BENEFIT PLANNING PROCESS

A. Developing the Hospital's Community Benefit Report and Plan

In developing the hospital's Community Benefit Plan, the process centered upon two objectives: 1) the determination of hospital programs that will have the greatest impact on addressing community need; and 2) the identification of potential community partners that have goals and missions aligned with GMHHC.

To prioritize the needs, the hospital analyzed the current community projects and identified where a gap existed between information identified in the community needs assessment and the current hospital programs.

Several of the health issues identified in the community needs assessment are addressed in various hospital programs. Note that not all community needs are directly addressed by GMHHC, primarily due to limited resource allocation or an adequate number of community resources exist to address those needs. In situations where there is no existing hospital program or community organization that currently meets a specific need, the establishment of a new hospital program and/or community partner may be considered.

There are several criteria used to identify community partners and programs that share a spirit of collaboration with GMHHC. The criteria include but are not limited to: resources (i.e. staffing, supplies, and financial assistance), desired outcome, measurable outcome, community needs, and community benefit. Other non-quantifiable factors are considered when selecting a program, such as the benefits of social interaction, support groups, and the overall improvement of community residents. For example, the high concentration of Armenian residents in the primary service area has resulted in several partnerships with programs geared toward the Armenian population. GMHHC provides financial, administrative and staff support to the Armenian Bone Marrow Registry, a program addressing specific health needs of this population. The Armenian Relief Center is another such program geared toward specific cultural community needs.

There are recent programs that the hospital has embraced. One such program is the Glendale Free clinic that began in April 2005. Local area physicians recognized the need for free or low cost primary care services. The Glendale Free Clinic was specifically designed to meet this basic community need. GMHHC has since partnered with this clinic offering supplies, staff and financial resources while offering hospital services to clinic patients when needed.

Many hospital programs address vulnerable populations as well as improve the health status of the community. For example, a program that addresses a vulnerable population is the Sweet Success Program. This program targets women with diabetes who are pregnant. The program teaches women to take charge of their health and understand how their pregnancy will affect their diabetes management.

To promote effective, sustainable community benefit programming in support of CHW's mission and tax-exempt status, GMHHC utilizes specified assessment and enhancement tools to review existing community benefit programs and discontinue, if appropriate, or establish enhancements that focus on disproportionate unmet health-related needs, and integrate as applicable the following principles: emphasis on communities with disproportionate unmet health needs, emphasis on primary prevention, contribute to a seamless continuum of care, build community capacity, and demonstrate collaborative governance.

B. Planning for the Uninsured/Underinsured Patient Population

As a member of CHW, GMHHC is committed to providing financial assistance to persons who have health care needs and are uninsured, under-insured, and ineligible for a government program and are otherwise unable to pay for medically necessary care based on their individual financial situations. Consistent with its mission to deliver compassionate, high quality, affordable health care services, and to advocate for those who are poor and disenfranchised, CHW strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Financial assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with CHW's procedures for obtaining financial assistance, and to contribute to the cost of their care based on individual ability to pay. Individuals with financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services. A summation of the CHW Payment Assistance Policy is included in the Appendix, Attachment C.

Information about the payment assistance the hospital offers is posted in prominent locations throughout the hospital and admitting room staff are available to assist patients with bill resolution and applications for government-sponsored health insurance programs.

VI - PLAN REPORT AND UPDATE INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

Below are the major initiatives and key community based programs operated or substantially supported by Glendale Memorial Hospital in 2011. Programs were developed in response to the current Community Health Needs Assessment and are guided by the following five core principles:

- **Disproportionate Unmet Health-Related Needs**
Seek to accommodate the needs to communities with disproportionate unmet health-related needs.
- **Primary Prevention**
Address the underlying causes of persistent health problem.
- **Seamless Continuum of Care**
Emphasize evidence-based approaches by establishing operational between clinical services and community health improvement activities.
- **Build Community Capacity**
Target charitable resources to mobilize and build the capacity of existing community assets.
- **Collaborative Governance**
Engage diverse community stakeholders in the selection, design, implementation, and evaluation of program activities.

In direct response to the identified needs of the community, Glendale Memorial Hospital is focused on the following key areas:

Primary Prevention – Altering susceptibility or reducing exposure for susceptible individuals

- The Glendale Community Free Clinic has as its primary purpose the provision of free healthcare to the uninsured and underinsured working poor and other low-income individuals who otherwise would not likely have access to such healthcare.
- Flu Shot Clinics are offered to decrease incidence of illness, decrease admissions and/or length of stay for flu/pneumonia.
- Health Promotion/Disease Prevention education is offered to change awareness, knowledge, attitudes and skills of the participants.

Secondary Prevention – Early detection and treatment of disease

- Diabetes Management Program designed to provide self-management education, increase health outcomes, and decrease utilization for chronic diseases.

PROGRAM DIGESTS

Diabetes Education Program	
Hospital CB Priority Areas	<input type="checkbox"/> Flu Shot Clinics <input type="checkbox"/> Health Promotion/Disease Prevention <input checked="" type="checkbox"/> Diabetes Management Programs <input checked="" type="checkbox"/> Disease Management
Program Emphasis	<input type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Diabetes Management and Education Nutrition Education
Program Description	The Diabetes Education Program at GMHHC provides outpatient education for individuals with Type I or Type II Diabetes. We offer classes in diabetes self-management, as well as individual instruction and nutrition counseling in English and Spanish. The Nutrition Clinic offers individual nutrition education and counseling for weight management, carbohydrate counseling, cardiac and any nutritional need as prescribed by a physician.
FY 2011	
Goal 2011	<ul style="list-style-type: none"> • Offer Diabetes self-management classes, in four part series. • Offer other classes as needed related to diabetes management such as carbohydrate counting and healthy eating. • Provide education and diabetes counseling for Sweet Success gestational diabetic patients. • Continue to offer diabetes classes and individualized instruction in Spanish. • Maintain ADA Recognition
2011 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Track and reduce Hg A1C levels of patients after completion of program. • Track participants' achievement of behavioral goals 3 months after completing the program. • Achieve 90% good to excellent customer satisfaction ratings in all categories. • Achieve financial viability.
Baseline	Our community is an especially high-risk population that is in need of diabetes and nutrition education. Diabetes care is still a key finding area of need in our Community Needs Assessment.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Continue to support outreach to the community as needed with education lectures, talks and information as requested. • Participate in community health fairs. • Follow up on inpatient floors with patients as well as with dietitians and nursing staff. • Meet with physician office staff and other outside agencies to promote the program.
Results FY 2011	<ul style="list-style-type: none"> • ADA recognition maintained. • Diabetes self-management classes have been maintained on a monthly basis both in English and Spanish. • Revenues for Adult Diabetic program has resulted in positive financial performance. • SWEET SUCCESS continues to see an increasing number of gestational patients.

FY 2012	
Goals FY 2012	<ul style="list-style-type: none"> • To continue to provide self-management education and skills to achieve patient participation necessary for optimum glucose control. • To offer a four part series of classes in English, Spanish and Armenian. • Provides one on one education and consultation and follow-up. • Maintain ADA Recognition • In addition to regular self-management classes, continue to offer a variety of classes related to diabetes management such as carbohydrate counting and healthy eating. • Conduct diabetes self-management classes on a monthly basis
2012 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Track participants' achievement of behavioral goals 3 months after completing the program and compare A1C levels pre and post program. • HbA1C levels every 3 months. Goal: achievement after 6 months to reduce by 0.5% or maintain below 7% in 75% of the patients. • BMI or Weight – attain ideal body weight; achieve weight loss of 5% or reduction in BMI over 6 months. • Reduce percentage of patients' readmission to hospital for complications resulting from DM related conditions.
Baseline	Our community is an especially high-risk population that is in need of diabetes and nutrition education. Diabetes care is still a key finding area of need in our Community Needs Assessment.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Follow-up telephone calls to keep patients in the program for one year. • Continue to support outreach to the community as needed with education lectures, talks and information as requested. • Participating in Health Fairs. • Follow-up on inpatient floors with patients as well as dietitians and nursing staff. • Meet with physician office staff and other outside agencies to promote the program.

Glendale Healthy Kids	
Hospital CB Priority Areas	<input type="checkbox"/> Flu Shot Clinics <input checked="" type="checkbox"/> Health Promotion/Disease Prevention <input type="checkbox"/> Diabetes Management Programs <input type="checkbox"/> Disease Management
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Affordable health and dental care, assistance for multiple health and social issues.
Program Description	Glendale Healthy KIDS. As a community benefit, this organization provides referrals for healthcare to children who are poor and cannot pay for needed services. GHK works closely with the Glendale Unified School District for these referrals. GMHHC has supported Glendale Healthy Kids since its inception in 1994, with provision on medical care and with in-kind medical contributions for low –income students and non-medical contributions such as sponsorship of one of their fundraising events, printing and mailing invitations for a major fundraising event, and mailings of the newsletter once or twice a year.
FY 2011	
Goal 2011	<ul style="list-style-type: none"> • To make 700 referrals for medical and dental treatment through the school site referral program. • To increase participation in “Give Kids a Smile Day” to 100 children. • To reach every first grade child in the District in the Dental Education Program; the number of children would depend on the enrollment. • To continue to work with Verdugo Mental Health to help our emotionally disturbed children and to find private psychiatrists who are willing to serve as providers. • To find funding to continue the good work of Project CHASE, educating child caretakers and parents on health issues and childhood diseases. Asthma will continue to be a curriculum topic, with new emphasis on childhood obesity and diabetes.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Continue School site referral program, increasing communication beyond nurses and health aids to all teachers and administrators • Increasing number of community media presentations in appropriate languages • Recruit at least 20 new providers at all levels to meet increased demand for services • Ensure that providers services are monitored appropriately’ • Continue the public relations effort of “April: Glendale Healthy Kids Month” to increase community awareness • Ensure that both the PSA and -the video are presented throughout the community • Recruit both volunteers and providers within the Korean community to reach an audience previously underserved. • Maintain current relationships within the Armenian community to continue to increase both services and providers, as well as much needed funding • Providing transportation if needed.

Results FY 2011	<p>As this is an ongoing, long term relationship and we are consistently able to achieve most of our goals each year. Specifically, in 2011 we:</p> <ul style="list-style-type: none"> • Made 554 referrals for medical and dental treatment through the school site referral program. • Enlisted 112 kids in the annual “Give Kids a Smile Day”. • Continue to reach all first grade children in the District’s Dental Education Program by visiting each classroom and providing educational materials to be brought home. • Continue to collaborate with agencies like the Verdugo Mental Health to help emotionally disturbed children find private psychiatrists who are willing to serve as providers. • Project CHASE as an “official” program has been discontinued with duties assigned to the Director of Health Education that was hired out of the original program. • Through a \$15,000 grant from the CHW Community Grants program, Case Management was provided for health care of low income underinsured children, including education and treatment in the areas of asthma, obesity and nutrition, providing tools for a healthy lifestyle.
FY 2012	
Goal 2012	<ul style="list-style-type: none"> • To make 700 referrals for medical and dental treatment • Provide 1400 units of healthcare service • Increase Give Kids A Smile day participation to 175 children completing restoring mouths to good health. • Provide Dental education to all first grade students in GUSD and pilot at least one session in a local private school • Continue mental health therapy as referred by school administrators and other community agencies • Provide a daylong health fair with 1000 participants on March 24, 2012. • Provide orthodontic services for 10 children in treatment
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Continue School site referral program, increasing communication beyond nurses and health aid to all teachers and administrators. • Increasing number of community media presentations in appropriate languages. • Recruit at least 25 new providers at all levels to meet increased demand for services. • Ensure that providers’ services are monitored appropriately. • Continue the public relations effort of “April: Glendale Healthy Kids Month” to increase community awareness. • Ensure that both the PSA and -the video are presented throughout the community. • Emphasis on recruitment of both volunteers and providers within the Korean community will reach an audience previously underserved. • Maintaining current relationships within the Armenian community will continue to increase services and providers, as well as much needed funding.

Breast Feeding Follow-up Clinic and Resource Center	
Hospital CB Priority Areas	<input type="checkbox"/> Flu Shot Clinics <input checked="" type="checkbox"/> Health Promotion/Disease Prevention <input type="checkbox"/> Diabetes Management Programs <input checked="" type="checkbox"/> Disease Management
Program Emphasis	<input type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Preventive healthcare
Program Description	The Breastfeeding Resource Center was funded by the Unihealth Foundation grant. The clinic has trained certified lactation educators and pediatric nurse practitioner to assist new mothers with breastfeeding needs and assess the wellbeing of the newborn after 48-72 hours after hospital discharge to decrease NICU admission for hyperbilirubinemia /jaundice or dehydration. The BF Follow-Up and Resource Center provides: three breastfeeding consultation up to the babies 6 weeks of discharge. The visit includes outpatient one on one lactation consultation and follow up if necessary to support breastfeeding and nursing mothers in the community, including weekly breastfeeding support group meetings (“Nursing Mothers Circle”) and telephone support.
FY 2011	
Goal 2011	Decrease the severity of morbidity of dehydration and hyperbilirubinemia to breastfeeding infants. This will be achieved by providing lactation rounding on the mothers on our labor/delivery units and postpartum units. Our lactation educators are scheduled to assist our mothers during various shifts, including days, nights, weekends and holidays. We refer all our breastfeeding mothers to the follow-up clinic within 24 hours – 7 days to assess mother/infant couplet as to the above and adequacy of breastfeeding – approximately 80% mothers will attend this clinic. We also provide nursing mother circle group which is held every week to provide networking among breastfeeding mothers in the community. Our breastfeeding classes are also offered in 3 different languages (English, Spanish, and Armenian) by our certified lactation Educators.
2011 Objective Measure / Indicator of Success	<ul style="list-style-type: none"> Track numbers of patients attending the clinic. Track unintended admissions rates to the NICU for dehydration and hyperbilirubinemia. Track patients satisfaction with overall breastfeeding support and education provided.
Baseline	We will continue this program from the Unihealth Grant, as there is no other program in our community that supports the health and education of breastfed infants and stresses the importance of breastfeeding.
Intervention Strategy for Achieving Goals	<ul style="list-style-type: none"> In-services provided to nursing staff. Communication with pediatrician and OB staff. Education and handouts to patients on the importance of follow-up. Performance Improvement projects addressing the above.

Results FY 2011	We were able to achieve all our goals for FY 2011. Many mothers and baby dyads are opting out of coming to the Breastfeeding follow up as they were able to get several visits from the Lactation Educators during their stay at the hospital and felt confident that they would not need the visit. They are aware that the follow up is still available to them along with the Support Group and Breastfeeding Hot Line. Our mothers are often referring friends to contact us for phone support or to attend the support group. We have had many happy mothers who were initially struggling with breastfeeding. No major increase in hyperbilirubinemia / admits to the NICU.
FY 2012	
Goal 2012	The Breastfeeding Resource Center continues to provide lactation services for inpatients and outpatients, thereby promoting healthy family goals. This will be achieved by providing lactation rounding to the mothers/baby/dad on our labor/delivery units and postpartum units as well as in the NICU. Our lactation educators are scheduled to assist our mothers during various shifts, including days, nights, weekends and most holidays. We offer all our breastfeeding mothers to the follow-up consultations and encourage attending within 24 hours – 7 days to assess mother/infant couplet as to the above, and adequacy of breastfeeding – approximately 35% of the mothers will attend the follow up due to breastfeeding issue. The nursing mother circle group which is held every week to provide support and allow networking among breastfeeding mothers in the community. Our breastfeeding classes are also offered in 3 different languages (English, Spanish, and Armenian) by our certified lactation Educators at no cost to the parents. Our Breastfeeding phone line will continue to assist all mothers in the community and surrounding areas at no cost. Adding one additional per diem CLE to our staff to sufficiently cover the night shift.
2012 Objective 2012 Measure / Indicator of Success	<ul style="list-style-type: none"> ▪ Track unintended admissions rates to the NICU for dehydration and hyperbilirubinemia. ▪ Track patients satisfaction with overall breastfeeding support and education provided. ▪ Track number of mothers attending the Breastfeeding Support Group and monitor their overall satisfaction with the services provided.
Baseline	We will continue this program and plan to add more coverage for the evening shift as there is no other program in our community that supports the health and education of breastfed infants and stresses the importance of breastfeeding.
Intervention Strategy for Achieving Goals	<ul style="list-style-type: none"> ▪ In-services provided to nursing staff. ▪ Communication with pediatrician and OB staff. ▪ Education and handouts to patients on the importance of follow-up. ▪ Performance Improvement projects addressing the above. ▪ Continue active Lactation rounding on all post-partum dyads. ▪ Covering more weekend and evening Lactation shifts.

Senior Services Programs	
Hospital CB Priority Areas	<ul style="list-style-type: none"> X Flu Shot Drive X Health Promotion/Disease Prevention <input type="checkbox"/> Diabetes Management Programs X Disease Management
Program Emphasis	<ul style="list-style-type: none"> <input type="checkbox"/> Disproportionate Unmet Health-Related Needs X Primary Prevention <input type="checkbox"/> Seamless Continuum of Care X Build Community Capacity <input type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Early detection screenings, preventive healthcare, promoting wellness lifestyle programs
Program Description	The major components of Senior Services are comprised of the 50plus-membership program which offers 2-3 free health education lectures, the annual Flu Drive-Through and senior flu out-reach, weekly walkers program for seniors promoting healthy physical activity and health social interactions. Additionally, the 50+ program offers social support to seniors via the day travel event, community informational lectures offered at both Glendale Memorial Hospital and the community setting through Senior centers in surrounding areas. Senior Services also support and participates in community health fairs to promote health information and wellness events.
FY 2011	
Goals 2011	<ul style="list-style-type: none"> ▪ Coordinate a minimum of 12 community service and/or educational senior lectures: Focus for health lecture on heart disease, diabetes, mental health, promoting healthy living, exercise, diet and early detection and intervention. ▪ Provide the coordination of a minimum of 200 flu shot vaccinations to seniors in residential retirement homes.
2011 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> ▪ Number of events held and participants who attended. ▪ Evaluate a minimum of half the informational lectures for quality and context as relevant for the seniors: scale of prior knowledge on the subject and value of information provided with assessment questionnaire with a specific area for input by seniors for topics of interest and importance ▪ Evaluation of at least half of the wellness events by a questionnaire as to the level of satisfaction with classes and social events.
Baseline	Community leaders identified the following as significant health needs for the senior population: wellness, screening and prevention programs, exercise and physical fitness programs and community informational resources needs.
Intervention Strategy for Achieving Goal 2011	<ul style="list-style-type: none"> ▪ Sr. Service Programs will be made known to the community via direct outreach to local surrounding senior centers and senior service agencies. ▪ Sr. Service Manager will participate in networking events to enhance the program exposure to senior residential facilities and agencies providing service to the senior community
Outcomes FY 2011	During FY 2011, 1,400 seniors were served through the program, including various health education topics of relevance, e.g. safe driving, Birthday Club, Walking Program, Travel Program, and Community Resource Program.

FY 2012	
Goals 2012	<ul style="list-style-type: none"> ▪ Coordinate a minimum of 12 community service and/or educational senior lectures: Focus for health lecture on heart disease, diabetes, mental health, promoting healthy living, exercise, diet and early detection and intervention. ▪ Provide the coordination of a minimum of 200 flu shot vaccinations to seniors in residential retirement homes and flu drive. Increase participation awareness in exercise through our senior walking program. ▪ Join effort with Glendale Senior center to provide monthly day trips. ▪ Provide multiple community resources including transportation program.
2012 Objective Measure / Indicator of Success	<ul style="list-style-type: none"> ▪ Number of events held and participants who attended ▪ Evaluate a minimum of half the informational lectures for quality and context as relevant for the seniors: scale of prior knowledge on the subject and value of information provided with assessment questionnaire with a specific area for input by seniors for topics of interest and importance. ▪ Evaluation of at least half of the wellness events by a questionnaire as to the level of satisfaction with classes and social events.
Baseline	Community leaders identified the following as significant health need for the senior population: wellness, screening and prevention programs, exercise and physical fitness programs and community informational resources needs.
Intervention Strategy for Achieving Goal 2012	<ul style="list-style-type: none"> ▪ Sr. Service Programs will be made known to the community via direct outreach to local surrounding senior centers and senior service agencies ▪ Sr. Service manager will participate in networking events to enhance the program exposure to senior residential facilities and agencies providing service to the senior community.

The Armenian Bone Marrow Registry	
Hospital CB Priority Areas	<input type="checkbox"/> Flu Shot Clinics <input checked="" type="checkbox"/> Health Promotion/Disease Prevention <input type="checkbox"/> Diabetes Management Programs <input checked="" type="checkbox"/> Disease Management
Program Emphasis	<input type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Cultural Issues/barriers to obtaining healthcare; language and communication issues.
Program Description	The Armenian Bone Marrow Registry is a member of the Bone Marrow Donors Worldwide, which provides international connections to help identify more patients in need, and assist in finding matches for bone marrow transplants. The Armenian Bone Marrow Registry was founded in 1999 as an independent, non-governmental, not-for-profit organization, whose mission is to ensure that every ethnic Armenian struck with a life-threatening blood-related disease is able to find hope for long-term survival through the identification of genetically suitable bone marrow.
2011	
Goals for 2011	<ul style="list-style-type: none"> • International Final accreditation of the Registry by the World Marrow Donor Association. • International accreditation of the Harvesting Center by Foundation for the Accreditation of Cellular Therapy. • Recruit 2,500 new donors for the Registry's computerized databank • Establish more recruitment centers worldwide.
Results for 2011	<ul style="list-style-type: none"> • To date, the registry has recruited over 20,000 mostly young males, in 13 countries across three continents. • Identified 1,696 patients, found 1,419 potential matches, and facilitated 12 bone marrow transplants. • Operational accreditation of the Registry by the World Marrow Donor Association. • Harvesting Center accreditation secured and accreditation by the Foundation for the Accreditation of Cellular Therapy following in process. • Hospital was title sponsor for the annual Walk for Life fundraising and marketing event. • Hospital sponsors numerous bone marrow drives at our facility. • Hospital staff on both the Board of Advisors and sub-committees.
2012	
Goals for 2012	<ul style="list-style-type: none"> • Maintain Life Sponsorship and support of program's various educational activities • Increase recruitment of new donors for the Registry's computerized databank by hosting donor bone marrow drives throughout the year. • Continue Title sponsorship of Walk for Life event. • Use Hospital's network of physicians and key staff to support program.

Intervention Strategy for Achieving Goal 2012

- Continue School site referral program, increasing communication beyond nurses and health aids to all teachers and administrators.
- Increasing number of community media presentations in appropriate languages.
- Recruit at least 25 new providers at all levels to meet increased demand for services.
- Ensure that providers services are monitored appropriately.
- Continue the public relations effort of “April: Glendale Healthy Kids Month” to increase community awareness.
- Ensure that both the PSA and -the video are presented throughout the community.
- Emphasis on recruitment of both volunteers and providers within the Korean community will reach an audience previously underserved.
- Maintaining current relationships within the Armenian community will continue to increase services and providers, as well as much needed funding.

VII. - COMMUNITY BENEFIT AND ECONOMIC VALUE

A. Classified Summary of Un-sponsored Community Benefit Expense

Glendale Memorial Hospital
 Complete Summary - Classified Including Non Community Benefit (Medicare)
 For period from 7/1/2010 through 6/30/2011

	Persons	Expense	Revenue	Benefit	% of Organization's	
					Expenses	Revenues
Benefits for Living in Poverty						
Traditional Charity Care	585	\$7,759,446	\$0	\$7,759,446	3.4	3.3
Unpaid Cost of Medicaid	22,737	\$86,743,021	\$57,593,962	\$29,149,059		12.3
					12.7	
Community Services						
Cash and In-Kind Contributions	0	\$1,179,458	\$0	\$1,179,458	0.5	0.5
Community Benefit Operations	0	\$52,123	\$0	\$52,123	0.0	0.0
Community Health Improvement Services	905	\$13,976	\$0	\$13,976	0.0	0.0
Totals for Community Services	905	\$1,245,557	\$0	\$1,245,557	0.5	0.5
Totals for Living in Poverty	24,227	\$95,748,024	\$57,593,962	\$38,154,062	16.6	16.1
Benefits for Broader Community						
Community Services						
Community Building Activities	0	\$649,879	\$0	\$649,879	0.3	0.3
Community Health Improvement Services	1,445	\$746,579	\$0	\$746,579	0.3	0.3
Health Professions Education	0	\$79,207	\$0	\$79,207	0.0	0.0
Research	0	\$287,362	\$0	\$287,362	0.1	0.1
Totals for Community Services	1,445	\$1,763,027	\$0	\$1,763,027	0.8	0.7
Totals for Broader Community	1,445	\$1,763,027	\$0	\$1,763,027	0.8	0.7
Totals - Community Benefit	25,672	\$97,511,051	\$57,593,962	\$39,917,089	17.4	16.9
Unpaid Cost of Medicare	21,283	\$79,261,333	\$72,745,035	\$6,516,298	2.8	2.8
Totals with Medicare	46,955	\$176,772,384	\$130,338,997	\$46,433,387	20.2	19.6
Totals Including Medicare	46,955	\$176,772,384	\$130,338,997	\$46,433,387	20.2	19.6

Community Benefit expenses are derived using a cost accounting methodology.

D. Non-quantifiable Benefit

Glendale Memorial Hospital and Health Center strives to maintain the highest quality of health for the residents of our community in the following ways: maintaining healthy and independent lifestyles for all adults over 50 years of age; improving the communities access to prenatal care services and to maintain and/or improve the health and well-being of pregnant women and their families; providing a safety net for women to know where they can come for their GYN care and care for their families; insuring all residents, of all ages, of the City of Glendale live a healthy and quality life; Providing children with the right to healthcare and a healthy future; maintaining access or providing vaccinations for the elderly community.

An example of Glendale Memorial Hospital participating in the health of the community is our involvement with the Glendale Healthier Community Coalition. The results in FY 2011 included a) Community wide focus group held with representation from at least 25 various social and health serving NGO's, b) Reviewing the results of the focus group study, as well as hospital priorities, and focus on 3 key (main) issues to be addressed, c) Assign a chair and vice chair for the 3 determined task groups, d) Develop objectives for each with a time line for completion, and e) Publicize all of the above to encourage/incorporate additional community at large support. Most importantly, one of the key goals for the Glendale Healthier Community Coalition in 2012 is reducing re-admission rates.

C. Telling the Story

Glendale Memorial Hospital and Health Center has internal and external reporting mechanisms to help share the Community Benefit Report and Plan. Internally, the plan is presented to the Hospital Community Board for approval. The Board's make up allows for the information to be dispersed quickly because many of the Board's members are affiliated with other organizations within the community. Once the Board approves the plan, the plan is shared with key leadership staff and employees who are interested in knowing how GMHHC has benefited the community.

Externally, the plan is presented to groups with which the hospital has a partnership. For example, the information is shared with the members of the Glendale Healthier Community Coalition, since the members of this group have a vested interest in knowing which health issues others in the community are addressing. The plan is shared with this group and others whose goals and values are aligned with Glendale Memorial Hospital and Health Center, which is to improve the health and quality of life of the people we serve.

This annual report and plan will also be posted to the Glendale Memorial Hospital Website in the "Who We Are" -- Serving the Community section.

Appendix Attachment A

Glendale Memorial Hospital & Health Center 2011 Board of Directors Roster

Mr. Sheldon Baker	Patrick Liddell
John Cabrera, MD	Mark A. Meyers*
Rev. Berdj Djambazian	Rob Mikitarian
Ms. Anita Gabrielian	Harold Scoggins
Robert Gall, MD*	Susan Shieff
Edward Keh	Kalust Ucar, MD
Jacob Lee	Petar Vukasin, MD
Louise Lewis	Douglas Webber, MD
	Roberto Zarate

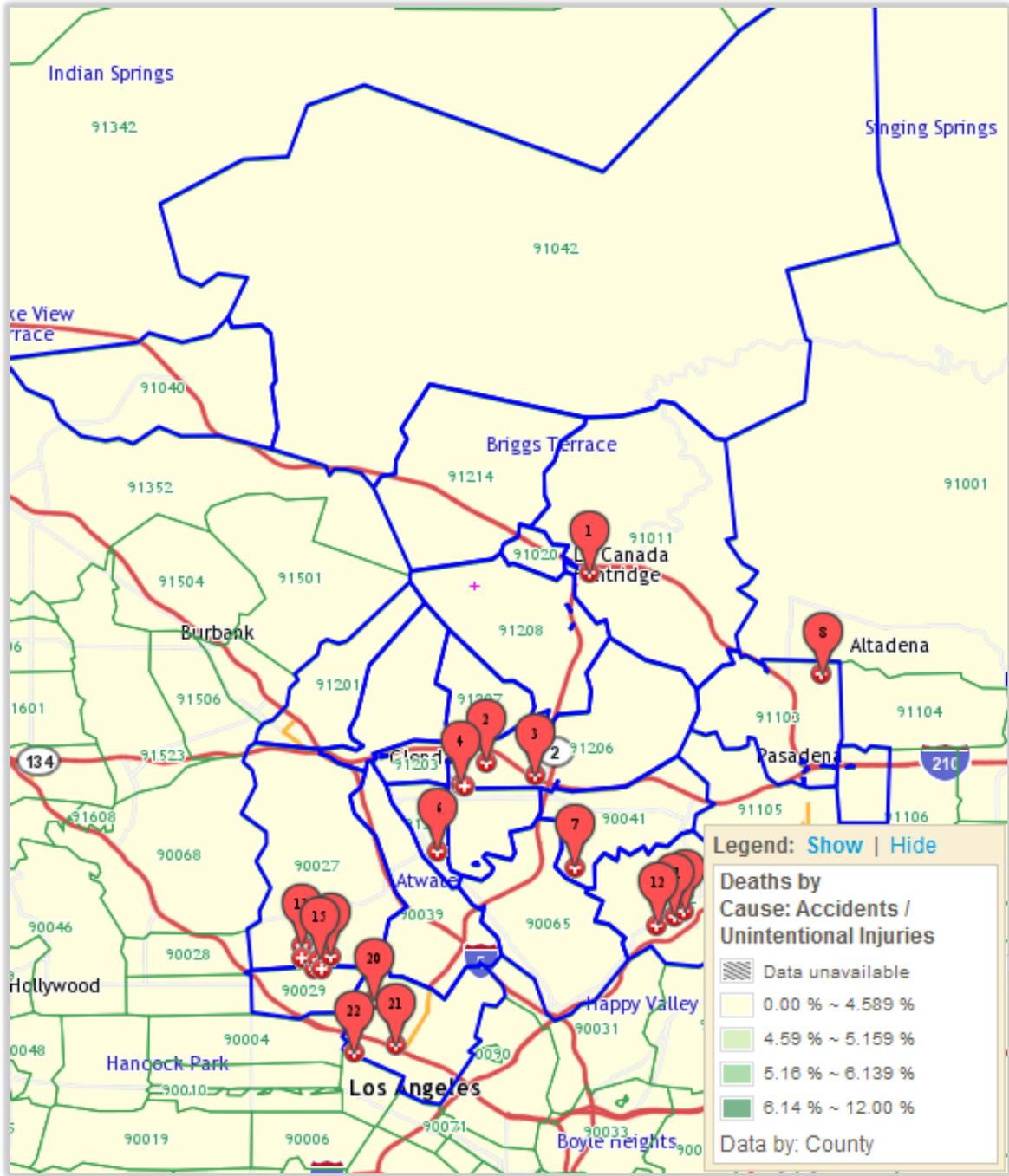
*Ex-officio

Appendix

Attachment B

Healthcare Map

- 1) VERDUGO HILLS HOSPITAL
- 2) L A COUNTY DEPARTMENT OF PUBLIC HEALTH GLENDALE HEALTH CENTER
- 3) GLENDALE ADVENTIST MEDICAL CENTER
- 4) GLENDALE COMMUNITY FREE HEALTH CLINIC
- 5) ALL FOR HEALTH, HEALTH FOR ALL
- 6) COMMUNITY HEALTH ALLIANCE OF PASADENA
- 7) CITY OF PASADENA PUBLIC HEALTH DEPARTMENT
- 8) GLENDALE MEMORIAL HOSPITAL AND HEALTH CENTER
- 9) QUEENSCARE FAMILY CLINICS - EAGLE ROCK
- 10) ARROYO VISTA FAMILY HEALTH CENTER
- 11) NORTHEAST COMMUNITY CLINIC WOMEN'S HEALTH CENTER
- 12) NORTHEAST COMMUNITY CLINIC
- 13) ASIAN PACIFIC HEALTH CARE VENTURE, INC.
- 14) MISSION CITY COMMUNITY NETWORK - HOLLYWOOD
- 15) CHILDREN'S HOSPITAL LOS ANGELES
- 16) KAISER PERMANENTE - LOS ANGELES MEDICAL CENTER
- 17) QUEENSCARE FAMILY CLINICS - HOLLYWOOD
- 18) HOLLYWOOD PRESBYTERIAN MEDICAL CENTER
- 19) QUEENSCARE FAMILY CLINICS
- 20) HOLLYWOOD SUNSET FREE CLINIC
- 21) DREAM CENTER
- 22) QUEENSCARE FAMILY CLINICS - ECHO PARK



Appendix Attachment C

CHW Patient Financial Assistance Policy

CATHOLIC HEALTHCARE WEST SUMMARY OF PATIENT FINANCIAL ASSISTANCE POLICY (June 2008)

Policy Overview:

Catholic Healthcare West (CHW) is committed to providing financial assistance to persons who have health care needs and are uninsured or under-insured, ineligible for a government program, and otherwise unable to pay for medically necessary care based on their individual financial situations. Consistent with its mission to deliver compassionate, high quality, affordable health care services, and to advocate for those who are poor and disenfranchised, CHW strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Financial assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with CHW's procedures for obtaining financial assistance, and to contribute to the cost of their care based on individual ability to pay. Individuals with financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services.

Eligibility for Patient Financial Assistance:

- Eligibility for financial assistance will be considered for those individuals who are uninsured, ineligible for any government health care benefit program, and unable to pay for their care, based upon a determination of financial need in accordance with the policy.
- The granting of financial assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, or immigration status, sexual orientation or religious affiliation.

Determination of Financial Need:

- Financial need will be determined through an individual assessment that may include:
 - a) an application process in which the patient or the patient's guarantor is required to cooperate and supply all documentation necessary to make the determination of financial need;
 - b) the use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay;
 - c) a reasonable effort by the CHW facility to explore and assist patients in applying for appropriate alternative sources of payment and coverage from public and private payment programs; and will take into account the patient's assets and other financial resources.
- It is preferred but not required that a request for financial assistance and a determination of financial need occur prior to rendering of services. The need for financial assistance may be re-evaluated at each subsequent rendering of services, or at any time additional information relevant to the eligibility of the patient for financial assistance becomes known.

- CHW's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of financial assistance. Requests for financial assistance shall be processed promptly, and the CHW facility shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

Patient Financial Assistance Guidelines:

Services eligible under the policy will be made available to the patient on a sliding fee scale, in accordance with financial need as determined by the Federal Poverty Level (FPL) in effect at the time of the determination as follows:

- Patients whose income is at or below 200% of the FPL are eligible to receive free care;
- Patients whose income is above 200% but not more than 350% of the FPL are eligible to receive services at the average rates of payment the CHW facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater in amount for the same services;
- Patients whose income is above 350% but not more than 500% of the FPL are eligible to receive services at 135% of the average rates the CHW facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater for the same services;
 - Patients whose income exceeds 500% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of the CHW facility.

CHW's administrative policy for Eligibility and Application for Payment Assistance shall define what qualifies as *income* for these purposes.

Communication of the Financial Assistance Program to Patients and the Public:

- Information about patient financial assistance available from CHW, including a contact number, shall be disseminated by the CHW facility by various means, including the publication of notices in patient bills and by posting notices in the Emergency and Admitting Departments, and at other public places as the CHW facility may elect. Such information shall be provided in the primary languages spoken by the populations served by the CHW facility.
- Any member of the CHW facility staff or medical staff may make referral of patients for financial assistance. The patient or a family member, a close friend or associate of the patient may also make a request for financial assistance.

Budgeting and Reporting:

- Specific dollar amounts and annual plans for patient financial assistance will be included within the Social Accountability Budget of the CHW facility. CHW facilities will report patient financial assistance calculated at cost in the annual Social Accountability Report and may voluntarily report such information as deemed appropriate.
- Patient financial assistance statistics shall be disclosed in annual financial statements but shall not include amounts that are properly considered to be bad debt or contractual discounts.

Relationship to Collection Policies:

- CHW system management has developed policies and procedures for internal and external collection practices by CHW facilities that take into account the extent to which the patient qualifies for financial assistance, a patient's good faith effort to apply for a governmental program or for financial assistance from CHW, and a patient's good faith effort to comply with his or her payment agreements with the CHW facility.
- For patients who qualify for financial assistance and who are cooperating in good faith to resolve their hospital bills, CHW facilities may offer interest-free extended payment plans to eligible patients, will not impose wage garnishments or liens on primary residences and will not send unpaid bills to outside collection agencies.

Regulatory Requirements:

In implementing this policy, CHW management and CHW facilities shall comply with all federal, state and local laws, rules and regulations that may apply to activities conducted pursuant to this policy.