Dignity Health.
California Hospital
Medical Center

California Hospital Medical Center

Community Benefit Report 2013
Community Benefit Implementation Plan 2014

A Message from the President and Chief Executive Officer of California Hospital Medical Center and the Board Chair

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 California Hospital Medical 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 California Hospital Medical Center we share a commitment to optimize the health of our community. In fiscal year 2013 California Hospital Medical Center provided $91,962,947 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 California Hospital Medical Center Community Board has reviewed and approved the annual Community Benefit Report and Implementation Plan at their October 24, 2013 meeting.

Craig G. Myers
President

Phillip C. Hill, Chairman
Hospital Community Board

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EXECUTIVE SUMMARY

California Hospital Medical Center (CHMC), founded in 1887, is a not-for-profit hospital located at 1401 S. Grand Ave., Los Angeles, CA. It became a member of Dignity Health, formerly Catholic Healthcare West (CHW)[1], in 2004. The facility has 316 licensed beds. CHMC has a staff of 1,186 and professional relationships with more than 500 local physicians. Major programs and services include emergency and trauma services, obstetrics, neonatal intensive care, pediatrics, medical/surgical services, critical care, orthopedics, skilled nursing, and cancer care. Two new service lines were added last spring: our cardiovascular service line that includes a new cardiovascular operating suite and two cardiac cath labs, and our stroke program.

In response to identified unmet health-related needs in the community health needs assessment, during FY 13 CHMC focused increasing access to health care for the broader and underserved disadvantaged members of the surrounding community. Major community benefit activities for FY13 focused on health coverage enrollment assistance, outreach health education and health screenings for common chronic conditions at over 55 sites in the community, referring individuals and families to local community clinics for on-going primary health care, and health education workshops for common chronic conditions both at some of the community clinics as well as at local schools, churches, and other community centers.

Health education was selected as a priority to address prevention of disease, to empower community members to assume responsibility for their health and to educate people about various medical conditions and the ability they have to make wise choices. Lecture topics were distributed in the following broad categories: family violence, mental health, safety, physical health, communicable diseases, and access to medical services. Self-management workshop series included: Healthier Living; Food, Fitness, and Diabetes Prevention; Living with Diabetes; Healthy Eating Lifestyle Program (addressing pediatric obesity); Freedom from Smoking; Asthma; and Heart H.E.L.P.

People with diabetes, especially those with poorly controlled diabetes, are more likely to have periodontal disease than people without diabetes. In fact, periodontal disease is often considered the sixth complication of diabetes and may make it more difficult for people with diabetes to control their blood sugar. What happens when you treat periodontal disease? Meta-analysis demonstrated a 0.46% fall in HbA1c with nonsurgical treatment of periodontal disease; a 0.4% fall in HbA1c per Cochrane Review in 2010. (For reference, a 1% fall in HbA1c represents 30 mg/dl fall in mean plasma glucose)
The **Community Dental Partnership** is a collaboration between Eisner Pediatric and Family Medical Center, the Southside Coalition of Community Clinics, and CHMC to provide access to free basic dental services and periodontal services for uninsured adults with medication-dependent type 2 diabetes living in Central Los Angeles. Participants must have their medical home at one of the clinics of the Southside

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

Coalition and must complete the *Living with Diabetes* workshop series and the Oral Hygiene class.

In September 1992 the **Hope Street Family Center (HSFC)** was established as a collaborative effort between the University of California Los Angeles (UCLA) and Dignity Health, formerly Catholic Healthcare West, dba CHMC to address several critical factors impacting the community: extreme poverty, predominant immigrant population, very low literacy rates, poor quality schools, high rates of disabilities in young children, gang violence, lack of access to health care including prenatal care and pediatric care, insufficient licensed child care, and the need for family mental health services. Today this collaboration has grown to include partnerships with over 30 community agencies. The HSFC exemplifies the mission of Dignity Health to empower and strengthen families by providing health services, education, and access to community resources through a seamless, flexible, comprehensive, culturally-sensitive, and responsive array of services free of charge to meet a family's individual and changing needs. HSFC's services are both hospital- and community-based and include: Early Head Start Program, three licensed early care and education centers, the Hope Street Youth Center, Family Childcare Network, Healthy Marriage and Responsible Fatherhood Programs, Family Literacy Program, on-site continuation high school, Nurse Family Partnership Program, Pico Union Family Preservation Network, Early Intervention Program, and Behavioral Health Program. The HSFC celebrated its belated 20th anniversary in October 2013, by moving into its new $16 million home, a four story building on the corner of Hope St and Venice Blvd, the Hope Street Margolis Family Center

CHMC has been a leader in perinatal services for over half a century. Therefore, it seemed only natural to become the host agency for the **Los Angeles Best Babies Network (LABBN) Center for Healthy Births**. The mission of the Center is to provide the infrastructure, programs, advocacy and support to enhance the capacity of the network of community stakeholders working to achieve healthy births throughout Los Angeles County. The Network provides training and technical assistance for seven Best Babies Collaboratives that are partnerships funded to provide interconception care for women at high risk for recurrent poor birth outcomes; leads Care Quality Improvement activities to help perinatal care providers implement evidence-based practice guidelines and to link health care providers to community-based services and resources; coordinates and institutionalizes a broad perinatal health policy agenda working with community stakeholders and others to build sustainable improvement of pregnancy and birth outcomes; promotes health literacy skill building through the use of *Baby Basics*; and partners with the Los Angeles County Perinatal Mental Health Task Force to promote universal screening for perinatal depression. On March 1, 2013 LABBN was selected as the Family Strengthening Oversight Entity by First 5 LA to oversee and support the implementation and standardization of First 5 LA's Welcome, Baby! universal perinatal home visitation program at 14 additional birthing hospitals across Los Angeles County. LABBN will also provide training, technical assistance and support to the new Select Home Visitation Programs working with these hospitals and develop referral pathways between Welcome, Baby!, Select Home Visitation Programs, and other existing perinatal home visiting programs in each Best Start Community.

CHMC chose the **Living with Diabetes Program** and **Heart H.E.L.P.** as its two Long Term Improvement Plans (LTIPs) for FY11-FY13. The goal of these LTIPs is to demonstrate a 50% reduction in hospital admissions for two of the most prevalent ambulatory care sensitive conditions in our community.

CHMC's FY2013 Community Benefit Report and FY2014 Community Benefit Implementation Plan document our commitment to the health and improved quality of life in our community. The total value of community benefit for FY2013 is $250,064,183 which excludes the unpaid costs of Medicare $38,568,415.

Mission Statement

Our Mission
California Hospital Medical Center and Dignity Health 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.

California Hospital Medical Center

California Hospital Medical Center (CHMC) is a non-profit public benefit health care center that has been a member of the downtown Los Angeles community since 1887. CHMC is committed to making quality, cost-effective healthcare available to, and improving the overall health of, the multi-ethnic communities it serves by providing specialized services, health screenings, and education which reflect the unique needs of these communities.

Several phrases written into the hospital's mission statement are key to the Community Benefit Plan:

- CHMC is committed to increasing access to care.
- CHMC will develop services based on the needs of the community.

- CHMC will work with available community resources in creating a network of care.

CHMC's vision statement: *CHMC is committed to improving the health and well being of the community by helping people help themselves.*

ORGANIZATIONAL COMMITMENT

California Hospital Medical Center's community benefit program reflects our commitment to improve the quality of life in the community we serve. The community benefit planning process is shaped by our Mission and Core Values, which emphasize collaboration, justice, stewardship, dignity of each person, and excellence. We seek to promote a healthier community by supporting partnerships with others. In keeping with our tradition of Catholic health care, we do this with special concern for the poor and disenfranchised.

The Community Benefit Committee of the Community Board consists of: Hospital President, Foundation President, and Senior Vice President of Business Development, Director of Community Benefit, Director of Grants and Contracts, and two members of the Community Board. This committee provides oversight and policy guidance for all charitable services and activities supported by the hospital and makes sure that the Board is regularly briefed on community benefit activities and developments. In addition, the entire Community Board is responsible for review and approval of the annual Hospital Community Benefit Report and Plan.

The Community Board has the following expectations regarding the Community Benefits Planning Process:

- The Plan should be responsive to the Community Needs Assessment and, when possible, to CHMC's Strategic Plan.
- To the extent possible, the Plan should be budget neutral, i.e., the majority of the programs should be grant funded.
- Programs should be culturally-sensitive and evidence-based.
- Programs should have measurable objectives and should be continuously monitored.

The Community Board delegates the following decisions to the Foundation President and his staff: budget decisions, program content, program design, program targeting, securing outside funding, program continuation or termination, and program monitoring. Any major deviations from the approved Community Benefit Implementation Plan must be brought back to the Community Advisory Board for its consideration and approval.

California Hospital Medical Center is also committed to **Dignity Health's annual community grants program** which supports the continuum of care in the community offered by other not-for-profit organizations. The director of community benefit oversees this program. Each summer a request for Letters of Intent (LOIs) is widely circulated to non-profits in the community who are asked to focus on specific needs identified in the hospital's Community Health Needs Assessment. This year we focused on 1) access to mental health services for the uninsured, 2) chronic disease prevention, and 3) type 2

diabetes. LOIs and later full proposals are reviewed and scored by the Grant Review Committee and the top seven proposals are forwarded to Corporate for funding.

In order to complete a 2013 (FY14) Community Health Needs Assessment, California Hospital Medical Center pooled its resources with two other hospitals to collect information about the health and well-being of residents in our service community. This group, called the Los Angeles Metropolitan Hospital Collaborative, includes: CHMC, Good Samaritan Hospital, and St. Vincent Medical Center. The Collaborative contracted with the Center for Nonprofit Management to collect and analyze the necessary data, conduct interviews and focus groups, and write an individualized Community Health Needs Assessment for each participating hospital.

In January 2009 and again in 2012 the Hope Street Family Center (HSFC) completed its own Community Needs Assessment for its service area, which is a subset of CHMC's primary service area. This Needs Assessment primarily focused on children, especially those aged 0-5 years, and their families.

The HSFC has its own Community Advisory Board comprised of: three members of the CHMC Community Board, six members of the CHMC Foundation Board, three members from Dignity Health Corporate Office, two professors from UCLA, two members involved in community development, one former HSFC participant, CHMC's President and Foundation President, and the Director of Community Benefits.

NON-QUANTIFIABLE BENEFITS

There are a variety of ways that California Hospital Medical Center contributes to the community we serve. Senior staff actively participates on many community boards, task forces, commissions, and committees in order to share expertise, resources, and contacts and to stay abreast of breaking community issues and challenges. For example, the director of community benefit is a member of: Women's Health Policy Council of Los Angeles County, the Interconception Care Collaborative of Los Angeles County, the Home Visitation Advisory Committee of Los Angeles County, the Health Committee of the Los Angeles Chamber of Commerce, the LA County Perinatal Mental Health Task Force, the First 5 LA Policy Roundtable, the LA County Department of Public Health's Early Childhood Obesity Prevention Project Steering Committee, the LA MOMs (Managing Obesity in Mothers) Advisory Committee, the LA County Substance Abuse Access Project Steering Committee, and the Preconception Health Council of California. Right now many meetings are focused on preparing for Health Reform in 2014 and it is critical for leadership to stay abreast of the rapidly moving changes – transformation of community clinics to medical-homes, the creation of accountable care organizations, the creation of Healthy Way LA by the LA County Department of Health Services, just to name a few.

One particularly exciting new collaboration has been with the Federal Reserve Bank of San Francisco's Los Angeles office. The director of community benefit has spoken at three of their meetings, actively exploring the nexus between community benefit programming and community development finance. We all know that people who live in supportive, connected, and economically-thriving communities tend to be healthier. Therefore, the Fed realized that perhaps the most important contribution that community

development finance provides – more than the affordable apartments, more than the startup capital for small businesses, more than the funding for a grocery store in a food desert, a charter school, or day care center – is the larger contribution of a more vibrant and healthier community. We both focus on the same community and desire the same outcomes – the end of health disparities by addressing the social determinants of health. On February 5, 2013, we convened a half-day meeting entitled *Meeting in the Middle: Responding to Community Needs* at the Federal Reserve Bank of San Francisco, Los Angeles office. Participants included community benefit directors/managers of non-profit hospitals in the Centinela Valley area of LA County, community investment bankers, representatives from philanthropic organizations and senior members of the LA County Department of Public Health. Dr. Jonathan Fielding, director of the LA County Department of Public Health, made the case for working together to address population health and its underlying determinants. Dr. Kevin Barnett described the changes to community benefit under the Affordable Care Act and a panel moderated by Lisa Richter gave a primer on Community Reinvestment. The meeting was a resounding success.

DESCRIPTION OF COMMUNITY SERVED BY THE HOSPITAL

California Hospital Medical Center is located in a federally designated Medically Underserved Area and serves a Medically Underserved Population (MUA/P ID #04011) (Census tract 2240.10). While CHMC is located in Service Planning Area (SPA) 4 of Metro Los Angeles, its service area, also includes parts of SPA 6 (South) and SPA 8 (South Bay). The CHMC service area encompasses a large area that includes all or portions of the following SPAs, Health Districts and cities:

California Hospital Medical Center (CHMC) Service Area

City/Community	Primary ZIP Codes*	Secondary ZIP Codes*	Service Planning Area
Crenshaw	90003	90001	4 – Metro
Los Angeles	90006	90002	5 – West
Pico-Union	90007	90004	6 – South
South Central	90011	90005	8 – South Bay
Westlake	90015	90008	
Wilshire	90016	90010	
	90018	90017	
	90019	90020	
	90037	90026	
	90044	90043	
	90062	90047	
	90071	90057	

Over one-half million people (664,393) live in CHMC's primary service area and a total of 1.2 million live in its primary and secondary service area. A majority of residents are Latino (63%) and are of Mexican origin (60%). The remaining population is mostly African-American (21%). Compared to the County there is a higher concentration of Latinos and African Americans in the CHMC service area. Two-thirds of the population in CHMC's service area speaks a language other than English at home.

Children under the age of 18 accounted for 29.4% of the population, while only 8.3% are seniors. Over half of the residents have not received a high school diploma, and household incomes are generally low with a median household income of only $23,328, nearly $20,000 less than the County median. Over a third of households live below the poverty level, almost three times the LA County rate. A majority of residents living below the poverty level are under 65 years of age. A third of households are experiencing food insecurity.

Three quarters of the housing units in CHMC's service area are renter-occupied, significantly higher than the LA County rate of 52%. Moreover, the majority of homes in CHMC's service area were built in 1939 or earlier (26%), between 1940-49 (17.6%) or between 1950-59 (17.4%) and are far older than housing structures in the rest of LA County. A fifth of households do not have a vehicle. Over half of the population are

unemployed or not in labor force. A quarter of the population ages 0-64 residing in CHMC's service area is uninsured. In zip code 90017, 1 in 3 people are uninsured.

45% of Los Angeles County's homeless population lives in CHMC's service area; only a third are sheltered while the rest live in streets, parks, vehicles, abandoned buildings, etc. 60% of homeless people are adult males, 32% adult females, and 8% children. 47% are African American, 29% Hispanic/Latinos, and 8% White.

The not-for-profit hospital/medical centers in or near CHMC's service area include:

- Children's Hospital Los Angeles — 7 miles north of CHMC
- Good Samaritan Hospital — 2 miles west
- Kaiser Foundation Hospital – Los Angeles — 7 miles north
- LAC+USC Medical Center — 5.5 miles east
- St. Vincent Medical Center — 3 miles west
- White Memorial Medical Center — 5 miles east

2013 Demographics
PSA: California Hospital Medical Center
Level of Geography: Zip Code

- Population: 1,571,248
- Diversity: 5.8% Caucasian | 65% Hispanic | 7.9% Asian/PI | 19.6% African American |
  1.7% Other
- Average Income: $47,328
- Uninsured: 30.5%
- Unemployment: 10.9%
- No HS Diploma: 40.6%
- Renters: 66.9%
- CNI Score: 5
- Medicaid Patients: 35.0%
- Other Area Hospitals: 6

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WHO WAS INVOLVED IN THE ASSESSMENT

In order to complete the 2010 (FY11) Community Health Needs Assessment, five hospitals pooled resources to collect information about the health and well-being of residents in their service community. This group, called the Los Angeles Metropolitan Hospital Collaborative, included: California Hospital Medical Center, Children's Hospital Los Angeles, Good Samaritan Hospital, Kaiser Foundation Hospital – Los Angeles, and St. Vincent Medical Center.

The first step in the project design was to work with the Los Angeles Metro Collaborative to review the previous needs assessments from 2004 and 2007, in order to refine the focus areas and to identify additional data sources to update local demographic and descriptive data for communities served by each member hospital. From this review, recommendations were put forth to the Collaborative, who were asked to assist in setting priorities of the health needs assessment as well as to determine the preferred format for the final report.

The Center for Nonprofit Management (CNM) in collaboration with Special Service for Groups (SSG) created a variety of data collection instruments, including standardized interview protocols, survey forms, document analysis tools and focus group protocols used in health needs assessments in general and specifically for the 2004 and 2007 health needs assessment for the hospital collaborative. These instruments provided useful templates for this health needs assessment and were refined to ensure all instruments were clear and could be used effectively.

The report summarizes key quantitative and qualitative findings for the Los Angeles Metro Collaborative. Overall, findings are organized in narrative and graphic formats by Service Planning Area (SPA), and/or zip codes. Findings are organized by the following major content areas: Community Health Profile, Health Access, Health Behaviors and Preventative Care, Risk Behaviors, Chronic Diseases, Cancer, HIV/AIDS, Communicable Diseases, Mental Health, and Community and Social Issues.

How the Assessment was Conducted

The report was developed using both quantitative and qualitative data sources. To the extent necessary, secondary or existing datasets were accessed to update the previous health needs assessment. Data sources for this purpose include reports from the Los Angeles County Department of Health Services, including the Los Angeles Health Survey, and additional data on live births and deaths. Additionally, the Project Team utilized 2009 projection data, instead of relying on outdated 2000 Census data (the 2010 Census data would not be available until after this project is completed, and American Community Survey data are not available in the lowest geography, such as zip codes or census tracts, desired by the hospital collaborative).

In addition, information from online sources such as Healthy City, United Way, as well as foundations conducting health research related to the needs and resources available in Los Angeles, was incorporated as appropriate. Data serving as social indicators were assembled from a number of data bases and included socioeconomic information, statistics on crime, violence, and on quality of housing. The pertinent research literature was searched to verify or complement the most up-to-date information on local demographic and health statistics. Secondary data and reference materials were retrieved from web-based sources and electronic files in addition to paper documents

gathered through literature searches and from recommendations made by key informants.

Primary Data Collection

Thirty key informant interviewees (mostly from community based organizations providing medical and social services) added important knowledge and experience for their target areas. Other community members and service recipients chosen by community-based agencies provided a broader and more precise perspective about health care services, gaps in services, and suggestions about how to fill them. Their input made it possible to conduct an informative needs assessment with direct implications for policies and resource allocation to address the individual member hospital's specific priorities. Ten focus groups were conducted to cover the number of communities served by the hospital collaborative. A majority of these focus groups were done with community residents identified by community agencies involved in previous needs assessments and by the collaborative.

The Project Team conducted interviews and focus groups. Candidates for focus groups and interviews were selected with the assistance of hospital collaborators and other recommendations from key informants during the data collection process. Project staff strictly adhered to standard ethical guidelines for research and maintained the confidentiality required to ensure the protection of participants and security of all data collected under this project. Data collection activities were conducted in English and Spanish to ensure community representatives in fact reflect the residents in these target areas.

Focus Groups – Topics in the focus group included major areas from previous needs assessments and other issues anticipated to be important in health care. Areas covered were: health care utilization, preventive and primary care, health insurance, access and barriers to care, emergency room use, chronic disease management and community issues. Groups that hospitals commonly identified as important stakeholders in the needs assessment were prioritized. These groups included residents from major ethnic groups, geographic areas and service providers in the collaborative's service areas. Residents from ethnic communities were African American and Latino, representing areas of downtown Los Angeles, East Los Angeles and other metro areas. Translation was provided in the Latino focus groups. Seniors, community health promoters and service providers were gathered separately.. Ten focus groups were conducted to cover the number of communities served by the hospital collaborative. A majority of these focus groups were done with community residents identified by community agencies involved in previous needs assessments and by the collaborative. An additional two focus groups included representatives of community agencies and service providers who interacted with residents on issues related to health care.

Interviews – Thirty interviews were conducted to gather information about the needs and challenges faced by the community in accessing and utilizing health care services, and to ensure reliable and representative information. Key informants included staff at collaborative hospitals and health care service organizations in the primary service areas. Interviews were conducted over the phone or in person and lasted approximately 45 minutes.

Focus groups were conducted across Los Angeles as part of the 2010 Community Health Needs Assessment in order to gather information from community members and community based organizations (CBOs) about health issues facing local communities. CBOs included agencies that provide health, social, and other types of services.. Information was gathered to identify areas of needs and services available or lacking to

meet those needs. There were two types of focus groups conducted in order to collect information from both the community member perspective as well as the CBO perspective. In addition, an online survey was made available to CBOs who were unable to attend a focus group. In total, there were ten focus groups conducted (5 with community members and 5 with CBOs). A total of 158 participants attended one of the ten focus groups. They were conducted in either English or Spanish, with a mixed age group, and they included both males and females. These focus groups took place in a variety of sites throughout Los Angeles County.

City/Site		Characteristics	Primary Language	Participants
Community Based Organizations				
1	Burbank/Buena Vista Library	Various agencies including health, social and other service providers	English	55
2	Los Angeles/ Esperanza Community Housing	Community promotoras; Hispanic; male and female; mixed age group	Spanish/English	7
3	Los Angeles/ Center for Nonprofit Management	Various agencies including health, social and other service providers	English	4
4	Los Angeles/ Center for Nonprofit Management	Various agencies including health, social and other service providers	English	14
5	Online	Various agencies including health, social and other service providers	English	5
Community Members				
6	Los Angeles/ Hope Street Family Center	Hispanic males (fathers); mixed age group	Spanish	19
7	Los Angeles/ Hope Street Family Center	Hispanic females (mothers); mixed age group	Spanish	20
8	Los Angeles/ St. Barnabus Senior Services	Mixed ethnicity; seniors; males and females	English	12
9	Los Angeles/ Amanecer Community Counseling Services	Hispanic; mixed age group; males and females; parents	Spanish	6
10	Pasadena/ City of Pasadena Human Services and Recreation Department	Mixed ethnicity; mixed age group; males and females	English	16
			Total	158

Health Needs Identified

Since the last needs assessment report in 2010, the communities within the CHMC's service area, much like the rest of the nation, have suffered through a devastating economic recession that left many of its residents more vulnerable. Many participants reported seeing more and more people losing health insurance. Some of this has to do with high unemployment rate, as many people lost their insurance coverage when they were laid off.

Both quantitative (or secondary) data and qualitative (or focus group and interview) data suggest that there has been a negative trend most prominently in the area of access to health care and three health-related issues: **mental health, diabetes and obesity**. Services or programs were either eliminated, hospitals were closed, or eligibility became more restricted. Or community members simply could not afford health services, or prioritized them below more basic needs, such as food and shelter. Both providers and

community members identified vision and dental services to be especially lacking in the community. The lack of access to health services affected the older adult population and undocumented population disproportionately.

The emergency room continues to be the last resort for many community members who are uninsured or who delay care. Having patients in the emergency room whose symptoms do not warrant emergency care taxes the quality and efficiency of the health care system. Increasingly, though, community clinics are becoming a regular source of care in Los Angeles health care landscape, especially for immigrants. While this cushioned some of economic blows to health access, it also created a seemingly fractured system.

Despite increasing health needs (or because of it), participants believed that there is a community interest in promoting healthy behavior and in focusing on prevention efforts. Access to green space and healthy food options were often cited as top priorities for the community. The quantitative data also suggested that certain health trends, such as smoking cession and breast cancer screening, turned positive, when there were concentrated efforts in social marketing, policy advocacy, and community health promotion and outreach.

Other community services have been similarly impacted by the recession. Consistent with the quantitative data, participants reported that there was a rise in childhood diabetes, as a result of increasing obesity rates in this population. Easy access to fast food and the elimination of physical fitness programs were just two reasons cited for this, as the recession had made the fast food option affordable to many families and, because of shrinking school budgets, many schools did not even offer physical education classes anymore. Participants also believed that the recession also had led to stressors, such as unemployment, overcrowding and financial instability, that further complicates the mental health of many community members. In addition, budget cuts have reduced the availability of mental health services.

Participants expressed optimism that hospitals like CHMC will play a leadership or convening role in improving health outcomes in their communities. Some participants suggested and others cited examples of collaboration between hospitals and clinics, schools and community-based organizations that serve hard-to-reach populations as a crucial strategy in promoting health. The community health promoter, or *promotora*, model was especially successful in the Latino community.

Community Assets Identified

The assessment identified a number of strong community assets. Community assets are documented in the *Hope Street Family Center's Bilingual* (English/Spanish) *Resource Guide* that is updated annually. Additionally, community resources can be accessed using L.A. County's 2-1-1 system, the largest information and referral (I&R) service in the nation, helping approximately 500,000 individuals and families in Los Angeles County each year. Since 1981, 211 LA County has provided free, confidential services 24 hours a day, 7 days a week in English, Spanish and more than 140 other languages via a tele-interpreting service. Services are also provided for individuals with hearing impairments.

California Hospital Medical Center's community benefit program reflects our commitment to improve the quality of life in the community we serve. The community benefit planning process is shaped by our Mission and Core Values, which emphasize

collaboration, justice, stewardship, dignity of each person, and excellence. We seek to promote a healthier community by supporting partnerships with others, which includes California Hospital Medical Center's commitment to Dignity Health's annual community grants program which supports the continuum of care in the community offered by other not-for-profit organizations. This year we focused on 1) access to mental health services for the uninsured, 2) chronic disease prevention, and 3) Type 2 diabetes. CHMC's community benefit program features:

- Health Ministry Program
- Para Su Salud
- The Hope Street Family Center
- Los Angeles Best Babies Network

Assets and Priorities

Initiative I: Improving Access to Healthcare
Initiative II: Improving Access to Mental Health Services
Initiative III: Improving Access to Oral Health Care and Improving Oral Health Status
Initiative IV: Improving Physical Activity and Dietary Habits and Reducing Obesity
Initiative V: Preventing and/or Managing Chronic Health Conditions
Initiative VI: Improving Birth Outcomes
Initiative VII: Improving Health Literacy
Initiative VIII: Injury Prevention

Next Steps

The Community Benefit Planning Work Group comprised of key community stakeholders and *promotoras* residing in CHMC's service area uses a process that focuses on two levels of decision-making to determine how identified health issues will be addressed:

- Content Areas
  - Size of the problem
  - Severity of the problem
  - Economic feasibility
  - Available expertise
  - Necessary time commitment
  - External salience
- Project Activities
  - Target population
  - Number of people (i.e., How many people will be helped by this intervention?)
  - Estimated effectiveness/efficiency
  - Existing efforts (i.e., Who else is working on this? What is our role? How can we best complement/enhance an existing effort?)

The Work Group considered the following documents as it began its deliberations:

- 2010 CHMC Community Needs Assessment
- 2012 Hope Street Family Center Community Needs Assessment
- CHMC Strategic Plan
- Problems linked to high utilization rates at CHMC
- Prevention Requirements of Level II Trauma Center
- Requirements of Stroke Program

Target Areas and Populations

California Hospital Medical Center is located in a federally designated Medically Underserved Area and serves a Medically Underserved Population (MUA/P ID #04011) (Census tract 2240.10). While CHMC is located in Service Planning Area (SPA) 4 of Metro Los Angeles, its service area, also includes parts of SPA 6 (South) and SPA 8 (South Bay). The CHMC service area encompasses a large area that includes all or portions of the following SPAs, Health Districts and cities:

Service Planning Areas	Health Districts	Cities/Areas
SPA 4 - Metro	HD 9 - Central	Crenshaw
SPA 6 - South	HD 34 - Hollywood/Wilshire	Los Angeles
SPA 8 - South Bay	HD 37 - Inglewood	Pico-Union
	HD 69 - South	South Central
	HD 72 - Southeast	Westlake
	HD 75 - Southwest	Wilshire
	HD 84 - West	

The Community that California Hospital Medical Center serves is defined by CHMC's primary and secondary service areas and is located in Central/Downtown and South Central Los Angeles.

Primary Service Area Zip Codes: 90003, 90006, 90007, 90011, 90015, 90016, 90018, 90019, 90037, 90044, 90062, 90071

Secondary Service Area Zip Codes: 90001, 90002, 90004, 90005, 90008, 90010, 90017, 90020, 90026, 90043, 90047, 90057, 90255

Community Needs Index (CNI)

To complement the traditional methodology used to conduct community needs assessments, CHW developed the CNI, a tool that uses socio-demographic and hospital utilization data to provide an "at a glance" view of disproportionate unmet health care needs in a geographic area. The CNI measures community need in a specific zip code by analyzing the degree to which a community has the following barriers to health care access: income, educational/literacy, cultural, insurance, and housing. Using statistical modeling, the combination of these barriers results in a score between 1 (less needy) and 5 (most needy). Analysis has indicated significant correlation (97%) between the CNI and preventable hospital admissions. Individuals living in communities with scores of "5" are more than twice as likely to need inpatient care for a preventable condition, i.e., otitis media or pneumonia, as those residing in communities with a score of "1". The CNI map of CHMC's service area is included in the Appendix A.

How the Implementation Strategy was Developed

In order to complete a 2010 Community Health Needs Assessment, California Hospital Medical Center pooled its resources with four other hospitals to collect information about the health and well-being of residents in our service community. This group, called the Los Angeles Metropolitan Hospital Collaborative, includes: CHMC, Children's Hospital Los Angeles, Good Samaritan Hospital, Kaiser Foundation Hospital- Los Angeles, and St. Vincent Medical Center. The Collaborative contracted with the Center for Nonprofit Management in collaboration with Special Service for Groups to collect and analyze the necessary data, conduct interviews and focus groups, and write individualized Needs

Assessments for each participating hospital. Each member hospital of the Los Angeles Metropolitan Hospital Collaborative developed its own Implementation Strategy.

In January 2009 and again in 2012 the Hope Street Family Center (HSFC) completed its own Community Needs Assessment for its service area, which is a subset of CHMC's primary service area. This Needs Assessment primarily focused on children, especially those aged 0-5 years, and their families.

The HSFC has its own Community Advisory Board comprised of: three members of the CHMC Community Board, six members of the CHMC Foundation Board, three members from Dignity Health Corporate Office, two professors from UCLA, two members involved in community development, one former HSFC participant, CHMC's President and Foundation President, and the Director of Community Benefits.

Major Needs and How Priorities Were Established

In response to identified unmet health-related needs in the community health needs assessment, during FY 3 CHMC focused on increasing access to health care for the broader and underserved disadvantaged members of the surrounding community. Major community benefit activities for FY13 focused on health coverage enrollment assistance, outreach health education and health screenings for common chronic conditions at over 55 sites in the community, referring individuals and families to local community clinics for on-going primary health care, and health education workshops for common chronic conditions at some of the community clinics as well as at local schools, churches, and other community centers.

Health education was selected as a priority to address prevention of disease, to empower community members to assume responsibility for their health and to educate people about various medical conditions and the ability they have to make wise choices. Lecture topics were distributed in the following broad categories: family violence, mental health, safety, physical health, communicable diseases, and access to medical services. Self-management workshop series included: Healthier Living; Food, Fitness, and Diabetes Prevention; Living with Diabetes; Healthy Eating Lifestyle Program (addressing pediatric obesity); Freedom from Smoking; Asthma; and Heart H.E.L.P.

People with diabetes, especially those with poorly controlled diabetes, are more likely to have periodontal disease than people without diabetes. In fact, periodontal disease is often considered the sixth complication of diabetes and may make it more difficult for people with diabetes to control their blood sugar. What happens when you treat periodontal disease? Meta-analysis demonstrated a 0.46% fall in HbA1c with nonsurgical treatment of periodontal disease; a 0.4% fall in HbA1c per Cochrane Review in 2010. (For reference, a 1% fall in HbA1c represents 30 mg/dl fall in mean plasma glucose)

The **Community Dental Partnership** is a collaboration between Eisner Pediatric and Family Medical Center, the Southside Coalition of Community Clinics, and CHMC to provide access to free basic dental services and periodontal services for uninsured adults living in Central Los Angeles with medication-dependent type 2 diabetes. Participants must have their medical home at one of the clinics of the Southside Coalition and must complete the *Living with Diabetes* workshop series and the Oral Hygiene class.

In September 1992 the **Hope Street Family Center (HSFC)** was established as a collaborative effort between the University of California Los Angeles (UCLA) and Dignity Health, formerly Catholic Healthcare West, dba CHMC to address several critical factors impacting the community: extreme poverty, predominant immigrant population, very low literacy rates, poor quality schools, high rates of disabilities in young children, gang violence, lack of access to health care including prenatal care and pediatric care, insufficient licensed child care, and the need for family mental health services. Today this collaboration has grown to include partnerships with over 30 community agencies. The HSFC exemplifies the mission of Dignity Health to empower and strengthen families by providing health services, education, and access to community resources through a seamless, flexible, comprehensive, culturally-sensitive, and responsive array of services free of charge to meet a family's individual and changing needs. HSFC's services are both hospital- and community-based and include: Early Head Start Program, three licensed early care and education centers, the Hope Street Youth Center, Family Childcare Network, Healthy Marriage and Responsible Fatherhood Programs, Family Literacy Program, on-site continuation high school, Nurse Family Partnership Program, Pico Union Family Preservation Network, Early Intervention Program, and Behavioral Health Clinic. The HSFC celebrated its belated 20th anniversary in October 2013, and moved into its new $16 million home, four story building on the corner of Hope St and Venice Blvd, the Hope Street Margolis Family Center.

CHMC has been a leader in perinatal services for over half a century. Therefore, it seemed only natural to become the host agency for the **Los Angeles Best Babies Network (LABBN) Center for Healthy Births**. The mission of the Center is to provide the infrastructure, programs, advocacy and support to enhance the capacity of the network of community stakeholders working to achieve healthy births throughout Los Angeles County. The Network provides training and technical assistance for seven Best Babies Collaboratives that are partnerships funded to provide inter-conception care for women at high risk for recurrent poor birth outcomes; leads Care Quality Improvement activities to help perinatal care providers implement evidence-based practice guidelines and to link health care providers to community-based services and resources; coordinates and institutionalizes a broad perinatal health policy agenda working with community stakeholders and others to build sustainable improvement of pregnancy and birth outcomes; promotes health literacy skill building through the use of *Baby Basics*; and partners with the Los Angeles County Perinatal Mental Health Task Force to promote universal screening for perinatal depression.

CHMC has chosen the **Living with Diabetes Program** and **Heart H.E.L.P.** as its two Long Term Improvement Plans (LTIPs) for FY11-FY13. The goal of these LTIPs is to avoid admissions among the participants in the program for two of the most prevalent ambulatory care sensitive conditions in our community.

Description of What CHMC Will Do to Address Community Needs

California Hospital Medical Center's community benefit program reflects our commitment to improve the quality of life in the community we serve. The community benefit planning process is shaped by our Mission and Core Values, which emphasize collaboration, justice, stewardship, dignity of each person, and excellence. We seek to promote a healthier community by supporting partnerships with others. In keeping with our tradition of Catholic health care, we do this with special concern for the poor and disenfranchised.

The Community Benefit Committee of the Community Board consists of: Hospital President, Foundation President, and Senior Vice President of Business Development,

Director of Community Benefit, Director of Grants and Contracts, and two members of the Community Board. This committee provides oversight and policy guidance for all charitable services and activities supported by the hospital and makes sure that the Board is regularly briefed on community benefit activities and developments. In addition, the entire Community Board is responsible for review and approval of the annual Hospital Community Benefit Report and Plan.

The Community Board has the following expectations regarding the Community Benefit Planning Process:

- The Plan should be responsive to the Community Health Needs Assessment and, when possible, to CHMC's Strategic Plan.
- To the extent possible, the Plan should be budget neutral, i.e., the majority of the Programs should be grant funded.
- Programs should be culturally-sensitive and evidence-based.
- Programs should have measurable objectives and should be continuously monitored.

The Community Board delegates the following decisions to the Foundation President and his staff: budget decisions, program content, program design, program targeting, securing outside funding, program continuation or termination, and program monitoring. Any major deviations from the approved Community Benefit Implementation Plan must be brought back to the Community Advisory Board for its consideration and approval.

California Hospital Medical Center is also committed to Dignity Health's annual community grants program which supports the continuum of care in the community offered by other not-for-profit organizations. The director of community benefit oversees this program.

Action Plan

Prologue: Each of the programs listed below that address the identified needs has its own evaluation plan that is monitored at least annually, particularly since the majority of programs are grant-funded. Programs developed in response to the current Community Health Needs Assessment are guided by the following five core principles:

- **Disproportionate Unmet Health-Related Needs**
  Seek to accommodate the needs of 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 links 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.

Access

- **Data documenting the need:**
- According to the 2005 California Health Interview Survey, all 12 zip codes in CHMC's primary service area and 9 of 12 zip codes in CHMC's secondary service area had a 20% uninsured rate for individuals under the age of 65.
- In 2007, the percentage of adults who reported a regular source of care in the Metro and South SPAs of CHMC's service area were lower compared to Los Angeles County (74.1% and 79.1% vs. 80.8%) and all other SPAs. However, the Metro and South SPAs had the highest percentage of adults receiving medical primary services from the Los Angeles County Health Department facilities.
- The percentages of adults and children who did not obtain dental care in the past 12 months because they could not afford it was higher in CHMC's Metro SPA 4 (27.7%) and South SPA 6 (28.8%) than in the Los Angeles County (23.3%).
- The cost of prescription medication continues to be a problem for low-income, uninsured and under-insured individuals and families. The percentage of adults who did not get their prescription medication in the past year because they could not afford it was also higher in CHMC's Metro SPA 4 (13.7%) and South SPA 6 (18.7%) than in the Los Angeles County (12.1%).
- Two of the biggest barriers to accessing care were transportation and lack of linguistic competence of providers. An additional barrier particular to senior care was a lack of primary service coordination among an overly fragmented and often competitive long-term care system.
- For community clinics, recent and impending budget cuts, delayed payments, and a growing low-income under-insured population have exacerbated an already overburdened system

The Action Plan to Improve Access to Healthcare

- *Para Su Salud* Program*
- Health Ministry Program*
- Charity Care for uninsured/underinsured and low income residents*
- Clinical experience for medical professional students*
- Dignity Health Community Grant Program- Care Management Linked to Supportive Housing for Chronically Homeless Patients*

Mental Health

- **Data documenting the need:**
- The need for mental health primary services has increased, given the high level of stress due to the worsening economy and unemployment.
- The most frequently cited community mental health issue continues to be depression. Diagnosis of depression had risen since 1999. In particular, women, older adults and American Indians had the highest rate of depression in Los Angeles County.
- In 2007, there were 13.6% of adults diagnosed with depression (up from 12.9% in 2005) in Los Angeles County. The largest increase occurred in CHMC's SPA 4 (11.9% vs. 14.6%). Within CHMC's service area, the average percent of adults diagnosed with depression was 13.8%.

The Action Plan to Improve Access to Mental Health Services

- Health Ministry Program*
- Hope Street Family Center
  - Early Head Start Program*
  - Nurse Family Partnership*

    - School Readiness Program*
    - Welcome, Baby! Program*
    - Pico Union Family Preservation Program*
    - Hope Street Youth Center*
    - CA Behavioral Health Clinic*
- Clinical experience for social work students*
- LA County Perinatal Mental Health Task Force*
- Los Angeles Best Babies Network
    - Best Babies Collaboratives*
    - Welcome, Baby! Replication Initiative and Implementation of Select Home Visitation Programs at 14 birthing hospitals in Los Angeles County
- Dignity Health Community Grant Programs
    - Immanuel Presbyterian Church and HSFC: Community Yoga/Exercise Classes and Health Workshops*
    - LA Child Guidance Clinic: First Steps Program*
    - Korean American Family Service Center: Community Mental Health Program*
    - Integrating Mental Health Services at LAUSD School-based Wellness Center
    - Enrichment Works: Hope Street Youth Circus*
    - Pathways LA: Positive Parenting & Stepping Stones for Families with Children with Special Needs and Disabilities

Oral Health Care

- **Data documenting the need:**
- 14.9%, 12.2%, and 11.3% of children ages 3-17 years in SPAs 6, 8, and 4 respectively did not obtain dental care (including check-ups) in the past year because they could not afford it.
- 35%, 27.4%, and 37.6% of adults in SPAs 6, 8, and 4 respectively did not obtain dental care (including check-ups) in the past year because they could not afford it

The Action Plan to Improve Access to Oral Health Care and Improving Oral Health Status

- Hope Street Family Center*
    - Partnership with USC School of Dentistry
- Health Ministry Program*
    - Oral Hygiene Classes
- UniHealth Community Dental Partnership for Uninsured Adults with Medication-Dependent Diabetes
    - A collaboration between CHMC, the Southside Coalition of Community Clinics and Eisner Pediatric and Family Medical Center

Health Behavior and Preventive Care

- **Data documenting the need:**
- The California Health Interview Survey reported less than half (42.8%) the adults in both CHMC's primary and secondary service areas consumed at least 5 servings of fruits and vegetables from 2003 to 2005.
- From 2005 to 2007, CHMC's service area had an increase in individuals who were overweight or obese. Nearly two-thirds of adults in CHMC's SPA 6 (65.2%) were overweight or obese compared to over half (57.4%) of Los Angeles County adults.
- 29%, 20.7% and 26.7% of children in grades 5, 7, and 9 who lived in SPAs 6, 8, and 4 respectively are obese (BMI above the 95th percentile)

The Action Plan for Improving Physical Activity and Dietary Habits and Reducing Obesity

- Health Ministry Program*
- Healthy Eating Lifestyle Program for pediatric obesity*
- Food, Fitness, and Diabetes Prevention Program*
- Hope Street Family Center
    - Early Head Start Program*
    - Nurse Family Partnership*
    - School Readiness Program*
    - Welcome, Baby! Program*
    - Hope Street Youth Center*
    - Licensed childcare centers (N=3)*
    - Family Childcare Network
    - Youth Fitness Program
- Dignity Health Community Grant Programs
    - Immanuel Presbyterian Church and HSFC: Community Yoga/Exercise Classes and Health Workshops*
    - Enrichment Works: Hope Street Youth Circus*
    - Salvation Army Red Shield: Diet and Exercise Program
- Los Angeles Best Babies Network
    - Community Transformation Grant: Healthy Weight Perinatal Care Quality Collaborative*
    - Centinela Valley Not-for-Profit Hospitals and Community Clinics Population Health Collaborative*

Chronic Diseases

- **Data documenting the need:**
- Within CHMC's service area, SPA 4 had the largest increase in the prevalence rate of diabetes from 2005 to 2007 (14.5% vs. 20.8%) and tied with SPA 7, with the second highest diabetic prevalence rate in Los Angeles County. CHMC's SPA 6 continues to report the highest diabetes prevalence rate in Los Angeles County and California.
- SPA 6 had an increase in the prevalence rate of asthma; while SPA 4 decreased.
- CHMC's service area had a 2.8% average increase in heart disease in ten years, compared to an average of 2.7% across all SPAs.
- There was also an increase in hypertension for CHMC's service area. The prevalence of hypertension in Metro SPA 4 had double-digit growth from 1997 to 2007 (13.8% vs. 24.8%). While SPA 6 continues to have the highest hypertension rates in Los Angeles County at 29.0%.
  SPA 4 and SPA 6 had the lowest high blood cholesterol estimates than Los Angeles County. Nevertheless, an average of 26% reported high blood cholesterol.
- The coronary heart disease death rate (age-adjusted per 100,000 population) is 178.2, 130.8, and 118.5 in SPAs 6, 8, and 4 respectively.
- The stroke death rate (age-adjusted per 100,000 population) is 45.5, 33.4, and 28.9 in SPAs 6, 8, and 4 respectively

The Action Plan to Prevent and/or Manage Chronic Health Conditions

- Health Ministry Program*
- Food, Fitness, and Diabetes Prevention Program*
- Living with Diabetes Program*

- Chronic Disease Self Management Program (CDSMP) aka Healthier Living Program*
- Heart H.E.L.P.*
- Healthy Eating Lifestyle Program for pediatric obesity*
- Freedom from Smoking*
- UniHealth Healthy Homes Approach to Reducing Severe Pediatric Asthma
    - A collaboration of CHMC and Esperanza Housing Corp.
- Komen Breast Cancer Diagnostic Program
- Dignity Health Community Grant Programs
    - *Regresar al Bienstar* (Return to Wellness) Program for Underserved Latinas with Breast Cancer
    - South Central Family Health Center: Exercise and Nutrition Program for Adults with Type 2 Diabetes
    - St Barnabus Senior Center of Los Angeles: Stanford Diabetes Self-Management Program

Reproductive Health

- **Data documenting the need:**
- Rate of births (per 1,000 live births) to teens ages 15-19 years is 51.1, 25.7, and 35.5 in SPAs 6, 8, and 4 respectively
- Percent of low birth weight (<2,500 grams) births (per 100 live births) is 8.1, 7.1, and 7.1 in SPAs 6, 8, and 4 respectively
- Percent of low birth weight (<2,500 grams) African-American births (per 100 live births) is 13.4, 10.6, and 11.7 in SPAs 6, 8, and 4 respectively
- Infant death rate (per 1,000 live births) is 6.1, 4.7, and 5.0 in SPAs 6, 8, and 4 respectively.
- African American infant death rate (per 1,000 live births) is 9.5, 11.2, and 14.4 in SPAs 6, 8, and 4 respectively

The Action Plan for Improving Birth Outcomes

- Los Angeles Best Babies Network
    - Community Transformation Grant: Healthy Weight Perinatal Care Quality Collaborative*
    - Best Babies Collaboratives*
    - Incorporating *Baby Basics* into Prenatal Healthcare Delivery*
    - LA County Perinatal Home Visitation Consortium*
    - Welcome, Baby! Expansion Initiative and Implementation of Select Home Visitation Programs in LA County
- Hope Street Family Center
    - Early Head Start Program*
    - Nurse Family Partnership*
    - Welcome, Baby! Program*

Healthy Literacy

- **Data documenting the need:**
- Literacy skills predict an individual's health status more strongly than age, income, employment status, education level, and racial or ethnic group, according to the nonprofit organization Partnership for Clear Health Communication.
- A higher percentage of adults in LA County (27%) are estimated to be at the lowest literacy proficiency level than for the state (19%) or the U.S. (20%).

Moreover, CHMC's service area has the highest rate of low literacy (66%) in the County. The greatest need for literacy services is for younger adults, particularly Latino and Asian/Pacific Islander populations.

- Disability is also correlated with lower literacy scores; CHMC's service area has disability rates well above the County average of 9% - with downtown LA at 11% and South Los Angeles at 14%.
- Almost without exception, the highest levels of limited English Proficiency (LEP) are the lowest literacy areas in the County. Every low-literacy area also has an above average proportion of recent immigrants. Moreover, residents of the lowest literacy areas show low levels of educational attainment.
- 50.2%, 39.1%, and 55.1% of adults living in SPAs 6, 8, and 4 respectively were not born in the United States.
- 38.8%, 18.9%, and 27.6% of adults living in SPAs 6, 8, and 4 respectively had less than a high school education.

The Action Plan for Improving Health Literacy

- Hope Street Family Center
  - Family Literacy Program*
  - School Readiness Program*
  - Early Head Start Program*
  - Licensed childcare centers (N=3)*
  - Family Childcare Network*
  - Hope Street Youth Center*
  - Central High Continuation School*
- Los Angeles Best Babies Network-Incorporating *Baby Basics* into Prenatal Healthcare Delivery*

Injury Prevention

- **Data documenting the need:**
- Homicide rate among adolescents and young adults ages 15-34 years (per 100,000 population) is 38.8, 22.6, and 10.7 for SPAs 6, 8, and 4 respectively
- Death rate attributed to motor vehicle crashes (age-adjusted per 100,000 population) is 9.6, 5.5, and 5.3 for SPAs 6, 8, and 4 respectively
- Rate of unintentional drug-related (includes alcohol) death (age-adjusted per 100,000 population) is 8.0, 6.5, and 6.8 in SPAs 6, 8, and 4 respectively.
- There were 9,917 homicides in LA County between 2000 and 2009; approximately 43% of these were gang-related homicides.
  - Homicide was the leading cause of premature death for Hispanic and African American males
  - Homicide rates among African American males were 6 times higher than the county overall
  - Homicide was the leading cause of premature death in SPA 6
  - Homicide was the second leading cause of premature death countywide (1999-2008) behind coronary heart disease. While an average of 4 years of life was lost from every coronary heart disease death, an average of 46 years of life lost was lost from every firearm homicide.
- In 2010 there were 798 firearm deaths in LA County, including 504 homicides, 281 suicides, and 13 other intent (unintentional shooting, legal intervention, undetermined).
  - Firearm death rates among youth in SPA 6 were nearly 8 times the county overall

- More than half (58%) of all deaths among African American youth were caused by firearm homicides

The Action Plan for Gang Prevention

- Hope Street Family Center
  - Hope Street Youth Center*
  - Youth Fitness Program
  - Central High Continuation School*
  - Nurse Family Partnership*
  - CA Behavioral Health Clinic*

The Action Plan for Pedestrian Safety

- Health Ministry Program*

The Action Plan for Child Car Seat Safety

- Maternity Tours*
- Free car seats given to all new parents delivering at CHMC*
- First 5 LA *Kit for New Parents*

The Action Plan for Prevention of Child Abuse and Neglect

- Hope Street Family Center
  - Pico Union Family Preservation Network*
  - Early Head Start Program*
  - Nurse Family Partnership*
  - Welcome, Baby! Program*
  - Licensed Childcare Centers (N=3)*
  - Family Childcare Network*
  - CA Behavioral Health Clinic*
  - Early Intervention Program*
- Los Angeles Best Babies Network
  - Best Babies Collaboratives*
  - LA County Perinatal Mental Health Task Force*
  - LA County Perinatal Home Visitation Consortium*
  - Welcome, Baby! Expansion Initiative and Implementation of Select Home Visitation Programs
- Dignity Health Community Grant Program
  - Pathways LA: Positive Parenting and Stepping Stones for Families with Children with Special Needs and Disabilities

The Action Plan for Family Violence Prevention

- Health Ministry Program*
- Hope Street Family Center
  - Pico Union Family Preservation Network*
  - Early Head Start Program*
  - Nurse Family Partnership*
  - Welcome, Baby! Program*
  - Early Intervention Program*
  - CA Behavioral Health Clinic*
- Los Angeles Best Babies Network
  - Best Babies Collaboratives*
  - LA County Perinatal Home Visitation Consortium*

    - Welcome, Baby! Expansion Initiative and Implementation of Select Home Visitation Programs
- Dignity Health Community Grant Programs
    - Immanuel Presbyterian Church and HSFC: Community Yoga/Exercise Classes and Health Workshops*
    - Korean American Family Service Center: Community Mental Health Program
    - Pathways LA: Positive Parenting and Stepping Stones for Families with Children with Special Needs and Disabilities

Next Step for Priorities

- Seek to accommodate the needs of communities with disproportionate unmet health-related needs.
- Address the underlying causes of persistent health problem.
- Emphasize evidence-based approaches by establishing operational links between clinical services and community health improvement activities.
- Target charitable resources to mobilize and build the capacity of existing community assets.
- Engage diverse community stakeholders in the selection, design, implementation, and evaluation of program activities.

Priority Needs Not Being Addressed and the Reasons

Cancer

- In Los Angeles County, 34,335 residents were diagnosed with cancer in 2010. Most cancer incidents were attributed to breast cancer, colon cancer, and cervical cancer. Since 2007, cancer screening rates continues to improve and cancer incidence rates have remained steady.
- In CHMC's primary and secondary service areas, more than two-thirds of women 40 years and older reported having a mammogram in 2007 or the previous two years. And nearly three-fourths of women 50 years and older reported having a mammogram in 2007 or the previous two years.
- Colon screening rates varied across Los Angeles County, from a low 35.6% in CHMC's SPA 4 to a high 43.3% in CHMC's SPA 6, compared to median 38.1% for Los Angeles County.
- All of CHMC's SPAs reported higher rates of cervical (Pap smear) screenings among women than Los Angeles County.

- **Rationale for not addressing Cancer**
- Cancer screening rates in our service area are fairly good and are likely to improve if we can assist individuals establish a medical home.
- Many cancers are increased in individuals who are overweight and obese and are likely to decrease if we can help individuals lose weight and/or maintain a healthy weight by eating a healthy diet and being physically active.
- We can help combat smoking by collaborating with the LA County Department of Public Health that provides smoking cessation aides (nicotine patches, gum, etc) and by continuing to provide Freedom from Smoking Classes through our Health Ministry Program.

HIV/AIDS

- The number of HIV/AIDS cases decreased from 2007 to 2010. However, a disproportionate

number of cases were reported among people of color and youths. Hispanic and immigrant groups lacked awareness in HIV prevention and proper use of HIV medication.

- In 2009, SPA 4 had the highest number of adolescents diagnosed with AIDS (74) than other SPAs in Los Angeles County. SPA 6 had the second highest number at 58.
- Although the number of HIV/AIDS cases has decreased, the number of individuals living with HIV has increased as many people living with HIV are living longer as a result of better medication.

- **Rationale for not addressing HIV/AIDS**

- In 1983, physicians at Children's Hospital Los Angeles identified the first case of pediatric AIDS in Southern California. Since then, Children's Hospital Los Angeles has become the largest pediatric AIDS and HIV care provider in the western United States, currently treating more than 300 children, adolescents and their families in the Hemophilia, Adolescent Medicine and Allergy/Immunology programs. The Children's AIDS Center is a multidisciplinary, coordinated and comprehensive program for the treatment of AIDS and HIV infections in youth between the ages of 12 and 23. The program focuses on the multiple and unique needs of HIV-infected children through a family-centered approach.
- Both LAC+USC Medical Center and Harbor-UCLA Medical Center have comprehensive treatment centers for patients with HIV/AIDS including HIV-positive pregnant women and their children and partners.
- West Hollywood has a plethora of resources for individuals with HIV/AIDS including:
    1. AID for AIDS that provides financial support for persons disabled by AIDS to pay for rent, utilities, security deposits, pharmaceuticals, food, and transportation
    2. AIDS Education for the Deaf that provides case management, advocacy, and interpretation services
    3. AIDS Healthcare Foundation that provides medical services
    4. AIDS Project LA that provides case management, HIV prevention & education and treatment advocacy, in-home health care, dental care, insurance/benefits advocacy, mental health and the Necessities of Life program
    5. AIDS Research Alliance that provides information about enrollment in drug trials and protocols
    6. Being Alive that provides peer support, peer counseling and programming, wellness center, acupuncture, chiropractic services, ceramic arts, social events and educational forums for persons living with HIV/AIDS
    7. HIV/LA, an online directory of HIV/AIDS services in LA County
    8. Life Group LA, a coalition of people dedicated to the education, empowerment, and emotional support of persons both infected and affected by HIV/AIDS so that they may make informed choices and decisions re their healthcare and personal wellbeing
    9. LA Gay and Lesbian Center that provides primary care for persons living with HIV/AIDS
    10. PAWS/LA that assists low-income pet owners who are seniors or living with HIV/AIDS or other life-threatening illness to keep and car for companion animals.

11. CHIRP/LA is a program of PAWS that provides free housing referrals and information for emergency, transitional, permanent housing and other supports.
12. Project Angel Food that provides home-delivered meals for people living with HIV/AIDS, cancer, and other life-threatening illnesses
13. Project Chicken Soup that prepares and delivers free, nutritious kosher meals two Sundays each month to people living with HIV/AIDs throughout LA County
14. Project New Hope that provides housing services and vocational training for people living with HIV/AIDS
15. The Saban Free Clinic that provides free confidential rapid HIV counseling, tesing and referrals
16. WEHO Life, an AIDS information and prevention program

Communicable Diseases

- The number of pertussis cases has increased in 2010. In CHMC's service area, the majority of cases occurred in SPA 6 (23.7%, n=14) followed by SPA 4 (17.0%, n=10).
- Among STDs, the rate of Chlamydia in Los Angeles County remained higher than California or the United States. SPA 6 reported the highest rate of Chlamydia cases with 960.0 cases per 100,000 in 2007, the highest rate of Chlamydia cases in Los Angeles County.

- **Rationale for not addressing Communicable Diseases**
- By helping people establish a primary medical home, we indirectly improve their access to necessary immunizations and screening for STDs.
- The LA County Department of Public Health's Acute Communicable Disease Control's mission is to reduce the incidence of communicable disease (other than TB, STDs, and AIDS) in Los Angeles County through prevention, surveillance, and outbreak control. People with TB and STDs can access free testing and treatment services at local Public Health Clinics located throughout LA County.

Approval

Each year the California Hospital Medical Center Community Board of Directors review and approve the annual Community Benefit Report and Implementation. This CHNA and Implementation Plan were approved on October 24, 2013.

PROGRAM DIGESTS

Health Ministry Program	
Hospital CB Priority Areas	Please add the Hospital Priority Areas identified in the Community Needs Assessment for your hospital here ☐ Priority Area 1 ☑ Priority Area 2 Health Promotion/Disease Prevention ☑ Priority Area 3 Disease Management ☐ Priority Area 4 ☐ Priority Area 5
Program Emphasis	Please select the emphasis of this program from the options below: ☑ Disproportionate Unmet Health-Related Needs ☑ Primary Prevention ☑ Seamless Continuum of Care ☐ Build Community Capacity ☐ Collaborative Governance
Link to Community Needs Assessment	Lack of access to healthcare, especially preventive care and health screenings
Program Description	CHMC sponsors Parish Nurses and community health promoters (CHPs) at over 55 local schools, churches, and community sites to provide health screenings, immunizations, health education and information, and referral services. Each site selects their health education classes from a menu of choices offered annually. Health Ministry staff also participates in local health fairs. CHPs together with a volunteer lay leader conduct Chronic Disease Self Management Program Workshops at selected Health Ministry sites.
FY 2013	
Goal FY 2013	Eliminate health disparities in CHMC's service area
2013 Objective Measure/Indicator of Success	Increase in awareness, knowledge, attitudes, and skill development/acquisition regarding high prevalence health conditions, especially chronic conditions Increase in health screens for chronic conditions Increase the ability of people with chronic conditions to manage their health and maintain active and fulfilling lives
Baseline	The following factors contribute to lack of access to health education, health screenings, and referrals to regular source of health care: high rates of uninsured adults, highest rates of low literacy in Los Angeles County, large percentage of foreign born residents, extreme poverty.
Intervention Strategy for Achieving Goal	Provide free health education classes in English and Spanish at Health Ministry sites on a variety of topics. Conduct pre- and post-tests to assess knowledge acquisition. Provide free health screenings for diabetes, hypercholesterolemia, hypertension, tuberculosis, anemia, obesity and depression. Provide referrals to local primary care clinics when screening tests are positive. Provide flu shots Participate in local health fairs. Provide CDSMP workshops
Result FY 2013	Please see tables documenting screenings and referrals following this Program Digest. 95% of class participants completed both pre- and post-tests. Of those, 90% demonstrated increased knowledge.
Hospital's Contribution / Program Expense	The hospital contributed the majority of the operating budget for this program and provided office space and office and testing equipment and supplies for staff. The annual budget is $ 383,329.63 for the Health Ministry Program.
FY 2014	
Goal 2014	Eliminate health disparities in CHMC's service area
2014 Objective Measure/Indicator of Success	Increase in awareness, knowledge, attitudes, and skill development/acquisition regarding high prevalence health conditions, especially chronic conditions Increase in health screens for chronic conditions Increase the ability of people with chronic conditions to manage their health and maintain active and fulfilling lives
Baseline	The following factors contribute to lack of access to health education, health screenings, and referrals to regular source of health care: high rates of uninsured adults, highest rates of low literacy in Los Angeles County, large percentage of foreign born residents, extreme poverty.
Intervention Strategy for Achieving Goal	Continue intervention strategy detailed above.

The parish nurse/health ministry program provides health education and health screenings to residents in CHMC's Service Area including the Downtown, Pico-Union/Westlake, Koreatown, South Los Angeles, and Crenshaw districts of Los Angeles, with a particular emphasis on underserved populations located near CHMC. Most of the people we serve have limited resources and no health insurance or regular healthcare. For them, the many health screenings we conduct can facilitate better health and save lives. This program promotes community health and preventive health education, assists in preventing disease and offers early detection, referral services, counseling and follow-up education. We provide a host of free health services and screenings and often identify the signs of serious health conditions, such as hypertension and uncontrolled diabetes that might otherwise go undetected and untreated. These screenings can lead to early diagnosis and referrals. Health education lectures and screenings are provided in collaboration with 28 health ministry sites in Los Angeles including community centers, churches, day laborer centers and car washes. Our overarching goal is to eliminate health disparities and promote health equity by increasing access to culturally competent, comprehensive healthcare services and health education for the underserved in our community.

ACCOMPLISHMENTS – FY2013

- Our bilingual parish nurse served 1,938 participants at 160 screening events, 16 public health chats and 1 health fair for a total of more than 10,945 participant encounters.

HEALTH SCREENINGS 2013

Screening Type	# Individuals Screened	# Referred
Blood glucose (diabetes)	1,691	231
Blood pressure (hypertension)	1,871	441
Body mass index (overweight/obesity)	1,612	132
Cholesterol	1,712	148
Hemoglobin (anemia)	1,489	224
Hemoglobin A1c (diabetes)	587	203
Smoking	532	171
Substance abuse and dependence	510	54
TOTAL	**10,004 screenings**	**1,604 referred**

- Offered 16 public health chats on topics ranging from obesity prevention, diabetes prevention and weight management, stroke prevention, STD prevention, hand hygiene, the dangers of excessive alcohol consumption, the importance of reducing sugary beverage consumption, and falls prevention for seniors. These chats are offered free of charge before screening events at places of worship, community-based organizations, day laborer centers, car washes, and other locations. In fiscal year 2013, we reached more than 192 participants at 12 locations.

- Gave away more than 400 brand-new and gently-used age-appropriate books to children aged 0-12 during health screenings; advised parents of children aged six months through 5 years old about the importance of reading and/or sharing books with their children to promote early literacy and school readiness.

- Given we see a wide range of health issues among the underserved in our community, appropriate referrals are made to provide necessary help for these individuals. We made an additional 1,864 referrals as illustrated below:

REFERRALS 2013

Type of Referral	# of Individuals Referred
Mammogram/Clinical Breast Exam/Pap testing	1,267
CHMC Living with Diabetes	112
CHMC Heart HELP	310
Dental Services	92
Vision Services	64
Mental Health Services	19
TOTAL	**1,864**

Following are referral partners that provide free or low-cost medical, dental and mental health care as well as other partners outside the healthcare system:

Medical Services

- Alcoholics Anonymous: Grupos Crecimiento and Latinos en Acción
- APAIT Health Center
- California Smokers' Helpline
- California Vision Foundation (free comprehensive eye exam and glasses)
- County of Los Angeles, Department of Public Health, Central Health Clinic
- County of Los Angeles Office of Women's Health
- County of Los Angeles Public Health: Substance Abuse and Prevention Control
- Eisner Pediatric & Family Medical Center
- Grand Avenue Imaging (free mammogram program with California Detection Program)
- H. Claude Hudson Comprehensive Health Center
- LAC+USC Healthcare Network
- LA Quits (for free nicotine patches)
- Northeast Community Clinic California Family Care & Women's Wellness Center
- Oscar A. Romero Clinic
- Planned Parenthood
- South Bay Family Health Care Centers

Dental Services

- Central City Community Clinic
- Chinatown Service Center
- Ostrow School of Dentistry at USC
- Queenscare Clinics

Mental Health Services

- APAIT Health Center
- Oscar A. Romero Clinic

Referrals Outside Healthcare System

- Food Forward Farmers' Market Recovery Program (free produce donations for day laborer center)
- Hope Street Family Center (ESL Program)
- St. Barnabas Senior Services (food pantry; Meals-on-Wheels)
- St. Francis Center (food pantry; free breakfast/lunch; senior services)
-

Type 2 Diabetes Prevention, Screening, and Intervention Program	
Hospital CB Priority Areas	Please add the Hospital Priority Areas identified in the Community Needs Assessment for your hospital here ☐ Priority Area 1 ☑ Priority Area 2 **Health Promotion/Disease Prevention** ☑ Priority Area 3 **Disease Management** ☐ Priority Area 4 ☐ Priority Area 5
Program Emphasis	Please select the emphasis of this program from the options below: ☑ Disproportionate Unmet Health-Related Needs ☑ Primary Prevention ☑ Seamless Continuum of Care ☐ Build Community Capacity ☑ Collaborative Governance
Link to Community Needs Assessment	In LA County, diabetes is the sixth leading cause of death since 1997, and an important cause of premature death since 1999. In 2007, 18.1% of adults ages 45 and over, ~1 in 5 have been diagnosed with diabetes, including borderline and pre-diabetes. **Diabetes is the fourth leading cause (age-adjusted) of mortality in the CHMC service area.** Between 1990 and 2000 there was an increase of 53% in diagnosed diabetes, suggesting a growing health care condition in L.A. County. Nationally, it is expected that diabetes among Latinos will increase by 100% between 2002 and 2020. CHMC's service area has a higher prevalence of diabetes (20.8% in Metro LA, 22.2% in South LA, and 19.2% in South Bay) compared to LA County (18.1%) and California (15.9%). This increasing prevalence likely reflects the impact of sedentary lifestyles and the obesity epidemic. Obesity is the single most important risk factor for type 2 diabetes, the major form of diabetes in adults. Other risk factors include increasing age, family history, and physical inactivity. In Los Angeles County, direct costs of medical care for diabetes and indirect costs associated with disability and lost productivity were estimated to be $5.6 billion in 2005. The LA County Health Survey (LACHS) identified large disparities in diabetes by race/ethnicity, income, and educational level. • Diabetes rates among Latinos (12.3%) and African Americans (12%) were nearly double the rates among Whites (5.6%) and Asian/Pacific Islanders (7.1%). • Nearly one in five adults 65 years and older have been diagnosed with diabetes according to the 2005 LACHS. • From 1997 to 2005, the rate of diabetes increased most rapidly among those living in poverty and was more than two times higher in this group than among those with incomes at or above 200% of FPL. • In 2005, the prevalence of diabetes among adults who did not graduate from high school (14%) was more than two times higher than the prevalence among adults who graduated from college (6%). • The prevalence rate of diabetes among adults was the highest in SPA 6 (14.5%) followed by SPA 4 (11.4%). The U.S. Healthy People 2010 preventive health targets for people with diabetes include self-monitoring blood glucose at least once a day, having a diabetic eye exam and foot exam once a year, and being up-to-date on immunizations. The 2005 LACHS revealed that adults with diabetes in LA County were far from complying with these targets. • 63% had received a foot exam in the past year. Diabetes can cause blood vessel and nerve damage that, without preventive measures, frequently lead to leg or foot amputation. • 57% had received an eye exam in the past year. Diabetes is the leading preventable cause of blindness in the U.S. • 47% had received a flu shot in the past year. Diabetics are at increased risk for severe complications of influenza. • 63% of adults (65 years and older) reported ever having a pneumonia shot. Diabetics are at increased risk for contracting pneumonia and developing complications from it. Having health insurance and access to a regular source of care are essential for effective management of diabetes. • In 2005, only 26% of adults with diabetes who did not have a regular source of care had an eye exam in the past year, compared to 60% of adults with diabetes who did have a regular source of care. • Similar to findings from 2002-3 LACHS, in 2005 a larger percentage of insured adults with diabetes (59%) reported having an eye exam compared to uninsured adults (43%). • In 2002-3, only 32% of uninsured adults with diabetes self-monitored their blood glucose at least once daily compared to 60% of insured adults with diabetes. Diabetics are at increased risk for heart disease and stroke, so addressing hypertension, high cholesterol, obesity, smoking and physical inactivity is important. Among adults with diabetes: • 58% had hypertension • 56% had high cholesterol. • 48% reported minimal to no regular physical activity • 41% were obese based on self-reported height and weight. • 14% reported being a current smoker.

Program Description	In 2004, the Chronic Disease Management Consortium (CHMC, Good Samaritan Hospital, Huntington Memorial Hospital, and the National Health Foundation) designed, submitted, and received a multi-year grant from the Good Hope Medical Foundation for a comprehensive program for the prevention, screening, and treatment of type 2 diabetes. This program has twodistinct goals: 1) To increase early identification of those at high-risk for developing diabetes and to provide education and promote behavioral changes that prevent its development (Primary Diabetes Prevention Services); 2) To increase early diagnosis of those with diabetes and to provide education and support to help them manage their disease (Secondary Prevention Services);
	CHMC's community health promoters provide outreach education about type 2 diabetes at local schools, churches, and community-based organizations and encourage all class participants to complete the American Diabetes Association's Diabetes Risk Test. Participants scoring 10 or more points are at a greater risk for having diabetes and will be referred to a health care provider to determine if they have diabetes. Participants not found to have diabetes will be invited to participate in Primary Diabetes Prevention Services, entitled ***Food, Fitness and Diabetes Prevention***, that includes 4 weekly workshops promoting healthy eating and increased physical activity.
	
	Diagnosed type 2 diabetics will be invited to participate in Secondary Prevention Services that include:
	• ***Living with Diabetes:*** 5 weekly workshops designed to help patients understand their condition. Topics include:
	  • Understanding what diabetes is
	  • Strategies and benefits of good diabetes control
	  • Importance of blood sugar monitoring
	  • Nutrition
	  • Lifestyle behaviors (physical activity, weight management, smoking cessation)
	  • Mental health
	  • Partnership with healthcare team
	  • Identifying and avoiding diabetes complications
	  • Social support
	  • Preventive care
	  • Community resources
	• *Additional educational interventions:*
	  Oral hygiene class given by Community Dental Partnership community health promoter.
	  Referrals for dental care and periodontal care through the UniHealth Community Dental Partnership Program for uninsured adults with medication-dependent diabetes
	  Referral to Heart HELP given by CHP to all diabetics.
	  Referrals for smoking cessation classes, as needed.
	
	All data are entered into the web-based data system housed at the National Health Foundation, the program evaluator.

	FY 2013
Goal FY 2013	1) To increase early identification of those at high-risk for developing diabetes and to provide education and promote behavioral changes that prevent its development (Primary Diabetes Prevention Services); 2) To increase early diagnosis of those with diabetes and to provide education and support to help them manage their disease (Secondary Prevention Services);
2013 Objective Measure/Indicator of Success	**Primary Diabetes Prevention Services** All of those with scores of ≥ 10 on ADA Risk Test will be referred to health care provider for definitive diagnostic testing for diabetes. 50% of those referred to health care providers will follow-up on these referrals and determine their diabetes status. 40% of those referred to health care provider but determined not to have diabetes yet will participate in the Primary Diabetes Prevention Services. Of those participating in the Diabetes Prevention Workshops: • 80% will self-identify as being at high-risk for diabetes. • 80% will report increasing their knowledge about healthy eating. • 80% will report increasing their knowledge about the importance of physical activity. • 60% will report increasing their amount of exercise (frequency and length of time): goal 30 minutes a day, 5 days a week. • 60% will report eating more healthily. • 50% will reduce their weight by 5-7%. • 70% will report asking their health care provider if they should be tested for pre-diabetes.

	Secondary Prevention Services • 60% of patients diagnosed with diabetes will participate in Living with Diabetes Program. Of patients participating in these services: • 70% will show reduced Hemoglobin A1c (goal < 7). • 50% will show reduced Body Mass Index ratios. • 50% will reduce their weight 5-7%. • 50% will show reductions in waist circumference. • 70% will report eating more well-balanced healthy meals. • 70% will report eating less fat. • 70% will report eating less calories. • 60% will report cooking more healthily (i.e., less fat). • 80% will know that their blood sugar records should be reviewed at every visit. • 80% will know that their blood pressure should be checked at every visit. • 80% will know that their weight should be checked at every visit. • 80% will know that their feet should be examined at every visit. • 80% will know that their HgbA1c should be measured every 3 months. • 80% will know that the target for the HgbA1c is less than 7. • 80% will know that their urine should be tested once a year for protein. • 80% will know that they should have a dilated eye exam once a year. • 80% will know that they should have a blood test to measure "fats" (i.e., a lipid profile) once a year. • 80% will know that they should have a flu shot once a year. • 80% will know that they should have a pneumonia vaccine at least once. • 80% of those who smoke will know that they should stop. • 50% will check blood sugars at least daily. • 50% will check their feet daily for sores. Of patients participating in the CDSMP: • 70% will complete the workshop series. • 80% will report increasing confidence in managing their care. • 70% will report increasing their physical activity. • 70% will report eating more well-balanced, healthy meals. • 70% will report taking their medication as directed by their health care provider. • 60% will report visiting their doctor for problems related to their diabetes. • 60% will report feeling more comfortable asking their doctor about their diabetes. • 70% will report feeling less sad, lonely, or down in the dumps due to their diabetes.
Baseline	Residents in our service area have a high prevalence of the following risk factors for type 2 diabetes: ethnicity, family history, obesity, lack of physical activity, food insecurity; and lack of access to prevention programs. Residents in our service area have the following risk factors for delayed diagnosis and treatment of type 2 diabetes: uninsured, poverty, lack of access to primary care for screening and initiation of treatment. Residents in our service area are at increased risk for morbidity/mortality secondary to type 2 diabetes because they lack access to regular source of care, lack access to specialty care, cannot afford medications or supplies (glucometer, test strips, lancets), and lack access to comprehensive diabetes education.
Intervention Strategy for Achieving Goal	*Living with Diabetes Program* was selected as one of our two LTIP programs for 2011-13. CHPs offer Diabetes: "Are You at Risk?" in the community and encourage participants to complete the ADA Risk Test. The Parish Nurse also screens for diabetes in the community using hemoglobin A1c: 5.7-6.4% = prediabetes; $\geq$ 6.5% = diabetes Those at high risk for diabetes are offered the *Food, Fitness, and Diabetes Prevention Program.* Those diagnosed with diabetes are offered *Living with Diabetes Program.* We also offer to provide *Living with Diabetes Program* at clinics belongs to the Southside Coalition of Community Clinics.
Result FY 2013	Because of staff cuts, *no Food, Fitness, and Diabetes Prevention* workshops were offered this fiscal year. 499 participants and 299 guests participated in the 5-wk series of *Living with Diabetes* workshops. Demographic profile of participants: 96% Hispanic/Latino, 3% African American, 1% other, 1% unknown; 67% female & 33% male; 67% with waist circumference at or above cut-off; 13% normal BMI, 35% overweight, 53% obese. HbA1c: $\leq$ 7: 17%; 7-8.9: 19%; 9-10: 6%; >10:15%. Past medical history of participants: heart attack 2%; kidney disease 3%; diabetic retinopathy 4%; amputation secondary to diabetes 1%; diabetic neuropathy 10%; poor circulation 8%; gastroparesis 5%.

	Paired data of Intervention participants demonstrated that by the end of the Program:
	• 32% lost weight from the beginning until 3-6 mo follow-up.
	• 9% lost ≥ 5% of their body weight by the 3-6 mo. follow-up visit.
	• 15% decreased their HgbA1c below 7; total of 56% had Hgb A1c < 7 at end.
	• 95% improved their confidence in being able to improve their eating habits.
	  o 45% eating ≥ 5 servings of fruits & vegetables/d
	  o 77% drinking ≥ 4 cups of water/d
	  o 70% eating breakfast daily
	  o 91% eating fast food 0-1 days in last week.
	• 88% improved their confidence in being able to improve their exercise habits.
	  o 33% started being physically active
	  o 12% physically active ≥ 4 times/wk; 72% total.
	  o 60% increased frequency
	  o 38% physically active ≥ 30 minutes each time; 94% total.
	  o 55% increased duration of PA
	  o 43% increased distance walked each time.
	• 33% increased their emotional wellbeing
	• 94% improved their confidence in being able to manage their diabetes.
	  o 23% began asking questions about their diabetes and treatment
	  o 64% increase in discussing their personal problems related to diabetes with their doctor
	  o 94% learned what the HgbA1c target was
	  o 86% checked feet daily for sores
	  o 88% had dilated eye exam in past year
	  o 3% quit smoking
	  o 25% requested pneumonia vaccine.
	  o 42% requested flu shot.

LTIP Results	See table below Program Digest. The impact of *Living with Diabetes* on healthcare utilization for glucose control was that there was an **100% decrease in hospitalizations and 100% decrease in ER visits** for glucose control during the six months following program participation compared to the 6 months prior to program participation.
Hospital's Contribution / Program Expense	CHMC provides office space and office equipment for program staff. CHMC Foundation provides grants management and fiscal oversight. CHMC received $228,013 per year for this 3-year project, which was funded by a grant from the Good Hope Medical Foundation. Due to delayed start-up, a no-cost extension was requested. Therefore the program's grant funding ended in December 2008. The promotora who provides diabetes workshops is currently funded by UniHealth Foundation through Community Dental Partnership grant.
FY 2014	
Goal 2014	1) To increase early identification of those at high-risk for developing diabetes and to provide education and promote behavioral changes that prevent its development (Primary Diabetes Prevention Services); 2) To increase early diagnosis of those with diabetes and to provide education and support to help them manage their disease (Secondary Prevention Services);
2014 Objective Measure/Indicator of Success	Maintain same modified measurable objectives as FY13. Outreach to federally qualified health centers (FQHCs) who care for many diabetics but may not have the resources to provide comprehensive diabetes education. .
Baseline	There is a growing need for this program in CHMC's service area
Intervention Strategy for Achieving Goal	Continue to monitor and report measurable objectives. Link the hospital discharge planning process to the Secondary Prevention Services Continue the collaborative agreements we have with local FQHCs that want us to provide diabetes education for their diabetics. Increase outreach to predominantly African American churches. Identify grant funding for the continuation of this program.

Impact of *Living with Diabetes* (LWD) on Healthcare Utilization for Glucose Control

Quarter	Completed LWD 6 mo ago	Contacted	6 mo prior to LWD		6 mo after LWD	
			Hospital Stay	ER visit	Hospital Stay	ER visit
FY13-Q1	53	41	0	0	0	0
FY13-Q2	28	24	2	5	0	0
FY13-Q3	33	29	0	1	0	0
FY13-Q4	33	27	0	0	0	0
Total	**147**	**121 (82.3%)**	**2 (1.6%)**	**6 (5%)**	**0**	**0**

Therefore, participation in *Living with Diabetes* Program resulted in 100% reduction in hospitalizations and ER visits for glucose control by participants. Diabetes is an important ambulatory sensitive condition and our program is very effective in helping people learn how to self-manage their disease.

CM's Story: *CM was eating a dozen homemade tortillas/day and his TG > 800 when we first met him. Most of his family member also have type 2 diabetes; he is very close to his sister who suffers with diabetes and lost vision in one eye due to the disease. The promotora at CHMC helped CM's sister by calling her and teaching her how to use the plate method and do carbohydrate counting. She was then able to lower her blood sugar reading from > 400 to below 130 fasting and < 140 after eating. CM invited his wife to attend the diabetes workshops with him so she would understand how to cook for him. CM lowered his HbA1c from 6.9% to 6.3% and now down to 5.6%. He lost 7lbs. His waist circumference decreased from 38 inches to 36 inches. His cholesterol decreased from 229 to 219. Now his physician is going to discontinue his medication for diabetes because he is able to control it with diet and exercise.*

JS's Story: *When we first met JS in October 2012 he already had major complications from uncontrolled diabetes: a stroke, blindness, and kidney failure. He used to spend most of his time in the ER here at CHMC. He was finally referred to our Living with Diabetes Program. JS attended LWD with his mother who also had diabetes. Since completing the program, JS has not been in the ER or hospitalized for his diabetes. He has lowered his HbA1c from > 14% to 5.2%. And because he controlled his diabetes so well, he was able receive a kidney and pancreas transplant in May 2013! He continues to visit our LWD workshops to encourage new participants to put the LWD program into action which worked so well for him and that he knows will work for them too. We were also able to identify a buddy friend who is also blind to help JS enroll at the Braille Institute so he can regain some of his independence.*

Formation of Diabetes Support Group In August 2012, at the urging of past participants of the Living with Diabetes Program, the promotora reserved space for a Diabetes Support Group. Initially 4 people came, then 7, then 14. Meetings are held the second Wednesday of the month. Although the promotora provides the infrastructure for the meetings, the meetings are actually run by the participants themselves. Members of the support group typically share their personal experiences and offer one another emotional comfort and moral support. They also offer practical advice and tips to help others cope with a particular situation. Benefits of participating in support groups include: feeling less lonely, isolated or judged; gaining a sense of empowerment and control; improving coping skills and sense of adjustment; talking openly and honestly about their feelings; reducing distress, depression or anxiety; developing a clearer understanding of what to expect with a given situation; getting practical advice or information about treatment options; and comparing notes about resources. The group has named itself **Grupo Viviendo Con Diabetes** and a total of 50 members, family, and friends plan to participate in the ADA Walk on November 2, 2013 at Griffith Park. They have team T-shirts contributed by Dr. Yonekura and they have secured an 85-passenger bus to transport them from CHMC to Griffith Park and back.

Hope Street Family Center Early Head Start Program	
Hospital CB Priority Areas	Please add the Hospital Priority Areas identified in the Community Needs Assessment for your hospital here ☐ Priority Area 1 ☐ Priority Area 2 ☐ Priority Area 3 ☐ Priority Area 4 ☑ Priority Area 5 Healthy Communities
Program Emphasis	Please select the emphasis of this program from the options below: ☑ Disproportionate Unmet Health-Related Needs ☑ Primary Prevention ☑ Seamless Continuum of Care ☑ Build Community Capacity ☑ Collaborative Governance
Link to Community Needs Assessment	In 2009, 105,267 children ages 0-4 yr lived in CHMC's service area. The majority identified themselves as Latino (68.5%), followed by African American (21%). This community is predominantly composed of young families. Overall, the rate of those living below the federal poverty level in CHMC's service area (32%) is almost three times the LA County rate (12%). The majority of people living in CHMC's service area have less than a HS education. The primary language spoken at home is Spanish (59%) for the majority of households. The majority of adults are either unemployed (>7%) or not in labor force (47%). The rate of teen mothers in our service area (14.8%) is much higher than the countywide percentage (9.5%).
Program Description	Core services of EHS include: early childhood education (ECE); healthcare and mental health services; parenting education; childcare; adult education; and housing, legal, and financial assistance. We have put into place a continuum of home and center-based early childhood education services that responsively meet the individual and changing needs of young families. Options currently available to families include: 1) home-based services with weekly in-home ECE, along with twice-per month socialization opportunities; 2) full-year, full-day center-based ECE, with monthly home visits; 3) combination option services, with daily center-based family literacy services, combined with biweekly in-home ECE; and biweekly in-home ECE, concurrent with enrollment in high-quality childcare and bimonthly visits at the childcare site. Priority for EHS enrollment is given to children with special needs; homeless families; foster children; parents interested in ESL or high school diploma/GED studies; and families participating in other HSFC programs. Enrollment priorities reflect Community Assessment data that document a high incidence of developmental disabilities and homelessness within the service area; large numbers of recent immigrant, mono-lingual young families; and low adult literacy and educational levels.
FY 2013	
Goal FY 2013	Optimize the overall development of infants and toddlers participating in HSFC's EHS program. Strengthen the economic and social self-sufficiency and stability of families. Enhance the local service delivery network of agencies serving young children and their families.
2013 Objective Measure/Indicator of Success	Maintain full enrollment Promote the overall (physical, cognitive, social, and emotional) development of infants and toddlers through a continuum of early childhood development and health services that include in-home and center-based ECE activities and opportunities, comprehensive health and nutrition services and anticipatory guidance on these matters. Enhance the capacity of parents to nurture and care for their very young children by providing a variety of parent education and family support services that bolster their roles as parents and the self-sufficiency of their families. Build on the existing service delivery network and foster community partnerships that will keep the network accessible, responsive, and sensitive to the developmental, cultural, and familial characteristics of the service population. Continuously refine and expand the existing base of knowledge, skills, and abilities of program staff to improve their capacity to serve very young children and their families, especially families at high risk due to developmental disabilities, substance abuse, domestic violence, or child abuse.
Baseline	HSFC's service area has the highest population density and the oldest housing stock in the county. It is the home of the working poor. The median annual household income is $19,930. Moreover, 42% of households earn less than $15,000 per year. More than 21,000 children under the age of five live below poverty, yet more than half of these children live in households in which one or both parents work. A third of the labor force is employed in the garment industry and other light manufacturing industries and a fifth in service occupations. In terms of ethnicity, 72% are Latino, 9% African American, 7% Asian, and 6% Caucasian. However, more than 90% of the elementary school-aged children are Latino. Children under age 14 represent 28% of the population and only 7% of residents are ≥ 65. Spanish is the primary language for more than 55% of families in the area. In a study of Latinos in South Central Los Angeles, 96% of the children were born in the U.S. compared to only 20% of their parents. Downtown Los Angeles is ranked as the lowest literacy area in the city. The region has high levels of limited English proficiency; more than 70% of school-aged children are limited English proficient. In the core service area, 23% of persons 16 years and older have a high school education or less; 36% have less than a ninth grade education; and 61% have only rudimentary education. Parents in this community often find themselves isolated, feeling depressed

	and overwhelmed by their daily struggle for economic survival. Hence, they are less likely to verbalize a great deal with their young children or to utilize communication styles that nurture early language skills. Likewise, the babysitters with whom they leave their children while they work are unaware of the importance of language development in children and how to foster such development in children in their care. This lack of knowledge can seriously impact children's futures since studies show that impairment of early language development becomes a disability for children, limiting their subsequent social and educational growth
Intervention Strategy for Achieving Goal	Continue to provide EHS services for qualifying families on our service area in accordance with EHS performance standards and guidance as specified in our contract and implementation plan.
Result FY 2013	During FY 13 the EHS program maintained full enrollment of 272. The percentage of children with disabilities averaged 15% (range 11-19%). This represents a nearly 2% increase over FY 12 while the number enrolled children decreased. The types of disabilities included developmental delay (16), speech/language impairment (22), health related (i.e. prematurity, seizures, Down Syndrome) (10), hearing impairment (1), visual impairment (1), mental retardation (1) and orthopedic impairment (1). The majority of families were enrolled in our center-based option or combination option. We served an average of 1,237 breakfasts/mo, 1,319 lunches/mo, and 1,224 snacks/mo. The impact of sequestration was as follows: There was a 5% ($189,073) reduction in funding for calendar year 2013- effective March 1, 2013. The current funding amount is $3,488,343. HSFC developed a plan to preserve services for children and families (maintain full enrollment of 272) and retain staff by implementing one mandatory flex day per month for all staff members and to close home-based and non-essential administrative services for three weeks- which coincided with holidays:May (27th -31st), July (1st -5th) and September (2nd – 6th). Center-based services remained open during these periods, per contractual requirements.
Hospital's Contribution / Program Expense	CHMC provides 1 ½ floors of Leavey Hall for Hope Street Family Center (SB 697 in-kind contribution value of $474,900). The annual EHS budget is $3,488,343. The US Department of Health and Human Services funds this program.
FY 2014	
Goal 2014	Optimize the overall development of infants and toddlers participating in HSFC's EHS program. Strengthen the economic and social self-sufficiency and stability of families. Enhance the local service delivery network of agencies serving young children and their families.
2014 Objective Measure/Indicator of Success	Maintain full enrollment Promote the overall (physical, cognitive, social, and emotional) development of infants and toddlers through a continuum of early childhood development and health services that include in-home and center-based ECE activities and opportunities, comprehensive health and nutrition services and anticipatory guidance on these matters. Enhance the capacity of parents to nurture and care for their very young children by providing a variety of parent education and family support services that bolster their roles as parents and the self-sufficiency of their families. Build on the existing service delivery network and foster community partnerships that will keep the network accessible, responsive, and sensitive to the developmental, cultural, and familial characteristics of the service population. Continuously refine and expand the existing base of knowledge, skills, and abilities of program staff to improve their capacity to serve very young children and their families, especially families at high risk due to developmental disabilities, substance abuse, domestic violence, or child abuse.
Baseline	Over the course of the past three years there has been no significant change in the demographic make-up of the EHS service area, the estimated number of eligible EHS children and families, or the ethnic and racial composition of eligible families. There are ~ 34,000 children under age 4 living in the service area, with approximately 47% meeting the federal definition of poverty. Among children in poverty living within the service area, 90% are Latino. The estimated number of children with disabilities, four years old or younger and living in the area is ~ 5% with speech or language delay being the most common disability. The changes that have occurred within the service area are a result of the significant construction and business expansion that has occurred within downtown Los Angeles, which comprises the northern portion of our service area. The expansion of the Staples Center and the related new condominium construction has the potential of offering increased employment opportunities and better wages. In addition, three new low-income housing developments, also undertaken in conjunction with Convention Center expansion, have positively impacted our community. As documented above, the target EHS population experiences a significant lack of resources (income, education, training, and housing) that place them at high risk for a variety of health and social problems. Better housing and increased economic development are important and emerging community strengths. However, the recent economic downturn has significantly impacted our community, with increased unemployment, deepening poverty, and homelessness. This, in turn, resulted in increased stress, anxiety, depression, substance abuse, and family violence.
Intervention Strategy for Achieving Goal	Continue to provide EHS services for qualifying families on our service area in accordance with EHS performance standards and guidance as specified in our contract and implementation plan.

Heart H.E.L.P.	
Hospital CB Priority Areas	Please add the Hospital Priority Areas identified in the Community Needs Assessment for your hospital here ☐ Priority Area 1 ☑ Priority Area 2 Health Promotion/Disease Prevention ☑ Priority Area 3 Disease Management ☐ Priority Area 4 ☐ Priority Area 5
Program Emphasis	Please select the emphasis of this program from the options below: ☑Disproportionate Unmet Health-Related Needs ☑Primary Prevention ☑Seamless Continuum of Care ☑Build Community Capacity ☑Collaborative Governance
Link to Community Needs Assessment	Heart disease is the leading cause of death in the U.S. for both men and women and is a major cause of disability. Risk factors for heart disease include: hypertension (32.1%), high blood cholesterol (16.9%), diabetes (10%), obesity (32%), current cigarette smoking (18.4%), and physical inactivity (39.5%). Approximately 37% of adults reported having 2 or more risk factors for heart disease and stroke. Fortunately, early death and disability from cardiovascular disease (CVD) is to a large degree preventable. In CHMC's service area heart disease is the number one cause of death. CHMC's primary service area had a larger number of deaths caused by heart disease (964 or 28.9%) than in CHMC's secondary service area (775 or 23.2%). The fourth leading cause of death is stroke. In 2007, 24 out of every 100 premature deaths in LA County were caused by coronary heart disease. The leading cause of premature death in 2007 was coronary heart disease in SPAs 2, 3,3,5,7 and homicide in SPA 6 only. Overall the prevalence of heart disease has increased every year in LA County from 1997 (4.8%) to 2007 (7.7%). Most SPAs in the Metro Collaborative fall under LA County's rate of 7.7% of residents diagnosed with heart disease, except CHMC's SPA 8 (9%). The largest reported chronic condition in LA County is high blood cholesterol; in 2007 29% of residents suffer with this condition. In 2007, CHMC's SPAs 5 (30.6%) and 8 (29.6%) reported higher percentages of adults diagnosed with high blood cholesterol than the LA County estimate of 29.1%. One out of four (24.7%) LA County adults were diagnosed with hypertension in 2007 compared to only 15.8% of adults in 1997. Similar increasing trends are evident across all SPAs in LA County including CHMC's SPAs. The prevalence of hypertension in SPA4 had double-digit growth from 1997 to 2007 (13.8% vs. 24.8%). The prevalence of hypertension in 2007 by SPA ranges from a low of 19.3% occurring in SPA 5 to a high of 29.0% occurring in SPA 6.
Program Description	In September 2009 CHMC launched the implementation phase of Heart H.E.L.P., a cardiovascular disease program for low-income and ethnically diverse patients. The program is designed to reduce risk, delay onset and/or reduce the progression of CVD among those participating. Heart HELP has two distinct components: 1) outreach which includes community education, risk assessments, and medical referrals; and 2) four consecutive weekly 2-hour lifestyle workshops that focus on modifiable risk factor reduction, especially in the areas of nutrition, physical activity, and smoking cessation. There is an optional fifth workshop focused on Heart Failure.
FY 2013	
Goal FY 2013	To help participants adopt healthier lifestyles, thereby reducing their risk of developing, dying from, or being disabled by CVD.

2013 Objective Measure/Indicator of Success	Clinical outcomes:
	• 50% of participants with BMIs 25 or more at program beginning will reduce their BMIs at program follow-up
	• 10% of participants with above normal blood pressures at program beginning will reduce their blood pressures by one or more categories at program follow-up
	• 10% of participants with abnormal total cholesterol (200 or higher) will decrease their cholesterols to normal at program follow-up
	Behavioral outcomes:
	• 25% of participants who smoke at program beginning will move one or more categories in favor of smoking cessation on Prochaska's Stages of Change at program follow-up
	• 60% of participants not exercising 30 minutes or more at program beginning will report exercising 30 minutes a day three or more days a week at program follow-up
	• 30% of participants will increase their fruit consumption by one or more servings per day
	• 30% of participants will increase their vegetable consumption by one or more servings per day
	• Of participants who do not have perfect scores on the CDC's Healthy Days Measure at program beginning (perfect score=report of excellent health and zero days of poor physical and mental health during the past 30 days):
	  o 30% will describe their general health as being better by one or more categories at program follow-up in comparison to program beginning
	  o 30% will reduce the number of days they report poor physical health during the last 30

	days at program follow-up in comparison to program beginning o 30% will reduce the number of days they report poor mental health during the last 30 days at program follow-up in comparison to program beginning o 30% will reduce the number of days that poor mental or physical health prevented them from doing usual activities at program follow-up in comparison to program beginning. Knowledge outcomes: • 30% of participants will report knowing how to read food labels • 30% of participants will report knowing how much sodium they should consume each day • 80% of participants will report knowing the amount of exercise adults should get on a daily basis in order to improve health.
Baseline	Residents in our service area have a high prevalence of the following risk factors for CVD: hypertension, high blood cholesterol, diabetes, obesity, current cigarette smoking, physical inactivity, and excessive alcohol intake. Residents in our service area have the following risk factors for delayed diagnosis and treatment of hypertension, high blood cholesterol, and diabetes: lack of health insurance, lack of access to primary care for screening and initiation of treatment, extreme poverty, very low literacy rate, language barrier, and transportation barrier.
Intervention Strategy for Achieving Goal	In the summer of 2009, the Chronic Disease Management Consortium obtained a three year grant from the Good Hope Medical Foundation and the Watts Health Foundation. Therefore, they began hiring staff in August 2009 in order to launch Heart H.E.L.P in September 2009.
Result FY 2013	199/303 (65.7%) completed the program in FY13; 93.5% were Hispanic and 95.4% were female. 34.7% were between 31-40 yr of age,30.1% between 41-50 , and 21.1% between 51-62 (range 18-66+). 22 workshop series were conducted; 1 in English and 21 in Spanish/English. In terms of medical conditions of the participants: 25% reported hypertension, 35% had abnormal lipid profile, 5% had had a heart attack in the past, 0% had a pacemaker and 10% had diabetes. Clinical outcomes: • 75% reduced BMI; 0% reduced weight by ≥ 10% • 70.8% with above normal blood pressure at program beginning reduced their blood pressure by one or more categories at the end of the program • 76% of participants with abnormal total cholesterol (≥ 200) decreased their cholesterol to normal by the end of the program Behavioral outcomes: • 34% of participants who were not exercising 30 minutes or more at program beginning reported exercising 30 minutes a day 3 or more days a week at the end of the program. In fact by the end of the program 57% were exercising 4 or more times a week; 76% were exercising for 30min-1 hour each time; and 24% were walking 5 or more miles a day. • 87% of participants reported increasing their fruit and vegetable consumption by at least one or more servings per day. By program end, o 22% were eating 5 or more servings of fruits and vegetables per day o 72% were drinking 4 or more cups of water per day o 57% were eating breakfast 7 days a week o 70% were eating fast food 0-1 day/wk o 28% reported eating high sodium prepared foods last week o 80% reported reading food labels before purchasing a product. Knowledge outcomes: • 86% reported knowing how to read a food label • 98% reported knowing how much sodium they should consume each day • 95% reported being familiar with the Dash diet • 100% knew how much exercise adults should get on a daily basis. As one participant said, *"Thank you for educating me. Since I started coming to these classes I am not buying cup of noodles and my blood pressure is much better."*
LTIP Result	Heart H.E.L.P. was selected as one of our two LTIPs for FY11-13. See table below Program Digest. The impact of Heart H.E.L.P. on healthcare utilization for CVD was that there was a 100% reduction in hospitalizations and a 100% reduction in ER visits for CVD after participating in the Heart H.E.L.P. program.
Hospital's Contribution / Program Expense	CHMC provides office space and office equipment for program staff. CHMC Foundation provides grants management and fiscal oversight. CHMC received $246,398 per year for this 3-year project that was funded by matching grants from the Good Hope Medical Foundation and the Watts Health Foundation. Funding ended in Dec. 2012. CHMC currently funds this program through its Health Ministry Program.
FY 2014	
Goal 2014	To help participants adopt healthier lifestyles, thereby reducing their risk of developing, dying from, or being disabled by CVD.
2014 Objective	Maintain same measurable objectives as FY13

Measure/Indicator of Success	Identify grant funding opportunities for continuation of this program beyond FY12.
Baseline	There is growing need for this program in CHMC's service area. The recession has brought increased poverty, food insecurity, depression/anxiety, alcohol abuse, cigarette smoking, and obesity, all of which contribute to increased risk factors for CVD.
Intervention Strategy for Achieving Goal	Continue to monitor the same measurable objectives Link the hospital discharge planning process to the program. Increase outreach to predominantly African American churches. Identify grant funding to replace the current matching grant which ends at the end of FY12.

Impact of Heart H.E.L.P. on Healthcare Utilization for CVD

Quarter	Completed Heart HELP 6 mo ago	Contacted	6 mo prior to Heart HELP		6 mo after Heart HELP	
			Hospital Stay	ER visits	Hospital Stay	ER visits
FY13-Q1	98	98	0	0	0	0
FY13-Q2	95	85	0	0	0	0
FY13-Q3	58	51	0	2	0	2
FY13-Q4	25	24	1	2	0	0
Total	**276**	**258(93.5%)**	**1 (0.4%)**	**4 (1.6%)**	**0**	**2 (0.8%)**

Therefore, participation in Heart HELP resulted in a 100% reduction in hospitalizations and a 50% reduction in ER visits for cardiovascular disease after participating in Heart HELP. Cardiovascular diseases such as high cholesterol, hypertension, etc. are important ambulatory sensitive conditions and our program is very effective in helping patients learn how to self-manage their disease.

COMMUNITY BENEFIT AND ECONOMIC VALUE

Report – Classified Summary of Unsponsored Community Benefit Expense
For period from 7/1/2012-6/30/2013

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses	% of Organization Revenues
Benefits for Living in Poverty						
Financial Assistance	**2,251**	**32,835,049**	**0**	**32,835,049**	**9.9**	**9.6**
Medicaid	**60,398**	**196,440,105**	**179,620,578**	**16,819,527**	**5.1**	**4.9**
Community Services						
Community Benefit Operations	0	403,372	0	403,372	0.1	0.1
Community Health Improvement Services	20,165	19,119,453	0	19,119,453	5.8	5.6
Financial and In-Kind Contributions	0	1,063,251	0	1,063,251	0.3	0.3
Totals for Community Services	**20,165**	**20,586,076**	**0**	**20,586,076**	**6.2**	**6.0**
Totals for Living in Poverty	**82,814**	**249,861,230**	**179,620,578**	**70,240,652**	**21.2**	**20.6**
Benefits for Broader Community						
Community Services						
Community Health Improvement Services	9,525	202,953	0	202,953	0.1	0.1
Health Professions Education	2,179	6,973,843	41,250	6,932,593	2.1	2.0
Totals for Community Services	**11,704**	**7,176,796**	**41,250**	**7,135,546**	**2.2**	**2.1**
Totals for Broader Community	**11,704**	**7,176,796**	**41,250**	**7,135,546**	**2.2**	**2.1**
Totals - Community Benefit	**94,518**	**257,038,026**	**179,661,828**	**77,376,198**	**23.3**	**22.6**
Unpaid Cost of Medicare	**8,792**	**38,568,415**	**23,981,666**	**14,586,749**	**4.4**	**4.3**
Totals with Medicare	**103,310**	**295,606,441**	**203,643,494**	**91,962,947**	**27.7**	**26.9**
Totals including Medicare & Bad Debt	**103,310**	**295,606,441**	**203,643,494**	**91,962,947**	**27.7**	**26.9**

Cost ratio calculations for Traditional Medicare, Medi-Cal care services, Charity Care and Other Government programs is based on cost report provided by Cost Reimbursement Department of the hospital.

Telling the Story

Communication Plan

Internal communication plan

- Updates on various community benefit programs are provided in the **weekly e-newsletter** distributed to all CHMC network users.
- New employees are briefly informed about community benefits programs during the New Employee Orientation Day. Each employee is given the latest copy of our annual *Service to Our Community Report.*
- The Contract Manager for Community Partnerships meets with individual Service Managers at least annually to provide an update on relevant Community Benefit Programs.
- The Director of Community Benefits provides an annual update on Community Benefit Programs and classes to all Department Managers at the request of the President.

External communication plan

- At least one community benefit program is highlighted in each edition of the **Foundation Update** that is published twice each year and mailed to our medical staff, donors, supporters, and Board members.
- Each quarter, the Director of Community Benefits informs new medical staff and their office staff about our community benefit programs and how they can refer patients to them.
- Each year CHMC publishes its annual ***Service to Our Community Report*** that summarizes our community benefits programs and services.

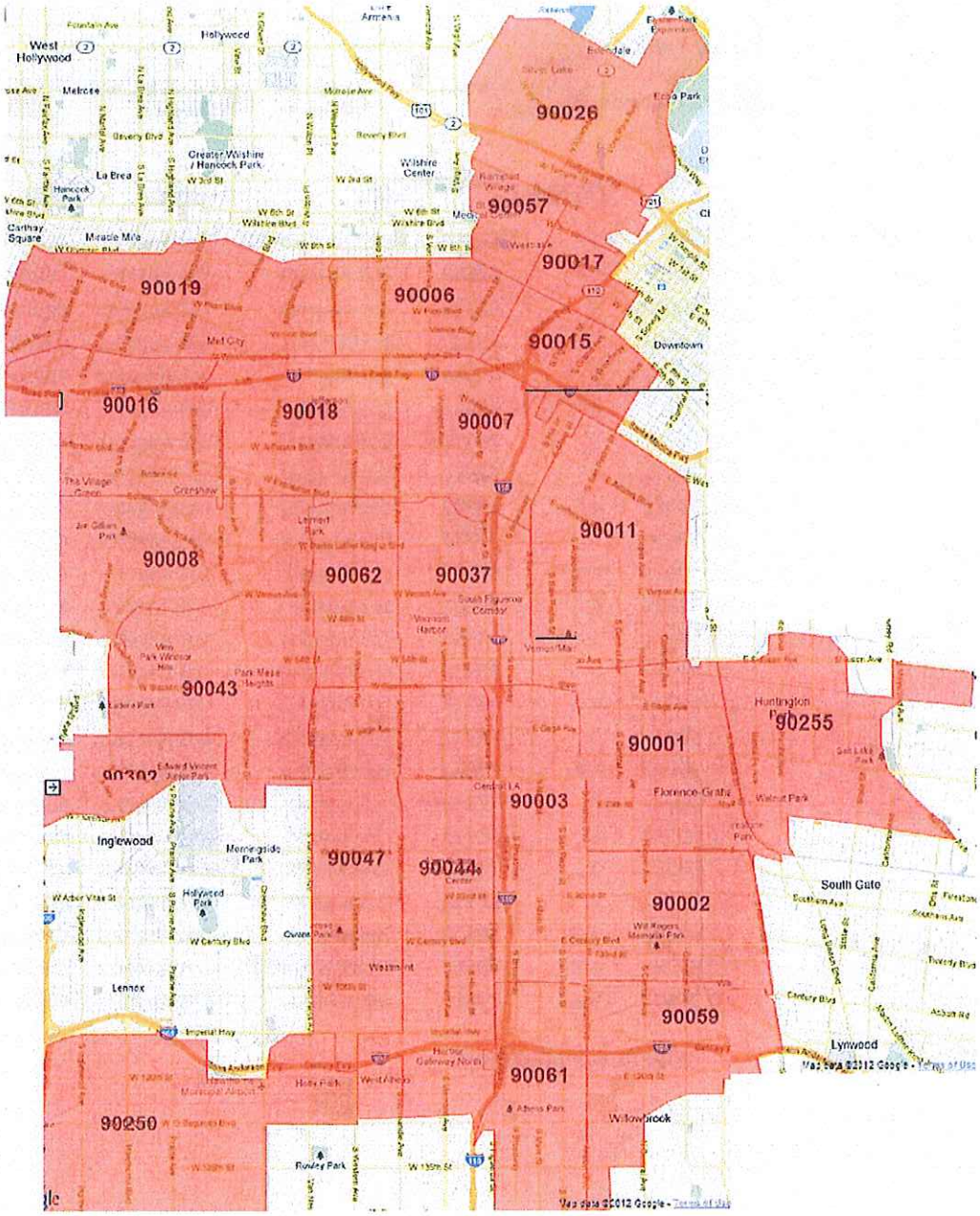
Appendix

A. Community Need Index, Map of the Community
B. Charity Care Policy
C. CHMC Community Board of Directors

APPENDIX A

California Hospital Medical Center

Community Need Index



Lowest Need — Need — Highest

- 1 - 1.7 Lowest
- 1.8 - 2.5 2nd Lowest
- 2.6 - 3.3 Mid
- 3.4 - 4.1 2nd Highest
- 4.2 - 5 Highest

Community Need Index

Lowest Need — Need — Highest

1 - 1.7 Lowest | 1.8 - 2.5 2nd Lowest | 2.6 - 3.3 Mid | 3.4 - 4.1 2nd Highest | 4.2 - 5 Highest

Zip Code	CNI Score	Population	City	County	State
90001	5	56616	Florence-Graham	Los Angeles	California
90002	5	47989	Los Angeles	Los Angeles	California
90003	5	65340	Los Angeles	Los Angeles	California
90006	5	65883	Los Angeles	Los Angeles	California
90007	5	45541	Los Angeles	Los Angeles	California
90008	4.4	31365	Los Angeles	Los Angeles	California
90011	5	105737	Los Angeles	Los Angeles	California
90015	5	20059	Los Angeles	Los Angeles	California
90016	4.8	48122	Los Angeles	Los Angeles	California
90017	5	27771	Los Angeles	Los Angeles	California
90018	4.8	50916	Los Angeles	Los Angeles	California
90019	4.8	69091	Los Angeles	Los Angeles	California
90026	5	74336	Los Angeles	Los Angeles	California
90037	5	58832	Los Angeles	Los Angeles	California
90043	4.6	44199	Los Angeles	Los Angeles	California
90044	5	90371	Los Angeles	Los Angeles	California
90047	4.8	47809	Los Angeles	Los Angeles	California
90057	5	47533	Los Angeles	Los Angeles	California
90059	5	40361	Los Angeles	Los Angeles	California
90061	5	26645	Willowbrook	Los Angeles	California
90062	5	28914	Los Angeles	Los Angeles	California
90250	4.8	96658	Hawthorne	Los Angeles	California
90255	4.8	80282	Huntington Park	Los Angeles	California
90302	4.8	30835	Inglewood	Los Angeles	California

CNI Score Median: 5

APPENDIX B

DIGNITY HEALTH
SUMMARY OF PATIENT PAYMENT ASSISTANCE POLICY
(June 2012)

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 (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater in amount for the same services;

- Patients whose income is above 350% but not more than 500% of the FPL are eligible to receive services at 135% of the average rates the Dignity Health facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater for the same services;

- Patients whose income exceeds 500% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of the Dignity Health facility.

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

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 C

CALIFORNIA HOSPITAL MEDICAL CENTER
COMMUNITY BOARD OF DIRECTORS - FY 2014

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