



California Hospital Medical Center

Community Benefit Report 2014 Community Benefit Implementation Plan 2015



Dignity Health.
California Hospital
Medical Center

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***A message from Margaret R. Peterson, PhD, President, California Hospital Medical Center,
and Phillip C. Hill, Chairman of the California Hospital Medical Center Community Board***

The Hello humankindness campaign launched by Dignity Health is a movement ignited and based on the proven idea that human connection, be it physical, verbal, or otherwise, leads to better health. At Dignity Health the comprehensive approach to community health improvement recognizes the multi-pronged effort needed to meet immediate and pressing needs, to partner with and support others in the community, and to invest in efforts that address the social determinants of health.

At California Hospital Medical Center we share a commitment to improve the health of our community and have offered programs and services to achieve that goal. The 2014 Annual Report and 2015 Plan for Community Benefit fulfills section 501 (r) of the Patient Protection and Affordable Care Act, where each hospital must complete a community health needs assessment every three years and develop a community health implementation plan to document how it will address the significant health needs of the community. We are proud to provide this report as a continuation of the work we have done over the past 127 years to better the health of those we serve in Downtown Los Angeles and surrounding communities.

In addition, California State Senate Bill 697 requires not-for-profit hospitals to annually report their community benefit efforts and measurable objectives as well as its plans for the coming year. Encouraged and mandated by its governing body, Dignity Health hospitals comply with both mandates at each of its facilities, including those in Nevada and Arizona, and are proud of the outstanding programs and services that have been offered to improve the health of the citizens within the communities we serve.

In fiscal year 2014, California Hospital Medical Center provided \$86,918,184 in financial assistance, community benefit, and unreimbursed patient care. Including the unreimbursed cost of caring for patients covered by Medicare, the total expense was \$91,886,194.

Dignity Health's California Hospital Medical Center Board of Directors has reviewed and approved the annual Community Benefit Report and Implementation Plan at its October 16, 2014 meeting.

Thank you for taking the time to review our report and plan. If you have any questions, please contact us at 213-742-5974.


Margaret R. Peterson, PhD, President


Phillip C. Hill, Chairman, 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 in 2013: 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 14 CHMC focused increasing access to health care for the broader and underserved disadvantaged members of the surrounding community. Major community benefit activities for FY14 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. Self-management workshop series included: Healthier Living aka Chronic Disease Self-Management Program (CDSMP); Food, Fitness, and Diabetes Prevention; Living with Diabetes; Healthy Eating Lifestyle Program (addressing pediatric obesity); and Heart H.E.L.P.

The Healthy Eating and Lifestyle Program (H.E.L.P.) is a 5 week educational program for families with children ages 5-12 years who are at risk of being overweight or obese. Parents must participate with their child(ren) who qualifies(y) for this program. The primary goal is to help these families adopt healthier eating habits and increase physical activity. The emphasis is on long-term lifestyle changes (such as making better food and beverage choices, integrating activity into their daily lives, and decreasing screen time to < 2 hr/d), rather than short-term diets. Each module is highly interactive so that program participants are able to both learn and apply the facts, principles, and concepts being taught. The Olympic Food Guide is a tool that was developed to help participants make healthier food choices. Foods belonging in the Gold category are packed with nutrients and are relatively low in fat and calories whereas foods in the Brick group are mainly fat and sugar and have many calories per bite and fewer vitamins or minerals.

Food, Fitness and Diabetes Prevention Program is designed to emphasize the importance of making healthy lifestyle changes to prevent diabetes. This program encourages participants to take an active role in leading healthy lives. Topics covered over the four weekly 2-hr sessions include how to prevent chronic conditions such as diabetes, heart disease, and high cholesterol and how these conditions are associated with poor eating habits and physical inactivity. Participants learn about the six important nutrients, choosing correct portion sizes, what a healthy breakfast is and why it's important, how to read food labels and how to be a smart shopper. Following completion of this educational program, participants are encouraged to enroll in the year-long Diabetes Prevention Program at their local YMCA to maintain their momentum.

Living with Diabetes is designed for individuals who have been diagnosed with type 2 diabetes mellitus. Topics covered during the five weekly 2-hr workshops include the difference between type 1 and type 2 diabetes and the signs, symptoms, and complications associated with this chronic illness. Participants learn the importance of managing diabetes using the *Diabetes Health Record*; this record helps them understand basic care guidelines, self-monitoring of blood sugar levels and the importance of regular health care visits. Workshop topics also include understanding the diabetic diet, the plate method, carbohydrate counting, reading food labels, healthy cooking, recipes, the importance of physical activity, and preventing complications and understanding your medications. Participation in Living with Diabetes Program has resulted in a 100% reduction in hospitalizations and ED visits for glucose control in the 6 months following program participation compared to the 6 months prior to participation.

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

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

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's dental clinic, the Southside Coalition of Community Health Centers, 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 Coalition and must complete the *Living with Diabetes* workshop series (or equivalent education classes at their medical home) 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, 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, Family Literacy Program, Nurse Family Partnership Program, Pico Union Family Preservation Network, Early Intervention Program, Family Wellness Center, and Behavioral Health Clinic. 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 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 and early childhood home visitation program at 14 additional birthing hospitals across Los Angeles County. LABBN also provides training, technical assistance and support to the new Select Home Visitation Programs working with these hospitals and developed referral pathways between Welcome, Baby!, Select Home Visitation Programs, and other existing perinatal home visiting programs in each Best Start Community.

The Esperanza Healthy Breathing Program is for children with asthma who have been seen in our emergency department or hospitalized at CHMC. Our program coordinator identifies potential candidates for this program and obtains written consent from the child's parent. Promotoras from the Esperanza Housing Corporation provide home visits after the child's release/discharge from CHMC in order to provide asthma education, explain how to use the spacer and peak flow meter, explain their medications, and inspect the home for possible asthma triggers, such as pet dander, evidence of vermin or cockroaches, mold, excess dust, etc. The parents learn how to mitigate these household triggers in order to improve the health of their child. The promotoras also make sure that the child has a medical home and attends regularly. They also make sure the child has medication both at home and at school and understands when and how to take them.

Heart H.E.L.P. is designed to reduce risk, delay the onset and/or reduce the progression of cardiovascular disease among those participating in its five weekly 2-hr workshops. These workshops focus on modifiable risk factor reduction, especially in the areas of nutrition (DASH diet), physical activity, and smoking cessation. The fifth class focuses on congestive heart failure. Participation in Heart HELP has resulted in a 100% reduction in hospitalizations and a 100% reduction in ED visits for cardiovascular disease in the 6 months following participation compared to the 6 months prior to participation.

To address one of the chronic care needs of the community, CHMC has chosen the **Heart H.E.L.P. Program**. The goal of this program is to improve quality of life for participants by increasing their self-efficacy and avoiding admissions.

CHMC's FY2014 Community Benefit Report and FY2015 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 FY2014 is \$86,918,184 which excludes the unpaid costs of Medicare \$4,968,010.

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.

Hello Humankindness

After more than a century of experience, we've learned that modern medicine is more effective when it's delivered with compassion. Stress levels go down. People heal faster. They have more confidence in their health care professionals. We are successful because we know that the word "care" is what makes health care work. At Dignity Health, we unleash the healing power of humanity through the work we do every day, in the hospital and in the community.

Hello Humankindness tells people what we stand for - health care with humanity at its core. Through our common humanity as a healing tool, we can make a true difference, one person at a time.

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) oral health, 3) substance abuse, 4) diabetes mellitus, and 5) obesity/overweight. LOIs and later full proposals are reviewed and scored by the Grant Review Committee that included the director of Community Benefit, Foundation President, Chairman of the Community Board and two members of the Community Board. The top three proposals are then 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 Perinatal and Early Childhood Home Visitation Advisory Committee of Los Angeles County, Metro YMCA's Diabetes Prevention Program Advisory Committee, 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. The director of community benefit was also invited to participate on a year-long Community Health Worker Work Group for OSHPD Healthcare Workforce Development Division and CA Healthcare Workforce Alliance. She also serves as one of seventeen members of the UCLA Clinical and Translational Science Institute's (CTSI) Community Advisory Board.

This year the director of Community Benefit worked closely with senior leadership of LA County department of Public Health to secure a sole source contract from the LA County Board of Supervisors to fund Healthy Communities Network (HCN) web-based informational system for Los Angeles County, entitled *Think Health LA*. The HCN tracks 75-200+ health and quality of life indicators, offers guidance on over 1800 community-level evidence-based interventions and includes features that help community members work with stakeholders to effect change. In the future all nonprofit hospitals in LA County can use this website for their "living" CHNA. Additionally it will be useful for facilitating communication and driving community engagement around community health improvement. We are now in the process of finalizing the website for its winter launch and developing an Advisory Board for HCN as well as a sustainable funding plan.

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 (650,103) 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 (62%) and are of Mexican origin (60%). The remaining population is mostly African-American (20%). 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 26.4% of the population, while only 8.9% are seniors. 40.8% of the residents have not received a high school diploma, and household incomes are generally low with a median household income of only \$32,127, nearly 40% less than the County median. Twice as many households (24.8% and 21.3%, respectively) have an annual income of <\$15,000 compared to LA County (12.9%). 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: 74.0%
- CNI Score: 5
- Medicaid Patients: 35.0%
- Other Area Hospitals: 6

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Community Needs Index (CNI)

To complement the traditional methodology used to conduct community needs assessments, Dignity Health 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 maps of CHMC’s primary and secondary service areas are included in the Appendix A

COMMUNITY BENEFIT PLANNING PROCESS

PLANNING PROCESS

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, added new requirements that nonprofit hospital organizations must satisfy to maintain tax-exempt status under section 501(c)(3) of the Internal Revenue Code. One such requirement added by ACA, to Section 501(r) of the Code, requires nonprofit hospitals to conduct a community health needs assessment (CHNA) at least once every three years. As part of the CHNA, each hospital is required to collect input from designated representatives in the community, including public health experts as well as members, representatives or leaders of low-income, minority, and medically underserved populations, and individuals with chronic conditions.

For the **2013 (FY14) CHNA**, three hospitals in metropolitan Los Angeles — California Hospital Medical Center, Good Samaritan Hospital, and St. Vincent Medical Center — collaborated, as they have in the past, to work with the Center for Nonprofit Management consulting team in conducting the CHNA. In the initial phase of the CHNA process, community input was collected through 10 focus groups and 29 interviews with key stakeholders, including health care professionals, government officials, social service providers, community residents, leaders, and other relevant individuals. The purpose of the primary data collection component of the CHNA is to identify broad health needs and key drivers, as well as assets and gaps in resources, through the perceptions and knowledge of varied and multiple stakeholders. These stakeholders represented a wide range of health and social service expertise as well as representatives from diverse ethnic backgrounds including African-American, Chinese, Filipinos, Koreans and Latinos (Appendix B)

The interviews were conducted primarily via telephone for approximately 30 to 45 minutes each; the conversations were confidential and interviewers adhered to standard ethical research guidelines. The interview protocol was designed to collect reliable and representative information about health and other needs and challenges faced by the community, access and utilization of health care services, and other relevant topics. Focus groups took place in a range of locations throughout the service area, with translation and interpretation services provided when appropriate. Focus group sessions were 45 to 60 minutes each. As with the interviews, the focus group topics also were designed to collect representative information about health care utilization, preventive and primary care, health insurance, access and barriers to care, emergency room use, chronic disease management and other community issues. The identified health needs and drivers of health were then presented during a community forum to allow for a richer discussion of secondary data and additional considerations.

Concurrently, over 100 indicators of secondary data were collected and compared to relevant benchmarks including Healthy People 2020, Los Angeles County or California rates or statistics when possible. Secondary data were collected from a wide range of local, county, and state sources to present demographics, mortality, morbidity, health behaviors, clinical care, social and economic factors, and physical environment. These categories are based on the Mobilizing Action Toward Community Health (MATCH) framework, which illustrates the interrelationships among the elements of health and their relationship to each other, including social and economic factors, health behaviors, clinical care, physical environmental, and health outcomes. The data were also collected for smaller geographies, when possible, to allow for more in-depth analysis and identification of community health issues. In addition, prior CHNAs were reviewed to identify trends and ensure that previously identified needs were not overlooked. Primary and secondary data were compiled into a scorecard to present health needs and health drivers with benchmarks included for comparison; when an indicator for CHMC fell below the comparison benchmark (Healthy People 2020, Los Angeles County and California indicators) it is shaded in black. The scorecard was designed to allow for a comprehensive analysis across all data sources and for use during the prioritization phase of the CHNA process.

As previously discussed, health needs and drivers were identified from both primary and secondary data sources using the magnitude or size of the problem relative to the portion of population affected by the problem, as well as the seriousness of the problem (impact at the individual, family, or community level). To examine the size and seriousness of the problem, these indicators from the secondary data were compared to the available benchmark (HP2020, county, or state). Those indicators that performed poorly against a benchmark were considered to have met the size and seriousness criteria and were added to the master list of health needs and drivers. Concurrently, health needs and drivers that were identified by stakeholders in the primary data collection were also added to the master list of health needs and drivers.

The Simplex Method was selected as the approach for the health needs prioritization process. A Simplex Method is the process in which input is gathered through a close-ended survey where respondents rate each health need and driver using a set of criteria. This approach was selected because of its inclusivity of stakeholders, its ease of use, and to involve a moderate amount of rigor.

Community Prioritization Forum

The community forum was designed to provide the opportunity for a range of stakeholders to engage in a discussion of the data and participate in the prioritization process. All individuals who were invited to take part in the primary data collection, irrespective of whether or not they had participated in that phase, were invited to attend a community forum. The forum included a brief presentation that provided an overview of the CHNA data collection and prioritization processes to date, and a review of the documents to be used in the facilitated discussion.

Participants were provided a list of identified health needs and drivers in the scorecard format, developed from the matrix described previously in this report, and a narrative document that included brief summary descriptions of the identified health needs. Participants then engaged in a facilitated discussion about the findings as presented in the scorecard and the narrative summaries, and prioritization of the identified health needs and drivers. Each participant was then asked to complete a survey and to rank each health need according to several criteria, as described below.

Community forum participants were asked to complete a questionnaire after the forum, rating each health need and driver according to scales for severity, change over time, resources available to address the needs and/or drivers, and the community's readiness to support initiatives to address the needs and/or drivers.

The responses to the 31 completed questionnaires were compiled and analyzed using Microsoft Excel. As described above, averages were computed for each criterion. The overall average was calculated by adding the total across 3 of the criteria severity (total possible score equals 4), change over time (total possible equals 4), and resources (total possible equals 4) for each survey (with a total possible score of 12). The total scores were divided by the total number of surveys for which data was provided, resulting in an overall average per health need.

Prioritized Community Health Needs and Drivers

Community health needs are conceptually divided into drivers and conditions. Drivers are considered the structural and social factors that correlate with health status. Conditions refer to the diseases and health concerns experienced by community members.

Table 1. Prioritized Drivers of Health

	Severe Impact on the Community	Gotten Worse Over Time	Shortage of Resources in the Community	Community Readiness to Address/Support	Overall Rating
1. Poverty (including unemployment)	3.4	3.3	2.9	2.5	11.7
2. Housing	3.4	3.3	3.0	2.7	9.0
3. Specialty Care Access	3.3	2.8	2.9	2.5	8.8
4. Homelessness	3.4	2.9	2.7	2.3	8.5
5. Disease Management	2.9	2.7	2.5	2.6	8.2
6. Health Care Access	3.2	2.5	2.6	2.8	8.2
7. Cultural Barriers	3.2	2.7	2.8	2.8	8.1
8. Immigrant Status	3.2	2.7	2.7	2.8	8.1
9. Social Barriers (i.e. family issues)	3.2	2.9	2.6	2.6	8.1
10. Alcohol and Substance Abuse	3.3	2.7	2.7	2.8	8.0
11. Community Violence	3.0	2.5	2.6	2.9	7.9
12. Coordinated Healthcare	3.0	2.3	2.6	2.6	7.7
13. Transportation	2.9	2.4	2.5	2.4	7.7
14. Healthy Eating	3.1	2.6	2.4	2.6	7.6
15. Physical Activity	3.0	2.7	2.4	2.6	7.6
16. Preventative Care Services	2.9	2.5	2.4	2.6	7.5
17. Health Education and Awareness	3.0	2.4	2.4	2.7	7.3

Table 2. Prioritized Health Needs

	Severe Impact on the Community	Gotten Worse Over Time	Shortage of Resources in the Community	Community Readiness to Address/ Support	Overall Rating
1. Mental Health	3.0	2.8	2.7	2.4	8.8
2. Oral health	3.0	3.0	2.9	2.6	8.6
3. Substance Abuse	3.2	3.0	2.7	2.7	8.2
4. Diabetes	3.2	2.9	2.2	2.8	8.1
5. Obesity/Overweight	3.2	2.9	2.3	2.7	8.1
6. Alzheimer's Disease	3.0	3.0	2.7	2.6	7.9
7. Cardiovascular Disease	3.0	2.7	2.2	2.6	7.9
8. Alcoholism	3.1	2.8	2.8	2.8	7.8
9. Sexually Transmitted Diseases	2.8	2.6	2.3	2.4	7.6
10. Allergies	2.8	3.1	2.6	2.5	7.5
11. Asthma	2.9	2.9	2.3	2.5	7.4
12. Hypertension	3.0	2.6	2.2	2.7	7.4
13. Vision	2.8	2.9	3.0	2.7	7.4
14. Cholesterol	2.6	2.5	2.3	2.8	7.2
15. Cancer, general	3.0	2.3	2.0	2.7	7.0
16. Colorectal Cancer	2.8	2.3	2.2	2.8	7.0
17. Arthritis	2.6	2.4	2.4	2.5	6.8
18. Breast Cancer	2.7	2.1	2.3	2.9	6.8
19. HIV/AIDS	2.7	2.1	2.0	2.4	6.0

Assets Assessment

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.

Developing the Hospital's Implementation Plan

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:

- FY14 CHMC Community Health Needs Assessment especially the Prioritized Health Needs
- 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

Plan to Address Prioritized Community Health Needs

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. Moreover, the programs are continuously monitored for performance and quality with ongoing improvement to facilitate their success. 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.

Initiative I: Improving Access to Mental Health Services

- Health Ministry Program
- Hope Street Family Center
 - Early Head Start Program
 - Nurse Family Partnership
 - Welcome Baby Program
 - Pico Union Family Preservation Program
 - Hope Street Youth Center
 - CA Behavioral Health Clinic
 - Early Intervention Program
 - Family Wellness Center
- Clinical experience for social work students
- Los Angeles Best Babies Network
 - Welcome Baby Replication Initiative and Implementation of Select Home Visitation Programs in 14 birth hospitals in Los Angeles County
 - Care Quality Collaborative Program
- Dignity Health Community Grants Program
 - Community Wellness Collaborative Project
 - Pathways LA's Positive Parenting & Stepping stones for Families with Children with Special Needs and Disabilities
 - 10th Decile Project: Health Care and Supportive Housing for Chronically Homeless Frequent Users

Initiative II: Improving Access to Oral Health Care and Improving Oral Health Status

- Hope Street Family Center
 - Partnership with USC Dental Program
 - Family Wellness Center
 - Oral Hygiene Classes
- Health Ministry Program
 - Oral Hygiene Classes
- UniHealth Community Dental Partnership for Uninsured Adults with Medication-Dependent Diabetes
 - Basic and periodontal services provided through a collaboration of:
 - Southside Coalition of Community Health Centers

- CHMC
- Eisner Pediatric and Family Medical Center's Dental Department

Initiative III: Prevention and Treatment of Substance Abuse and Alcoholism

- Prevention of Child Abuse and Neglect and Family Violence Prevention
 - Hope Street Family Center
 - Pico Union Family Preservation Program
 - Early Head Start Program
 - Nurse Family Partnership Program
 - Welcome Baby Program
 - Licensed Childcare Centers
 - Family Childcare Network
 - CA Behavioral Health Clinic
 - Early Intervention Program
 - Family Wellness Center
 - Los Angeles Best Babies Network
 - Welcome Baby Replication Initiative and Implementation of Select Home Visitation Programs in 14 birth hospitals in Los Angeles County
 - LA County Perinatal and Early Childhood Home Visitation Consortium's Policy Subcommittee
 - Dignity Health Community Grants Program
 - Pathways LA's Positive Parenting & Stepping stones for Families with Children with Special Needs and Disabilities
 - Community Wellness Collaborative Project

- Treatment of Substance Abuse and Alcoholism
 - Hope Street Family Center
 - Pico Union Family Preservation Network
 - Early Head Start Program
 - Nurse Family Partnership Program
 - Welcome Baby Program
 - CA Behavioral Health Clinic
 - Family Wellness Center
 - Los Angeles Best Babies Network
 - Welcome Baby Replication Initiative and Implementation of Select Home Visitation Programs in 14 birth hospitals in Los Angeles County
 - Dignity Health Community Grants Program
 - 10th Decile Project: Health Care and Supportive Housing for Chronically Homeless Frequent Users

Initiative IV: Prevention and Treatment of Diabetes

- Prevention of Diabetes
 - Health Ministry Program
 - Food, Fitness, and Diabetes Prevention
 - Referrals to YMCA's Diabetes Prevention Program
 - Hope Street Family Center
 - Family Wellness Center
 - Food, Fitness, and Diabetes Prevention
 - Healthy Cooking Demonstrations
 - Referrals to YMCA's Diabetes Prevention Program
 - Los Angeles Best Babies Network
 - CDC Community Transformation Grant & Good Hope Medical Foundation Grant: Healthy Weight Perinatal Care Quality Collaborative
 - Welcome Baby Replication Initiative and Implementation of Select Home Visitation Programs in 14 birth hospitals in Los Angeles County

- Dignity Health Community Grants Program
 - Community Wellness Collaborative
- Treatment of Diabetes
 - Health Ministry Program
 - Living with Diabetes Program
 - Diabetes Support Group
 - Hope Street Family Center
 - Family Wellness Center
 - Healthy Cooking Demonstrations
 - Chronic Disease Self-Management Program (CDSMP)
 - Dignity Health Community Grants Program
 - South Central Family Health Center's Exercise and Nutrition Program for Adults with Diabetes
 - St. Barnabas Senior Center of Los Angeles: Diabetes Self-Management Program
 - UniHealth Community Dental Partnership for Uninsured Adults with Medication-Dependent Diabetes
 - Basic and periodontal services provided through a collaboration of:
 - Southside Coalition of Community Health Centers
 - CHMC
 - Eisner Pediatric and Family Medical Center's Dental Department
 - CCF Coordinated Care Initiative
 - Selected FOHCs in the Centinela Valley: UMMA, South Central Family Health Center, T.H.E. Clinic
 - CHMC

Initiative V: Improving Physical Activity and Dietary Habits and Reducing Overweight/Obesity

- Health Ministry Program
 - Food, Fitness, and Diabetes Prevention
 - Referrals to YMCA's Diabetes Prevention Program
- Hope Street Family Center
 - Early Head Start Program
 - Nurse Family Partnership Program
 - Welcome Baby Program
 - Hope Street Youth Center
 - Licensed Childcare Centers
 - Family Childcare Network
 - Youth Fitness Program
 - Family Wellness Center
 - Healthy Eating Lifestyle Program
 - Healthy Cooking Demonstrations
 - Referrals to YMCA's Diabetes Prevention Program
- Dignity Health Community Grants Program
 - Community Wellness Collaborative
 - Red Shield Diet and Exercise Program
- Los Angeles Best Babies Network
 - CDC Community Transformation Grant and Good Hope Medical Foundation Grant: Healthy Weight Perinatal Care Quality Collaborative

Initiative VI: Prevention and Treatment of Cardiovascular Disease

- Health Ministry Program
 - Smoking Cessation Assistance Program
 - Heart H.E.L.P.
 - Living with Diabetes Program
- Heart H.E.L.P. Program
- Living with Diabetes Program
- Chronic Disease Self-Management Program
- Hope Street Family Center
 - Family Wellness Center

- CDSMP
 - Healthy Cooking Demonstrations
- CCF Coordinated Care Collaborative
 - Selected FQHCs in Centinela Valley; UMMA, South Central Family Health Center, T.H.E. Clinic
 - CHMC

Initiative VII: Improving Access To Health Care

- *Para Su Salud*
- Health Ministry Program
- Charity Care for uninsured/underinsured and low income residents
- Clinical experience for medical professional students
- Dignity Health Community Grant Program
 - 10th Decile Project: Health Care and Supportive Housing for Chronically Homeless Frequent Users

Initiative VIII: Preventing and/or Managing Other Chronic Health Conditions

- Health Ministry Program
 - Chronic Disease Self-Management Program (CDSMP)
- Komen Breast Cancer Diagnostic Program
- UniHealth Esperanza Healthy Breathing Project for Children with Asthma
 - CHMC
 - Esperanza Housing Corporation

Initiative IX: Improving Birth Outcomes

- Hope Street Family Center
 - Early Head Start Program
 - Nurse Family Partnership Program
 - Welcome Baby Program
- Los Angeles Best Babies Network
 - CDC Community Transformation Grant and Good Hope Medical Foundation Grant: Healthy Weight Perinatal Care Quality Collaborative
 - Incorporating *Baby Basics* into Prenatal Healthcare Delivery
 - LA County Perinatal and Early Childhood Home Visitation Consortium
 - Welcome Baby Replication Initiative and Implementation of Select Home Visitation Programs in 14 birth hospitals in Los Angeles County

Initiative X: Improving Health Literacy

- Hope Street Family Center
 - Family Literacy Program
 - Early Head Start Program
 - Licensed Childcare Centers
 - Family Childcare Network
 - Hope Street Youth Center
- Los Angeles Best Babies Network
 - Incorporating *Baby Basics* into Prenatal Healthcare Delivery

Initiative XI: Injury Prevention

- **Gang Prevention**
 - Hope Street Family Center
 - Hope Street Youth Center
 - Youth Fitness Program
 - Nurse Family Partnership Program
 - CA Behavioral Health Clinic
- **Pedestrian Safety**
 - Health Ministry Program

- **Child Car Seat Safety**
 - Maternity Tours
 - Free car seats for all new parents delivering at CHMC
 - First 5 LA *Kit for New Parents*
- **Child Abuse and Neglect Prevention**
 - Hope Street Family Center
 - Pico Union Family Preservation Program
 - Early Head Start
 - Nurse Family Partnership Program
 - Welcome Baby Program
 - Licensed Childcare Centers
 - Family Childcare Network
 - CA Behavioral Health Clinic
 - Early Intervention Program
 - Los Angeles Best Babies Network
 - LA County Perinatal & Early Childhood Home Visitation Consortium
 - Welcome Baby Replication Initiative and Implementation of Select Home Visitation Programs in 14 birth hospitals in Los Angeles County
 - Dignity Health Community Grants Program
 - Pathways LA's Positive Parenting & Stepping stones for Families with Children with Special Needs and Disabilities
- **Family Violence Prevention**
 - Health Ministry Program
 - Hope Street Family Center
 - Family Preservation Program
 - Early Head Start Program
 - Nurse Family Partnership Program
 - Welcome Baby Program
 - Early Intervention Program
 - CA Behavioral Health Clinic
 - Family Wellness Center
 - Los Angeles Best Babies Network
 - LA County Perinatal & Early Childhood Home Visitation Consortium
 - Welcome Baby Replication Initiative and Implementation of Select Home Visitation Programs in 14 birth hospitals in Los Angeles County
 - Dignity Health Community Grants Program
 - Community Wellness Collaborative
 - Pathways LA's Positive Parenting & Stepping stones for Families with Children with Special Needs and Disabilities

Priority Needs Not Being Addressed and the Reasons

Alzheimer's Disease

- In 2010 the Alzheimer's mortality rate in CHMC service area was three times higher (9.8) than California (2.9)
- Only 8.9% of the residents in CHMC's primary and secondary service areas are seniors.
- **Rationale for not addressing Alzheimer's Disease**
- The average age of the populations in our service area was in the mid-thirties, slightly younger than in Los Angeles County.
- The Alzheimer's Association's CA Southland Chapter has a 54 page Resource Directory for LA County; it can be accessed at http://www.alz.org/socal/documents/helpingyou_Directory.pdf

Allergies

- In 2007 just over a quarter of teens (27.1%) in CHMC overall service area was diagnosed with allergies – slightly higher compared to Los Angeles County (24.9%).
- Larger percentages of teens were diagnosed with allergies in SPAs 6 (45.6%) and 8 (29.5%) when compared to the CHMC overall service area and Los Angeles County.
- **Rationale for not addressing allergies**
- Children's Hospital Los Angeles and Harbor-UCLA Medical Center both have pediatric departments that address allergies.
- Assisting adolescents to establish a medical home will likely enable them to access specialty care for their allergies.

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 care 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, testing and referrals
 16. WEHO Life, an AIDS information and prevention program

Sexually Transmitted Diseases

- **Rationale for not addressing STDs**
- 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 16, 2014.

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 <input checked="" type="checkbox"/> Priority Area 1 Improving access to mental health services <input checked="" type="checkbox"/> Priority Area 2 Improving access to oral health services <input checked="" type="checkbox"/> Priority Area 3 Prevention & treatment of diabetes <input checked="" type="checkbox"/> Priority Area 4 Reducing Overweight/Obesity <input checked="" type="checkbox"/> Priority Area 5 Prevention & treatment of CVD
Program Emphasis	Please select the emphasis of this program from the options below: <input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Lack of access to healthcare, especially preventive care and health screenings
Program Description	CHMC sponsors Parish Nurse 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 2014	
Goal FY 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	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 Begin offering health screening at HSFC's Family Wellness Center
Result FY 2014	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 \$ 402,000 for the Health Ministry Program.
FY 2015	
Goal 2015	Eliminate health disparities in CHMC's service area
2015 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.
Community Benefit Category	Community Health Improvement Services: <ul style="list-style-type: none"> • Community-based clinical services • Community-based health education

ACCOMPLISHMENTS – FY2014

- Our bilingual parish nurse served 1,507 participants at 138 screening events, 3,355 total referrals made.

HEALTH SCREENINGS 2014

Screening Type	# Individuals Screened	# Referred
Blood glucose (diabetes)	1,001	364
Blood pressure (hypertension)	1,522	310
Body mass index (overweight/obesity)	1,221	48
Cholesterol	1,298	138
Hemoglobin (anemia)	1,113	33
Hemoglobin A1c (diabetes)	911	290
Smoking	532	171
Substance abuse and dependence	510	39
TOTAL	8,108 screenings	1,393 referred

- 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 1,962 referrals as illustrated below:

REFERRALS 2014

Type of Referral	# of Individuals Referred
Mammogram/Clinical Breast Exam/Pap testing	1,735
CHMC Living with Diabetes	81
CHMC Heart HELP	47
Dental Services	21
Vision Services	58
Mental Health Services	9
Spanish language literacy course	3
Shelter/social services	8
TOTAL	1,962

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)
- Centro Latino Literacy (Spanish language literacy classes)
- Good Shepard Center for Women & Children (shelter, social services)

Educational Materials Provided

Title	Number
Medicines for Type 2 Diabetes, AHRQ	216
Protect Your Heart Against Diabetes, NHLBI	1287
Where Do I Begin? Living with Type 2 Diabetes, ADA	222
A1c and eAG, Krames	911
Control Diabetes: the A1c Test, Krames	911
What's Your Number?, ADA	911
Blood Pressure Tracking Booklet, NYC Health	1422
Caring for Your Heart, AHA	1422
Choosing Medicines for High Blood Pressure, AHRQ	272
Measuring Your Blood Pressure at Home, AHRQ	412
Your Guide to Lowering Blood Pressure, NHLBI	604
What is Hypotension?, NHLBI	36
Do You Need to Lose Weight?, USDHHS	1196
Eating Out, Eating Well, NYC Health	1218
Facts About Healthy Weight, NHLBI	1218
How to Use Fruits & Vegetables to Help You Manage Your Weight	1218
Let's Eat for the Health of It, USDHHS	1218
Soda: How Sizes Have Changed, NYC Health	1218
What' on Your Plate?, ChooseMyPlate.gov	1218
In Brief: Your Guide to Anemia, NHLBI	101
Iron Rich Foods, ARC	101
High Hemoglobin Count, Mayo Clinic	12
Do You Know Your Cholesterol Levels?, NHLBI	1421
Treating High Cholesterol: A Guide for Adults, NHLBI	291

Type 2 Diabetes Prevention, Screening, and Intervention Program

<p>Hospital CB Priority Areas</p>	<p>Please add the Hospital Priority Areas identified in the Community Needs Assessment for your hospital here</p> <ul style="list-style-type: none"> <input type="checkbox"/> Priority Area 1 <input type="checkbox"/> Priority Area 2 <input checked="" type="checkbox"/> Priority Area 3 Improving access to oral health care <input checked="" type="checkbox"/> Priority Area 4 Treatment of Diabetes <input type="checkbox"/> Priority Area 5
<p>Program Emphasis</p>	<p>Please select the emphasis of this program from the options below:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
<p>Link to Community Needs Assessment</p>	<p>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.</p> <p>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.</p> <p>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.</p> <ul style="list-style-type: none"> • 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%). <p>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.</p> <ul style="list-style-type: none"> • 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. <p>Having health insurance and access to a regular source of care are essential for effective management of diabetes.</p> <ul style="list-style-type: none"> • 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. <p>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:</p> <ul style="list-style-type: none"> • 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.
<p>Program Description</p>	<p>In 2004, the Chronic Disease Management Consortium (CHMC, Good Samaritan Hospital, Huntington Memorial Hospital, and the National Health Foundation) designed, submitted, and</p>

	<p>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 two distinct 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);</p> <p>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.</p> <p>Diagnosed type 2 diabetics will be invited to participate in Secondary Prevention Services that include:</p> <ul style="list-style-type: none"> • Living with Diabetes: 5 weekly workshops designed to help patients understand their condition. Topics include: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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. <p>All data are entered into the web-based data system housed at the National Health Foundation, the program evaluator.</p>
FY 2014	
Goal FY 2014	<ol style="list-style-type: none"> 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	<p>Primary Diabetes Prevention Services</p> <p>All of those with scores of ≥ 10 on ADA Risk Test will be referred to health care provider for definitive diagnostic testing for diabetes.</p> <p>50% of those referred to health care providers will follow-up on these referrals and determine their diabetes status.</p> <p>40% of those referred to health care provider but determined not to have diabetes yet will participate in the Primary Diabetes Prevention Services.</p> <p>Of those participating in the Diabetes Prevention Workshops:</p> <ul style="list-style-type: none"> • 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. <p>Secondary Prevention Services</p> <ul style="list-style-type: none"> • 60% of patients diagnosed with diabetes will participate in Living with Diabetes Program. <p>Of patients participating in these services:</p>

	<ul style="list-style-type: none"> • 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.
Baseline	<p>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.</p> <p>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.</p> <p>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.</p>
Intervention Strategy for Achieving Goal	<p>The Parish Nurse also screens for diabetes in the community using hemoglobin A1c: 5.7-6.4% = prediabetes; $\geq 6.5\%$ = diabetes</p> <p>Those at high risk for diabetes are offered the <i>Food, Fitness, and Diabetes Prevention Program</i>.</p> <p>Those diagnosed with diabetes are offered <i>Living with Diabetes Program</i>.</p> <p>We also offer to provide <i>Living with Diabetes Program</i> at clinics belongs to the Southside Coalition of Community Health Centers.</p>
Result FY 2014	<p>Because of staff cuts, <i>no Food, Fitness, and Diabetes Prevention</i> workshops were offered this fiscal year.</p> <p>181 participants and 305 guests participated in the 5-wk series of <i>Living with Diabetes</i> workshops.</p> <p>Demographic profile of participants: 100% Hispanic/Latino; 79% female & 21% male; 79% with waist circumference at or above cut-off; 4% normal BMI, 34% overweight, 62% obese. HbA1c: ≤ 7: 21%; 7-8.9: 34%; 9-10:17%; >10:9%.</p> <p>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%.</p> <p>Paired data of Intervention participants demonstrated that by the end of the Program:</p> <ul style="list-style-type: none"> • 32% lost weight from the beginning until 3-6 mo follow-up. • 9% lost $\geq 5\%$ 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. <ul style="list-style-type: none"> ○ 45% eating ≥ 5 servings of fruits & vegetables/d ○ 77% drinking ≥ 4 cups of water/d ○ 70% eating breakfast daily ○ 91% eating fast food 0-1 days in last week. • 88% improved their confidence in being able to improve their exercise habits. <ul style="list-style-type: none"> ○ 33% started being physically active ○ 12% physically active ≥ 4 times/wk; 72% total. ○ 60% increased frequency ○ 38% physically active ≥ 30 minutes each time; 94% total. ○ 55% increased duration of PA ○ 43% increased distance walked each time. • 33% increased their emotional wellbeing • 94% improved their confidence in being able to manage their diabetes. <ul style="list-style-type: none"> ○ 23% began asking questions about their diabetes and treatment ○ 64% increase in discussing their personal problems related to diabetes with their

	<ul style="list-style-type: none"> o 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 <i>Living with Diabetes</i> 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. The promotora who provides diabetes workshops is currently funded by UniHealth Foundation through Community Dental Partnership grant - \$176,137/yr.
FY 2015	
Goal 2015	<ol style="list-style-type: none"> 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);
2015 Objective Measure/Indicator of Success	Maintain same modified measurable objectives as FY14. 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	<p>Continue to monitor and report measurable objectives.</p> <p>Link the hospital discharge planning process to the Secondary Prevention Services</p> <p>Continue the collaborative agreements we have with local FQHCs that want us to provide diabetes education for their diabetics.</p> <p>Increase outreach to predominantly African American churches</p> <p>Offer classes on Saturdays to accommodate the working patients.</p>
Community Benefit Category	Community Health Improvement Services: <ul style="list-style-type: none"> • Community health education

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
FY14-Q1	27	21	0	0	0	0
FY14-Q2	49	39	0	0	0	0
FY14-Q3	32	26	0	1	0	0
FY14-Q4	18	16	0	0	0	0
Total	126	102(80.9%)	0	0	0	0

Therefore, participation in *Living with Diabetes* Program resulted in no 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.

Community Dental Partnership	
Hospital CB Priority Areas	<p>Please add the Hospital Priority Areas identified in the Community Needs Assessment for your hospital here</p> <p><input type="checkbox"/> Priority Area 1 <input checked="" type="checkbox"/> Priority Area 2 Increasing access to oral health care & improving oral health status <input type="checkbox"/> Priority Area 3 <input checked="" type="checkbox"/> Priority Area 4 Prevention & treatment of diabetes <input type="checkbox"/> Priority Area 5</p>
Program Emphasis	<p>Please select the emphasis of this program from the options below:</p> <p><input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance</p>
Link to Community Needs Assessment	<p>Prioritized health need #2: Access to Oral health</p> <p>Severe periodontal disease often coexists with severe diabetes mellitus. Diabetes is a risk factor for severe periodontal disease and periodontal disease increases the severity of diabetes and complicates metabolic control. Periodontal disease is a n inflammatory disease that affects the soft and hard structures that support the teeth. Periodontitis is characterized by retraction of the gums from the tooth. When periodontitis becomes severe, the gums become very inflamed due to toxins released by harmful bacterial and the body's own immune system response. If not treated, the inflammation will lead to increasing soft tissue and bone damage, and eventually teeth loss. ~1/3 of individuals with diabetes have severe periodontal disease. Uncontrolled periodontal disease can make it more difficult for diabetics to control their blood sugar. Adults age 45 and older who have poorly controlled diabetes are 3 times more likely to have severe periodontal disease and if that person also smoke, that number increases to almost 5 times more likely to have severe periodontitis. Periodontal disease and resulting tooth and gum damage can affect the patient's diet; patients are unable to eat fresh fruits, vegetables and whole grains and they become more reliant on highly processed foods that exacerbate their diabetes, increasing their risk for cardiovascular complications and worsening periodontitis.</p> <p>Medicaid dental benefits for adults are optional. Many states cover only emergency services or have fairly low caps on adult dental expenditures. During the financial crisis, CA eliminated dental benefits for adult Medicaid beneficiaries. These benefits were partially reinstated on May 1, 2014 but periodontal services remains excluded from the list of restored benefits. There is growing evidence that treating periodontal disease reduces medical costs. In one Cigna study the medical cost savings amounted to ~\$1,418/pt in the first year of dental coverage. Another study by United Healthcare showed a reduction of \$1,750/yr in cost of care when patients received periodontal treatment. A 2013 retrospective study conducted by Aetna on 1.5 million patients suggest that dental-medical integration models result in less hospital admissions (-3.5%); lower medical claims costs (-17%); less dental claims for major/basic services (-42%); and improved diabetes control (+45%). A recent landmark study conducted by United Concordia examined almost 350,000 patients with periodontal disease and found that good periodontal maintenance resulted in a reduction of healthcare costs of 40.2% or \$2,840 for patients with T2DM and 39.4% reduction in hospital admissions.</p>
Program Description	<p>The Community Dental Partnership is a collaboration between Eisner Pediatric and Family Medical Center's dental clinic, the Southside Coalition of Community Health Centers, 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 Coalition and must complete the <i>Living with Diabetes</i> workshop series (or equivalent education classes at their medical home) and the Oral Hygiene class.</p>
FY 2014	
Goal FY 2014	<p>Improve CDP project coordination, communication, & rapidity of problem-solving</p> <p>Provide periodontal care to 300 unduplicated, uninsured adults with diabetes that require medication for control</p> <p>Improve care and care coordination for diabetic patients</p> <p>Analyze data to determine whether periodontal services and care coordination improved health outcomes for diabetic patients who participated in the project.</p>
2014 Objective Measure/Indicator of Success	<p>Number of new patients with medication-dependent diabetes that are enrolled</p> <p>Number of these diabetic patients that received diabetes self-management education</p> <p>Number of these diabetic patients that attended oral hygiene class</p> <p>Total number of these diabetics that received basic dental services</p> <p>Total number of these diabetics that received periodontal services</p> <p>Number of these diabetics that completed their dental treatment plan</p>
Baseline	<p>Currently Denti-Cal that was partially reinstated on May 1, 2014 does not pay for periodontal services. The periodontist funded by this grant is the only periodontist working in a FQHC in Los Angeles County. Without this program, some of these patients would have not have access to basic dental services and none of them would have access to periodontal services.</p>
Intervention Strategy for Achieving Goal	<p>MOUs between Eisner, CHMC, and each of the community health centers belonging to the Southside Coalition of Community Health Centers when this project began in 2011. CHMC staff and staff from the dental clinic met monthly to review data from the prior month and problem-solve any issues. Referrals from each health center were sent to the promotora who scheduled the patients for diabetes self-management education, such as Living with Diabetes, and for Oral Hygiene Class. After completing the oral hygiene class, the patients were given a basic dental appointment if their medical home did not offer dental services, or a periodontal appointment if their medical homes did</p>

	provide basic dental services. After completing basic dental services at Eisner, patients were referred to periodontist if necessary. Some patients needed services not provided by the grant; they generally opted for a payment plan at Eisner and paid for these services over time.
Result FY 2014	<p>A total of 683 medication-dependent diabetics were enrolled which exceeded our goal of 500.</p> <ul style="list-style-type: none"> • Central City 12 • Clinica Oscar Romero 181 • Eisner 213 • South Central 67 • St. John's 114 • T.H.E. 75 • UMMA 8 <p>224 of these diabetics received diabetes self-management education. Due to their work schedules many diabetics were unable to attend diabetes self-management classes. 1124 diabetics attended oral hygiene class and learned how to brush and floss their teeth. 336 diabetics received basic dental services at Eisner. The "no show" rate for basic dental appointments was only 8.5% 577 unduplicated diabetics received periodontal services at Eisner. This exceeded our goal of 300. A total of 1126 periodontal appointments took place. 85 diabetics completed their dental treatment plans. 80/85 completed the Patient Satisfaction Survey; overall the patients were "very satisfied" with both the staff and the services they received. Periodontal services resulted in a mean improvement of HbA1c of -1.34%, the equivalent of a fall in mean blood sugar of 40.3 mg/dL (range -6.6 to +0.3). This is equivalent to last year's result!</p>
Hospital's Contribution / Program Expense	This program is funded by the UniHealth Foundation. \$176,137/yr Office space, supplies, etc. for the promotora are provided by CHMC.
FY 2015	
Goal 2015	<p>Recruit and provide case management services for at least 575 unduplicated, uninsured adults with diabetes that require medication for control from the community health centers belonging to the Southside Coalition. Provide at least 700 periodontal visits annually for 350 unduplicated adults with medication-dependent diabetes. Provide follow-up maintenance periodontal visits for the 350 diabetics receiving periodontal services.</p>
2015 Objective Measure/Indicator of Success	Same as for 2014 above.
Baseline	The prevalence of diabetes continues to increase in our community and the periodontist funded through this grant remains the only such professional serving this population.
Intervention Strategy for Achieving Goal	Because the literature documents the importance of maintenance visits following periodontal treatment, the new 3-yr grant allows us to provide this additional service. Otherwise, our strategy remains the same as for FY14.
Community Benefit Category	<p>Community Health Improvement Services:</p> <ul style="list-style-type: none"> • Community Health Education • Community-based Clinical Services

Hope Street Family Center Early Head Start Program	
Hospital CB Priority Areas	<p>Please add the Hospital Priority Areas identified in the Community Needs Assessment for your hospital here</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Priority Area 1 Increase access to mental health services <input checked="" type="checkbox"/> Priority Area 2 Increase access to oral health services <input checked="" type="checkbox"/> Priority Area 3 Prevention & treatment of substance abuse/alcoholism <input type="checkbox"/> Priority Area 4 <input checked="" type="checkbox"/> Priority Area 5 Improving physical activity & dietary habits and reducing overweight/obesity
Program Emphasis	<p>Please select the emphasis of this program from the options below:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	<p>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.</p> <p>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%).</p>
Program Description	<p>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.</p> <p>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.</p>
FY 2014	
Goal FY 2014	<p>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.</p>
2014 Objective Measure/Indicator of Success	<p>Maintain full enrollment</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>
Baseline	<p>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</p>

	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 2014	<p>During calendar year 2013 the EHS program maintained full enrollment of 272. The percentage of children with disabilities averaged 15.5% (range 12-19%). 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).</p> <p>The majority of families were enrolled in our center-based option or combination option. We served an average of 1,120 breakfasts/mo, 1,208 lunches/mo, and 1,002 snacks/mo.</p> <p>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 was \$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. Sequestered funds were restored and a cost of living adjustment was approved in June 2014.</p>
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 \$375,335). The annual EHS budget is \$3,724,056. The US Department of Health and Human Services funds this program.
FY 2015	
Goal 2015	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.
2015 Objective Measure/Indicator of Success	<p>Maintain full enrollment</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>
Baseline	<p>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.</p> <p>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.</p> <p>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.</p>
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 <input type="checkbox"/> Priority Area 1 <input type="checkbox"/> Priority Area 2 <input type="checkbox"/> Priority Area 3 <input type="checkbox"/> Priority Area 4 <input type="checkbox"/> Priority Area 5 <input checked="" type="checkbox"/> Priority Area 6 Prevention & Treatment of Cardiovascular Disease
Program Emphasis	Please select the emphasis of this program from the options below: <input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> 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 2014	
Goal FY 2014	To help participants adopt healthier lifestyles, thereby reducing their risk of developing, dying from, or being disabled by CVD.
2014 Objective Measure/Indicator of Success	Clinical outcomes: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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): <ul style="list-style-type: none"> ○ 30% will describe their general health as being better by one or more categories at program follow-up in comparison to program beginning ○ 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 ○ 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 ○ 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: <ul style="list-style-type: none"> • 30% of participants will report knowing how to read food labels

	<ul style="list-style-type: none"> • 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	<p>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.</p> <p>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.</p>
Intervention Strategy for Achieving Goal	Recruit participants at our various Health Ministry sites, community clinics, referrals of discharged patients from CHMC, referrals from physicians in the community
Result FY 2014	<p>363/423 (86%) completed the program in FY14; 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)</p> <p>Clinical outcomes:</p> <ul style="list-style-type: none"> • 49% reduced BMI; 0% reduced weight by $\geq 10\%$ • 33% of males and 47% of females reduced their waist circumference • 56% with above normal blood pressure at program beginning reduced their blood pressure by one or more categories at the end of the program; by program end, 77% had normal BP • 7% of participants with abnormal total cholesterol (≥ 200) decreased their cholesterol to normal by the end of the program; by program end, 77% of participants had normal cholesterol levels <p>Behavioral outcomes:</p> <ul style="list-style-type: none"> • 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, <ul style="list-style-type: none"> 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. <p>Knowledge outcomes:</p> <ul style="list-style-type: none"> • 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. <p>As one participant said, <i>"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."</i></p>
LTIP Result	<p>Heart H.E.L.P. was selected as the chronic care program for us to report to Dignity Health. See table below Program Digest.</p> <p>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 during the 6 months following participation in the Heart H.E.L.P. program.</p>
Hospital's Contribution / Program Expense	<p>CHMC provides office space and office equipment for program staff. CHMC Foundation provides grants management and fiscal oversight.</p> <p>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.</p>
FY 2015	
Goal 2015	To help participants adopt healthier lifestyles, thereby reducing their risk of developing, dying from, or being disabled by CVD.
2015 Objective Measure/Indicator of Success	Maintain same measurable objectives as FY14 Same as for FY14
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	<p>Continue to monitor the same measurable objectives</p> <p>Link the hospital discharge planning process to the program.</p> <p>Increase outreach to predominantly African American churches.</p> <p>Identify grant funding for this program.</p>
Community Benefit Category	<p>Community Health Improvement Services</p> <ul style="list-style-type: none"> • Community Health Education • Community-based clinical services

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	ED visit	Hospital Stay	ED visit
FY14-Q1	105	103 (98%)	1(1%)	3 (3%)	0	0
FY14-Q2	133	109 (81.9%)	0 (0%)	1(1%)	0	0
FY14-Q3	76	76 (100%)	0(0%)	5 (6.5%)	0	0
FY14-Q4	82	82(100%)	1(1%)	1(1%)	0	0
Total	396	370 (93.4%)	2 (0.5%)	10 (2.7%)	0	0

Therefore, **participation in Heart HELP resulted in a 100% reduction in hospitalizations and a 100% 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 Un-sponsored Community Benefit Expense

For period from 7/1/2013-6/30/2014

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses Revenues	
<u>Benefits for Living In Poverty</u>						
Financial Assistance	385	23,446,327	0	23,446,327	7.2	7.4
Medicaid	66,400	196,678,298	144,345,277	52,333,021	16.0	16.4
Community Services						
Community Benefit Operations	0	429,084	0	429,084	0.1	0.1
Community Health Improvement Services	18,023	20,453,334	12,810,165.	7,643,169	6.2	2.4
Financial and In-Kind Contributions	0	486,136	0	486,136	0.1	0.2
Totals for Community Services	18,023	21,368,554	0	8,558,389	6.5	2.7
	84,808					
Totals for Living In Poverty		241,493,179	157,155,442	84,337,737	29.7	26.5
<u>Benefits for Broader Community</u>						
Community Services						
Community Health Improvement Services	9,174	164,562	0	164,562	0.1	0.1
Health Professions Education	48	2,457,135	41,250	2,415,885	0.7	0.8
Totals for Community Services	9,222	2,621,697	41,250	2,580,447	0.8	0.8
	9,222					
Totals for Broader Community		2,621,697	41,250	2,580,447	0.8	0.8
Totals - Community Benefit	94,030	244,114,876	157,196,692	86,918,184	30.5	27.3
Medicare	8,296	30,614,808	25,646,798	4,968,010	1.5	1.6
Totals with Medicare	102,326	274,729,684	182,843,490	91,886,194	32.0	28.8
Totals Including Medicare	102,326	274,729,684	182,843,490	91,886,194	32.0	28.8

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-Huddle** 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. Stakeholders participating in CHNA
- C. Charity Care Policy
- D. CHMC Community Board of Directors

APPENDIX A

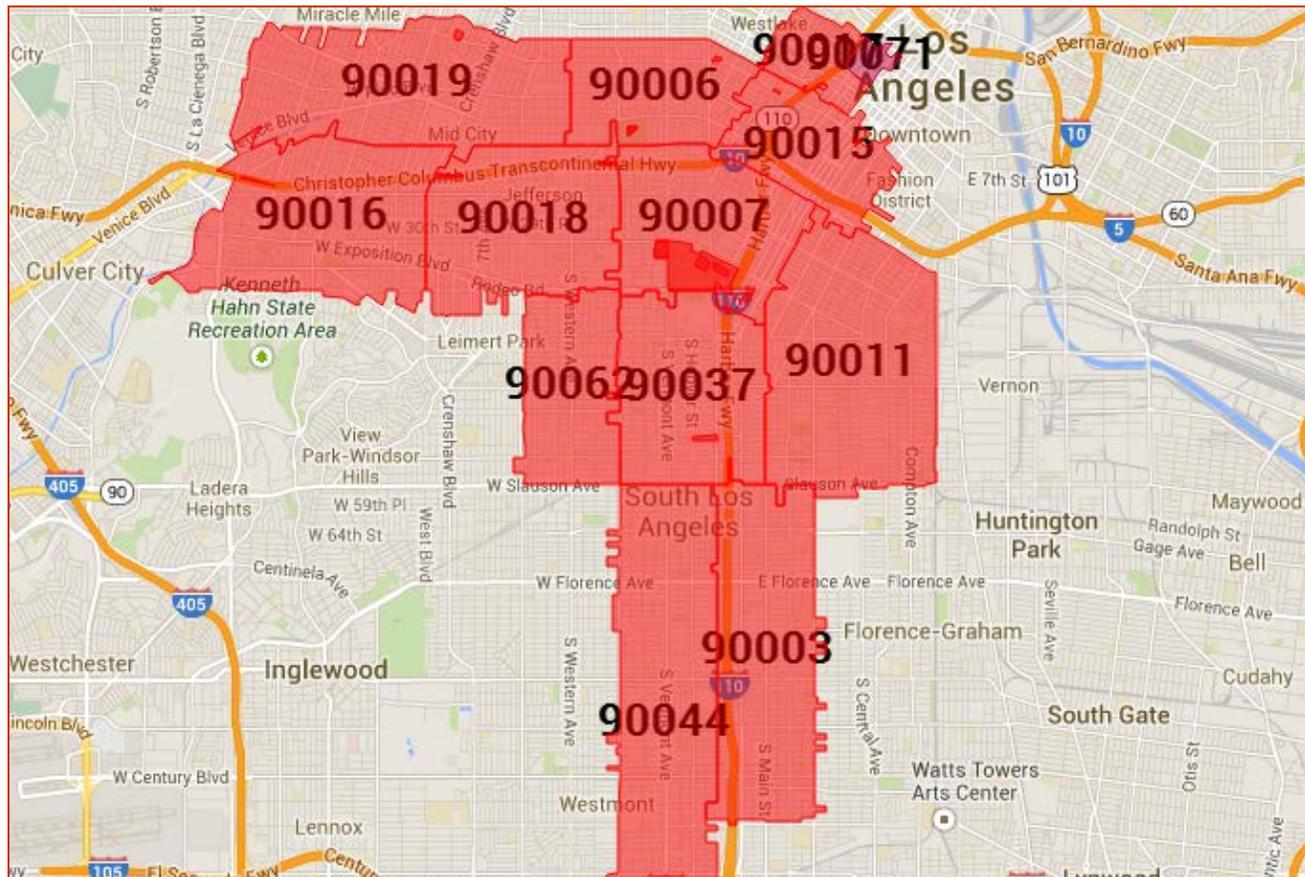
California Hospital Medical Center

Community Need Index

CALIFORNIA HOSPITAL MEDICAL CENTER (PSA)

Lowest Need

Highest Need

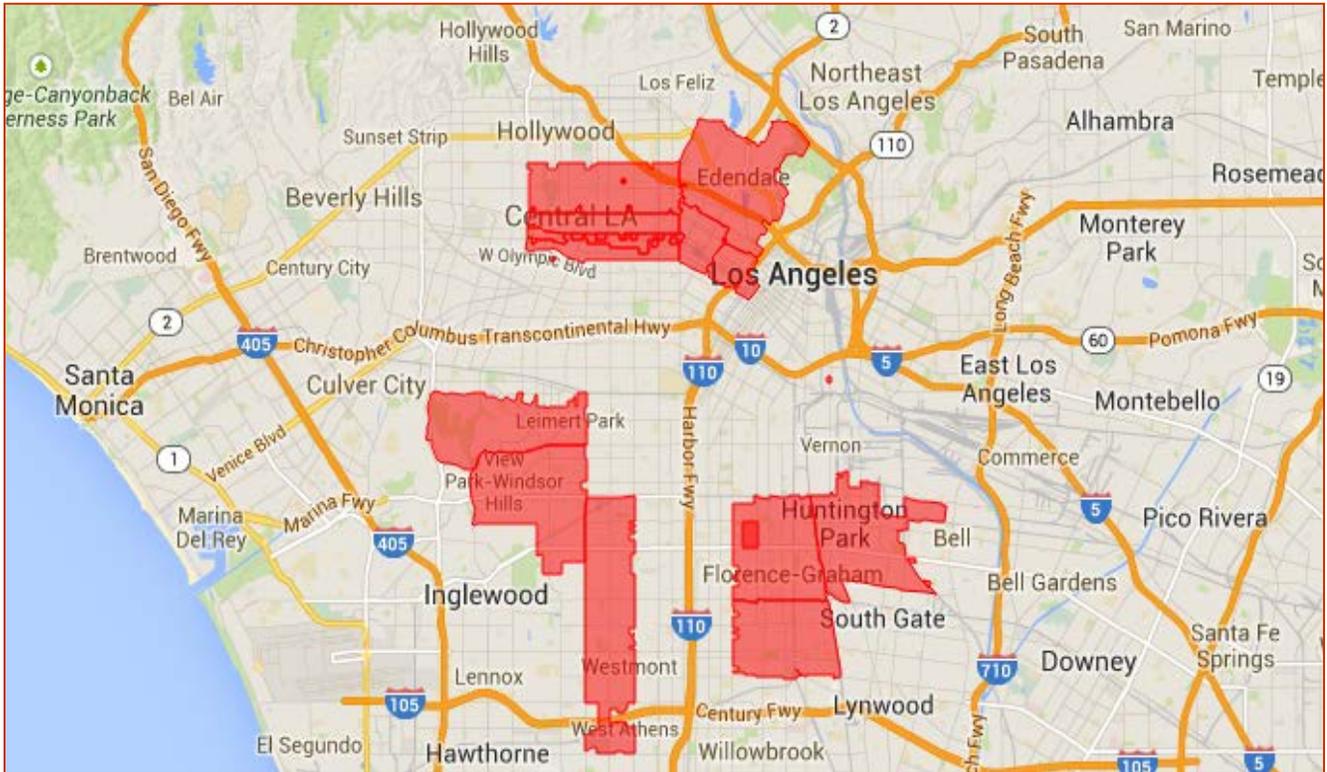


Zip Code	CNI Score	Population	City	County	State
90003	5	65,340	Los Angeles	Los Angeles	California
90006	5	65,883	Los Angeles	Los Angeles	California
90007	5	45,541	Los Angeles	Los Angeles	California
90011	5	105,737	Los Angeles	Los Angeles	California
90015	5	20,059	Los Angeles	Los Angeles	California
90016	4.8	48,122	Los Angeles	Los Angeles	California
90017	5	27,771	Los Angeles	Los Angeles	California
90018	4.8	50,916	Los Angeles	Los Angeles	California
90019	4.8	69,091	Los Angeles	Los Angeles	California
90037	5	58,832	Los Angeles	Los Angeles	California
90044	5	90,371	Los Angeles	Los Angeles	California
90062	5	28,914	Los Angeles	Los Angeles	California
90071	4	5	Los Angeles	Los Angeles	California

CALIFORNIA HOSPITAL MEDICAL CENTER (SSA)

Lowest Need

Highest Need



CNI MEDIAN SCORE: 5

Zip Code	CNI Score	Population	City	County	State
90001	5	56,616	Florence-Graham	Los Angeles	California
90002	5	47,989	Los Angeles	Los Angeles	California
90004	5	70,385	Los Angeles	Los Angeles	California
90005	5	44,897	Los Angeles	Los Angeles	California
90008	4.4	31,365	Los Angeles	Los Angeles	California
90010	4.6	5,018	Los Angeles	Los Angeles	California
90017	5	27,771	Los Angeles	Los Angeles	California
90020	4.8	44,817	Los Angeles	Los Angeles	California
90026	5	74,336	Los Angeles	Los Angeles	California
90043	4.6	44,199	Los Angeles	Los Angeles	California
90047	4.8	47,809	Los Angeles	Los Angeles	California
90057	5	47,533	Los Angeles	Los Angeles	California
90255	4.8	80,282	Huntington Park	Los Angeles	California

APPENDIX B

Focus Group Participants (Identification)

	Group Size	Description of Leadership, Representative, or Member Role	What Group(s) Do They Represent?
1.	6 participants	Health care providers	Health access, children, youth and families, minority populations
2.	6 participants	Promotoras	Minority populations, underserved, dental care, reproductive care, outreach
3.	10 participants	Residents and clients	Latino, minority, and underserved populations
4.	4 participants	Residents and clients	Pilipino, Tagalog-speaking, minority, and underserved populations
5.	6 participants	Residents and clients	Chinese/Mandarin-speaking, minority, and underserved populations
6.	16 participants	Social service providers	Social service providers serving low-income, minority, chronic disease populations
7.	3 participants	Business and education leaders	Serving youth, business development, and land use
8.	16 participants	Residents and clients	Latino, minority, and underserved populations
9.	9 participants	Promotoras	Minority populations, underserved, dental care, reproductive care, outreach
10.	9 participants	Residents and clients	Latino, minority, and underserved populations

Interviews Participants (Identification)

	Name (Last First)	Title	Affiliation	Public Health Knowledge/ Expertise
1.	Alexander, Patricia	Community Liaison Representative	Los Angeles County Department of Public Health	Public health and health services
2.	Alfaro, Verenisa	Clinical Social Worker	LAUSD Parent & Community Engagement	Social services
3.	Anderson, Margot	CEO	The Laurel Foundation	Business management, camp management, serving youth and families with HIV/AIDS
4.	Ballesteros, Al	CEO	JWCH Institute (John Wesley Community Health)	FOHC, primary care, mental health care for homeless and dual-diagnosis, HIV services
5.	Blakeney, Karen	Executive Director	Chinatown Service Center	Serving Asian Pacific immigrant and Latino communities (family resource center, clinics, workforce development)
6.	Boller, Robert	Director of Programs	Project Angel Food	Men, women, and children affects by HIV/AIDS, cancer, and other life-threatening illnesses.
7.	Bryan, Cynthia	Vice President, Human Resources	Didi Hirsh Mental Health Services	Human resource management
8.	Chidester, Cathy	Director of EMS	Los Angeles County ER Services	Public health and health services, emergency response services
9.	Coan, Carl	Executive Director	Eisner Pediatric Child and Family Center	Public health, health care administration, and management
10.	Cox, Debra	Senior Director Foundation Relations	American Heart Association	Health equity, research and funding
11.	Donovan, Kevin	Staff Analyst	Los Angeles County Department of Public Health, Maternal, Child and Adolescent Health Programs	Maternal, child, and adolescent health
12.	Kappos, Barbara	Executive Director	East Los Angeles Women's Center	Domestic violence, sexual assault and HIV
13.	Kim, Chrissy InHwe	Director of Health Program	American Cancer Society	General cancer education, research and resources
14.	Mandel, Susan, Ph.D.	President, CEO	Pacific Clinics	Clinical management and administration
15.	Marin, Maribel	Los Angeles Executive Director	211	Information and referral service serving LA County
16.	Martinez, Margie	CEO	Community Health Alliance of Pasadena	Public health
17.	Mondy, Cristin	Health Officer	Los Angeles County Department of Public Health	Public health and health services
18.	Munoz, Randy	Vice Chair	Latino Diabetes Association	Diabetes, preventive medicine, low-income, undocumented, and un/underinsured
19.	Murphy, Colleen	Director of Community Initiatives	PATH	Homeless population
20.	Nathanson, Niel, DDS	Associate dean	USC School of Dentistry	Low-income dental care services including children, youth and adults, both in mobile and clinical contexts. Primary populations are low-income, disadvantaged and/or indigent. Includes homeless adults
21.	Portillo, Cesar	VP Advancement	LA Child Guidance Center	Low-income health care services including children, youth, and adults. Primary populations are low-income, disadvantaged and/or indigent.

	Name (Last First)	Title	Affiliation	Public Health Knowledge/ Expertise
22.	Rayfield, Beth	Director of Development	Coalition for Humane Immigrant Rights of Los Angeles	International labor union; organizing, working conditions, and contractual rights
23.	Reyna, Franco	Associate Director	American Diabetes Association	Diabetes, preventive medicine, low-income, undocumented, and un/underinsured
24.	Sayno, Jeanette H.	Bi-lingual Community Outreach Development Worker	Filipino American Service Group, Inc.	Low-income health and mental care services for low-income seniors.
25.	Schiffer, Wendy MSPH	Director of Planning and Evaluation	California Children's Medical Services	Public health and health services

Individuals Consulted from Federal, Tribal, Regional, State or Local Health Departments or Other Departments or Agencies with Current Data or Other Relevant Information

	Name (Last, First)	Title	Affiliation	Type of Department
1.	Chidester, Cathy MSN	Director of EMS	Los Angeles County Emergency Medical Services (EMS)	Coordinating emergency services, including fire department, hospitals, and ambulance companies
2.	Donovan, Kevin	Staff Analyst	Los Angeles County Department of Public Health– Maternal, Child and Adolescent Health Programs	Local health department
3.	Murata, Dennis	Deputy Director	Los Angeles County Department of Mental Health	Local health department

Prioritization Participants

	Name (Last, First)	Affiliation	Public Health Knowledge/Expertise	Prioritization Session	Prioritization Survey
1.	Bantug, Shirley B.	Filipino American Service Group, Inc.	Low-income health and mental care services for low-income seniors	Yes	Yes
2.	Boller, Robert	Project Angel Food	Men, women, and children with HIV/AIDS, Cancer, and life-threatening illnesses	No	Yes
3.	Brown, Tony	Heart of Los Angeles (HOLA)	Underserved youth living in high-risk communities	Yes	Yes
4.	Cervantes, Rachel	Alexandria House	Women and children in need of transitional housing and services	Yes	Yes
5.	Coan, Carl	Eisner Pediatric and Family Medical Center	Public health, human genetics, health care administration, and management	Yes	Yes
6.	del Rosario, Jesse	Filipino American Service Group, Inc.	Low-income health and mental care services for low-income seniors.	Yes	Yes
7.	Diaz, Carmen Molina	USC School of Dentistry	Low-income dental care services including children, youth, and adults, both in mobile and clinical contexts. Primary populations are low-income, disadvantaged and/or indigent.	No	Yes
8.	Donahue, Carole	SOSMentor	At-risk and underserved youth, health education, and advocacy	No	Yes
9.	Forman, Linda	Alliance for Housing and Healing	Men, women, children and families living with HIV/AIDS	Yes	Yes
10.	Gibb, Gordon	St. Barnabas Senior Services	Ageing population, nutrition and health education	Yes	Yes
11.	Goddard II, Terry	Alliance for Housing and Healing	Men, women, children and families living with HIV/AIDS	No	Yes
12.	Gorman, Dale	Kids Community Dental Clinic	Low-income children and their families in need of oral health care services	No	Yes
13.	Gramajo, Lilian	St. Vincent Medical Center	Public health and health services	No	Yes

	Name (Last, First)	Affiliation	Public Health Knowledge/Expertise	Prioritization Session	Prioritization Survey
14.	Guzman, Laura M.	Braille Institute	Blind and visually impaired both	Yes	Yes
15.	Hoh, John MD	Asian Pacific Health Care Venture, Inc	Health services including general diagnosis and treatment, behavioral health services, walk-in pregnancy testing, testing for HIV/AIDS and STIs, and screenings for bone density, breast, and cervical cancer.	No	Yes
16.	Howland, Susan	Alzheimer's Association	Alzheimer's disease and dementia	Yes	Yes
17.	Joe, Connie Chung	Korean American Family Services (KFAM)	Health and social services for Korean-American families	Yes	Yes
18.	Jordan, Christine	Toberman Neighborhood Center	Social support services and program for at-risk children and families	No	Yes
19.	Krowe, William	Alexandria House	Women and children in need of transitional housing and services	Yes	Yes
20.	Leal, Jesus	St. Vincent Medical Center, Casa de Amigos Community Learning Center	Public health and health services	No	Yes
21.	Lee, Susan	CSH - Corporation for Supportive Housing	Housing support services for at-risk populations	No	Yes
22.	Martin, Margaret	Harmony Project	At-risk youth in underserved communities	Yes	Yes
23.	Matos, Veronica	Heart of Los Angeles (HOLA)	Underserved youth living in high-risk communities	Yes	Yes
24.	Nathason, Niel	USC School of Dentistry	Low-income dental care services including children, youth, and adults, both in mobile and clinical contexts. Primary populations are low-income, disadvantaged and/or indigent.	No	Yes
25.	Nunez, Trini E.	A Window Between Worlds	Domestic violence support services	Yes	Yes
26.	Pardo, Luis	Worksite Wellness LA	Low-income, underserved families; health education	No	Yes
27.	Portillo, Cesar	Los Angeles Child Guidance Center	Low-income health care services including children, youth, and adults. Primary populations are low-income, disadvantaged and/or indigent.	Yes	Yes
28.	Reyes, Perla S.	Mother Movement	At-risk mothers	Yes	Yes
29.	Rivera, Jennifer	Los Angeles County Department of Public Health - Community Health Service	Public health and health services	Yes	Yes
30.	Sayno, Jeanette H.	Filipino American Service Group, Inc.	Low-income health and mental care services for low-income seniors.	Yes	Yes
31.	Strickland, Myungeum	Angelus Plaza Senior Housing	Low-income seniors	Yes	Yes

APPENDIX C

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 purposes

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

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

Budgeting and Reporting:

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

- Patient payment assistance statistics shall be disclosed in annual financial statements but shall not include amounts that are properly considered to be bad debt or contractual discounts.

Relationship to Collection Policies:

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

Regulatory Requirements:

IN IMPLEMENTING THIS POLICY, DIGNITY HEALTH MANAGEMENT AND DIGNITY HEALTH FACILITIES SHALL COMPLY WITH ALL FEDERAL, STATE AND LOCAL LAWS, RULES AND REGULATIONS THAT MAY APPLY TO ACTIVITIES CONDUCTED PURSUANT TO THIS POLICY.

Appendix D

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