



Glendale Memorial Hospital and Health Center

Community Benefit Report 2012
Community Benefit Implementation Plan 2013

**A message from Glendale Memorial Hospital and Health Center's Chief Executive Officer
and Board Chair**

At Glendale Memorial Hospital and Health Center, we share a commitment to optimize the health of the community we are privileged to serve. Vital to this effort is the collaboration we enjoy with our community partners. How we contribute to the quality of life and the environment in our communities has always been a key measure of our success, and it will continue to be so as we move forward.

In January 2012 Dignity Health, formerly Catholic Healthcare West, announced changes in our governance structure and name that will better position the system to welcome new partners in a changing health care landscape. The new name, Dignity Health, was chosen because dignity has been one of our core values since our founding. It is deeply embedded in our culture and clearly describes who we are and what we stand for. Our new governance structure more accurately reflects our current composition of both religiously sponsored and community sponsored hospitals.

During fiscal year 2012 we, like the nation, were impacted by the continuing economic downturn and experienced both successes and challenges. Despite declining revenue from government sponsored patients, we provided \$59,017,445 in charity care, community benefits and unreimbursed patient care.

At Glendale Memorial Hospital and Health Center, we strive to manage our resources and advance our healing ministry in a manner that benefits the common good now and in the future. Despite today's challenges, we see this as a time of great hope and opportunity for the future of health care. We want to acknowledge and thank the women and men who have worked together in a spirit of collaboration to address the health priorities of our community through health and wellness programs and services.

In accordance with policy, the Glendale Memorial Hospital and Health Center Board of Directors has reviewed and approved the annual Community Benefit Report and Implementation Plan at their November 13, 2012 meeting.



Jack Ivie
President



Patrick Liddell
Chair, Board of Directors

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EXECUTIVE SUMMARY

Glendale Memorial Hospital and Health Center (GMHHC), founded in 1926, is located at 1420 S. Central Ave., Glendale, CA. It became a member of Dignity Health, formerly Catholic Healthcare West (CHW)¹, 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. The primary and secondary service areas representing approximately 80% of hospital discharges consists of 1.2 million people. Patient admissions totaled 12,975 during FY 2012. GMHHC has a staff of more than 1,300 employees and professional relationships with more than 540 physicians. In addition, we have a large team of active volunteers. On any given month, over 200 volunteers provide services and support for our hospital, patients, and families. During FY12, GMHHC celebrated its eighty-sixth year of providing 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
- Aquatic Therapy

Cancer Center Services

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

¹ For more information on the name change, please visit www.dignityhealth.org

Women's Health Services

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

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

Patient Safety

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

Cardiac

- 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)

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)

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)

Appendectomy

- Five-Star Recipient for Appendectomy in 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 (2010), during FY12 GMHHC provided programs and services for the broader community and also for the underserved disadvantaged members of the surrounding community. Community benefit activities for FY12 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 FY12, the unsponsored expense for community benefit excluding the unpaid cost of Medicare was \$45,992,685. The total unsponsored community benefit expense, including the unpaid cost of Medicare, was \$59,017,445.

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

A Community Board, comprised of up to 22 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 FY 2012 Board of Directors.

The Community Board provides a community perspective and support for the Hospital President and the Dignity Health system to achieve the mission and values of GMHHC and Dignity Health. By assessing community health needs, the needs of the GMHHC Medical Staff and national trends in healthcare delivery, the Community Board assists the Hospital President in developing the strategic direction of GMHHC consistent with the needs of the community. In addition, they monitor the implementation of its goals and strategic initiatives. The Community Benefit plan is developed in accordance with policies and procedures of 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 2012, over \$100,000 was allocated to support the following organizations who are addressing unmet health-related needs of the community:

1. Alliance for Housing
2. Glendale Association for the Retarded
3. Glendale Commission on the Status of Women—Camp Rosie
4. Glendale Community Free Health Clinic
5. Glendale Healthy Kids
6. Holy Family High School
7. Los Angeles Fire Department Foundation
8. Red Cross

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, was initiated by Glendale's three hospitals, which have now successfully worked together for over 20 years on many high-profile community-wide projects. These include: Glendale Healthy Kids; the city's Quality of Life Indicators; and healthcare projects serving the homeless, as well as collaborating every 3 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 has been meeting quarterly since December 2011 with the agenda planned and program led by GMHHC staff.

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. If approved, this project will provide for a "health coach" to facilitate transition into the home setting for patient at high-risk for re-hospitalization. The application written by GMHHC will benefit selected patients residing within our community who have been hospitalized at one of the three hospitals. GMHHC staff has invested over 150 hours of service dedicated to projects, working groups, activities, and the application process in service to the goals of GHCC.

Finally, many of our Senior Leaders and 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, Physician Relations: American Armenian Bone Marrow Donor Registry

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: Southern California Association of Directors of Volunteer Services

Senior Pharmacist: Glendale Community Free Health Clinic

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 (GMHHC) 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 special note, within the Glendale ZIP Codes of 91201 to 91208, 27.7% of the population is of Armenian descent. 46.6% (209,227) of residents over the age of 18 are foreign born, and 23.8% (106,858) are not U.S. citizens. The average age of a patient admitted to our hospital is 76 years. The 2010 population of the GMHHC Community Health Needs Assessment service area is estimated at 591,678 persons and is considered a federally designated medically underserved area.

Community Demographics

- Population
 - Total population for primary service area—1,147,351
 - AGE GROUP
 - 0-14: 20.6%
 - 15-17: 4.1%
 - 18-24: 9.5%
 - 25-34: 16%
 - 35-54: 29.6%
 - 55-64: 9.7%
 - 65+: 10.5%
- Diversity:
 - White Non-Hispanic: 32.8%

- Black Non-Hispanic: 3.5%
- Hispanic: 48.2%
- Asian & Pacific Islanders Non-Hispanic: 13.3%
- All Others—2.3%
- Average Income: \$61,822
 - <\$15K: 16.1%
 - \$15-25K: 12.9%
 - \$25-50K: 27.3%
 - \$50-75K: 17.3%
 - \$75-100K: 10%
 - >\$100K: 16.3%
- Uninsured: 27.74%
- Unemployment: 6.8%
- No High School Diploma: 26.6%
- Renters: 59.2%
- CNI Score: 4.6
- Medicaid Patients: 22.79%
- Other Area Hospitals: 2 (Glendale Adventist Medical Center; Verdugo Hills Hospital)

Our most 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.

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:

- 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

In 2010, FMA Community Health Consulting prepared the assessment on behalf of the three not-for-profit hospitals serving the Glendale community: Glendale Memorial Hospital and Health Center, Glendale Adventist Medical Center, and Verdugo Hills Hospital. During the assessment process, GMHHC collaborated with Glendale Adventist Medical Center and Verdugo Hills Hospital, provided information as needed to the consulting group, and assisted with arrangements for the focus group.

The assessment 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. 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.

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

- Secondary data (quantitative)
- Qualitative research
- Assets mapping

Secondary Data

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

- American Heart Association
- California Alcohol and Drug Data System
- California Department of Finance
- California Department of Health Services
- Birth Records
- Center for Health Statistics
- Death Records
- Diabetes Prevention and Control Program
- MediCal Care Statistics
- California Department of Justice: Criminal Justice Statistics Center
- California Health Interview Survey
- California Healthcare Foundation (Employee Benefit Research Institute)
- California Managed Risk Medical Insurance Board
- California Office of Statewide Health Planning and Development²
- Healthcare Information Resource Center: Healthcare Quality and Analysis Division
- Healthcare Workforce and Community Development Division
- Centers for Disease Control: National Health Interview Survey; National Center for Health Statistics
- Centers for Medicare and Medicaid (formerly Health Care Financing Administration)
- Los Angeles County Cancer Surveillance Program, Department of Preventive Medicine, University of Southern California
- Los Angeles County Child Welfare Services; Case Management System Datamart
- Los Angeles County Department of Children and Family Services
- Los Angeles County Department of Public Health
- Data Collection and Analysis Unit
- Immunization Program
- Maternal Child and Adolescent Health Program
- Office of Health Assessment and Epidemiology
- National Center for Chronic Disease Prevention and Health Promotion: Behavioral Risk Factor Surveillance System
- Office of Statewide Health Planning and Development
- RAND California
- California Department of Education
- California Department of Justice
- Department of Alcohol and Drug Data Programs
- California Highway Patrol Statewide Integrated Traffic Records System
- U.S. Department of Health and Human Services: Health Resources and Services Administration

Qualitative Research

Thirty community leaders and representatives representing 24 community-based organizations provided community insight for the Community Benefit and Health Needs Assessment by participating in a focus group. The Glendale Healthier Community

Coalition generously offered to host the focus group during a regularly scheduled meeting. Participating agencies resided and provided services in both Glendale and the surrounding communities of Northeast Los Angeles. Participants represented many sectors of the community including education, philanthropic, social services, health care, faith-based organizations, and other community agencies. The following organizations participated:

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

Results of the Needs Assessment

Community leaders and representatives from community organizations identified the following as the most important health problems of Glendale and the surrounding communities (“Health problems” are defined as those problems having the greatest impact on community health):

- Risk Behaviors
 - Smoking
 - Obesity
 - Poor nutrition and food choices
 - Lack of physical activity
 - Underlying cultural issues that affect health behaviors
- Access to Healthcare
 - Uninsured adults
 - Lack of coordination related to management of chronic diseases

- Need for culturally sensitive, language appropriate health education
- Access to dental care – Seniors
- Medical Conditions
 - Asthma – Children
 - Dental issues – Children
 - Stress
 - Cardiovascular disease
 - Diabetes
 - Falls – Seniors
 - Disability among seniors

Based on data from the 2010 Community Health Needs Assessment, results tabulated from the Automated Health Priority Matrix demonstrate that resources should be invested in the following *health conditions* (listed in order of rank) for the GMHHC service area:

- Heart disease
- Mental health
- Hypertension
- Diabetes
- Pneumonia and Influenza
- Respiratory conditions (COPD, Asthma)

Based on data from the 2010 Community Health Needs Assessment, results tabulated from the Automated Health Priority Matrix demonstrate that overall resources should be invested to address the following *health behaviors* (listed in order of rank):

- Poor nutrition—Adults
- Overweight and obesity
- Lack of physical activity—Children and adults
- Poor nutrition—Children
- Uninsured Status

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

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

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

Assets Assessment

Inventory of our community assets was determined through two methods: Connecting with the participants in the focus group (see above for list of key community organizations) and through FMA Community Health Consulting's assets mapping.

Using data analysis and GIS (geographic information system) mapping capabilities in combination with data from Healthycity.org, FMA Community Health Consulting reviewed approximately sixty categories and sub-categories of resources in the community that may have an impact on program development. These resource categories include: Housing (23 resources named); Food Basic Needs (18 resources named); Education (161 schools named); Health, Healthcare, Health Education(132 resources named); Income Support and Employment (35 resources named); Mental Health Services (45 resources named); Substance Abuse Services (32 resources named); Disaster Services (33 resources named) and Non-Profit Centers (145 resources named).

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

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

To 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 community needs assessment and the current hospital programs.

Several of the health issues identified in the community needs assessment are addressed in various hospital programs. Note that not all community needs are directly addressed by GMHHC, primarily due to limited resource allocation or an adequate number of community resources 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.

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 2012. Programs were developed in response to the current Community Health Needs Assessment and are guided by the following five core principles:

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

Primary Prevention: Altering susceptibility or reducing exposure for susceptible individuals

- Flu Shot Clinics offered to seniors to decrease incidence of illness, decrease admissions and/or length of stay for flu/pneumonia.
- 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.

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

PROGRAM DIGESTS

50+ Senior Services	
Hospital CB Priority Areas	<ul style="list-style-type: none"> X Flu Shot Clinics X Health Promotion/Disease Prevention <input type="checkbox"/> Chronic Disease Self-Management X Disease Treatment
Program Emphasis	<ul style="list-style-type: none"> <input type="checkbox"/> Disproportionate Unmet Health-Related Needs X Primary Prevention <input type="checkbox"/> Seamless Continuum of Care X Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Early detection screenings, preventive healthcare, promoting wellness lifestyle programs.
Program Description	<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"> • Education <ul style="list-style-type: none"> ○ 2-3 free health education lectures every year ○ Informational lectures offered at GMHHC and local community venues ○ Partnership with Dial Ride to provide transportation to the Senior lectures • Annual Flu Drive-Through and senior flu outreach • Promotion of social well being through: <ul style="list-style-type: none"> ○ Weekly walkers program for seniors promoting healthy physical activity and social interactions ○ Social support to seniors via day travel events ○ Holiday Luncheon • Senior Services also support and participates in community health fairs to promote health information and wellness events.
FY 2012	
Goal FY 2012	<ul style="list-style-type: none"> • Coordinate a minimum of 12 community service and/or educational senior lectures: Focus for health lecture on heart disease, diabetes, mental health, promoting healthy living, exercise, diet and early detection and intervention. • Provide the coordination of a minimum of 200 flu shot vaccinations to seniors in residential retirement homes and flu drive. Increase participation awareness in exercise through our senior walking program. • Join effort with Glendale Senior center to provide monthly day trips. • Provide multiple community resources including transportation program.
2012 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Number of events held and participants who attended. • Evaluate a minimum of half the informational lectures for quality and context as relevant for the seniors: scale of prior knowledge on the subject and value of information provided with assessment questionnaire with a specific area for input by seniors for topics of interest and importance. • Evaluation of at least half of the wellness events by a questionnaire as to the level of satisfaction with classes and social events.
Baseline	Community leaders identified the following as significant health needs for the senior population: wellness, screening and prevention programs, exercise and physical fitness programs and community informational resources needs.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Sr. Service Programs will be made known to the community via direct outreach to local surrounding senior centers and senior service agencies. • Sr. Service manager will participate in networking events to enhance the program exposure to senior residential facilities and agencies providing service to the senior community.
Result FY 2012	We have increased the membership of our senior program, resulting in more overall health education and prevention to the seniors in our community.
Hospital's Contribution / Program Expense	Hospital personnel time and food services for events.
FY 2013	
Goal 2013	Increase the community awareness in our community and partner with community resources to provide other services.
2013 Objective Measure/Indicator of Success	To increase our membership to our 50Plus program.
Baseline	Community leaders identified the following as significant health needs for the senior population: wellness, screening and prevention programs, exercise and physical fitness programs, and community informational resources needs. Our service to our senior population has doubled and there is greater need to have programs that will address the needs of the community.
Intervention Strategy for Achieving Goal	Develop an outreach initiative to work more closely with the service area city programs and senior clubs to raise awareness.
Community Benefit Category	A1: Community Health Education

Breastfeeding Resource Center	
Hospital CB Priority Areas	<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
Program Emphasis	<input type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Preventive healthcare
Program Description	<p>GMHHC's Breastfeeding Resource Center has trained certified lactation educators and one IBCLC 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.</p>
FY 2012	
Goal FY 2012	<p>The Breastfeeding Resource Center continues to provide lactation services for inpatients and outpatients, thereby promoting healthy family goals. This will be achieved by providing lactation rounding to the mothers/baby/dad on our labor/delivery units and postpartum units as well as in the NICU. Our lactation educators are scheduled to assist our mothers during various shifts, including days, nights, weekends and most holidays. We offer all our breastfeeding mothers to the follow-up consultations and encourage attending within 24 hours – 7 days to assess mother/infant couplet as to the above, and adequacy of breastfeeding – approximately 35% of the mothers will attend the follow up due to breastfeeding issue. The nursing mother circle group which is held every week to provide support and allow networking among breastfeeding mothers in the community. Our breastfeeding classes are also offered in 3 different languages (English, Spanish, and Armenian) by our certified lactation Educators at no cost to the parents. Our Breastfeeding phone line will continue to assist all mothers in the community and surrounding areas at no cost. We also would like to add one additional per diem CLE to our staff to sufficiently cover the night shift.</p>
2012 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Track unintended admissions rates to the NICU for dehydration and hyperbilirubinemia. • Track patients satisfaction with overall breastfeeding support and education provided. • Track number of mothers attending the Breastfeeding Support Group and monitor their overall satisfaction with the services provided.
Baseline	<p>We will continue this program and plan to add more coverage for the evening shift as there is no other program in our community that supports the health and education of breastfed infants and stresses the importance of breastfeeding.</p>
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • In-services provided to nursing staff. • Communication with pediatrician and OB staff. • Education and handouts to patients on the importance of follow-up. • Performance Improvement projects addressing the above. • Continue active Lactation rounding on all post-partum dyads. • Covering more weekend and evening Lactation shifts.
Result FY 2012	<ul style="list-style-type: none"> • We have hired a new per diem evening Lactation Educator to assist with the night shift to ensure that all mothers are being assessed and assisted with breastfeeding. • Our support group has continued to draw mothers from the Glendale and surrounding areas as well as pediatricians and Doulas. • We are getting more referrals for consultations for in-patients and out-patients from OB's and Pediatricians.
Hospital's Contribution / Program Expense	<p>Our hospital provides for the broader community:</p> <ul style="list-style-type: none"> • Free weekly support group. • Free Breastfeeding Hot line. • Free outpatient visits for our patients up to the baby's 6 weeks of discharge.

FY 2013	
Goal 2013	<ul style="list-style-type: none"> • Continue to offer free outpatient visits to our patients to ensure that they succeed in their breastfeeding goals. • Continue to market our free support group and classes. • Start a free Spanish-speaking weekly support group. • Market our free hot line, classes and support group to surrounding clinics in the community.
2013 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Track patients satisfaction with overall breastfeeding support and education provided. • Track number of mothers attending the Breastfeeding Support Group and monitor their overall satisfaction with the services provided.
Baseline	<p>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 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> <p>Healthy People requirements urge the education and support of breastfeeding which is supported by the CDC, UNICEF and JAHCO.</p>
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Continue education for OBs, Pediatricians, and RNs to encourage them to support breastfeeding and increase referrals. • Education and handouts to patients on the importance of follow-up. • Performance Improvement projects addressing the above. • Continue active Lactation rounding on all post-partum dyads. • Covering more weekend and evening Lactation shifts.
Community Benefit Category	AC—Subsidized Health Services

CHF Program	
Hospital CB Priority Areas	<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
Program Emphasis	<input type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	CHF disease management and education
Program Description	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.
FY 2012	
Goal FY 2012	<ul style="list-style-type: none"> • To decrease 30 day readmission for CHF and all cause • To decrease average length of stay • To increase patient's perceived quality of life
2012 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • 30 day CHF readmission • 30 day all cause readmission • Average length of stay • Quality of life score
Baseline	<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 28.2 percent, demonstrating our hospital's need to address this health concern. Our baseline metrics are:</p> <ul style="list-style-type: none"> • 30 day CHF readmission = 8.2% • 30 day all cause readmission = 18.1% • LOS = mean 6.1, median 4 • Quality of life score = 46
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Daily rounds for screening and enrollment • Patient education • Follow-up phone calls
Result FY 2012	30 day CHF readmission = 3.7%, which represents a 55% reduction 30 day all cause readmission = 11.9%, which represents a 34% reduction LOS = mean 5.6, median 4 Quality of life score = 31, which represents a 12% improvement
Hospital's Contribution / Program Expense	Program expense = \$90,734
FY 2013	
Goal 2013	<ul style="list-style-type: none"> • To decrease 30 day readmission for CHF and all cause • To decrease average length of stay • To increase patient's perceived quality of life
2013 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • 30 day CHF readmission • 30 day all cause readmission • Average length of stay • Quality of life score
Baseline	<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 28.2 percent, demonstrating our hospital's need to address this health concern. Our baseline metrics are:</p> <ul style="list-style-type: none"> • 30 day CHF readmission = 8.2% • 30 day all cause readmission = 18.1% • LOS = mean 6.1, median 4 • Quality of life score = 46
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Daily rounds for screening and enrollment • Patient education • Follow-up phone calls
Community Benefit Category	A2—Community Based Clinical Services

Diabetes Program	
Hospital CB Priority Areas	<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
Program Emphasis	<input type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Diabetes Management and Education Nutrition Education
Program Description	The Diabetes Education Program at GMHHC provides outpatient education for individuals with Type I or Type II Diabetes. We offer classes in diabetes self-management, as well as individual instruction and nutrition counseling in English and Spanish. The Nutrition Program offers individual nutrition education and counseling for weight management, carbohydrate counseling, cardiac and any nutritional need as prescribed by a physician.
FY 2012	
Goal FY 2012	<ul style="list-style-type: none"> To continue to provide self-management education and skills to achieve patient participation necessary for optimum glucose control. To offer a four part series of classes in English, Spanish and Armenian. Provides one on one education and consultation and follow-up. Maintain ADA Recognition. In addition to regular self-management classes, continue to offer a variety of classes related to diabetes management such as carbohydrate counting and healthy eating. Conduct diabetes self-management classes on a monthly basis.
2012 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> Track participants' achievement of behavioral goals 3 months after completing the program and compare A1C levels pre and post program. HbA1C levels every 3 months. Goal: achievement after 6 months to reduce by 0.5% or maintain below 7% in 75% of the patients. BMI or Weight – attain ideal body weight; achieve weight loss of 5% or reduction in BMI over 6 months. Reduce percentage of patients' readmission to hospital for complications resulting from DM related conditions.
Baseline	Our community is an especially high-risk population that is in need of diabetes and nutrition education. Diabetes care is still a key finding area of need in our Community Health Needs Assessment.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> Follow-up telephone calls to keep patients in the program for one year. Continue to support outreach to the community as needed with education lectures, talks and information as requested. Participating in Health Fairs. Follow-up on inpatient floors with patients as well as dietitians and nursing staff. Meet with physician office staff and other outside agencies to promote the program.
Result FY 2012	<ul style="list-style-type: none"> 88% had an A1c of <7% or a total decrease of 1% post DSME and our target was 75%. Approximately 77% of patients lost weight and our target was 75%. 82% of participants attained their goals and our target was 75%. Satisfaction survey results indicate 100% were satisfied with the program and experience.
Hospital's Contribution / Program Expense	The hospital supports this program by providing funding for staff and materials, and use of facility.
FY 2013	
Goal 2013	<ul style="list-style-type: none"> Increase total volume by 20%. Focus on the Hispanic population to reflect demographics of community. Continue to provide program and follow-up after program completion at 3, 6, 9 and 12 months via phone or individual follow-up appointments.
2013 Objective Measure/Indicator of Success	Continue to track HbA1c's, weight, BMI, hospital or ED admits, and goal achievement with a target of 75% success.
Baseline	Our community is an especially high-risk population that is in need of diabetes and nutrition education. Diabetes care is still a key finding area of need in our Community Needs Assessment.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> FAX flyers with class dates to physician offices. Visit physician offices twice per quarter with information regarding our program. Screen DM in-patients and request referral at least once per week.
Community Benefit Category	A2—Community Based Clinical Services

Glendale Healthy Kids	
Hospital CB Priority Areas	<input 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
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Affordable health and dental care for children.
Program Description	The mission of Glendale Healthy Kids is to provide access to free healthcare for low income underinsured children, and offer preventative health education to the community. Glendale Healthy Kids was founded in 1994 to meet an assessed community need for children who are low-income and under insured, thereby unable to access needed health care. The Glendale Healthy Kids program provides 2 major components: health care access through referral to health care providers in their offices during their work day, and health education to the community in the areas of asthma, oral health, and nutrition. Annually, over 1500 units of service are provided and over 3,000 adults and children participate in education. An annual Kids Fitness and Health Expo serves about 1000 with free screenings and tests, as well as resources for parents.
FY 2012	
Goal FY 2012	<ul style="list-style-type: none"> • To make 700 referrals for medical and dental treatment. • Provide 1400 units of healthcare service. • Increase Give Kids A Smile day participation to 175 children completing restoring mouths to good health. • Provide Dental education to all first grade students in GUSD and pilot at least one session in a local private school. • Continue mental health therapy as referred by school administrators and other community agencies. • Provide a daylong health fair with 1000 participants on March 24, 2012. • Provide orthodontic services for 10 children in treatment.
2012 Objective Measure/Indicator of Success	Measurements are recorded by our case manager (R.N.), who keeps statistics and case management records. Our Director of Health Education maintains records and statistics for all educational classes.
Baseline	In economically disadvantaged areas of the service area, 23,972 children (29.3%) and the majority of children (58.4% are living in homes with income levels less than 200% of the Federal Poverty Level. Within the Glendale Unified School District (most comprehensive statistics) 4,500 (15.2%) of children receive temporary assistance for needy families (TANF) benefits and 13,480 (45.5%) participate in the Federal Lunch Program. (SB697 Community Benefit and Health Needs Assessment). In the Glendale Healthy Kids service area, 21,599 (26.4%) children have some form of MediCal, 6,873 (8.4%) are enrolled in Healthy Families, and 7,936 school age children (9.7%) are uninsured. Especially after closures of several Los Angeles county clinics and hospitals, our county health department has become even more burdened leaving little opportunity for medical and dental care of uninsured and underinsured children.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Continue School site referral program, increasing communication beyond nurses and health aides to all teachers and administrators. • Increase number of community media presentations in appropriate languages. • Recruit at least 25 new providers at all levels to meet increased demand for services. • Ensure that providers' services are monitored appropriately. • Continue the public relations effort of "April: Glendale Healthy Kids Month" to increase community awareness. • Ensure that both the PSA and the video are presented throughout the community. • Emphasis on recruitment of both volunteers and providers within the Korean community will reach an audience previously underserved. • Maintaining current relationships within the Armenian community will continue to increase services and providers, as well as much needed funding.
Result FY 2012	<ul style="list-style-type: none"> • Referrals to Glendale Healthy Kids increased nearly 17%. • Our volunteer provider base was stable and we added 13 new providers who are providing service to the program. • We had a successful Community Health Fair, reaching over 700 people. A new vision screening unit was added, which indicated a tumor in one child's eye. Had she not attended this health fair, this would not have been found. • The number of community volunteers increased this year. I am especially proud of the high

	<p>school students who work in the office after school or support the dental clinic. As there are only four employees, we are very dependent upon volunteer support.</p> <ul style="list-style-type: none"> • We expanded our education programs to include an asthma and nutritional component. • The orthodontic evaluation program has continued to work and we currently have 10 students in full orthodontia treatment. Students referred to Glendale Healthy Kids in need of orthodontia are prioritized based upon need. • Several students had surgeries that corrected hearing or vision problems. In August of this year, a student received eye surgery for a detached retina (he was blind in this eye). I'm proud to say that he has recovered his vision. All services were donated.
Hospital's Contribution / Program Expense	Our hospital has an agreement with Glendale Healthy Kids to provide services for referred patients. Most of the clinic's physician's have privileges at GMHHC; they provide in-kind services. Glendale Memorial donates all types of services to GHK clients; ED visits, lab work, x-rays, physical therapy and (very rarely) services for surgery.
FY 2013	
Goal 2013	<p>Most dental disease can be prevented, but this requires a commitment from families, dental professionals and the community. GHK has long been a proponent of preventative oral health education, providing education programs that stress the importance of oral health, increase understanding of disease process, promote healthful behaviors, and reinforce the importance of professional dental care for prevention and early intervention. Research indicates that in order for these educational programs to be effective, they must be theory-based and behavior change must be their primary goal. In addition, they must be continually reinforced throughout a child's lifetime. These are the principles by which GHK programs operate.</p> <p>Our educational programs target 2-5 year olds (Tots 'n Teeth program), 1st grade students, 14-16 year olds through high school health fairs, and parents through educational materials that are taken home. We partner with the American Dental Association and local dentists to provide our version of "Give Kids a Smile Day", through which children and adolescents receive preventative dental services, such as sealants, fillings, and fluoride varnishes. Such services are also provided during our annual health fairs at the high schools, and during our annual Kids Health Expo. GHK ensures that children with dental decay are identified and treated when preventative measures have failed. Our virtual clinic partners with over 300 medical/dental care providers to ensure that children without dental insurance are referred for restorative treatment, preventing dental decay from negatively affecting learning and quality of life.</p>
2013 Objective Measure/Indicator of Success	Measurements are recorded by our case manager (R.N.), who keeps statistics and case management records. Our Director of Health Education maintains records and statistics for all educational classes.
Baseline	<p>In economically disadvantaged areas of the service area, 23,972 children (29.3%) and the majority of children (58.4% are living in homes with income levels less than 200% of the Federal Poverty Level. Within the Glendale Unified School District (most comprehensive statistics) 4,500 (15.2%) of children receive temporary assistance for needy families (TANF) benefits and 13,480 (45.5%) participate in the Federal Lunch Program. (SB697 Community Health Needs Assessment). In the Glendale Healthy Kids service area, 21,599 (26.4%) children have some form of MediCal, 6,873 (8.4%) are enrolled in Healthy Families, and 7,936 school age children (9.7%) are uninsured. Especially after closures of several Los Angeles county clinics and hospitals, our county health department has become even more burdened leaving little opportunity for medical and dental care of uninsured and underinsured children. As a result, these children are much less likely to receive oral health prevention services as well as treatment of acute and chronic dental conditions. According to the Dental Foundation's Oral Health Needs Assessment, tooth decay is the number one health problem for California's kids. Dental disease in California is an epidemic, five times more common in children than asthma. By 3rd grade, 70% of children have a history of tooth decay.</p> <p>In addition to Glendale proper, our geographic service area extends from Sunland Tujunga through the foothills east to La Canada, Eagle Rock, Atwater Village and around to Burbank. Rather than continuing extension of the area, GHK stands ready to assist local communities to replicate our program matching their local needs. Eligible children are those with income levels as defined at poverty level by the federal government and with no insurance or full scope MediCal. Families of 62% of children in the area have income levels of less than 200% of Federal Poverty Level. 39% are Hispanic and 35.2% are Caucasian, with 27.7% Armenian Caucasian, and 16.4% Asian/Pacific Islander.</p>
Intervention Strategy for Achieving Goal	<p>Health Education Programs & Promotions</p> <ol style="list-style-type: none"> 1. Asthma Classes to be held at locations such as The Salvation Army, GCC, Head Start, etc. 2. Nutrition/Obesity Classes to be held at locations in La Crescenta, various Head Start locations; Grains for Brains at preschools, libraries, etc. 3. Tots 'n Teeth Classes—18 classes to be held at preschools (2-5 yrs old) 4. Dental Education Program—GHK presents a comprehensive dental education program to more than 2200 first grade students in 20 schools in the Glendale Unified School District. Over 30 trained volunteers visit the classrooms during three sessions and teach proper tooth brushing and flossing procedures, proper nutrition, tooth safety, and what to expect when visiting the dentist. Program is delivered in three fun, interactive, and developmentally appropriate methods. 20 – 30 volunteers are extensively trained by our Director of Health Education.

	<p>5. High School Health Fairs—2 health fairs are held for 9th & 10th grades at two high schools in the community in order to increase awareness of GHK in the community.</p> <p>6. Fit 'N Ready—Grant from Kaiser will enable us to hold 10 sessions in collaboration with AGBU. This is a pilot program this year.</p> <p>7. Annual Health and Fitness Expo (April 6)—In order to increase attendance, awareness, and in the spirit of collaboration, a different venue should be researched. Possible locations: YWCA, Fire Station 22 (in correlation with their open house)</p> <p>Health Care Services</p> <p>1. Virtual Health Management Clinic/Referral Program—School site nurses, health clerks, and School District refer children with unmet health needs to GHK, which provides no-cost comprehensive care services through our network of volunteer health professionals. Parents are also able to contact GHK directly.</p> <p>2. Every Day is Give Kids a Smile Day—Through our version of the ADA's Give Kids a Smile Day, our dentists provide "screen, clean & seal" clinics to children. The children with additional needs are referred for further follow-up and care through our virtual clinic.</p> <p>3. Orthodontic Evaluation Program—10 children in full orthodontia treatment per year.</p>
Community Benefit Category	A2—Community Based Clinical Services

This implementation strategy specifies 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 implementation 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, 2013, other organizations in the community may decide to address certain needs, indicating that the Hospital then should 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 7/1/2011 through 6/30/2012 (Please note that Community Benefit expenses are derived using a cost accounting methodology.)

	Persons	Expense	Revenue	Benefit	% of Organization's	
					Expenses	Revenues
<u>Benefits for Living in Poverty</u>						
Financial Assistance	286	\$6,705,321	\$0	\$6,705,321	2.9	3.0
Unpaid Cost of Medicaid	23,527	\$86,292,334	\$49,562,762	\$36,729,572	16.1	16.3
Community Services						
Financial and In-Kind Contributions	320	\$3,401	\$0	\$3,401	0.0	0.0
Totals for Community Services	320	\$3,401	\$0	\$3,401	0.0	0.0
Totals for Living in Poverty	24,133	\$93,001,056	\$49,562,762	\$43,438,294	19.0	19.2
<u>Benefits for Broader Community</u>						
Community Services						
Community Benefit Operations	0	\$40,106	\$0	\$40,106	0.0	0.0
Community Building Activities	0	\$149,120	\$0	\$149,120	0.1	0.1
Community Health Improvement Services	1,828	\$640,274	\$0	\$640,274	0.3	0.3
Financial and In-Kind Contributions	200	\$985,027	\$0	\$985,027	0.4	0.4
Health Professions Education	4	\$45,640	\$0	\$45,640	0.0	0.0
Research	0	\$694,224	\$0	\$694,224	0.3	0.3
Totals for Community Services	2,032	\$2,554,391	\$0	\$2,554,391	1.1	1.1
Totals for Broader Community	2,032	\$2,554,391	\$0	\$2,554,391	1.1	1.1
Totals - Community Benefit	26,165	\$95,555,447	\$49,562,762	\$45,992,685	20.1	20.4
Unpaid Cost of Medicare	22,041	\$84,827,364	\$71,802,604	\$13,024,760	5.7	5.8
Totals with Medicare	48,206	\$180,382,811	\$121,365,366	\$59,017,445	25.8	26.1

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 as well as on the Dignity Health website.

APPENDIX A: 2012 GMHHC BOARD OF DIRECTORS

Sheldon Baker

John Cabrera, MD
Vice Chair

Rev. Berdj Djambazian

Anita Gabrielian

Robert Gall, MD*
Chief of Staff

Edward Keh

Jacob Lee
Secretary

Patrick Liddell
Chair

Mark A. Meyers*
GMHHC President

Rob Mikitarian

Harold Scoggins

Susan Shieff

Kalust Ucar, MD

Ignacio Valdes, MD

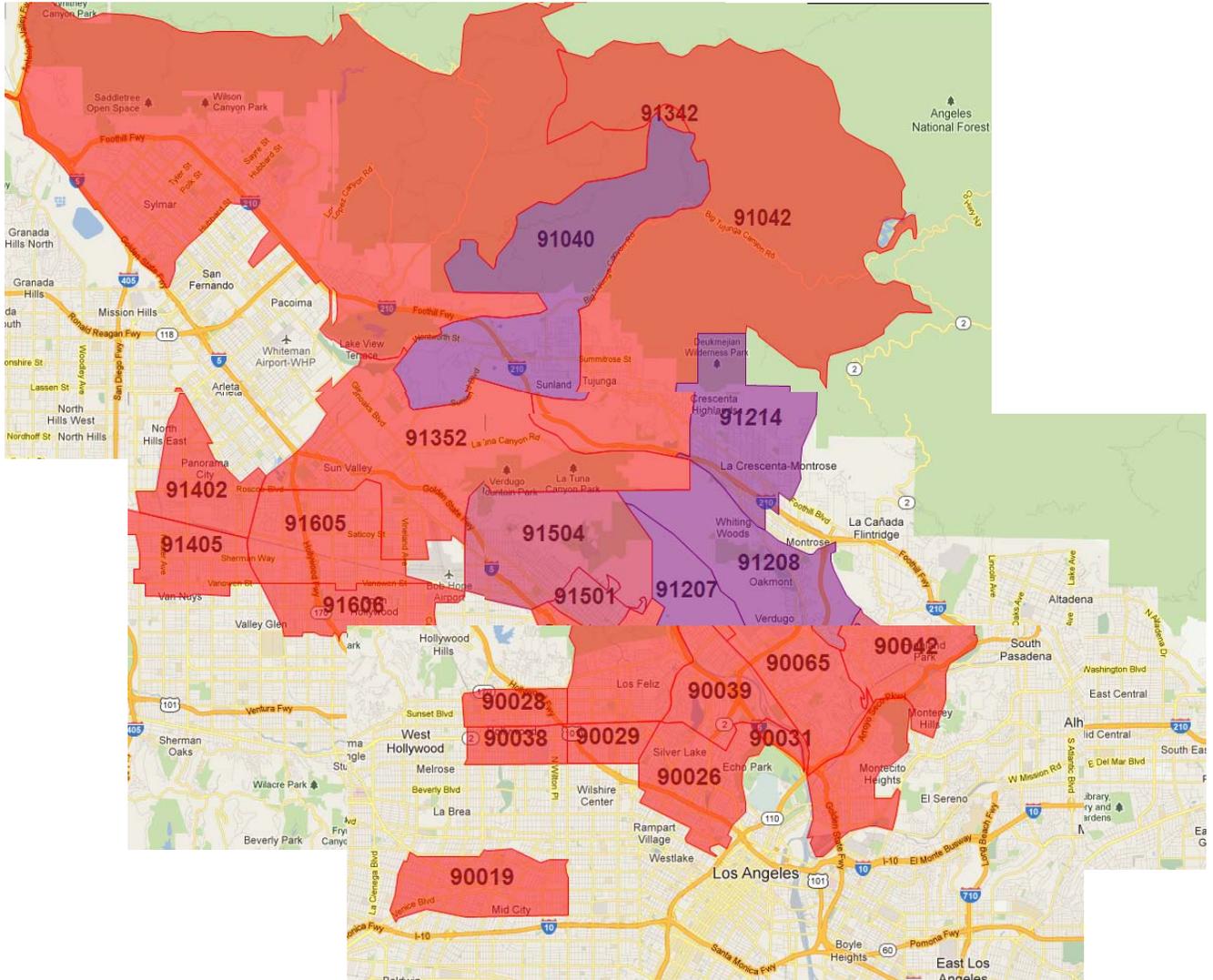
Petar Vukasin, MD

Douglas Webber, MD

Roberto Zarate

**Ex-officio*

APPENDIX B: COMMUNITY NEED INDEX MAP



Lowest Need

1 - 1.7 Lowest

1.8 - 2.5 2nd Lowest

2.6 - 3.3 Mid

3.4 - 4.1 2nd Highest

Highest Need
4.2 - 5 Highest

<u>Zip Code</u>	<u>CNI Score</u>	<u>Population</u>	<u>City</u>	<u>County</u>	<u>State</u>
90019	4.8	69091	Los Angeles	Los Angeles	California
90026	5	74336	Los Angeles	Los Angeles	California
90027	4.6	49895	Los Angeles	Los Angeles	California
<u>Zip Code</u>	<u>CNI Score</u>	<u>Population</u>	<u>City</u>	<u>County</u>	<u>State</u>
90028	4.8	31145	Los Angeles	Los Angeles	California
90029	5	42486	Los Angeles	Los Angeles	California
90031	5	39377	Los Angeles	Los Angeles	California
90038	5	31808	Los Angeles	Los Angeles	California
90039	4.2	29651	Los Angeles	Los Angeles	California

90041	3.8	29062	Los Angeles	Los Angeles	California
90042	4.8	66809	Los Angeles	Los Angeles	California
90065	4.8	48362	Los Angeles	Los Angeles	California
91040	3.2	20818	Sunland	Los Angeles	California
91042	4.2	27131	Tujunga	Los Angeles	California
91201	4.4	25348	Glendale	Los Angeles	California
91202	3.6	22683	Glendale	Los Angeles	California
91203	4.4	15389	Glendale	Los Angeles	California
91204	4.8	17661	Glendale	Los Angeles	California
91205	4.6	42953	Glendale	Los Angeles	California
91206	3.8	33403	Glendale	Los Angeles	California
91207	2.8	9857	Glendale	Los Angeles	California
91208	2.6	15661	Glendale	Los Angeles	California
91214	2.6	31090	La Crescenta-Montrose	Los Angeles	California
91342	4.2	89950	Sylmar	Los Angeles	California
91352	4.8	47297	Los Angeles	Los Angeles	California
91402	4.8	72717	Los Angeles	Los Angeles	California
91405	4.8	55579	Los Angeles	Los Angeles	California
91501	3.8	20723	Burbank	Los Angeles	California
91502	4.4	12563	Burbank	Los Angeles	California
91504	3.6	24856	Burbank	Los Angeles	California
91605	5	61676	Los Angeles	Los Angeles	California
91606	5	49157	Los Angeles	Los Angeles	California

CNI Score Median: 4.6

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.