



## Glendale Memorial Hospital and Health Center

Community Benefit Report 2013  
Community Benefit Implementation Plan 2014



A message from Jack Ivie, President, and Patrick Liddell, Board Chair, Glendale Memorial Hospital and Health Center:

When we talk about health care today, the words *budget*, *cut*, and *restraint* get used a lot. It is impersonal and it is a way to look at health care by the numbers rather than by the patient. One word that has somehow lost its meaning is also the word we believe in most of all – the word *care*. At Glendale Memorial Hospital and Health Center we strive to reintroduce humankindness to an industry focused on finance.

The Affordable Care Act created the National Prevention Council and called for the development of a National Prevention Strategy to realize the benefits of prevention for the health of all Americans. The overarching goals of the plan are to empower people, ensure healthy and safe community environments, promote clinical and community preventive services, and eliminate health disparities.

The Dignity Health system goals reflect those of health reform, namely expanding access, redesigning the delivery system, and utilizing limited resources in better, more coordinated ways so that quality can be continuously improved and patients and communities are healthier. These goals will be achieved through thoughtful *care*, whether it is demonstrated in the hospital or through the programs and services we offer in the community.

At Glendale Memorial Hospital and Health Center we share a commitment to optimize the health of our community. In Fiscal Year 2013 Glendale Memorial Hospital and Health Center provided \$70,039,145 in financial assistance, community benefit and unreimbursed patient care. Because we care, how we contribute to the quality of life and the environment in our communities has always been and will continue to be a key measure of our success.

In accordance with policy, the Glendale Memorial Hospital and Health Center Community Board has reviewed and approved the annual Community Benefit Report and Implementation Plan at their November 12, 2013 meeting.



Jack Ivie  
President



Dr. John Cabrera  
Community Board Chair

# TABLE OF CONTENTS

<b>Executive Summary</b>	4
<b>Mission Statement</b>	
Dignity Health Mission Statement	7
<b>Organizational Commitment</b>	
Organizational Commitment	8
Non-Quantifiable Benefit	9
<b>Community</b>	
Definition of Community	11
Description of the Community	11
Community Demographics	11
<b>Community Benefit Planning Process</b>	
Community Health Needs Assessment Process	13
Assets Assessment Process	17
Developing the Hospital's Implementation Plan (Community Benefit Report and Plan)	17
Planning for the Uninsured/Underinsured Patient Population	19
<b>Plan Report and Update including Measurable Objectives and Timeframes</b>	
Summary of Key Programs and Initiatives – FY 2013	20
Description of Key Programs and Initiatives (Program Digests)	23
<b>Community Benefit and Economic Value</b>	
Report – Classified Summary of Un-sponsored Community Benefit Expense	28
Telling the Story	29
<b>Appendices</b>	
Appendix A: Roster of Hospital Community Board Members	30
Appendix B: Community Need Index	31
Appendix C: Dignity Health Patient Payment Assistance Policy	33
Appendix D: CHNA Stakeholders	36

## **EXECUTIVE SUMMARY**

Founded in 1926, Glendale Memorial Hospital and Health Center (GMHHC) is located at 1420 S. Central Ave., Glendale, CA. It became a member of Dignity Health, formerly Catholic Healthcare West, in 1998. The facility is an acute care hospital with 334 licensed beds. Geographically, the hospital serves the city of Glendale including the surrounding communities of La Crescenta, La Canada/Flintridge, portions of Burbank and northern sections of the greater Los Angeles metropolitan area. Patient admissions totaled 11,852 during FY 2013. GMHHC has a staff of more than 1,100 employees and professional relationships with more than 540 physicians. In addition, we have a large team of active volunteers. On any given month, 200 volunteers provide services and support for our hospital, patients, and families. During FY 2013, GMHHC celebrated its eighty-seventh year of providing quality healthcare to Glendale and the surrounding areas.

Glendale Memorial Hospital and Health Center Service Lines include:

### ***Heart Center***

- Non-invasive Diagnostic Services
- Invasive Interventional Procedures
- Surgical Services
- Vascular Services
- Chest Pain Center
- Cardiac Research Studies
- Cardiac Fitness Center
- Chronic Disease Management Program

### ***Colorectal Surgery Institute***

- Screening Services
- Surgical Procedures
- Research and Clinical Trials

### ***Orthopedic and Spine Services***

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

### ***Cancer Center Services***

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

### ***Women's Health Services***

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

### ***Minimally Invasive Surgical Services***

### ***Emergency Services***

## **Stroke Program**

### **Center for Wound Healing and Hyperbaric Medicine**

Glendale Memorial is continually ranked by HealthGrades® among the best in the entire country in:

#### Appendectomy

- Five-Star Recipient for Appendectomy for 2 years in a row (2012-2013)

#### Cardiac

- Five-Star Recipient for Treatment of Heart Attack for 3 years in a row (2011-2013)
- Five-Star Recipient for Treatment of Heart Failure for 11 years in a row (2003-2013)
- Recipient of the HealthGrades Cardiac Care Excellence Award™ in 2012
- Ranked among the top 10% in the Nation for Overall Cardiac Services in 2012
- Ranked #6 in CA for Overall Cardiac Services in 2012
- Ranked #9 in CA for Cardiology Services in 2012
- Ranked among the top 10 in CA for Overall Cardiac Services for 2 years in a row (2011-2012) (Ranked 6 in 2012)
- Ranked among the top 10 in CA for Cardiology Services in 2012 (Ranked 9 in 2012)
- Five-Star Recipient for Cardiology Services in 2012
- Five-Star Recipient for Coronary Bypass Surgery for 3 years in a row (2010-2012)
- Five-Star Recipient for Treatment of Heart Attack for 2 years in a row (2011-2012)
- Five-Star Recipient for Treatment of Heart Failure for 10 years in a row (2003-2012)

#### Maternity Care

- Recipient of the HealthGrades Maternity Care Excellence Award™ in 2013
- Recognized by HealthGrades for Superior Performance in Maternity Care in 2013
- Among the top 5% of Hospitals Evaluated for Maternity Care in 2013
- Five-Star Recipient for Maternity Care for 2 years in a row (2012-2013)

#### Neurosciences

- Recipient of the HealthGrades Stroke Care Excellence Award™ for 8 years in a row (2005-2012)
- Ranked among the top 10% in the nation for Treatment of Stroke for 10 years in a Row (2003-2012)
- Five-Star Recipient for Treatment of Stroke for 10 years in a row (2003-2012)

#### Orthopedic

- Five-Star Recipient for Hip Fracture Treatment (2013)

#### Patient Safety

- Recipient of the HealthGrades Patient Safety Excellence Award™ in 2012

#### Pulmonary

- Five-Star Recipient for Treatment of Chronic Obstructive Pulmonary Disease for 7 years in a row (2006-2012)
- Five-Star Recipient for Treatment of Pneumonia for 7 years in a row (2006-2012)

#### Women's Health

- Recipient of the HealthGrades Women's Health Excellence Award™ for 2 years in a row (2010/2011-2011)
- Ranked among the top 5% in the nation for Women's Health for 2 years in a row (2010/2011 – 2011)
- Five-Star Recipient for Women's Health for 2 years in a row (2010/2011 – 2011)

In response to some identified unmet health-related needs in our hospital's most recent Community Health Needs Assessment (2013), during FY 2013 GMHHC provided programs and services for the broader community and also for the underserved disadvantaged members of the surrounding community. Community benefit activities for FY 2013 focused on education and support, as well as health services. GMHHC also

engaged in coalition building through enhanced partnership with the Glendale Healthier Community Coalition.

Our **50+ Senior Services** program continues to provide seniors 50 years old and over with opportunities for socialization, fitness support groups, and health promoting education.

Our **Breast Center** continues to provide education and support for women and their partners through monthly Breast Cancer Support groups and educational booths at events such as Komen Race for the Cure.

Our **Breastfeeding Resource Center** continues to provide a wide range of robust services for our community. Breastfeeding classes, support groups, and telephone line continue to be a valuable resource for new mothers.

GMHHC continues to support **Glendale Healthy Kids**, a local free community clinic which provides health and dental services for underinsured and uninsured children. GMHHC provides laboratory, radiology, pharmacy and other services.

To address two of the chronic care needs of the community and to promote chronic disease self-management, GMHHC has chosen the Congestive Heart Failure Management Program and Diabetes Management Program to monitor in fulfillment of Dignity Health's system Community Benefit Metric Goal. The goal of these programs is to improve quality of life for participants by increasing their self-efficacy and avoiding admissions.

In FY 2013, the unsponsored expense for community benefit excluding the unpaid cost of Medicare was \$47,061,426. The total unsponsored community benefit expense, including the unpaid cost of Medicare, was \$70,039,145.

# MISSION STATEMENT

## Dignity Health Mission

We 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 sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community to improve the quality of life.

## Our Vision

A vibrant, national healthcare system known for service, chosen for clinical excellence, standing in partnership with patients, employees and physicians to improve the health of all communities served.

## Our Values

Dignity Health is committed to providing high-quality, affordable health care to the communities we serve. Above all else we value:

- **Dignity** - Respecting the inherent value and worth of each person.
- **Collaboration** - Working together with people who support common values and vision to achieve shared goals.
- **Justice** - Advocating for social change and acting in ways that promote respect for all persons and demonstrate compassion for our sisters and brothers who are powerless.
- **Stewardship** - Cultivating the resources entrusted to us to promote healing and wholeness.
- **Excellence** - Exceeding expectations through teamwork and innovation.

As a member of Dignity Health, GMHHC is committed to furthering the mission, values, and vision of Dignity Health. Our local hospital mission also supports the mission, values, and vision of Dignity Health:

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

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

## ORGANIZATIONAL COMMITMENT

Our hospital leadership is comprised of our Hospital President/CEO, Executive Management Team, and our Community Board. Our Community Board, comprised of up to 15 members, 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, and hospital staff. This Board reviews and approves the annual Community Benefit Report and Plan. See Appendix A for a roster of FY13 Hospital Community Board of Directors.

The Community Board provides a community perspective and support for the Hospital President, Executive Management Team, and the Dignity Health system to achieve the mission and values of GMHHC and Dignity Health. The Hospital President and Executive Management Team are invited to participate in focus groups for the triennial Community Health Needs Assessment, and have an opportunity to provide feedback and input into the final document produced. In addition, the Community Board reviews and approves our Community Needs Health Assessment at regularly scheduled board meetings, as needed.

By assessing community health needs and unmet health-related needs, the needs of the GMHHC Medical Staff and national trends in healthcare delivery, the Community Board assists the Hospital President and Executive Management Team 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 Dignity Health and incorporates system wide performance measures identified by the Dignity Health Board for community benefit programs.

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.

GMHHC participates in the Dignity Health Community Grants Program which supports the continuum of care in the community offered by other not-for-profit organizations. Our Community Grants Selection Committee is comprised of members of the Mission Council plus other hospital employees who are connected to and/or knowledgeable about local community organizations. After submitting grant proposals, local organizations are chosen to receive a grant based upon how closely their programs and initiatives respond to the strategic priorities identified in our most recent Community Health Needs Assessment. The Community Board fully supports the Dignity Health Community Grants Program. For FY 2013, over \$100,000 was allocated to support the following organizations who are addressing unmet health-related needs of the community:

1. Armenian Relief Society
2. Ascencia
3. City of Glendale Commission on the Status of Women—Camp Rosie
4. Corporation for Supportive Housing
5. Glendale Association for the Retarded

6. Glendale Community Free Health Clinic
7. Glendale Healthy Kids
8. Salvation Army
9. YWCA of Glendale

### ***Non-Quantifiable Benefits***

In addition to supporting local organizations through grant monies, GMHHC has also provided leadership and support to a key organization which supports a healthier Glendale community. Glendale Healthier Community Coalition (GHCC), comprised of key community leaders representing local community agencies and Glendale's hospitals, was initiated by Glendale's three hospitals and has now successfully worked on many high-profile community-wide projects for 20 years (since 1994). These include: Glendale Healthy Kids; the city's Quality of Life Indicators; and healthcare projects serving the homeless, as well as collaborating every three years on a comprehensive Community Health Needs Assessment.

In August 2011, GHCC selected "community care transitions" as its primary focus of concern. GHCC has since developed three coalition initiatives to reduce readmissions, including: (1) managing relations with skilled nursing facilities and home health agencies, including implementation of a newly developed patient transfer form for use between these organizations; (2) an initiative to address the risk of readmission among homeless patients; and, (3) a broader integration of community agencies that have relevant supportive health resources, e.g., exercise and fitness programs, nutrition programs, and case management services, including mental health support.

GMHHC has been an active member of the Coalition since inception. Additionally, GMHHC has taken the leadership role managing the efforts of two working groups' key to success in our re-hospitalization reduction efforts: skilled nursing facilities (SNF) and home health agencies (HH). Each group began meeting quarterly since December 2011 with the agenda planned and program led by GMHHC staff. In 2012, the groups chose to meet together and continue to meet quarterly.

In September 2012, GMHHC submitted an application to CMS for demonstration project funding to support care transition efforts in the three hospitals in Glendale: Glendale Adventist Medical Center, Verdugo Hills Hospital, and GMHHC. The project was approved and began to enroll patients at high risk for re-hospitalization for transition services provided by Partners in Care Foundation (PICF). PICF provides a "health coach" to facilitate transition into the home setting. As the project applicant, GMHHC provides the continuing oversight and administrative support to the program.

Finally, many of our Executive Management Team and hospital Directors have affiliations with community organizations to further strengthen our connection to our community as well as provide on-going leadership, support, and input into these organizations that support the overall health of the community:

**Chief Operating Officer: Rotary Club International**

Vice President, Business Development: Glendale Chamber of Commerce

Vice President, Foundation: Glendale Kiwanis International; Southern California Association of Healthcare Development Officers

Vice President, Human Resources: Holy Family Girls Academy; Pasadena/Foothill YWCA

Director, Mission Integration: Glendale Religious Leaders Association; Glendale Healthier Community Coalition

Director, Food & Nutrition Services: Glendale Healthy Kids

Manager, Community Outreach: Glendale Healthy Kids; Glendale Kiwanis International; Glendale Latino Association; Glendale YMCA; Glendale YWCA

Manager, Volunteer Services: Cerritos School Foundation

Senior Pharmacist: Glendale Community Free Health Clinic

Disaster Coordinator: Glendale American Red Cross, Glendale Veterans Coalition, Wellness Works, and Glendale YWCA

# COMMUNITY

## *Definition of Community*

Dignity Health hospitals define the community they serve as the geographic area served by the hospital, considered its primary service area. This is based on a percentage of hospital discharges and is also used in various other departments of the system and local hospital for strategy and planning. Therefore, the GMHHC service area is a geographic one defined by the following 30 ZIP Codes:

- Burbank (91501, 91502, 91504)
- Glendale (91201, 91202, 91203, 91204, 91205, 91206, 91207, 91208)
- La Crescenta (91214)
- Los Angeles (90004, 90026, 90027, 90028, 90029, 90031, 90032, 90038, 90039, 90041, 90042, 90065)
- North Hollywood (91605, 91606)
- Panorama City (91402)
- Sunland (91040)
- Sun Valley (91352)
- Tujunga (91042)

## *Description of the Community*

Our community includes a diverse ethnic and socioeconomic population. Of note, Glendale has a large population of Armenians and Hispanic/Latinos. The average age of a patient admitted to our hospital is 76 years. The 2013 population of the GMHHC Community Health Needs Assessment service area is estimated at 552,535 persons and is considered a federally designated medically underserved area. In addition, in 2011, nearly half (44.4%) of the population in the cities of Glendale and Montrose were born outside of the United States, a higher proportion when compared to the population in Los Angeles County (35.6%).

## *Community Demographics*

- Population
  - Total population for primary service area—1,436,704
  - Total population for CHNA geographic area—552,535
- Diversity
  - Caucasian: 28.7%
  - Hispanic: 50.9%
  - Asian/Pacific Islanders: 13.0%
  - African American: 5.3%
  - American Indian/Alaskan Native: 0.2%
  - Two or more races: 1.7%
  - Other: 0.2%

- Average Income: \$63,363
- Uninsured: 23.3%
- No High School Diploma: 28.8%
- Renters: 61.7%
- CNI Score: 4.8
- Medicaid Patients: 26.9%
- Other hospitals serving the area: Glendale Adventist Medical Center and Verdugo Hills Hospital

Our current Community Need Index map (CNI map) is attached as Appendix B. This map highlights the highest and lowest need, based on the socioeconomic barriers of the areas surrounding GMHHC by ZIP code and population. The socioeconomic barriers include: income, insurance, education, housing and culture/language. The need ranking score is lowest at 1 and the greatest need is at 5. Our current score is 4.8.

# COMMUNITY BENEFIT PLANNING PROCESS

## *Community Health Needs Assessment Process*

Our Community Health Needs Assessment is conducted triennially. For purposes of our Community Health Needs Assessment, we narrowed our primary service area to a smaller geographic region defined by the following 17 ZIP codes (this region represents the area where most of our patients come from):

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

For the 2013 Community Health Needs Assessment, the three Glendale hospitals—Glendale Memorial Hospital and Health Center, Glendale Adventist Medical Center, and Verdugo Hills Hospital—collaborated, as they have in the past, to work with the Center for Nonprofit Management consulting team in conducting the CHNA. During the initial phase of the CHNA process, community input was collected during a focus group with key stakeholders, including health care professionals, government officials, social service providers, community residents, leaders, and other relevant individuals. Appendix D lists the stakeholders involved. Concurrently, secondary data were collected and compared to relevant benchmarks including Healthy People 2020, Los Angeles County or California when possible. The data were also collected at smaller geographies, when possible, to allow for more in-depth analysis and identification of community health issues. In addition, previous CHNAs were reviewed to identify trends and ensure that previously identified needs were not overlooked. Primary and secondary data were compiled into a scorecard presenting health needs and health drivers with highlighted comparisons to the available data benchmarks. The scorecard was designed to allow for a comprehensive analysis across all data sources and for use during the second, prioritization phase of the CHNA process.

## **Results of the Needs Assessment**

Though the finalization of the CHNA is scheduled for September 2013, the preliminary results of the assessment were utilized for purposes planning programs and services for FY 2014. The following list of nine prioritized health needs and nine drivers of health resulted from the above-described process:

## **1. Obesity/overweight**

Obesity is on the rise, reaching epidemic levels in the United States with 68% of adults age 20 years and older being overweight or obese. Obesity reduces life expectancy and causes devastating and costly health problems, increasing the risk of coronary heart disease, stroke, high blood pressure, diabetes, and a number of other chronic diseases. Obesity is associated with factors including poverty, inadequate consumption of fruits and vegetables, breastfeeding, and lack of access to grocery stores, parks, and open space. In 2011, a third (34.8%) of the population in the GMHHC service area was overweight and another 20.6% were obese. In addition, a third (34.6%) of teens was overweight or obese. Stakeholders added that overweight and obesity is on the rise and impacts low-income and underserved children and adults in the northern sections of Glendale.

## **2. Mental health**

Mental illness is a common cause of disability and untreated disorders may leave individuals at-risk for substance abuse, self-destructive behavior, and suicide. Additionally, mental health disorders can have a serious impact on physical health and are associated with the prevalence, progression and outcome of chronic diseases. In 2011, adults in the GMHHC service area reported experiencing 3.5 unhealthy days per month due to poor mental health, slight higher when compared to Los Angeles County (3.3 days). Seven percent (7.3%) of adults reported being diagnosed with anxiety, a high percentage when compared to Los Angeles County (6.4%). Another 13.7% of adults in the GMHHC service area reported being diagnosed with depression, higher than for Los Angeles County (12.2%). Also, 600.8 per 100,000 adults were hospitalized for mental health-related issues, much higher when compared to Los Angeles County (551.7). Stakeholders in Glendale mentioned that poor mental health is on the rise particularly among youth and immigrant populations. They also added that poor mental health is closely linked to job-related stress and neighborhood safety.

## **3. Diabetes**

Diabetes affects an estimated 23.6 million people and is the seventh leading cause of death in the United States. Diabetes lowers life expectancy by up to 15 years, increases the risk of heart disease by two to four times, and is the leading cause of kidney failure, lower-limb amputations, and adult-onset blindness. A diabetes diagnosis can indicate an unhealthy lifestyle—a risk factor for further health issues—and is also linked to obesity. In 2011, 8.3% of the population in the GMHHC service area were diagnosed with diabetes of which over half (59.6%) were receiving disease management services, which is lower when compared to Los Angeles County (68.7%). In 2010, 135.6 per 100,000 adults were hospitalized due to diabetes, slight higher when compared to Los Angeles County (131.3). In addition, 12.9 per 100,000 persons were hospitalized due to uncontrolled diabetes, higher when compared to Los Angeles County (9.5). Stakeholders added that diabetes is prevalent in the Glendale community but particularly among the homeless and ethnic populations. They also acknowledged the link between diabetes, unhealthy eating habits and lack of exercise.

## **4. Alcohol and substance abuse**

Alcohol and substance abuse have a major impact on individuals, families, and communities. The effects of alcohol and substance abuse contribute significantly to costly

social, physical, mental, and public health problems, including teenage pregnancy, HIV/AIDS, STDs, domestic violence, child abuse, motor vehicle accidents (unintentional injuries), physical fights, crime, homicide, and suicide. Heavy alcohol consumption is an important determinant of future health needs, including cirrhosis, cancers, and untreated mental and behavioral health needs. In 2011, over half (52.7%) of the GMHHC service reported consuming an alcoholic beverage, higher when compared to Los Angeles County, 51.9%). Another 17.1% reported binge drinking (higher when compared to Los Angeles County, 15.4%), 4.2% reported heavy drinking (higher when compared to Los Angeles County, 3.5%), and another 17.1% sought treatment for alcohol and/or drug abuse (higher when compared to Los Angeles County, 14.1%). Stakeholders in Glendale added that alcohol and drug use is on the rise among youth, often resulting reckless driving. Concerning tobacco use, 14.4% of GMHHC service area residents reported smoking, which is higher than the percentage for Los Angeles County (13.1%). Stakeholders added that although smoking is becoming less prevalent, this is still an issue among the Armenian population.

## **5. Cardiovascular disease**

Cardiovascular disease or coronary heart disease includes several health conditions related to plaque buildup in the walls of the arteries, or atherosclerosis often leading to heart attacks. Currently, more than one in three adults (81.1 million) in the United States lives with one or more types of cardiovascular disease. In addition to being one of the leading causes of death in the United States, heart disease results in serious illness and disability, decreased quality of life, and hundreds of billions of dollars in economic loss every year. Cardiovascular disease is closely linked to a number of chronic health conditions such as high cholesterol, diabetes, high blood pressure, HIV, heavy alcohol consumption, metabolic syndrome, obesity, stroke and others. In 2011, 5.7% of the GMHHC service area was diagnosed with heart disease, slight higher when compared to Los Angeles County (5.6%). In addition, 473.2 out of every 100,000 persons in the GMHHC service area were hospitalized due to heart disease which is much higher when compared to Los Angeles County (361.7). In addition, 18.9 out of every 10,000 persons in the GMHHC service area died of heart disease, higher when compared to California (15.6). Stakeholders added that heart disease is prevalent among community members, particularly the adult homeless population.

## **6. Hypertension**

Hypertension affects one in three adults in the United States. High blood pressure, if untreated, can lead to heart failure, blood vessel aneurysms, kidney failure, heart attack, stroke, and vision changes or blindness. High blood pressure is associated with smoking, obesity, the regular consumption of salt and fat, excessive drinking, and physical inactivity. According to stakeholders, hypertension is a top health concern among the Glendale community and stakeholders understand that the condition is closely linked to other chronic diseases including diabetes and cardiovascular disease.

## **7. Cholesterol**

Cholesterol is one of the leading causes of death in the United States. About one of every six adults in the United States has high blood cholesterol. In addition, 2,200 Americans die of heart disease each day, an average of one death every 39 seconds. Some health

conditions, as well as lifestyle and genetic factors, can put people at a higher risk for developing high cholesterol including age, being diabetic, having a diet high in saturated fats, trans fatty acids (trans fats), dietary cholesterol, or triglycerides, being overweight, not being physical active; the condition can also be hereditary. In 2011, a quarter (26.3%) of the GMHHC service area was diagnosed with high cholesterol which is slightly higher when compared to Los Angeles County (25.6%).

## **8. Disability**

An umbrella term for impairments, activity limitations, and participation restrictions, disability is the interaction between individuals with a health condition (e.g., cerebral palsy, Down syndrome, and depression) and personal and environmental factors (e.g., negative attitudes, inaccessible transportation and public buildings, and limited social supports). Over a billion people—corresponding to about 15% of the world population—are estimated to live with some form of disability. Between 110 million (2.2%) and 190 million (3.8%) people 15 years and older have significant difficulties functioning. In California alone, 5.7 million adults, or 23 percent of the adult population, have a disability. The proportion of the population with disabilities increases with age and among females and African American, Whites, or American Indian/ Alaskan Native populations. People with disabilities are also more likely than others to be poorly educated, unemployed, and living below the poverty level. In 2011, 16.1% of the children between the ages of 0 and 17 in the GMHHC service area had special health care needs, including developmental delays, which is slightly higher when compared to Los Angeles County (15.8%). Stakeholders indicated that there has been an increase in children diagnosed with developmental delays. Also, parents are experiencing difficulty when trying to obtain an Individualized Education Program for their child due to their inability to navigate the health care system.

## **9. Oral health**

Oral health is essential to overall health and is relevant as a health need because engaging in preventative behaviors decreases the likelihood of developing future oral health and related health problems. In addition, oral diseases such as cavities and oral cancer cause pain and disability for many Americans. Behaviors that may lead to poor oral health include tobacco use, excessive alcohol consumption, and poor dietary choices. Barriers that prevent or limit a person's use of preventative intervention and treatments for oral health include limited access to and availability of dental services, lack of awareness of the need, cost, and fear of dental procedures. Social factors associated with poor dental health include lower levels or lack of education, having a disability, and other health conditions such as diabetes. In 2011, over half (55.1%) of the GMHHC service area did not have dental insurance which is higher when compared to Los Angeles County (51.8%). A third (33.7%) of adults could not afford to get dental insurance, higher when compared to Los Angeles County (30.3%). Stakeholders added that poor oral health is prevalent in the Glendale community and attribute this to community members not knowing where to go for educational materials as well as the cost of oral health services.

The CHNA is shared with the City of Glendale, Glendale Healthier Community Coalition, and other local government agencies with the objective of achieving a more coordinated allocation of both public and private health resources in Glendale. The CHNA is located on the hospital's website at [www.GlendaleMemorialHospital.org](http://www.GlendaleMemorialHospital.org) and on the Dignity Health

website at [www.DignityHealth.org](http://www.DignityHealth.org) In addition, it is hoped that the findings of the Community Health Needs Assessment will also stimulate greater collaboration between and among healthcare providers, government agencies, and community organizations.

### ***Assets Assessment***

Asset mapping is a process by which local community assets are identified for potential community partners and as a way to identify gaps in health and other services. The approach taken in 2013 was to review local community assets identified in the 2010 Community Health Needs Assessment and check to see which still existed in the community, which do not exist anymore, and note any name changes. Local community assets were identified and categorized as: Food Basic Needs, Housing, Education, Community Services, Health Care, Income Support and Employment, Mental Health Services, Substance Abuse Services and Nonprofit Headquarters

### ***Developing the Hospital's Implementation Plan (Community Benefit Report and Plan)***

For the 2013 CHNA, a process to prioritize health needs and drivers was introduced for the first time. This process consisted of a facilitated group session that engaged participants from the first phase of collecting community input and new participants in a discussion of secondary and primary data (compiled and presented in the scorecards and accompanying health need narratives) and an online survey. At the session, participants were provided with a brief overview of the CHNA process, a list of identified needs in the scorecard format, and the brief narrative summary descriptions of the identified health needs described above. Then, in smaller groups, participants considered the scorecards and health needs summaries in discussing the data and identifying key issues or considerations that were then shared with the larger group.

As a follow-up to this session, participants and other members of the hospital collaborative's network—including the Glendale Healthier Community Coalition—completed an online questionnaire about health needs, drivers, and resources, and ranked each health need according to several criteria including severity, change over time, resources available to address the need or driver, and community readiness to support action on behalf of any health need or driver. The survey results were used to prioritize the health needs and drivers of health identified in the first session. The list of stakeholders who participated in the follow-up session and online questionnaire are also listed in Appendix D.

Drivers of health, such as those listed below, are linked with and impact the health of community members. For this reason, drivers were also considered during the health need identification and prioritization process. The following list includes drivers identified in prioritized order.

1. Alcohol and substance abuse
2. Healthy eating
3. Health care access

4. Physical activity
5. Health education and awareness
6. Cultural competency
7. Poverty
8. Homelessness
9. Dental care access

In developing the hospital's Community Benefit Plan, the process includes 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 promote effective, sustainable community benefit programming in support of Dignity Health's mission, GMHHC reviews existing community benefit programs and discontinues, if appropriate, or establishes 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. To prioritize the needs, the hospital analyzed the current community projects and identified where a gap existed between information identified in the CHNA and the current hospital programs.

Several of the health issues identified in the CHNA 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 currently existing 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. For example, GMHHC provides financial, administrative, and staff support to the Armenian Bone Marrow Registry, a program addressing specific health needs of this population.

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.

### ***Planning for the Uninsured/Underinsured Patient Population***

As a member of Dignity Health, GMHHC is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, 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, Dignity Health 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 Dignity Health'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 Dignity Health Payment Assistance Policy is included as Appendix C.

Information about the payment assistance that GMHHC offers is posted in prominent locations throughout the hospital and admitting room staff is available to assist patients with bill resolution and applications for government-sponsored health insurance programs. Payment assistance information is also available on the hospital website, [www.GlendaleMemorialHospital.org](http://www.GlendaleMemorialHospital.org).

# PLAN REPORT AND UPDATE INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

Below are the major initiatives and key community based programs operated or substantially supported by GMHHC in FY 2013. Programs were developed in response to the 2010 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.

Primary Prevention: Altering susceptibility or reducing exposure for susceptible individuals

- Health promotion/Disease prevention education offered to raise and change awareness, knowledge, attitudes and skills of the participants.

Secondary Prevention – Early detection and treatment of disease

- Chronic disease management programs to provide self-management education, increase health outcomes, and decrease utilization for chronic diseases.
- Disease treatment at community clinic.

For FY 2014, our 2013 Community Health Needs Assessment indicates a need to focus on nine prioritized health concerns. Some of these identified needs are new and some are ongoing from the 2010 CHNA. Our plan to address these needs includes the following:

## 1. Obesity/overweight

- a. Our hospital's Director of Quality and Director of Mission Integration and Spiritual Care both serve on the Glendale Healthier Community Coalition. GHCC is currently working to develop strategies to address obesity in the community.
- b. Our hospital has provided grant money for FY 2014 to the following organizations who are addressing obesity in the programs/activities we are funding:
  - i. *City of Glendale Commission on the Status of Women—Camp Rosie*: Camp Rosie is a summer day camp for teen girls in the City of Glendale committed to education and training in a holistic approach to

self-development that includes: financial literacy, self-empowerment, fitness and nutrition, self-defense, healthy relationships, and non-traditional careers.

- ii. *Glendale Association for the Retarded*: The Vocational Integration Program (VIP) helps our clients with developmental disabilities learn various tasks, such as basic living skills (nutrition, exercise, street safety, personal hygiene), basic computer skills and vocational training for our clients who already have English language capability. Several of our clients have high blood pressure and/or diabetes, so we strive to teach them about healthful eating, including preparing healthy meals, and better lifestyle choices, including exercise.
- iii. *Glendale Healthy Kids*: In collaboration with Glendale Unified School District (GUSD) middle schools, Glendale Healthy Kids (GUSD) proposes to employ a unique population management strategy that assesses 8<sup>th</sup> grade students for obesity and diabetes (diabetes) risk and then follows the origins of that risk back to their families. Identified families at risk will be 1) invited to participate in obesity, type 2 diabetes, and cardiovascular disease risk assessments and 2) be given referral case management to medical care and risk reduction resources through GHK and our community partners. The proposed project consists of three components: 1) outreach, 2) education, and 3) family diabetes intervention. Successful implementation of the proposed project will serve vulnerable populations that do not routinely have access to screenings and health care.

## 2. Mental health

- a. In response to the growing need for mental health services in our area, our hospital will open a Behavioral Health Unit in September 2013.
- b. Our hospital is also partnering with Corporation for Supportive Housing to identify homeless individuals to engage and place homeless high utilizers in housing connected to integrated primary and behavioral health services.
- c. Our hospital has provided grant money for FY 2014 to the following organizations who are addressing mental health in the programs/activities we are funding:
  - i. *City of Glendale Commission on the Status of Women—Camp Rosie*
  - ii. *Glendale Association for the Retarded*
  - iii. *Ascencia*: The project will assign an outreach staff member to identify and engage homeless people living in public places who frequently use hospital services. Project staff will work directly with first responders and medical providers to identify homeless patients, and will connect those patients to permanent housing and ongoing case management. The project is expected to show improved quality of life and health for 25 program participants, and reduced impact on emergency and medical services.
  - iv. *Corporation for Supportive Housing*: CSH is guiding local collaboratives of hospitals, federally qualified health centers (FQHCs), and housing and social service providers in communities across LA to identify, engage, and place homeless high utilizers in housing

connected to integrated primary and behavioral health services. The key partners in the Glendale collaborative include Ascencia, Glendale Memorial Hospital, and Glendale Adventist Medical Center.

- v. **YWCA:** Domestic Violence Program is a premiere program, uniquely designed to help women and their children begin their lives anew by providing everything from counseling/therapy and legal advocacy to job training and community education to emergency and transitional housing to move victims away from their abusers permanently and end the cycle of violence, which has an overall negative impact on the local community.

### **3. Diabetes**

- a. Our hospital offers an Outpatient Diabetes Program that entails 4 sessions of 2 hour classes over 4 weeks. We also offer a program called Sweet Success for pregnant women with gestational diabetes.
- b. Our hospital serves on the Glendale Healthier Community Coalition. GHCC is currently working to develop strategies to address diabetes in the community.
- c. Our hospital has provided grant money for FY 2014 to the following organizations who are addressing diabetes in the programs/activities we are funding:
  - i. *Glendale Association for the Retarded*
  - ii. *Glendale Healthy Kids*

### **4. Cardiovascular disease**

- a. Our hospital offers a program to provide chronic disease management to patients with congestive heart failure. Our CHF Program provides education and follow-up for persons with CHF to improve overall health and reduce hospital readmissions.
- b. Our hospital has provided grant money for FY 2014 to the Glendale Healthy Kids who is addressing cardiovascular disease in the programs/activities we are funding:

### **5. Hypertension**

- a. Our hospital has provided grant money for FY 2014 to Glendale Association for the Retarded who is addressing hypertension in the programs/activities we are funding.

### **6. Disability**

- a. Our hospital has provided grant money for FY 2014 to the following organizations who are addressing disability in the programs/activities we are funding:
  - i. Ascencia
  - ii. Glendale Association for the Retarded

At this time, our hospital will not be addressing Alcohol and Substance Abuse, Cholesterol, and Oral Health due to limited resources. In November of 2013, our Hospital Community Board will be meeting to discuss strategic planning for our hospital. During this time, the prioritized needs from the 2013 CHNA will be revisited and the plan for the next one to three years may be revised and possibly include the three areas not currently being addressed.

The following pages include Program Digests for a few key programs that address one or more of the Initiatives listed above from FY 2013:

<b>50+ Senior Services</b>	
<b>Hospital CB Priority Areas</b>	<input checked="" type="checkbox"/> Flu Shot Clinics <input checked="" type="checkbox"/> Health Promotion/Disease Prevention <input type="checkbox"/> Chronic Disease Self-Management <input checked="" type="checkbox"/> Disease Treatment
<b>Program Emphasis</b>	<input type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
<b>Link to Community Needs Assessment</b>	Early detection screenings, preventive healthcare, promoting wellness lifestyle programs.
<b>Program Description</b>	<p>The major components of our hospital's senior services are comprised of the 50+ membership program which offers:</p> <ul style="list-style-type: none"> <li>• Education             <ul style="list-style-type: none"> <li>○ 2-3 free health education lectures every ear</li> <li>○ Informational lectures offered at GMHHC and local community venues</li> <li>○ Partnership with Dial Ride to provide transportation to the Senior lectures</li> </ul> </li> <li>• Promotion of social well being through:             <ul style="list-style-type: none"> <li>○ Weekly walkers program for seniors promoting healthy physical activity and social interactions</li> <li>○ Social support to seniors via day travel events</li> <li>○ Holiday Luncheon</li> </ul> </li> <li>• Senior Services also support and participates in community health fairs to promote health information and wellness events.</li> </ul>
<b>FY 2013</b>	
<b>Goal FY 2013</b>	Increase the community awareness and partner with community resources to provide other services.
<b>2013 Objective Measure/Indicator of Success</b>	To increase our membership to our 50Plus program.
<b>Baseline</b>	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. Our service to our senior population has doubled and there is greater need to have programs that will address the needs of the community.
<b>Intervention Strategy for Achieving Goal</b>	Develop an outreach initiative to work more closely with the service area city programs and senior clubs to raise awareness.
<b>Result FY 2013</b>	We have increased the membership of our senior program, resulting in more overall health education and prevention to the seniors in our community.
<b>Hospital's Contribution / Program Expense</b>	Hospital personnel time and food services for events.
<b>FY 2014</b>	
<b>Goal 2014</b>	Increase the community awareness and partner with community resources to provide other services.
<b>2014 Objective Measure/Indicator of Success</b>	To increase our membership to our 50Plus program.
<b>Baseline</b>	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.
<b>Intervention Strategy for Achieving Goal</b>	Develop an outreach initiative to work more closely with the service area city programs and senior clubs to raise awareness.
<b>Community Benefit Category</b>	A1: Community Health Education

<b>Breastfeeding Resource Center</b>	
<b>Hospital CB Priority Areas</b>	<input type="checkbox"/> Flu Shot Clinics <input checked="" type="checkbox"/> Health Promotion/Disease Prevention <input type="checkbox"/> Chronic Disease Self-Management <input type="checkbox"/> Disease Treatment
<b>Program Emphasis</b>	<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
<b>Link to Community Needs Assessment</b>	Preventive healthcare
<b>Program Description</b>	GMHHC's Breastfeeding Resource Center has trained certified lactation educators to assist new mothers with breastfeeding needs and assess the mother /baby dyad to ensure that the baby is breastfeeding effectively. The short-term and long-term benefits of breastfeeding for mother and child are well documented (e.g., for mother—breastfeeding linked to a lower risk of these types of health problems: Type 2 diabetes, breast cancer, cervical cancer, and post-partum depression; for baby—breastfeeding linked to lower risk of Type 1 & 2 Diabetes, childhood leukemia, lower respiratory infections, asthma, and obesity). We encourage the mother to follow up with the Breastfeeding Resource Center after 48-72 hours after hospital discharge to decrease NICU admission for hyperbilirubinemia /jaundice or dehydration. The Breastfeeding Resource Center and follow-up provides: three breastfeeding consultations up to the baby's 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.
<b>FY 2013</b>	
<b>Goal FY 2013</b>	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 some holidays. We encourage mothers to follow up with WIC or private consultations (Breastfeeding consultations are covered under most healthcare plans) within 24 hours – 7 days to assess mother/infant couplet as to the above, and adequacy of breastfeeding... 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. We also would like to add one additional per diem CLE to our staff to sufficiently cover the night shift.
<b>2013 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>Track unintended admissions rates to the NICU for dehydration and hyperbilirubinemia.</li> <li>Track patients satisfaction with overall breastfeeding support and education provided.</li> <li>Track number of mothers attending the Breastfeeding Support Group and monitor their overall satisfaction with the services provided.</li> </ul>
<b>Baseline</b>	We will continue this program and hope to add more coverage for the evening/weekend 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.
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>In-services provided to nursing staff.</li> <li>Communication with pediatrician and OB staff.</li> <li>Education and handouts to patients on the importance of follow-up.</li> <li>Performance Improvement projects addressing the above.</li> <li>Continue active Lactation rounding on all post-partum dyads.</li> <li>Covering more weekend and evening Lactation shifts.</li> </ul>
<b>Result FY 2013</b>	<ul style="list-style-type: none"> <li>Our support group has continued to draw mothers from the Glendale and surrounding areas as well as pediatricians and Doulas</li> <li>We are getting more referrals for consultations for in-patients and NICU from OB's and Pediatricians.</li> </ul>
<b>Hospital's Contribution / Program Expense</b>	Our hospital provides for the broader community: <ul style="list-style-type: none"> <li>Free weekly support group.</li> <li>Free Breastfeeding Hot line.</li> <li>Free Breastfeeding Classes in English and Spanish</li> </ul>
<b>FY 2014</b>	
<b>Goal 2014</b>	<ul style="list-style-type: none"> <li>Continue to offer free outpatient visits to our patients to ensure that they succeed in their breastfeeding goals.</li> <li>Continue to market our free support group and classes.</li> <li>Nurture a free Spanish-speaking weekly support group.</li> <li>Community awareness that Breastfeeding Consultations and Breast pump purchase assistance is now available through most Health Insurance Plans.</li> <li>Market our free hot line, classes and support group to surrounding clinics in the community.</li> </ul>
<b>2014 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>Track patients satisfaction with overall breastfeeding support and education provided.</li> <li>Track number of mothers attending the Breastfeeding Support Group and monitor their overall satisfaction with the services provided.</li> </ul>
<b>Baseline</b>	Mothers and babies do not have very many options in the community to receive free education or assessment of their breastfeeding. Often when a mother is not breastfeeding well, she does not have the resources to get good clinical assistance. Many low income mothers only have WIC and depend on the staff at WIC; however there are limited staff who have the knowledge or the clinical skills that may be needed to help the mother /baby dyad. If they pay for a Lactation consult, it can

	<p>cost them from \$80 - \$125/ hour. Many mothers do not have the resources to pay for a breastfeeding class that may make the difference in their choice to breastfeed or not. In choosing to breastfeed, it saves them from purchasing formula (average \$2,500 per year), and often the infant is much healthier lowering the cost of healthcare for the infant and preventing the mother from having to take time from her place of employment.</p> <ul style="list-style-type: none"> <li>• Most Mothers are not yet aware that Health Insurance plans now cover Breastfeeding Consultations and assist in purchase / rental of breast pumps.</li> <li>• Healthy People requirements urge the education and support of breastfeeding which is supported by the CDC, UNICEF and JAHCO.</li> </ul>
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Continue education for OBs, Pediatricians, and RNs to encourage them to support breastfeeding and increase referrals.</li> <li>• Education and handouts to patients on the importance of follow-up.</li> <li>• Patient awareness of Health Insurance plans and breastfeeding.</li> <li>• Performance Improvement projects addressing the above.</li> <li>• Continue active Lactation rounding on all post-partum dyads.</li> <li>• Covering more weekend and evening Lactation shifts.</li> </ul>
<b>Community Benefit Category</b>	AC—Subsidized Health Services

<b>CHF Program</b>	
<b>Hospital CB Priority Areas</b>	<input type="checkbox"/> Flu Shot Clinics <input type="checkbox"/> Health Promotion/Disease Prevention <input checked="" type="checkbox"/> Chronic Disease Self-Management <input type="checkbox"/> Disease Treatment
<b>Program Emphasis</b>	<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
<b>Link to Community Needs Assessment</b>	CHF disease management and education
<b>Program Description</b>	The Program provides one to one education to patients and caregivers about congestive heart failure, using teach back method. Making daily rounds on new admissions with congestive heart failure diagnosis and making follow up phone calls within 24-48 hours of discharge to the patients enrolled in the program.
<b>FY 2013</b>	
<b>Goal FY 2013</b>	<ul style="list-style-type: none"> <li>• To decrease 30 day readmission for CHF and all cause</li> <li>• To decrease average length of stay</li> </ul>
<b>2013 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• 30 day CHF readmission</li> <li>• 30 day all cause readmission</li> <li>• Average length of stay</li> </ul>
<b>Baseline</b>	<p>As identified in the most recent Community Health Needs Assessment, with respect to Ambulatory Care Sensitive Conditions for Ages 65 and over, the percentage of our hospital discharges for CHF patients is 21.3 percent, demonstrating our hospital's need to address this health concern. Our baseline metrics are:</p> <ul style="list-style-type: none"> <li>• 30 day CHF readmission = 8.2%</li> <li>• 30 day all cause readmission = 18.1%</li> <li>• LOS = mean 6.1, median 4</li> </ul>
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Daily rounds for screening and enrollment</li> <li>• Patient and caregiver education using teach back method</li> <li>• Follow-up phone calls within 24 – 48 hours of discharge</li> </ul>
<b>Result FY 2013</b>	<ul style="list-style-type: none"> <li>• 30 day CHF readmission = 3.2%, which represents a 61% reduction</li> <li>• 30 day all cause readmission = 7.4%, which represents a 59% reduction</li> </ul>
<b>Hospital's Contribution / Program Expense</b>	Program expense = \$114,038
<b>FY 2014</b>	
<b>Goal 2014</b>	<ul style="list-style-type: none"> <li>• To decrease 30 day readmission for CHF and all cause</li> <li>• To decrease average length of stay</li> <li>• To increase patient's perceived quality of life</li> </ul>
<b>2014 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• 30 day CHF readmission</li> <li>• 30 day all cause readmission</li> <li>• Average length of stay</li> <li>• Assess Quality of life score</li> </ul>
<b>Baseline</b>	As identified in the most recent Community Health Needs Assessment, with respect to Ambulatory Care Sensitive Conditions for Ages 65 and over, the percentage of our hospital discharges for CHF patients is 21.3 percent, demonstrating our hospital's need to address this health concern. Our

	baseline metrics are: <ul style="list-style-type: none"> <li>• 30 day CHF readmission =3.2%</li> <li>• 30 day all cause readmission = 7.41%</li> </ul>
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Daily rounds for screening and enrollment</li> <li>• Patient and caregiver education using teach back method</li> <li>• Follow-up phone calls within 24 – 48 hours of discharge</li> </ul>
<b>Community Benefit Category</b>	A3

<b>Diabetes Program</b>	
<b>Hospital CB Priority Areas</b>	<input type="checkbox"/> Flu Shot Clinics <input type="checkbox"/> Health Promotion/Disease Prevention <input checked="" type="checkbox"/> Chronic Disease Self-Management <input type="checkbox"/> Disease Treatment
<b>Program Emphasis</b>	<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
<b>Link to Community Needs Assessment</b>	Diabetes Management and Education Nutrition Education
<b>Program Description</b>	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 Program offers individual nutrition education and counseling for weight management, carbohydrate counseling, cardiac and any nutritional need as prescribed by a physician.
<b>FY 2013</b>	
<b>Goal FY 2013</b>	<ul style="list-style-type: none"> <li>• To continue to provide self-management education and skills to achieve patient participation necessary for optimum glucose control.</li> <li>• To offer a four part series of classes in English, Spanish and Armenian.</li> <li>• Provides one on one education and consultation and follow-up.</li> <li>• Maintain ADA Recognition.</li> <li>• 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.</li> <li>• Conduct diabetes self-management classes on a monthly basis.</li> </ul>
<b>2013 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• Track participants' achievement of behavioral goals 3 months after completing the program and compare A1C levels pre and post program.</li> <li>• HbA1C levels every 3 months. Goal: achievement after 6 months to reduce by 0.5% or maintain below 7% in 75% of the patients.</li> <li>• BMI or Weight – attain ideal body weight; achieve weight loss of 5% or reduction in BMI over 6 months.</li> <li>• Reduce percentage of patients' readmission to hospital for complications resulting from DM related conditions.</li> </ul>
<b>Baseline</b>	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 Health Needs Assessment.
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Follow-up telephone calls to keep patients in the program for one year.</li> <li>• Continue to support outreach to the community as needed with education lectures, talks and information as requested.</li> <li>• Participating in Health Fairs.</li> <li>• Follow-up on inpatient floors with patients as well as dietitians and nursing staff.</li> <li>• Meet with physician office staff and other outside agencies to promote the program.</li> </ul>
<b>Results FY 2013</b>	<ul style="list-style-type: none"> <li>• Pre-program HbA1c collection. Achieved 92.6%</li> <li>• Further develop usage of electronic database to track interventions, patient monitoring, and outcome metrics. Achieved: Have been successful at using Access for data collection</li> <li>• Achieved: 76.3% of patients were followed up at least once between 3-12 months.</li> <li>• Follow –up with patients at 3 month intervals following completion of program. Achieved: Baseline Wt, BMI metrics obtained for 100% of pts ; ED/hospital visits (none)</li> <li>• Increase patient volume in adult diabetes program by 5%.: Not achieved. 2.5% increase in pt volume for diabetes class pts.</li> </ul>
<b>Hospital's Contribution / Program Expense</b>	<ul style="list-style-type: none"> <li>• The hospital supports this program by providing funding for staff and materials, and use of facility.</li> <li>• \$170,000</li> </ul>
<b>FY 2014</b>	
<b>Goal 2014</b>	<ul style="list-style-type: none"> <li>• Increase volume by 5%</li> <li>• Obtain <math>\geq</math>60% post program HbA1C</li> </ul>

<b>2014 Objective Measure/Indicator of Success</b>	Continue to track HbA1c's, weight, BMI, hospital or ED admits, and goal achievement with a target of 75% success.
<b>Baseline</b>	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 Health Needs Assessment.
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Visit in-patients with Diabetes</li> <li>• Refer to outpatient clinic</li> <li>• Continue with post program discharge calls and follow-up</li> </ul>
<b>Community Benefit Category</b>	A2—Community Based Clinical Services

This implementation strategy specified community health needs that GMHHC has determined to meet in whole or in part and that are consistent with its mission. GMHHC reserves the right to amend this implantation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During the three years ending December 31, 2016, other organizations in the community may decide to address certain needs, indicating that the hospital should then refocus its limited resources to best serve the community.

# COMMUNITY BENEFIT AND ECONOMIC VALUE

## ***Summary of Un-sponsored Community Benefit Expense***

For the period from 7/1/2012 through 6/30/2013 (Please note that Community Benefit expenses are derived using a cost accounting methodology.)

	Persons	Expense	Revenue	Benefit	% of Organization's Expenses Revenues	
<b><u>Benefits for Living in Poverty</u></b>						
Financial Assistance	295	4,538,392	0	4,538,392	2.0	2.2
Unpaid Cost of Medicaid	23,572	82,906,058	43,675,225	39,230,833	16.9	18.9
Community Services						
Community Health Improvement Services	5	9,203	0	9,203	0	0
Financial and In-Kind Contributions	301	978,923	0	978,923	0.4	0.5
<b>Totals for Community Services</b>	<b>306</b>	<b>988,126</b>	<b>0</b>	<b>988,126</b>	<b>0.4</b>	<b>0.5</b>
<b>Totals for Living in Poverty</b>	<b>24,173</b>	<b>88,432,576</b>	<b>43,675,225</b>	<b>44,757,351</b>	<b>19.2</b>	<b>21.6</b>
<b><u>Benefits for Broader Community</u></b>						
Community Services						
Community Benefit Operations	0	72,715	0	72,715	0.0	0.0
Community Building Activities	0	168,472	0	168,472	0.1	0.1
Community Health Improvement Services	3,363	576,915	0	576,915	0.2	0.3
Financial and In-Kind Contributions	0	278,427	0	278,427	0.1	0.1
Health Professions Education	52	265,424	0	265,424	0.1	0.1
Research	0	942,122	0	942,122	0.4	0.5
<b>Totals for Community Services</b>	<b>3,415</b>	<b>2,304,075</b>	<b>0</b>	<b>2,304,075</b>	<b>1.0</b>	<b>1.1</b>
<b>Totals for Broader Community</b>	<b>3,415</b>	<b>2,304,075</b>	<b>0</b>	<b>2,304,075</b>	<b>1.0</b>	<b>1.1</b>
Totals - Community Benefit	27,588	90,736,651	43,675,225	47,061,426	20.2	22.7
Unpaid Cost of Medicare	21,828	79,956,107	56,978,388	22,977,719	9.9	11.1
<b>Totals with Medicare</b>	<b>49,416</b>	<b>170,692,758</b>	<b>100,653,613</b>	<b>70,039,145</b>	<b>30.1</b>	<b>33.8</b>

## ***Telling the Story***

GMHHC has internal and external reporting mechanisms to help share the Community Benefit Report and Implementation 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 widely as 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 GMHHC.

This annual report and plan, as well as the most recent Community Health Needs Assessment, will also be posted to the GMHHC website: "Who We Are—Serving the Community" section, [www.GlendaleMemorialHospital.org](http://www.GlendaleMemorialHospital.org) as well as on the Dignity Health website at [www.DignityHealth.org](http://www.DignityHealth.org).

## APPENDIX A: 2012 GMHHC BOARD OF DIRECTORS

Jean-Pierre Antaki, MD  
Physician  
*Chief of Staff*

John Cabrera, MD  
Physician  
*Board Chair*

Rev. Berdj Djambazian  
Pastor, Holy Trinity Armenian Church

Robert Gall, MD  
Physician  
*Guest*

Jack Ivie  
*GMHHC President*

Jacob Lee  
COO/General Counsel, HYI  
*Secretary*

Patrick Liddell  
Attorney, Melby & Anderson, LLP

Rob Mikitarian  
President, Burbank Home Health Care

Harold Scoggins  
Fire Chief, Glendale Fire Department  
*Vice Chair*

Susan Shieff  
Educator, Glendale Community College

Tyrone Tartt  
Retired Attorney

Kalust Ucar, MD  
Physician

Ignacio Valdes, MD  
Physician

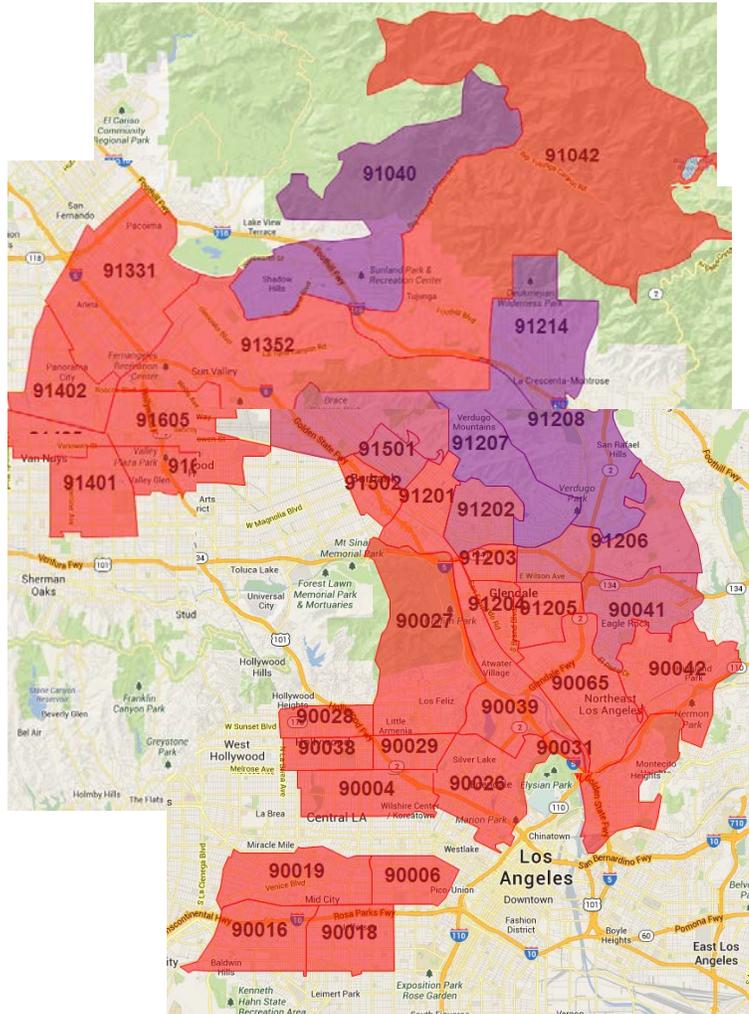
Petar Vukasin, MD  
Physician  
*Guest*

Douglas Webber, MD  
Physician

Susan Whitten  
VP, Business & Operational  
Development, Dignity Health

Roberto Zarate  
Owner, Tinto Restaurant

# APPENDIX B: COMMUNITY NEED INDEX MAP



	Zip Code	CNI Score	Population	City	County	State
	91201	4.4	25,348	Glendale	Los Angeles	California
	91202	3.6	22,683	Glendale	Los Angeles	California
	91203	4.4	15,389	Glendale	Los Angeles	California
	91204	4.8	17,661	Glendale	Los Angeles	California
	91205	4.6	42,953	Glendale	Los Angeles	California
	91206	3.8	33,403	Glendale	Los Angeles	California
	91207	2.8	9,857	Glendale	Los Angeles	California
	91208	2.6	15,661	Glendale	Los Angeles	California
	91214	2.6	31,090	La Crescenta	Los Angeles	California
	90004	5	70,385	Los Angeles	Los Angeles	California
	90006	5	65,883	Los Angeles	Los Angeles	California
	90016	4.8	48,122	Los Angeles	Los Angeles	California

	90018	4.8	50,916	Los Angeles	Los Angeles	California
	90019	4.8	69,091	Los Angeles	Los Angeles	California
	90026	5	74,336	Los Angeles	Los Angeles	California
	90027	4.6	49,895	Los Angeles	Los Angeles	California
	90028	4.8	31,145	Los Angeles	Los Angeles	California
	90029	5	42,486	Los Angeles	Los Angeles	California
	90031	5	39,377	Los Angeles	Los Angeles	California
	90038	5	31,808	Los Angeles	Los Angeles	California
	90039	4.2	29,651	Los Angeles	Los Angeles	California
	90041	3.8	29,062	Los Angeles	Los Angeles	California
	90042	4.8	66,809	Los Angeles	Los Angeles	California
	90065	4.8	48,362	Los Angeles	Los Angeles	California
	91040	3.2	20,818	Sunland	Los Angeles	California
	91042	4.2	27,131	Tujunga	Los Angeles	California
	91331	4.6	100,588	Pacoima	Los Angeles	California
	91352	4.8	47,297	Sun Valley	Los Angeles	California
	91401	4.8	42,605	Van Nuys	Los Angeles	California
	91402	4.8	72,717	Panorama City	Los Angeles	California
	91405	4.8	55,579	Van Nuys	Los Angeles	California
	91501	3.8	20,723	Burbank	Los Angeles	California
	91502	4.4	12,563	Burbank	Los Angeles	California
	91504	3.6	24,856	Burbank	Los Angeles	California
	91605	5	61,676	North Hollywood	Los Angeles	California
	91606	5	49,157	North Hollywood	Los Angeles	California

**CNI MEDIAN SCORE: 4.8**

# APPENDIX C: SUMMARY OF PATIENT PAYMENT ASSISTANCE POLICY

## Policy Overview:

Dignity Health is committed to providing payment 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, Dignity Health strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Payment assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with Dignity Health's procedures for obtaining payment 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 Payment Assistance:

- Eligibility for payment 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 payment 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 Dignity Health 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 payment assistance and a determination of financial need occur prior to rendering of services. The need for payment 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 payment assistance becomes known.
- Dignity Health's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of payment assistance.

Requests for payment assistance shall be processed promptly, and the Dignity Health facility shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

#### Patient Payment 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 termination 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 Dignity Health facility would receive from Medicare, Medicaid (MediCal), 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 Dignity Health facility would receive from Medicare, Medicaid (MediCal), 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 Dignity Health facility.

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

#### Communication of the Payment Assistance Program to Patients and the Public:

- Information about patient payment assistance available from Dignity Health, including a contact number, shall be disseminated by the Dignity Health 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 Dignity Health facility may elect. Such information shall be provided in the primary languages spoken by the populations served by the Dignity Health facility.
- Any member of the Dignity Health facility staff or medical staff may make referral of patients for payment assistance. The patient or a family member, a close friend or associate of the patient may also make a request for payment assistance.

#### Budgeting and Reporting:

- Specific dollar amounts and annual plans for patient payment assistance will be included within the Social Accountability Budget of the Dignity Health facility. Dignity Health facilities will report patient payment assistance calculated at cost in the annual Social Accountability Report and may voluntarily report such information as deemed appropriate.
- Patient payment 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:

- Dignity Health system management shall develop policies and procedures for internal and external collection practices by Dignity Health facilities that take into account the extent to which the patient qualifies for payment assistance, a patient's good faith effort to apply for a governmental program or for payment assistance from Dignity Health, and a patient's good faith effort to comply with his or her payment agreements with the Dignity Health facility.
- For patients who qualify for payment assistance and who are cooperating in good faith to resolve their hospital bills, Dignity Health 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, Dignity Health management and dignity health facilities shall comply with all federal, state and local laws, rules and regulations that may apply to activities conducted pursuant to this policy.

## APPENDIX D: COMMUNITY HEALTH NEEDS ASSESSMENT STAKEHOLDERS

Focus Group Participants:

Individuals with special knowledge of or expertise in public health						
	Name (Last First)	Title	Affiliation	Public Health Knowledge/ Expertise	Date of Consult	Type of Consult
1	Kassabian, Armen	MD	Armenian American Medical Society	Family medicine	2/11/2013	Focus Group
2	Momijian, Manuel	MD	Armenian American Medical Society	Family medicine	2/11/2013	Focus Group
3	McDaniel, Sharon	RN, M.S.N., P.M.H.N.P	Didi Hirsch Mental Health Services	Mental health, substance abuse	2/11/2013	Focus Group
4	Virola, Iris	Director of Marketing	Drier's Nursing Care Center	Long-term care and rehabilitation services	2/11/2013	Focus Group
5	Reyes, Toni	Program Manager Health Services	Glendale Community College	Student health services	2/11/2013	Focus Group
6	Roth, Sharon	CEO	Glendale Healthy Kids	Low-cost/no-cost health insurance for children	2/11/2013	Focus Group
7	Sinclair, Kim	Teacher	Glendale High School	Public health, health and psychology	2/11/2013	Focus Group
8	Sergile, Kara	Consultant	KWS Consulting	Public health	2/11/2013	Focus Group
9	Stanley, Terri	VP, Strategy and Business Development	Partners in Care Foundation	Public health, community care	2/11/2013	Focus Group
10	Gonzalez, Jessica		Comprehensive Community Health Centers	FQHC, public health, reproductive health, teens	2/11/2013	Focus Group
11	Nelson, Bruce	Director of Community Services	Glendale Adventist Medical Center	Community services and health	2/11/2013	Focus Group

<b>Individuals with special knowledge of or expertise in public health</b>						
	<b>Name (Last First)</b>	<b>Title</b>	<b>Affiliation</b>	<b>Public Health Knowledge/ Expertise</b>	<b>Date of Consult</b>	<b>Type of Consult</b>
12	Shaw, Sally	DrPH, Project Director	Glendale Adventist Medical Center	Community services and health	2/11/2013	Focus Group
13	Roberts, Kevin	CEO	Glendale Adventist Medical Center	Hospital administration	2/11/2013	Focus Group
14	MacDougall, Teryl	Guest Relations Manager	Glendale Adventist Medical Center	Community services and health	2/11/2013	Focus Group
15	McCarty, Rev. Cassie, M.Div., BCC	Director, Mission Integration & Spiritual Care Services	Glendale Memorial Hospital and Health Center	Community services and health	2/11/2013	Focus Group
16	Davis-Quarrie, Yulanda	Foundation President	Verdugo Hills Hospital	Hospital administration	2/11/2013	Focus Group
17	Petrossian, Celine	Marketing/PR Specialist	Verdugo Hills Hospital		2/11/2013	Focus Group
18	Rivera, Mantha		Glendale Memorial Hospital and Health Center	Hospital administration	2/11/2013	Focus Group

<b>Leaders, representatives, or members of medically underserved populations, low-income persons, minority populations, and populations with chronic disease needs</b>						
	<b>Leader / Rep. Name (Last, First)</b>	<b>Leadership, Representative, or Member Role</b>	<b>Affiliation</b>	<b>Group(s) Represented? (medically underserved, low income, minority population, population with chronic disease)</b>	<b>Date of Consult</b>	<b>Type of Consult</b>
1	Komuro, Natalie	Executive Director	Ascencia	Homeless populations (adults and children)	2/11/2013	Focus Group
2	McDaniel, Sharon	RN, M.S.N., P.M.H.N.P	Didi Hirsch Mental Health Services	Mental health, substance abuse, uninsured, low income	2/11/2013	Focus Group

Leaders, representatives, or members of medically underserved populations, low-income persons, minority populations, and populations with chronic disease needs						
	Leader / Rep. Name (Last, First)	Leadership, Representative, or Member Role	Affiliation	Group(s) Represented? (medically underserved, low income, minority population, population with chronic disease)	Date of Consult	Type of Consult
3	Doughty, Sandy	Executive Director	GAR	Adults with developmental disabilities	2/11/2013	Focus Group
4	Roth, Sharon	CEO	Glendale Healthy Kids	Uninsured children	2/11/2013	Focus Group
5	Gunnell, Marilyn	Safe Place, LACMA	YMCA	Youth in crisis and recovery	2/11/2013	Focus Group
6	Bearchell, Ryan		Salvation Army	Seniors, families and youth who are low-income, homeless, accessing Salvation Army programs	2/11/2013	Focus Group
7	Raggio, Lisa		Glendale YMCA	Domestic violence victims and families	2/11/2013	Focus Group
8	Dzhanhyan, Eliza		Glendale Youth Alliance	Low-income youth	2/11/2013	Focus Group
9	Gonzalez, Jessica		Comprehensive Community Health Centers	Teens	2/11/2013	Focus Group
10	Fecske, Fran	Emeritus at Casa Glendale	Casa Glendale	Seniors	2/11/2013	Focus Group

### Community Forum Participants (Prioritization)

	Name (Last, First)	Title	Affiliation	Public Health Knowledge/ Expertise	Date of Consult	Type of Consult
1	Gonzalez, Jessica		Comprehensive Community Health Centers	FQHC, public health, reproductive health, teens	5/30/2013	Prioritization Session

	Name (Last, First)	Title	Affiliation	Public Health Knowledge/ Expertise	Date of Consult	Type of Consult
2	Nelson, Bruce	Director of Community Services	Glendale Adventist Medical Center	Community services and health	5/30/2013	Prioritization Session
3	Shaw, Sally	D.Ph., Project Director	Glendale Adventist Medical Center	Community services and health	5/30/2013	Prioritization Session
4	Petrosian, Celine	Marketing/PR Specialist	Verdugo Hills Hospital	Hospital	5/30/2013	Prioritization Session
5	Eckart, Marina		Didi Hirsch Mental Health	Community services and health	5/30/2013	Prioritization Session
6	Seck, Nancy	Director of Quality Management	Glendale Memorial Hospital and Health Center	Hospital	5/30/2013	Prioritization Session
7	Lancaster, Katy		Glendale Adventist Medical Center	Hospital	5/30/2013	Prioritization Session
8	Graf, Angela		Glendale Adventist Medical Center	Hospital	5/30/2013	Prioritization Session
9	Aleksani, A.		Glendale Adventist Medical Center	Hospital	5/30/2013	Prioritization Session
10	Sadler, S.		Glendale Adventist Medical Center	Hospital	5/30/2013	Prioritization Session
11	Correa, Sharon		Glendale Adventist Medical Center	Hospital	5/30/2013	Prioritization Session
12	Khanoyan, Sirvard, MD		Family Practice of Glendale	Medical service provider	5/30/2013	Prioritization Session
13	Townsend, Sharon		Glendale Healthy Kids	Medical service provider	5/30/2013	Prioritization Session
14	De Pacina, Nona		Oakpark Healthcare	Skilled Nursing Facility	5/30/2013	Prioritization Session
15	Sefilyan, Esther		Partners in Care Foundation	Community services and health	5/30/2013	Prioritization Session

**Individuals consulted from Federal, tribal, regional, state, or local health departments, or other departments or agencies with current data or other relevant information**

Name (Last, First, Academic Distinction)	Title	Affiliation	Type of Department	Date of Consult	Type of Consult
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1	Powers, Christine		City of Glendale	City administration	5/30/2013	Prioritization Session
2	Mozian, Rita	Health Educator	LA County Dept. of Public Health, SPAs 1 and 2	Public health	5/30/2013	Prioritization Session
3	Ochoa, Scott	City Manager	City of Glendale	City administration	5/30/2013	Prioritization Session

**Leaders, representatives, or members of medically underserved populations, low-income persons, minority populations, and populations with chronic disease needs**

	<b>Leader / Rep. Name (Last, First)</b>	<b>Leadership, Representative, or Member Role</b>	<b>Affiliation</b>	<b>Group(s) Represented (medically underserved, low-income, minority population, populations with chronic disease)</b>	<b>Date of Consult</b>	<b>Type of Consult</b>
1	Komuro, Natalie	Executive Director	Ascencia	Homeless populations (adults and children)	5/30/2013	Prioritization Session
2	Gunnell, Marilyn	Safe Place, LACMA	YMCA	Youth in crisis and recovery	5/30/2013	Prioritization Session

**Other sources of community input (such as consumer advocates, nonprofit organizations, academic experts, local government officials, community-based organizations, health care providers, private businesses, and/or health insurance and managed care organizations)**

*Does not include sources of community input in preceding tables*

	<b>Name (Last, First)</b>	<b>Title</b>	<b>Affiliation</b>		<b>Date of Consult</b>	<b>Type of Consult</b>
1	Saikali, George	CEO	YMCA of Glendale	Community services and health	5/30/2013	Prioritization Session
2	Cordon, Jeanett		YMCA of Glendale	Community services and health	5/30/2013	Prioritization Session
3	Snively, C.		Deloitte		5/30/2013	Prioritization Session
4	Murray, John		SAP		5/30/2013	Prioritization Session
5	Sahakian, Shant		Sedna Solutions	Marketing and design	5/30/2013	Prioritization Session

**Other sources of community input (such as consumer advocates, nonprofit organizations, academic experts, local government officials, community-based organizations, health care providers, private businesses, and/or health insurance and managed care organizations)**

*Does not include sources of community input in preceding tables*

	<b>Name (Last, First)</b>	<b>Title</b>	<b>Affiliation</b>		<b>Date of Consult</b>	<b>Type of Consult</b>
6	Babayan, Ida		Glendale Youth Alliance	Community services and health	5/30/2013	Prioritization Session
7	Burlison, Lydia		Glendale Unified School District	Education	5/30/2013	Prioritization Session
8	Vargas, Chad		Health Services Advisory Group	Health care management services	5/30/2013	Prioritization Session

### Prioritization Survey Participants

	<b>Name (Last, First)</b>	<b>Affiliation</b>	<b>Public Health Knowledge/Expertise</b>	<b>Date of Consult</b>	<b>Type of Consult</b>	<b>Prioritization Session</b>
1	Momjian, Manuel	Armenian American Medical Society	Community services and health	June 2013	Online Survey	
2	Gonzalez, Jessica	Comprehensive Community Health Centers	Community services and health	June 2013	Online Survey	
3	Khanoyan, Sirvard	Family Practice of Glendale/Family Medicine Residency Program	Medical services	June 2013	Online Survey	Y
4	Townsend (Roth), Sharon	Glendale Healthy Kids	Community services and health	June 2013	Online Survey	Y
5	Sergile, Kara	KWS Consulting	Mental health services	June 2013	Online Survey	
6	Shaw, Sally	Glendale Adventist Medical Center	Community services and health	June 2013	Online Survey	Y
7	Sadler, Karen	Glendale Adventist Medical Center	Community services and health	June 2013	Online Survey	
8	Macdougall, Teryl	Glendale Adventist Medical Center	Community services and health	June 2013	Online Survey	
9	Rivera, Martha	Glendale Adventist Medical Center	Community services and health	June 2013	Online Survey	Y

	<b>Name (Last, First)</b>	<b>Affiliation</b>	<b>Public Health Knowledge/Expertise</b>	<b>Date of Consult</b>	<b>Type of Consult</b>	<b>Prioritization Session</b>
10	Garcilazo, Al	Glendale Adventist Medical Center	Community services and health	June 2013	Online Survey	
11	Miller, Denise	Glendale Adventist Medical Center	Community services and health	June 2013	Online Survey	
12	Seck, Nancy	Glendale Memorial Hospital and Health Center	Community services and health	June 2013	Online Survey	Y
13	Petrossian, Celine	Verdugo Hills Hospital	Community services and health	June 2013	Online Survey	Y
14	McCurry, Judith	Verdugo Hills Hospital	Community services and health	June 2013	Online Survey	

	Name (Last, First)	Affiliation	Public Health Knowledge/Expertise	Date of Consult	Type of Consult	Prioritization Session
<b>Individuals consulted from Federal, tribal, regional, state, or local health departments, or other departments or agencies with current data or other relevant information</b>						
	Name (Last, First, Academic Distinction)	Affiliation	Knowledge, Expertise	Date of Consult	Type of Consult	Prioritization Session
1	Mozian, Rita	LA County Department of Public Health	Community services and health	June 2013	Online Survey	Y
2	Sinclair, Kimberley	Glendale High School	Education	June 2013	Online Survey	
3	Burlison, Lynda	Glendale Unified School District	Education	June 2013	Online Survey	Y
4	Reynolds, Carol	Glendale Unified School District	Education	June 2013	Online Survey	

<b>Leaders, representatives, or members of medically underserved populations, low-income persons, minority populations, and populations with chronic disease needs</b>						
	Name (Last, First)	Affiliation	Knowledge, Expertise	Date of Consult	Type of Consult	Prioritization Session
1	Sardar, Melina	Ark Family Center, Inc.	Mental health services	June 2013	Online Survey	
2	Zinzalian, Sona	Armenian Relief Society, Social Services	Community services	June 2013	Online Survey	
3	Molano, Herbert	Apartment Association of Greater Los Angeles	Housing	June 2013	Online Survey	
4	Komuro, Natalie	Ascencia	Homeless services	June 2013	Online Survey	
5	Bearchell, Ryan	The Salvation Army	Community services and health	June 2013	Online Survey	
6	Babayan, Ida	Glendale Youth Alliance	Youth development	June 2013	Online Survey	Y
7	Peters, Tim	Door of Hope	Homeless services	June 2013	Online Survey	

<b>Other sources of community input (such as consumer advocates, nonprofit organizations, academic experts, local government officials, community-based organizations, health care providers, private businesses, and/or health insurance and managed care organizations)</b>						
<i>Does not include sources of community input in preceding tables</i>						
	Name (Last, First)	Affiliation	Knowledge, Expertise	Date of Consult	Type of Consult	Prioritization Session
1	Gonzalez, Juan	City of Glendale	City administration	June 2013	Online Survey	
2	Fish, Greg	Glendale Fire Department	Public services	June 2013	Online Survey	

3	Cordon, Jeanett	YMCA of Glendale	Community services and health	June 2013	Online Survey	Y
4	Raggio, Lisa	YWCA Glendale	Community services and health	June 2013	Online Survey	Y
5	Karinski, Edna	Community Foundation of the Verdugos		June 2013	Online Survey	