

## Glendale Adventist Medical Center

2017 Community Health Plan  
(Implementation Strategy)  
2016 Update/Annual Report



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## Adventist Health Overview

**Glendale Adventist Medical Center** is an affiliate of Adventist Health, a faith-based, not-for-profit, integrated health care delivery system headquartered in Roseville, California. We provide compassionate care in communities throughout California, Hawaii, Oregon and Washington.



### OUR MISSION:

To share God's love by providing physical, mental and spiritual healing.

### OUR VISION:

Adventist Health will be a recognized leader in mission focus, quality care and fiscal strength.

Adventist Health entities include:

- 20 hospitals with more than 2,700 beds
- More than 235 clinics and outpatient centers
- 14 home care agencies and 7 hospice agencies
- Four joint-venture retirement centers
- Workforce of 28,600 includes more than 20,500 employees; 4,500 medical staff physicians; and 3,600 volunteers

We owe much of our heritage and organizational success to the Seventh-day Adventist Church, which has long been a promoter of prevention and whole person care. Inspired by our belief in the loving and healing power of Jesus Christ, we aim to bring physical, mental and spiritual health and healing to our neighbors of all faiths. Every individual, regardless of his/her personal beliefs, is welcome in our facilities. We are also eager to partner with members of other faiths to enhance the health of the communities we serve.

Our commitment to quality health care stems from our heritage, which dates back to 1866 when the first Seventh-day Adventist health care facility opened in Battle Creek, Michigan. There, dedicated pioneers promoted the “radical” concepts of proper nutrition, exercise and sanitation. Early on, the facility was devoted to prevention as well as healing. They called it a sanitarium, a place where patients—and their families—could learn to be well.

More than a century later, the health care system sponsored by the Seventh-day Adventist Church circles the globe with more than 170 hospitals and more than 500 clinics, nursing homes and dispensaries worldwide. And the same vision to treat the whole person—mind, body and spirit—continues to provide the foundation for our progressive approach to health care.

## Letter from the CEO



Dear Friends and Colleagues,

In 1905, a handful of insightful, inspired and passionate pioneers determined to establish a place for preventive health and healing in this community. Now, 112 years later, Glendale Adventist Medical Center continues to "share God's love with our community by promoting healing and wellness for the whole person." This simple and powerful mission is as pertinent today as it was in the last century.

Of course, science and medicine have progressed significantly over the years. Though we remain very old fashioned about why we're here and what inspires us, we are also very passionate about providing world-class quality and service. Therefore, we pursue and develop the best-known practices in the care we deliver. Our investment in cutting edge technology enables the daily provision of this world-class care. I hope that as you experience our hospital you discover these commitments to be true every time.

2016 was a banner year in terms of quality and safety at GAMC. We had our "best ever" results in many key areas such as hospital-acquired conditions, patient falls, and physician satisfaction. Through post-discharge surveys, our patients rewarded us with the "best ever" ranking related to "I would recommend GAMC to my friends and family". We will continue, through partnering with our amazing physicians, developing leaders and collaborating with our board, to build upon these results. Health care reform is a serious call to action and change. What we will never change is our commitment to you!

This 2016 Community Health Plan Report represents our summary of how we lived this mission during the past year. You'll read of our outreach into the community and the many services we provide beyond acute hospital care.

Enjoy the read!

Kevin A. Roberts, RN, FACHE

President and CEO

## Community Health Development Team



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To request a copy, provide comments or view electronic copies of current and previous community health needs assessments:

<https://www.adventisthealth.org/pages/about-us/community-health-needs-assessments.aspx> or [AdventistHealth.org/communitybenefit](https://www.adventisthealth.org/communitybenefit)

Hospital Identifying Information



**Glendale Adventist Medical Center** Number  
of Hospital Beds: 515

Kevin Roberts, CEO

Scott Reiner, Chair, Governing Board

1509 Wilson Terrace

Glendale, CA 91206

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## Invitation to a Healthier Community

### Fulfilling AH 's Mission

Where and how we live is vital to our health. We recognize that health status is a product of multiple factors. To comprehensively address the needs of our community, we must take into account health behaviors and risks, the physical environment, the health system, and social determinant of health. Each component influences the next and through strategic and collective action improved health can be achieved.

The Community Health Plan marks the second phase in a collaborative effort to systematically investigate and identify our community's most pressing needs. After a thorough review of health status in our community through the Community Health Needs Assessment (CHNA), we identified areas that we could address through the use of our resources, expertise, and community partners. Through these actions and relationships, we aim to empower our community and fulfill our mission, "to share God's love by providing physical, mental and spiritual healing."

### Identified Community Needs

The results of the CHNA guided the creation of this document and aided us in how we could best provide for our community and the most vulnerable among us. As a result, **Glendale Adventist Medical Center** has adopted the following priority areas for our community health investments for 2016-2018:

- Cardiovascular Health - Integrate Patient Education into Cardiovascular Services
- Improve Stroke Education and Support
- Population Health for Chronic Disease
- Wellness and Support for Patients Diagnosed with Cancer

Additionally, we engage in a process of continuous quality improvement, whereby we ask the following questions for each priority area:

- Are our interventions making a difference in improving health outcomes?
- Are we providing the appropriate resources in the appropriate locations?
- What changes or collaborations within our system need to be made?
- How are we using technology to track our health improvements and provide relevant feedback at the local level?
- Do we have the resources as a region to elevate the population's health status?

Building a healthy community requires multiple stakeholders working together with a common purpose. We invite you to explore how we intend to address health challenges in our community and partner to achieve change. More importantly though, we hope you imagine a healthier region and work with us to find solutions across a broad range of sectors to create communities we all want for ourselves and our families.

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## Community Profile - Glendale Adventist Medical Center (GAMC)

GAMC is one of Glendale's oldest businesses, founded by the Seventh-Day Adventist Church in 1905, one year before the city's incorporation. Founded as the Glendale Sanitarium, it was located in the former 75-room Glendale Hotel, a Victorian structure. Medical services were primarily focused on treatment for obesity and lung ailments, based on a common-sense and wellness approach. The affiliation with the Seventh-day Adventist Church underscored a community service focus; its mission of teaching people how to stay healthy, not just treating the sick, formed its reputation as a "health resort" of choice. Throughout the 20th century, the hospital's growth mirrored that of the surrounding region, and the 515-bed full-service facility is now part of the Adventist Health system that includes 19 hospitals and other health care organizations in California, Oregon, Washington, and Hawaii.

GAMC's mission compels the hospital beyond the role of a typical community-based hospital, with a commitment to offering services that position GMAC as one of the leading medical institutions in Southern California.

### **GAMC offers:**

- State-of-art diagnostic technologies, including advanced MRI and CT scanning
- Innovative techniques for cardiac surgery, neurosurgery, spine surgery, microsurgery, and other specialized surgical procedures
- Advancements and alternatives to traditional surgery, including endovascular surgery, minimally invasive surgery, brachytherapy for cardiac and cancer patients, and non-surgical treatment options
- Advanced capabilities that enhance services, including a perinatal high-risk pregnancy program, hyperbaric services for wound care, an aquatic therapy program for orthopedic and rehab patients, and many other service enhancements
- Outpatient services in all specialty areas
- Family practice residency program



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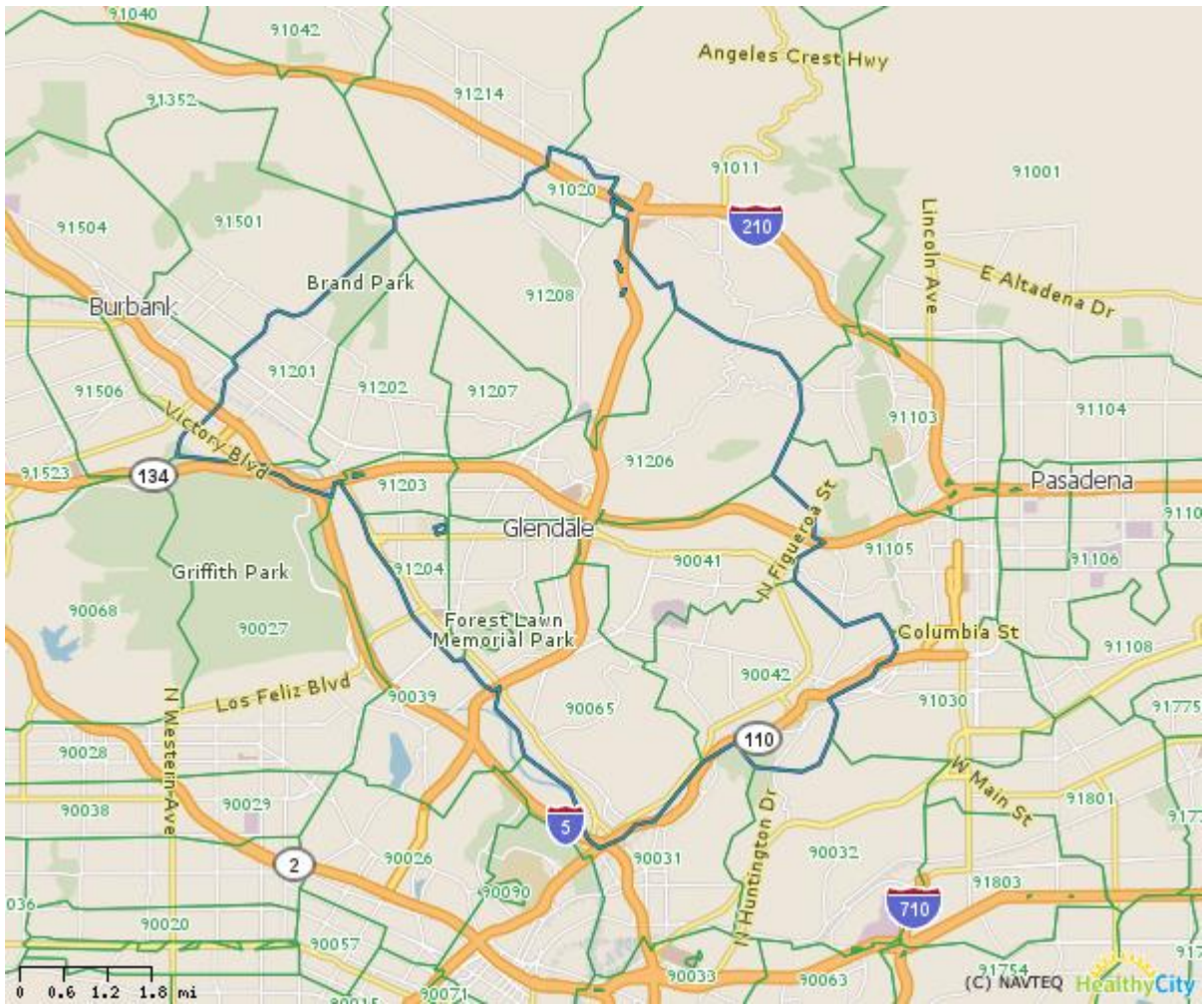
## Service Area Definition

The Glendale Adventist Medical Center (GAMC) Service Area provides health services in 12 ZIP codes, six cities or communities, and two Service Planning Areas (SPAs) within Los Angeles County. Shaded in white are the ZIP codes in SPA 4–Metro and shaded in gray are ZIP codes in SPA 2–San Fernando Valley.

**Glendale Adventist Medical Center Service Area**






City/Community	ZIP Code	Service Planning Area
Eagle Rock	90041	4
Highland Park	90042	4
Glassell Park	90065	4
Montrose	91020	2
Glendale	91201	2
Glendale	91202	2
Glendale	91203	2
Glendale	91204	2
Glendale	91205	2
Glendale	91206	2
Glendale	91207	2
Glendale	91208	2

Glendale Adventist Medical Center Service Area by ZIP Code



## Demographic Overview

A description of the community serviced by GAMC is provided in the following data tables and narrative. All data provided in the following tables are presented by ZIP code.

				
<b>57%</b> are between 25-64 years old*	<b>68%</b> of households speak another language aside from English at home	<b>35%</b> have up to a high school education (or GED completion)	<b>22%</b> of families earned below 100% FPL*	<b>27%</b> die from heart disease**
*Reflects largest age group of the service area population		*In 2014, the FPL for a household of one was \$11,670 per year; and a family of four \$23,850 per year		
**Primary cause of death in the service area				

The population of the GAMC service area currently stands at 325,441 and is expected to grow by 3.4% to 336,351 in 2020. The fastest growing ZIP codes are in Glendale (91207 and 91204) and Highland Park (90042), with percentages that exceed the expected growth for the area.

Overall, the GAMC service area population tends to be older relative to the total population of Los Angeles County. Adults over the age of 45 account for 45% of the population, while the same age group in the county accounts for 38% of the residents.

The racial/ethnic composition of the area is highly diverse and geographically concentrated. Over half of the population (54%) in the city of Glendale is foreign born, with large concentrations of Armenian and Mexican immigrants. Overall, 68% of households in the service area do not speak English at home: 44% of households in the Glendale ZIP codes reported speaking an Indo-European language at home, while 58% of households in Glassell Park and Highland Park reported speaking Spanish at home.

The unemployment rate in the service area was slightly lower (7.2%) than that reported for Los Angeles County (7.6%); however, in some locations—Highland Park and areas of Glendale (ZIP code 91204 and 91205)—the unemployment rates were up to 9.5%. Overall, a lower percentage of families in the service area than in the county live below poverty (12% vs. 15%), and 8% of families with children live below poverty in the service area.

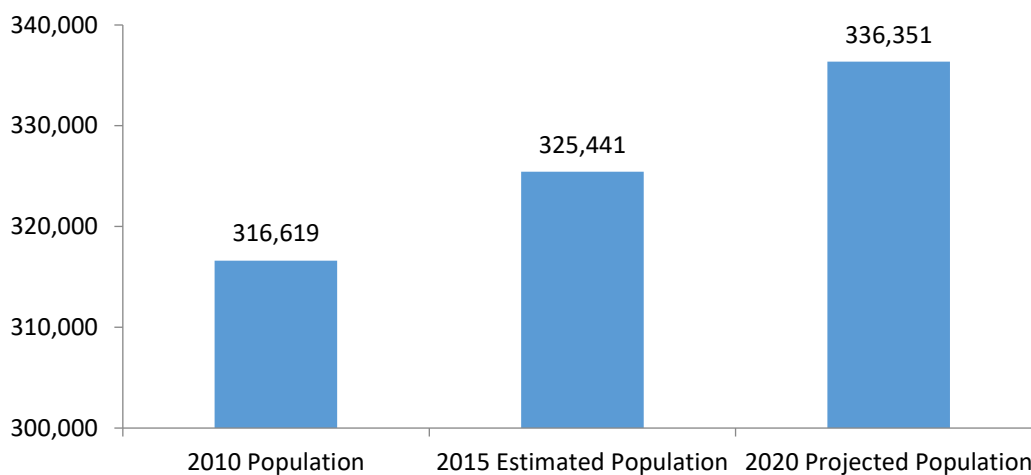
In 2012, there were 3,565 births in the service area. Mothers were typically 20 to 29 years of age (37%), followed by 30 to 34 years of age (33%). The service area had a greater percentage of 30 to 34-year-old mothers relative to the county (27%). Of the babies born in the service area for 2012, 7% were categorized as having low to very low birth weights (less than 2,500g).

The leading cause of death in the service area is heart disease (27%) followed by cancer (26%) - these values are in accordance with Los Angeles County percentages (28% and 25% accordingly). A higher percentage of the residents die from Alzheimer's disease (5.6%) relative to the county (3.3%).

### Population

In 2010, the population in the GAMC service area was 316,619 and in 2015 it was estimated to have grown to 325,441 – this represents a 2.8% increase. By 2020, the population is projected to increase by 3.4% to 336,351. The ZIP codes that have experienced the greatest increases in population are 91207 and 91204 (in Glendale) by 5.1% and 4.4%, respectively, as well as 90042 (Highland Park) by 4.5%. These same areas are projected to have the greatest increases in population by 2020.

**Change In Service Area Population**



### Gender

As in previous years, slightly more than half of the population (51.9%) in the GAMC service area in 2015 was female. This trend was also observed in the population of individual ZIP codes with the exception of 90065—Glassell Park, the only place in the service area where the male population approached 50.2%.

### Age

A majority of the population in the GAMC service area ranged between the ages of 25 and 64 (56.6%). However, some geographic areas differ from this trend: minors (under age 18) account for approximately a quarter of the population in 90042—Highland Park (24.3%) and 90065—Glassell Park (23.6%). Conversely, approximately one in five residents is over the age of 65 in Glendale ZIP codes: 91207 (21.9%), 91208 (19.4%) and 91206 (19.2%). The GAMC service area has a higher percentage of 45 and above residents (44.5%) relative to Los Angeles County (37.5%).

In 2015, residents in the GAMC service area were slightly older (41.1 years old) than Los Angeles County (37.3 years old).

### Race and Ethnicity

In 2015, a majority of the population living in the GAMC service area was either White (44.7%) or Hispanic/Latino (35.5%). In comparison, Los Angeles County had a higher percentage of Hispanic/Latino residents (48.8%) and a significantly lower percentage of White residents (26.4%) than the service area. The Black/African-American population in the GAMC service area (1.6%) was one fifth of Los Angeles County (8.0%). The Asian population in the service area (15.5%) was approximately that of Los Angeles County (14.0%).

The GAMC service area consists of highly diverse, geographically concentrated ethnic communities that contribute to the area's vibrancy and community-based assets. For example, Glendale is home to 80,000 Armenians. According to the 2000 US Census, 54.4% of the population in Glendale (ZIP codes including 91201, 91202, 91203, 91204, 91205, 91206, 91207, 91208) was foreign born. Iran (22.7%) and Armenia (16.4%) were the most common foreign places of birth. Armenian (29.3%) and Mexican (10.5%) were the most common ancestries among both the US-born and foreign-born populations<sup>1</sup>. This profile makes Glendale unique to Los Angeles County.

The GAMC service area also includes communities with large Latino populations such as Highland Park where 51% of the residents are of Mexican ancestry, and of the foreign-born population (45.1% of all residents), Mexico (55.3%) and El Salvador (12.0%) are the most common foreign places of birth<sup>2</sup>. Similarly, 51.5% of Glassell Park residents are foreign born. Mexico (51.2%) and the Philippines (16.2%) are the most common foreign places of birth<sup>3</sup>.

### Language

In 2015, the percent of residents in the GAMC service area who exclusively spoke English at home (31.7%) was slightly lower than in Los Angeles County (42.9%). Conversely, the percentage of the GAMC service area population speaking only a language of Indo-European origin (31.7%) at home was almost six times that of Los Angeles County (5.6%). The category for Indo-European languages is broad and is defined as "including most languages of Europe and the Indic languages of India" and lists approximately 70 languages<sup>4</sup>. Given the ethnic/racial context of the GAMC community, it is most likely that the high percentage of Indo-European speakers reflects the size of the Armenian population. In particular, parts of Glendale: ZIP codes 91201 (54.3%), 91203 (49.8%), 91205 (48.4%), 91202 (46.7%), and 91206 (43.4%), the percent of Indo-European speakers was eight to ten times the observed county percentage.

While the percent of residents in the GAMC service area who spoke only Spanish at home (22.3%) was lower than in Los Angeles County (39.6%), there are specific geographic areas where the percent almost triples the

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<sup>1</sup> Los Angeles Times. Mapping LA. Los Angeles, CA. Available at <http://maps.latimes.com/neighborhoods/neighborhood/glendale/>. Accessed [August 28, 2016]

<sup>2</sup> Los Angeles Times. Mapping LA. Los Angeles, CA. Available at <http://maps.latimes.com/neighborhoods/neighborhood/highland-park/>. Accessed [August 28, 2016]

<sup>3</sup> Los Angeles Times, Mapping LA. Los Angeles, CA. Available at <http://maps.latimes.com/neighborhoods/neighborhood/glassell-park/>. Accessed [August 28, 2016]

<sup>4</sup>United States Census Bureau. American Community Survey Reports. Language Use in the United States. Available at <https://www.census.gov/prod/2013pubs/acs-22.pdf>. Accessed [August 31, 2016]

service area average. ZIP codes 90065—Glassell Park (58.4%) and 90042—Highland Park (57.1%) have high concentrations of Spanish-speakers at home. There are also smaller groups of people who speak an Asian/Pacific Islander language at home – these are located in 91020—Montrose (23.1%), and two ZIP codes in Glendale: 91203 (15.6%) and 91204 (14.9%).

There are three ZIP codes in which at least four in 5 households spoke any other language at home than English were in Glendale: 91203 (83.0%) and 91204 and 91205 (both at 82.2%). It is important to mention that speaking a language aside from English at home is not an indicator for a population's ability to speak English.

### Education

The population in the GAMC service area represented a higher percentage of individuals that have completed a degree in higher education (AA, Bachelor's or Master's) (46.1%) than Los Angeles County (36.5%).

In two ZIP codes, almost a third of residents had low educational attainment, meaning that residents had less than a ninth-grade education and/or some high school education but no completion or GED. These are: 90042—Highland Park (30.5%) and 90065—Glassell Park (29.7%).

### Marital Status

In 2015, the percentage of the population that was married and had their spouse present was higher in the GAMC service area (44.0%) than in Los Angeles County (38.3%). The community with the highest percent of married, spouse absent persons was in Glendale (91204 – 8.6%) which had high percentage of non-English speaking households (82.2%). However communities with high Spanish speaking populations and low education levels have relatively high levels of married couples with spouse absent, which suggests newcomer/migrant population. These are 90065—Glassell Park (7.9%) and 90042—Highland Park (7.3%).

### Household Income

Households in the GAMC service area earning an average income of less than \$50,000 (47.7%) reflected a higher percentage than Los Angeles County (46.9%). The percentage of households earning greater than \$150,000 in the GAMC service area (11.9%) was similar to Los Angeles County (11.6%).

### Employment Status

In 2015, a majority of the GAMC service area population was employed (56.2%), which was similar to Los Angeles County (57.0%). Only 7.2% of the population in the GAMC service area was unemployed, slightly lower than Los Angeles County's 7.6% unemployment rate. In particular, 90042—Highland Park (9.5%), and communities in Glendale 91205 (9.5%), and 91204 (9.1%) reflected areas with the highest percentage of unemployed residents in the GAMC service area. The remaining 36.5% of the population in the GAMC service area were not classified as currently in the labor force because they were students, retired, seasonal workers, or taking care of their homes and families (homemakers).

### Poverty

The level of poverty in an area can have an impact on overall health and create barriers to everyday necessities, including healthy and affordable foods, health care, and other basic needs.

The Department of Health and Human Services issues Federal Poverty Guidelines (better known as Federal Poverty Level or simply FPL) that are used to determine financial eligibility for certain programs (e.g., Medicaid

and the State Children's Health Insurance Program).<sup>5</sup> The guidelines vary by family size and are updated annually. For example, in 2014, a family (or household) of one earning an annual income of \$11,670 and a family of four earning an annual income of \$23,850, would both be considered earning at 100% the Federal Poverty Level. Research indicates that families in California can earn two or more times the Federal Poverty Level and still struggle to meet their basic needs.<sup>6</sup>

In the GAMC service area, almost one in five households (21.6%) were estimated to have earned below 100% FPL in 2014 – a figure similar to Los Angeles County (21.0%) – while almost half of the service area households (48.7%) lived below 200% FPL, a percent slightly higher relative to Los Angeles County.

## Natality

### Births

In 2012, there were a total of 503,788 births in California, and 3,565 took place in the GAMC service area. A quarter of the births in the service area are from mothers who reside in 90042—Highland Park (24.0%).

### Births by Mother's Age

In 2012, most births in the GAMC service area were to women between the ages of 20 and 29 (37.3%), a trend also observed in Los Angeles County (44.5%); however, a greater percentage of women between 30 and 34 years of age are having babies in the service area (32.8%) relative to Los Angeles County (27.3%).

### Births by Mother's Ethnicity

By ethnicity, nearly half (43.4%) of births in the GAMC service area in 2012 were to Hispanic mothers, while a third (35.9%) were to mothers who are White.

### Birth Weight

In the GAMC service area in 2012, 203 babies were born with low birth weight (1,500 to 2,500g) and another 56 with very low birth weight (<1,500g). Most low and very low birth weights (under 2,500g) were to mothers from 90042—Highland Park (61 total), which accounted for a quarter (23.6%) of low and very low birth weights in the service area.

### Breastfeeding

Breastfeeding is an important element in the development of newborns. In the GAMC service area, over half (52.1%) of mothers breastfed their babies for at least six months, which is more than in Los Angeles County (49.7%) but fewer than the Healthy People 2020 goal of  $\geq 60.6\%$ .

Similarly, almost a third (32.2%) of mothers in the GAMC service area breastfed their babies for at least twelve months, a larger percentage than in Los Angeles County (27.6%) but still falling short of the Healthy People 2020 goal ( $\geq 34.1\%$ ).

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<sup>5</sup> United States Department of Health and Human Services. Frequently Asked Questions Related To The Poverty Guidelines And Poverty. <https://aspe.hhs.gov/frequently-asked-questions-related-poverty-guidelines-and-poverty#differences> [Accessed September 8, 2013]

<sup>6</sup> Lucile Packard Foundation for Children's Health. Self-Sufficiency Standard. Palo Alto, CA. Available at [Self-Sufficiency Standard](#). Accessed [September 6, 2016].

## Disability

An umbrella term for impairments, activity limitations, and participation restrictions, disability is the interaction between individuals with a health condition (e.g., cerebral palsy, Down syndrome, depression) and personal and environmental factors (e.g., negative attitudes, inaccessible transportation and public buildings, and limited social supports).<sup>7</sup> Examples of disabilities include hearing, vision, movement, thinking, remembering, learning, communication, and/or mental health and social relationships. Disabilities can affect a person at any point in the life cycle.<sup>8</sup>

In California alone, 5.7 million adults, or 23% of the adult population, have a disability. The proportion of the population with disabilities increases with age and among females and African-American, White, or American Indian/Alaskan native populations. People with disabilities are also more likely than others to be poorly educated, unemployed, and living below the poverty level.<sup>9</sup>

## Prevalence of Disability

In 2014, the population living in the GAMC service area with disability status due to physical, mental or emotional conditions (27.3%) was slightly lower than in Los Angeles County (28.6%).

In 2012, a smaller percentage of adults (14.8%) cared for or assisted other adults with a long-term illness or disability in the GAMC service area when compared to Los Angeles County (20.0%).

## Special Health Care Needs in Children

Children with Special Health Care Needs (CSHCN) are identified via a Screening Tool from the Foundation for Accountability. The CSHCN screener has three "definitional domains." These are: (1) Dependency on prescription medications; (2) Service use above that considered usual or routine; and (3) Functional limitations.<sup>10</sup>

In 2015, a 14.4% of children between 0 and 17 years of age met the criteria for special health care needs in the GAMC service area, which is similar to that in Los Angeles County (14.5%).

## Disparities with Disability

Almost one in six children between 12 and 17 years old had a special health care need in Los Angeles County in 2015. Another 16.6% of children between 6 and 11 years old and 9.8% of children between 0 and 5 years old had a special health care need.

## Children with Special Needs by Ethnicity

By ethnicity, nearly a third (32.4%) of African-American children had a special health care need. In addition, 17.5% of White children and 12.0% of Latino children have a special health care need. Only 10.5% of

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<sup>7</sup> World Health Organization. Disability and Health Fact Sheet. Geneva, Switzerland. Available at <http://www.who.int/mediacentre/factsheets/fs352/en/index.html>. Accessed [August 2, 2016].

<sup>8</sup> Center for Disease Control and Prevention. Disability Overview. Atlanta, GA. Available at <http://www.cdc.gov/ncbddd/disabilityandhealth/types.html>. Accessed [August 2, 2016].

<sup>9</sup> California Department of Public Health. Planning for Today, Thinking of Tomorrow—California's 2011-2016 Strategic Directions for Promoting the Health of People with Disabilities. Sacramento, CA. Available at [http://www.cdph.ca.gov/HealthInfo/injviosaf/Documents/Planning\\_for\\_Today.pdf](http://www.cdph.ca.gov/HealthInfo/injviosaf/Documents/Planning_for_Today.pdf). Accessed [August 2, 2016].

<sup>10</sup> Los Angeles County Department of Public Health. Los Angeles County Health Survey 2015. Topics & Data. "Percent of Children (0-17 years old) Who Meet Criteria for Having Special Health Care Needs (SHCNs)" Available at <http://www.publichealth.lacounty.gov/ha/LACHSDDataTopics2015.htm>. Accessed [September 1, 2016]





Asian/Pacific Islander children and 8.7% of American Indian/Alaskan Native children have special health care needs.

## Mortality

### Deaths

In 2012, the 3,618 deaths in the GAMC service area comprised 6.3% of the total deaths in Los Angeles County. Most deaths in the service area occurred in 90042—Highland Park (14.1%) and 90065—Glassell Park (12.3%), as well as parts of Glendale: 91205 (13.4%) and 91206 (11.9%).

### Deaths by Age Group

In 2012, more than half of all deaths were of those 75 years and older. Deaths were most common among those 85 years old and over in the GAMC service area (33.6%), similar to the rate in Los Angeles County (32.2%). In the service area, generally deaths decrease with decreasing age; however, a greater percentage of infants less than one year of age die (1.0%) than 1 to 24 year-olds combined (0.8%).

### Cause of Death

In 2010, the most common cause of death in the GAMC service area was heart disease (27.1%), slightly lower than in Los Angeles County (27.9%). The second leading cause of death was cancer (25.9%), slightly higher than in the county (24.6%). The percentages for other causes of death are comparable to those reported for the county, except for Alzheimer's disease where the rate for the GAMC service area (5.6%) is greater than that reported for the county (3.3%).

## Community Health Needs Assessment Overview

The current CHNA report, approved and made available in October of 2016, can be viewed at:

<https://www.adventisthealth.org/glendale/pages/about-us/community-needs-assessment.aspx>

### Needs Assessment Methodology and Process

This section outlines the steps taken to identify the 2016 community health needs, via data indicators (secondary data), and community input (primary data).

#### Secondary Data

The CHNA included the collection of over 300 data indicators that helped illustrate the health states of the community. Secondary data were collected from a wide range of local, county, state and national 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: social and economic factors, health behaviors, clinical care, physical environmental, and health outcomes.

Data available at the ZIP code level were compiled for the hospital's service area. When not available by ZIP code, then the data for the appropriate representative portion of the SPA was utilized.

A comprehensive data matrix was created listing all identified secondary indicators and noting trends from the qualitative stakeholder data. The Scorecard included hospital-level secondary data (averaged across the service area for each hospital) and primary data mentions (count of mentions in focus groups as the issues emerged as priorities among community stakeholders). The Scorecard also included benchmark data in the form of the nationally recognized Healthy People 2020 (HP2020) goals. Additionally, the most recent county or state-level statistic for each health outcome and driver was used as a comparison.

#### Primary Data—Stakeholder Feedback

Two community focus groups held on Tuesday April 5 and Thursday April 7, 2016 were attended by 48 people including health care professionals, social service providers, city and public health officials, members from the local police department and other community leaders. Participants were invited by the Glendale Hospital Collaborative, leveraging its extensive networks and relationships within the greater Glendale area and the Glendale Healthier Community Coalition.<sup>11</sup> These stakeholders represented a broad range of geographic, public health, and population interest in compliance with the ACA. For more information on the focus group process.

The goal of this component of the CHNA was to identify broad health outcomes and drivers (which, combined are health needs), as well as assets and gaps in resources, through the perceptions and knowledge of varied and multiple stakeholders.

To begin to gain a sense for the perceived severity of each health need in the community, each participant was given a total of ten sticker dots and asked to vote for the five most severe health outcomes and the five most

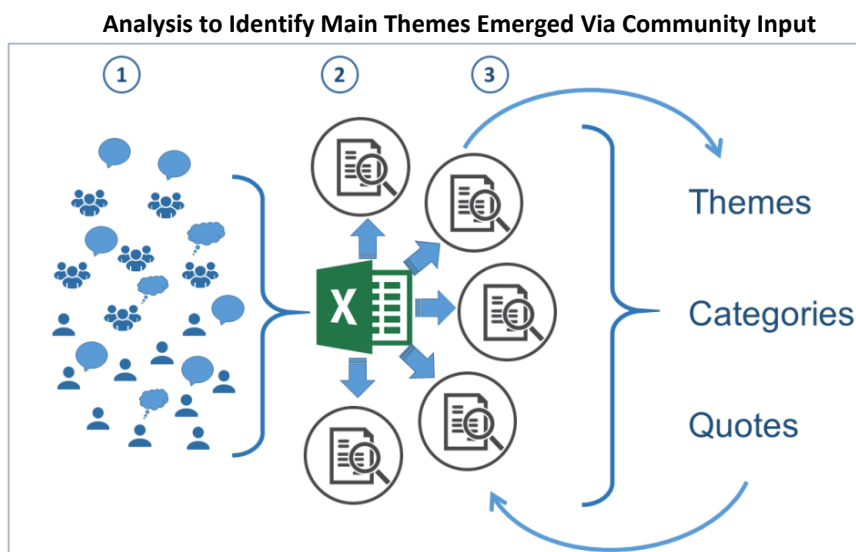
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<sup>11</sup> <http://www.healthyclendale.org/>

severe health drivers on a grid created during the focus group. For the purpose of the voting activity, severity was defined as the level to which a health need or health driver affected the health and lives of those in the community.

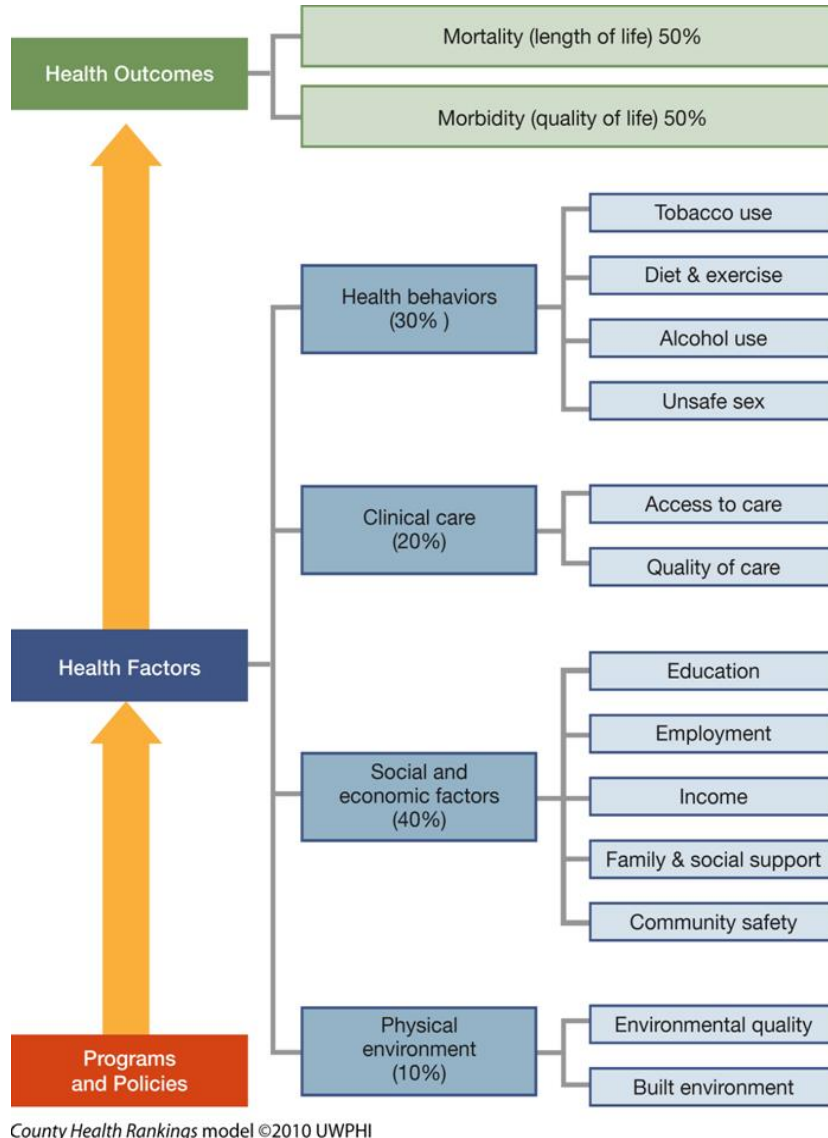
### Analytical Methods Used To Identify Community Health Needs

The CNM consultant team used a modified content analysis to identify the main themes that emerged from community input through the focus groups. This was a three-step process for analyzing and interpreting primary data (community input): 1) all information gathered during focus groups and interviews were entered into Microsoft Excel, 2) spreadsheet data were reviewed multiple times using content analysis to begin sorting and coding the data, and 3) through the coding process, themes, categories and quotes were identified.



To help identify health needs, two requirements needed to be met: 1) a health need had to be mentioned in the primary data collection more than once and 2) a secondary data indicator associated with the need had to perform poorly against a designated benchmark (county averages, state averages, or Healthy People 2020 goals). Once a health need met both requirements, it was designated as an identified health need.

**Mobilizing Action Toward Community Health (MATCH)**



### List of identified health needs, in alphabetical order

- Access to Health Care
- Cancer
- Cardiovascular
- Communicable/Infectious Disease
- Dental Care
- Diabetes
- Geriatric Support
- Homelessness/Housing
- Mental Health
- Obesity
- Poverty
- Preventative Wellness
- Sexual Health/STDs
- Stroke
- Substance Abuse
- Transportation
- Violence/Injury

### Data Limitations and Gaps

The secondary data allows for an examination of the broad health needs within a community. However, there are some limitations with regard to this data, as is true with any secondary data. Data were not always available at the ZIP code level, so county level data as well as SPA level data were also utilized. Moreover, disaggregated data for age, ethnicity, race, and gender are not available for all data indicators, which limited the examination of disparities of health issues within the community. At times, a stakeholder-identified health issue may not have been reflected by the secondary data indicators. In addition, data are not always collected on an annual basis, meaning that some data are several years old.

## Prioritization of Health Needs

Once a list of health needs was developed, a process was completed to prioritize the health needs. The steps to that process are outlined in the section that follows.

### Community Ranking of Health Needs

A total of 34 community stakeholders convened May 24, 2016 for a Prioritization Forum with the goal of ranking the identified health needs. Many of the forum participants had also attended the focus groups. Participants were provided the data Scorecard and allowed time to review the data and discuss in small groups. CNM consultants were available to answer data questions. To capture all groups' observations, each group was given worksheet to provide input on geographic areas impacted, specific populations, organizations and programs in the community and gaps in resources. After a large group discussion, participants were given the opportunity to provide input via voting and a survey.

All participants were given sticker dots (10 sticker dots each), presented with the list of identified health needs and asked to cast their sticker votes for the most severe health needs in the community.

Post-voting, they were asked to complete a written survey that presented all of the identified health needs, and asked them to score each health need based on the following criteria:

- severity of the health need in the community
- change over time (improved or gotten worse)
- availability of community resources
- community readiness to address the health need

Participants were given a companion document that further explained the four criteria and the scoring system. Absent participants were allowed the opportunity to complete the survey online if they were not able to attend Prioritization Forum. A total of 33 participants completed the survey in person and 13 online, for a total of 46.

### Analysis of Survey Scores

The results of the dot-voting process and scores from the surveys were combined to develop a Prioritized Health Needs list. The needs were first ranked based on the outcome of the scoring in the survey (i.e., highest scores meant a higher ranking) and second, ranked by the outcome of the survey.

Prioritized Health Needs, Separated by Outcomes and Drivers

Rank	Health Outcomes
1	Mental Health
2	Obesity/Overweight
3	Substance Abuse
4	Diabetes
5	Cardiovascular Disease
6	Cancer
7	Stroke
8	Communicable/Infectious Diseases
9	Sexual Health / Sexual Transmitted Diseases

Rank	Health Drivers
1	Homelessness and Housing
2	Substance Abuse
3	Poverty
4	Access to Health Care
5	Dental Care
6	Violence/Injury/Safety
7	Preventive Wellness
8	Geriatric Support
9	Transportation

## Identified Priority Needs from 2016 CHNA

After conducting the CHNA, we asked the following questions:

- 1) What is really hurting our communities?
- 2) How can we make a difference?
- 3) What are the high impact interventions?
- 4) Who are our partners?
- 5) Who needs our help the most?

From this analysis, four primary focus areas were identified as needing immediate attention, moving forward:

### Priority Area 1 - Cardiovascular Health - Improve Aortic Stenosis Education and Support

#### *Identified Need*

*“Valvular heart diseases represent an underappreciated yet serious and growing public health problem that should be addressed.”*

– V.T. Nkomo, Mayo Clinic, Rochester, USA

Epidemiological studies have determined that more than one in eight people aged 75 and older have moderate or severe aortic stenosis.

#### *Goal*

Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors of aortic stenosis. Early identification and proper treatment of aortic stenosis.

Adventist Glendale Medical Center has pursued and achieved proficiency in the placement of a minimally invasive trans-apical valve replacement. The pursuit of this program began in 2015 and was achieved in November 2016. The program is apprised of invasive cardiologists, cardiothoracic surgeons, anesthesiologists, various clinical staff from both surgical services and cath lab, and the program coordinator. Identified patients are referred to the committee for clinical appropriateness and optimal treatment options. A comprehensive database through the American College of Cardiology is a requirement of participation within this program. After the onset of symptoms, average survival is 50% at two years and 20% at 5 years.

#### *Objective*

Expand community education and early symptom identification. Adventist Glendale Medical Center will reach out and educate the community regarding the risk factors, signs, and symptoms of aortic stenosis as well as the preventative measures that can be taken in order to potentially reduce its occurrence. The goal is to continually expand these activities as additional community contacts and links are established.



### *Interventions / Measures*

- A two--day C.A.R.E. event will be held with approximately 180 attending
- GAMC will host four educational series, with approximately 1,000 attending
- Cholesterol screenings will be held with an estimated 500 participating
- The GAMC STEMI Center will serve 50 uninsured/un--reimbursed patients
- The Chest Pain Center will serve 50 patients
- At least three heart healthy MD seminar talks will be held with 170 attending
- Incorporate and track response to web--based health interventions, including social networking sites, online video viewing sites, and visits to online health encyclopedias (R.O.I. for direct mail engagements and campaigns)
- Use the metrics provided by the direct mail and email provider to determine actual incremental increase in patient contact

### *Evaluation Indicators:*

#### *Short--term*

Increase the number of sites for community--based management for heart disease, and community members' ability to monitor their health and disease. Improve the ED patient's arrival time accuracy to better be able to track turnaround times for important measures such as length of stay, troponin turnaround time, STEMI reperfusion times, and door to EKG times, which all improve patient care and patient satisfaction.

#### *Long--term*

Decrease hospital readmission rates for acute myocardial infarction. Overall, decrease hospital length of stay and quality measure turnaround times.

### *Partners*

- Adventist Glendale Cardiac Rehabilitation Program
- American College of Cardiology
- American College of Cardiology
- American Heart Association
- American Red Cross
- Covidien
- Edwards Life Sciences
- Glendale YMCA
- Hospital and community physicians
- La Cañada YMCA
- Los Angeles County Department of Health
- Society for Interventional Radiology

- Society of Chest Pain Centers
- Toshiba
- Verdugo Hills Hospital for cardiac rehab

## Priority Area 2 - Improve Stroke Education and Support

### Identified Need

- Stroke kills almost 130,000 Americans each year—that's 1 out of every 20 deaths
- On average, one American dies from stroke every 4 minutes
- Every year, more than 795,000 people in the United States have a stroke
- About 610,000 of these are first or new strokes
- About 185,000 strokes—nearly one of four—are in people who have had a previous stroke
- About 87% of all strokes are ischemic strokes, when blood flow to the brain is blocked
- Stroke costs the United States an estimated \$34 billion each year. This total includes the cost of health care services, medications to treat stroke, and missed days of work
- Stroke is a leading cause of serious long-term disability

Know the warning signs and symptoms of stroke so that you can act fast if you or someone you know might be having a stroke. The chances of survival are greater when emergency treatment begins quickly.

- In a 2005 survey, most respondents—93%—recognized sudden numbness on one side as a symptom of stroke. Only 38% were aware of all major symptoms and knew to call 9-1-1 when someone was having a stroke.
- Patients who arrive at the emergency room within 3 hours of their first symptoms tend to have less disability 3 months after a stroke than those who received delayed care

**Goal:** Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke; early identification and treatment of heart attacks and strokes; and, prevention of repeat cardiovascular events. Increase the number of patients with stroke symptoms accessing the GAMC Emergency Department via Emergency Medical Services rather than walk-in or private transportation.

The Certified Advanced Primary Stroke Center at Glendale Adventist has been established to serve this need in the Glendale region. The Center was first certified in March of 2008 by the Joint Commission and is re-audited every 2 years. A Stroke Alert Team is available 24/7 and offers the latest modalities of treatment available. GAMC submits data for its stroke patients to the Joint Commission and the American Stroke Association (a division of the American Heart Association). Last year, the GAMC Stroke Center received a Gold Plus Award from the American Heart Association for meeting the criteria set by the Get with the Guidelines program, which recognizes hospitals that implement evidence-based best practices for stroke care. In addition to the Gold Plus award, GAMC has qualified to join the Target: Stroke Honor Roll Award, a national quality improvement initiative that focuses on improving the timeliness of administration of intravenous tissue plasminogen activator (IV-tPA) to eligible patients. The goal is to achieve a door-to-needle time of 60 minutes or less. In 2015, GAMC became a Certified Comprehensive Stroke Center (CSC), a higher level of certification by DNV Healthcare. The CSC designation means that hospital met or exceeded all required standards to care and treat complex neurological cases.

**Objective:** Expand community--based stroke prevention and education activities through additional community access points and network formulation.

The GAMC Neuroscience Institute will offer stroke education and support to community members and stroke survivors.

In addition, a key mission of the GAMC Neuroscience Institute is to reach out and educate the community regarding the risk factors, signs, and symptoms of stroke, as well as the preventative measures that can be taken in order to potentially reduce its occurrence. The community outreach initiatives completed thus far are detailed below. The goal of the Neuroscience Institute is to continue to expand these activities as additional community contacts and links are established.

### *Interventions*

- Provide community education regarding the signs and symptoms of stroke and the need to call 911 vs driving to the ED.
- The stroke support group will serve 15 to 20 participants per month.
- Continued free Stroke Medication Management and Education Clinic; in 2014, pharmacy consults were built into our process to ensure patients receive free consultation with the pharmacist prior to discharge.
- The Neuroscience Institute will provide at least 4 free stroke awareness community presentations.
- The Neuroscience Institute will evaluate the effectiveness of the stroke community education by performing a pre--test and a post--test survey.
- GAMC will provide stroke risk assessment including blood pressure screening in at least 4 community events.
- GAMC will work with local partners to incorporate at least two community health navigators to assist patients with aftercare and reduce utilization of specialists.
- The Neuroscience Institute will continue to utilize the state-of-the-art interactive mobile stroke education unit in at least 3 community events.
- The Community Mobility Program is anticipated to serve 10 to 15 participants per year.
- Incorporate and track response to web--based health interventions, including social networking sites, online video viewing sites, and visits to online health encyclopedias (R.O.I. for direct mail engagements and campaigns).
- Use the metrics provided by the direct mail and email provider to determine actual incremental increase in patient contact.
- Integrate education into Clinical Research services and educate physicians accordingly, especially primary physicians.

## Evaluation Indicators

### Short-term

- Increase the proportion of adults who have had their blood pressure measured within the preceding 2 years and can state whether their blood pressure was normal or high.
- The stroke support group will serve 15 to 20 participants per month.
- Increase utilization of the Stroke Medication Management and Education Clinic.
- The Neuroscience Institute will provide at least 4 free stroke awareness community presentations.
- The Neuroscience Institute will evaluate the effectiveness of the stroke community awareness presentations by performing a pre--test and a post--test survey.
- We will provide stroke risk assessment including blood pressure screening in at least 4 community events.
- Increase utilization of the Neuroscience Institute will continue to utilize the state-- of--the--art interactive mobile stroke education unit.
- The Community Mobility Program is anticipated to serve 10 to 15 participants.

### Long-term

- Increase the sites for community--based management for strokes to reduce stroke--related deaths.
- Work with local partners to incorporate at least two community health navigators to assist patients with aftercare and reduce utilization of specialists.
- Incorporate and track response to web--based health interventions, including social networking sites, online video viewing sites, and visits to online health encyclopedias (R.O.I. for direct mail engagements and campaigns).
- Integrate education into Clinical Research services and educate physicians accordingly, especially primary physicians.

## Program Highlights

GAMC created a Community Mobility Program for people who have had a stroke and are experiencing neurological deficits that may impair driving ability. Because the loss of driving ability is one of the most difficult losses stroke patients face, GAMC offers this service in order to evaluate patients from a clinical and an on--the--road perspective to determine driving ability. Some are evaluated as being able to drive immediately; some as needing special training and others as having lost the dexterity to drive again. GAMC's Community Mobility Program is operated in partnership with the Department of Motor Vehicles.

A free monthly stroke support group meets with a volunteer licensed clinical social worker from GAMC Rehabilitation Services. GAMC welcomes stroke survivors from all local hospitals and created an outreach initiative encouraging stroke survivors to avail themselves of this resource. Approximately 15 to 20 stroke survivors attend this ongoing monthly meeting.

The GAMC Neuroscience Institute offers FREE Stroke Medication Management & Education Clinics – the first of its kind in the community. Stroke patients receive a consultation with a Glendale Adventist pharmacist including answers to their medication/prescription questions, discussing adjustments to medication dosage (if necessary) and receiving guidance regarding post--stroke rehabilitation. Armenian and Spanish--speaking pharmacists are also available for patients upon request. In addition to continued marketing initiatives through the GAMC website and Health Quarterly, pharmacy consults are built into our process to ensure patients receive a free consultation from the pharmacist prior to discharge.

Going forward, the GAMC Neuroscience Institute will continue to offer free ongoing stroke awareness community presentations. These community events are supported by GAMC website podcasts that address warning signs, methods of prevention, services offered, and treatment options for stroke.

### *Partners*

- American Heart/Stroke Association
- National Stroke Association
- Center for Neuro Skills
- Los Angeles Stroke Coordinator's Network(LASCN)
- American Association of Neuroscience Nurses(AANN)
- Department of Motor Vehicles
- Genentech
- Glendale Merchants Association
- Glendale News--Press
- Local membership organizations

## Priority Area 3 - Population Health for Chronic Disease

### *Identified Need*

Over the course of 20 years, the collaborative efforts between Glendale Adventist Medical Center (GAMC), the non-profit, municipal, healthcare, education, and faith sectors continue to yield fruitful results in the community ownership of health. Understanding that preventative care is key to deterring life-long chronic disease, GAMC recognizes the importance of evidence-based, population health initiatives that improve diabetes management and diabetes outcomes. Diabetes is a serious condition that can lead to heart and kidney disease, stroke, amputation, blindness, and death. It lowers life expectancy by up to 15 years, and for those with the disease, it increases the risk of heart disease two to four times over those without diabetes. Obesity is one of the identified risk factors for Type 2 diabetes and thirty-four percent of adults and teens in the greater Glendale service area are diagnosed with being overweight, and an additional 20% are diagnosed with obesity. The Glendale community and GAMC are impacted by undiagnosed and poorly controlled, or uncontrolled diabetes and experience higher rates of diabetes hospitalizations than the statewide average. The state of California's hospitalization rate for uncontrolled diabetes per 100K is 145.6, as compared to Glendale zip codes 91204 (237) and 91205 and in service area zip codes 90065 (204.3) and 90042 (201.8). Poorly controlled or uncontrolled, and undiagnosed diabetes decreases quality of life and increases cost of care. An important next step in "owning" the health of our children, their families and our community, is increasing access to health education, disease management, and health promotion activities.

A key element in this strategy is creating access to services and resources delivered by the Choose Health LA Kids program. CHLAKids is a population health, early childhood diabetes prevention initiative. Funded by the LA County Department of Public Health and First 5 LA, it is designed to reach children 0-5 years of age and their families. Its mission is to implement community based education, skill building, and environmental changes that promote physical activity and healthy eating. These preventative health measures are emphasized through community engagement and cross-sector collaboration. Focusing our health promotion and disease prevention efforts on the 0-5 population creates a unique opportunity for cooperation for all community members. It likewise presents the chance, for all those invested in community health, to create a deeply embedded network that functions to support, protect, and follow the health of our community members from birth into adulthood. At its heart this strategy means we will be working together to own the health of our community.

The Diabetes Community Engagement Project (DCEP) is a multi-pronged, evidence-based, population health initiative that will improve diabetes management and outcomes among those who live, work, and play in both Glendale and its respective communities. Funded by the UniHealth Foundation, the Diabetes Community Engagement Project will screen 3,000 community members for diabetes, cardiovascular disease and

hypertension over the course of two years. The program has three basic strategies which serve at-risk multi-cultural populations in Glendale. Clinicians and practitioners, community health workers, and business and healthcare sectors will collaborate to achieve assessment and identification of undiagnosed diabetes and pre-diabetes, and will help individuals manage diabetes through an integration of community-based, worksite, and healthcare best practices. These include: free clinical follow-up for those identified as at risk with an HbA1c and total cholesterol test; referral to one of eight partnering Federally Qualified Health Clinics (FQHC) should it be required, and to Diabetes Self-Management Programs which focus on educating and empowering community members to self-manage their chronic condition.

Focusing our energies towards full sector collaboration to improve diabetes outcomes creates a unique opportunity for everyone to collectively own the health of our community. DCEP continues to expand its efforts by supporting Glendale's Collective Impact Initiative by providing free outreach and health screenings that attracts and functions as an initial engagement with community partners who are specifically serving vulnerable populations. In doing so, we form a broad based collaborative that synergistically works to coordinate health promotion, and disease prevention efforts.

This allows us to collectively achieve a positive health trajectory for Glendale's community members.

### Goal

Reduce the illness, disability, and number of deaths caused by chronic disease among low-income, at-risk, and vulnerable populations in the GAMC service area.

### Objectives

1. Reduce diabetes risk in community members who live, work, and play in Glendale and its respective communities; including engaging parents and caregivers of children 0-5 to participate in a comprehensive early intervention initiative effort to manage population health.
2. Implement a targeted diabetes risk reduction program, including programs specifically supporting children 0-5, including linking diagnosed patients to primary care services and diabetes self-management programming, in areas identified by GIS health risk mapping, and by educating and screening patients we reach through Occ Med's job-specific medical surveillance.
3. Develop & implement a diabetes management education and training program for mid-level clinicians at six FQHC Safety Net clinics and other primary care providers, and facilitate the development of employee wellness programs among businesses in the community.
4. Implement the project's community engagement strategy with four bilingual Promotoras conducting the diabetes self-management program in cooperation with community partners
5. Increase the knowledge of healthy eating and active living, as it relates to children 0-5 and their families, through community based participatory relationships that collaborate to improve the lives of young children.

### Interventions / Measures

- Engage and enlist 100 organizations to participate in DCEP outreach efforts.
- Assess 3,000 individuals for diabetes, cardiovascular disease and hypertension via the 100 collaborative relationships.
- Provide free HbA1c and total cholesterol clinical follow-up to identified at-risk individuals.



- Collaborate with eight FQHCs/PCP as well as the Heart and Vascular Institute for referral process of community members identified as at-risk and/or without a medical home.
- Engage community partners such as CBOs, FBOs, businesses, and non-profits to become Diabetes Self-Management Program sites.
- Refer 27%--35% of DCEP participants to a CBO--based DSMP or GAMC Hospital-- based diabetes management program.
- Provide twelve DSMP Promotora led community based six--week workshops that are culturally and linguistically relevant.
- Support larger city--wide initiative developed to address chronic disease.
- Conduct a community health needs assessment capturing areas of need.
- Conduct health education / health promotion and community behavioral interventions (ex: food demonstrations and physical activity exercises).
- Deliver nutrition and physical activity education and resources to families with children ages 0--5.
- Engage and encourage local restaurants to join the Choose Health LA Restaurant program, and enhance their children's meal menu by offering healthier food options.
- Provide nutrition education and skills--building learning opportunities to parents and other care providers of children ages 0--5 in grocery stores/and or markets by conducting store tours with local participatory retailers.
- Convene a 30--member parent collaborative that works to build support for civic engagement goals, and promote healthy living among parents of children 0--5.
- Develop participatory collaborative relationships with other community based organizations that work on or behalf of eligible families with children 0--5; i.e., WIC, CalFresh, and other community assistance programs.

*Evaluation Indicators:*

*Short--term* -- Increase healthy behaviors in vulnerable populations, including a special focus on children 0--5 and their family members who may be at risk for chronic disease.

*Long--term* -- Implement policy change that supports healthy eating and physical activity among children ages 0--5 and their families. Support "We Own the Health of Our Community," a city--wide collective impact initiative that will reverse current health trends as it relates to chronic disease across all demographics.

Partners

- Glendale City Manager Scott Ochoa
- Glendale Senior Community Services Supervisor Moises Carrillo
- City of Glendale Fire Department
- Glendale Unified School District
- Cerritos Elementary School
- Edison Elementary School
- Horace Mann Elementary School
- Marshall Elementary School
- Pacific Avenue Education Center
- Healthy Kids, Healthy Lives Parent Collaborative
- Glendale WIC
- Trader Joe’s, Ralphs, Vons, Smart & Final
- Department of Social Services
- Glendale Healthier Community Coalition
- Crescenta Valley Alliance
- Pacific Clinics Head Start, Early Start
- Bellies, Babies, and Bosoms
- Los Angeles County Department of Public Health – CHLAKids and CHLA
- Restaurants
- Da Juice Bar
- El Ruby Café
- Que Ricos
- Didi Hirsch
- Heart and Vascular Institute
- GAMC Laboratory -- Thomas Paw
- Partners in Care Foundation
- HSAG -- Health Services Advisory Group
- Lutheran Church of the Foothills
- Rapid Urgent Care Clinic-- La Cañada/Montrose
- Eagle Rock Seventh Day Adventist Church
- Vallejo Church
- GAMC chapter of CHLAKids
- GHCC
- Glendale Community College
- Incarnation Catholic Church
- Glendale Communitas Initiative
- Filipino Seventh Day Adventist Church
- Christian Books and Veggie Foods
- All for Health, Health for All
- GAMC Senior Live Well Center
- Spanish Seventh Day Adventist Church
- JosyInn Center, Burbank
- Glendale YWCA
- Salem Church
- St. Matthews Church
- Glendale City Church
- Armenian American Nurses Association
- Living Stones Seventh Day Adventist Church
- Holy Family Catholic Church
- Solheim Lutheran Home
- La Cañada YMCA
- Bethel Latino Temple United
- St. Ignatius of Loyola
- Crescenta Valley Adventist School
- Christian Outreach for Armenians Church
- Glendale Unified School District
- St. Gregory Armenian Catholic Church
- Pacific Park
- West Hollywood SDA

## Priority Area 4 - Wellness and Support for Patients Diagnosed with Cancer

### Identified Need

Glendale Adventist Medical Center (GAMC) serves a culturally diverse community, including many people of Armenian origin. There is a significant need for many types of community screening programs, including lung cancer screening.

According to the American Cancer Society, lung cancer is the leading cause of cancer-related deaths in the Glendale community. Currently, lung cancer is predominantly detected in stage 4 or later where survival rates are at their lowest. 5-year survival rates for lung cancers detected in stages 1 & 2 can be 35 – 50% higher than those detected in stage 4.

### Goal

In 2017, establish a baseline of population screenings performed for longitudinal comparative low-dose CT screenings in the Lung Health Program at GAMC using Invivo software. The Invivo software gives clinicians the ability to more effectively do comparative studies of those screened with incidental findings. GAMC's goal is to install the Invivo software no later than Q2 2017 and screen a minimum of 75 people.

Per National Lung Screening Trial (NLST) and National Comprehensive Cancer Network (NCCN) guidelines, target population should include individuals 55-74 years old, have smoked 30+ pack years, stopped smoking less than 15 years ago.

In addition to making the investment, in 2017, for the Invivo software, GAMC will develop and implement a communications plan to increase awareness of the importance of early detection via low-dose CT screening for lung cancer. This communication will reach physicians and the Glendale community.

### Criteria

Individuals who are 55-74 years old, have smoked 30+ pack years, stopped smoking less than 15 years ago. Guidelines defined by National Lung Screening Trial (NLST) and National Comprehensive Cancer Network (NCCN).

### Objective

By 2018, screen 80% of adults ages 50 and older for colorectal cancer by collaborating with the American Cancer Society and other area providers who have also committed to this objective.

### Interventions:

1. Host a minimum of one colorectal screening program for the community
2. Host a physician--led educational session at GAMC to heighten the awareness amongst primary care physicians of the services offered at GAMC within radiation, medical oncology and surgical oncology and promote the 80% by 2018 initiative
3. Develop smoothly functioning system of care to facilitate screening tests to include both patient and physician reminders around screening
4. Monitor quality of screening and reports out of the National Cancer Data Base

### *Evaluation Indicators*

*Short-term:* Increase the proportion of adults in our service area who receive screenings for cancer; and, increase the proportion of adults in our service area who receive appropriate care once diagnosed with cancer.

*Long-term:* Increase early detection of cancer in our service area.

### *Partners*

- American Cancer Society
- American College of Radiology (ACR)
- American College of Surgeons (ACoS)
- American Lung Association
- Cancer Care Guild through the GAMC Foundation
- Ingeborg Zerne Foundation
- Invivo
- Los Angeles County Department of Health and Human Services
- National Comprehensive Cancer Network (NCCN)
- National Junior Charity League
- Oncology Nursing Society (ONS)
- Referring physicians

## Cross Cutting Objective - Health Resource Education / Marketing

### Goal

Provide the public with health education to better the health of our communities using effective messaging to reach the right audience at the right time. The strategy includes using marketing channels including, but not limited to:

- Print and outdoor media advertising focused on service line promotions, hospital awards and achievements earned for positive patient outcomes
- Publications which reach employees, patients and visitors, medical staff the community, and donors; content includes health education, service line promotions, physician information, and hospital awards and recognitions.
- TV health education shows featuring GAMC physicians – Healthline and the Dr. Narine Arutyunian show – help educate the community on service lines, disease states, and conditions
- Online education through tools and interactive resources to help browsers learn about treatments and procedures for diseases and conditions
- Social media engagement
- Community awareness events and lectures

### Objectives

The GAMC Marketing Department will provide print, TV, and web--based multimedia resources for health education; and, directly engage the community, increasing direct access to hospital services.

### Partners

- StayWell for online health education
- ARTN for TV shows
- Participating physicians for HealthLine TV show
- Coffey Communications for HQ community newsletter
- eOrthopod for online education
- Influence Health for website management
- Eruptr for online Search Engine Marketing
- Facebook social media
- Twitter social media
- YouTube social media
- LinkedIn social media

## Making a difference: Evaluation of 2014-2016 CHP

### Priority Area 1 Evaluation: Cardiovascular Health - Integrate Patient Education into Cardiovascular Services

#### Goal

Increase the access and/or number of impactful community educational events that provide heart health education and related health screenings.

#### 2014 Interventions and Outcomes

- Mega heart event at the Glendale Galleria with free blood pressure screenings.
- Women's Tea Time event to discuss chest pain and cardiac health.
- HV+I will host an on-campus "Heart Healthy Cooking Class & Presentation. Program was well-received and well-attended. Participants enjoyed a healthy alternative holiday dinner as they watched a fresh food chef demonstrate. A cardiologist and cardio-thoracic surgeon spoke on basic heart anatomy and ways to stay heart healthy all year long.
- The opening of the Heart and Vascular Institute in an exciting highlight for 2014. Provides a place for our patients to turn to for management of chronic heart conditions and helps to lower the risk of readmissions and ED admissions. Cardiologists, interventional radiologists, and cardiothoracic surgeons are available daily to see patients and perform testing such as echocardiograms and stress imaging. It is a state of the art facility and provides treatment and care for arrhythmias, heart failure, valve disorders, coronary artery disease, chronic care management, cardiac and vascular primary screenings, population health screenings, nuclear camera, treatment and echo rooms.
- The newly revised "LEGS FOR LIFE" event has been redesigned and is now called "C.A.R.E," Cardiac Arterial Risk Evaluation. Screenings offered include: Abdominal aortic aneurysm, carotid ultrasound, ankle brachial index, and also newly added cholesterol, CRP blood test, BP, and BMI. A cardiac consult will be available in Spanish and Armenian.

#### 2015 Interventions and Outcomes

- GAMC collaborated with the LA STEMI center to obtain two standing screens displaying the signs and symptoms of acute coronary syndrome and how this manifests differently for men and women, and also a message emphasizing the importance of calling 911 when someone shows these symptoms. These screens are displayed at events in the community and on our hospital grounds for visitors to see.
- GAMC initiated a monthly class wherein the chest pain coordinator and the cardiovascular clinician share tips with patients in cardiac rehab about how to reach a better quality of life. Classes educate patients about healthy living, healthy eating, medication management, warning signs for complications, family support, social support, risk of depression, and complications after surgery. Also, the classes create a place where patients can feel welcome to ask questions and network with people who have had a similar experience.

- “C.A.R.E.,” Cardiac Arterial Risk Evaluation Event. Screenings offered include: Abdominal aortic aneurysm, carotid ultrasound, ankle brachial index, and also newly added cholesterol, CRP blood test, BP, and BMI. A cardiac consult will be available in Spanish and Armenian.

### 2016 Interventions and Outcomes

- HV+I will host an on-campus “Heart Healthy Cooking Class & Presentation. Program was well-received and well-attended. Participants enjoyed a healthy alternative holiday dinner as they watched a fresh food chef demonstrate. A cardiologist and cardio-thoracic surgeon spoke on basic heart anatomy and ways to stay heart healthy all year long.
- GAMC collaborated with the LA STEMI center to obtain two standing screens displaying the signs and symptoms of acute coronary syndrome and how this manifests differently for men and women, and also a message emphasizing the importance of calling 911 when someone shows these symptoms. These screens are displayed at events in the community and on our hospital grounds for visitors to see.
- “C.A.R.E.,” Cardiac Arterial Risk Evaluation Event. Screenings offered include: Abdominal aortic aneurysm, carotid ultrasound, ankle brachial index, and also newly added cholesterol, CRP blood test, BP, and BMI. A cardiac consult will be available in Spanish and Armenian.

## Priority Area 2 Evaluation: Improve Stroke Education and Support

### Goal

Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke; early identification and treatment of heart attacks and strokes; and prevention of repeat cardiovascular events.

### 2014 Interventions and Outcomes

- A Community Mobility Program has been initiated for people who have had a stroke and are experiencing neurological deficits that may impair driving ability. Because the loss of driving ability is one of the most difficult losses stroke patients face, GAMC offers this service in order to evaluate patients from a clinical and an on-the road perspective to determine driving ability. Some are evaluated as being able to drive immediately; some as needing special training and others as having lost the dexterity to drive again. GAMC’s Community Mobility Program is operated in partnership with the Department of Motor Vehicles. A free monthly stroke support group meets with a volunteer licensed clinical social worker from GAMC Rehabilitation Services. GAMC welcomes stroke survivors from all local hospitals and has put an outreach initiative in place designed to encourage stroke survivors to avail themselves of this resource. Approximately 15 to 20 stroke survivors attend this ongoing monthly meeting.
- The GAMC Neuroscience Institute offers FREE Stroke Medication Management & Education Clinics – the first of its kind in the community. Stroke patients receive a consultation with a Glendale Adventist pharmacist including answers to their medication/prescription questions, discussing adjustments to medication dosage (if necessary) and receiving guidance regarding post-stroke rehabilitation. Armenian and Spanish-speaking pharmacists are also available for patients upon request. In addition to continued marketing initiatives through the GAMC website and Health

Quarterly, pharmacy consults are built into our process to ensure patients get free consultation with the pharmacist prior to discharge.

- We had four opportunities to provide stroke risk assessment and blood pressure screenings in 2014. A total of 300 screenings were completed.
- The state-of-the-art interactive mobile stroke education unit was utilized during the stroke awareness month in May 2014. The Community Mobility Program had 11 participants in 2014. Of the 11, 3 had a history of stroke.
- In May 2014, two of GAMC's board-certified neurologist joined the "Stroke Awareness Hotline" to answer questions on stroke prevention. The event was a special telecast by AB7 Eyewitness News in celebration of the stroke awareness month. About 25 phone consults were served by our neurologists that day.

### 2015 Interventions and Outcomes

- We provided stroke risk assessment and blood pressure screenings in 2015. A total of 57 blood pressure screenings were completed.
- Stroke Support Group has continuously provided stroke survivors and their families an opportunity to connect with other survivors and deal with the physical and emotional difficulties after stroke. The support group convenes an average of 15 participants monthly.
- The Community Mobility Program had 11 participants in 2015. Of the 11 participants, 8 had a history of stroke.

### 2016 Interventions and Outcomes

- Community stroke awareness presentations were held in 2016 with an average attendance of 35 participants per event. Attendees were evaluated on their understanding of stroke signs and symptoms, risk factors, B.E.F.A.S.T. acronym and TPA medication. Results of the survey showed that 75% of the participants did well on their post-test as compared to 38% on their pre-test survey.
- The Community Mobility Program had 16 participants in 2016. Of the 16 participants, 5 had a history of stroke.

## Priority Area 3 Evaluation: Population Health for Chronic Disease

### Goal

Reduce the illness, disability, and number of deaths caused by chronic disease to low-income, at-risk, and vulnerable populations in the GAMC service area.

### 2014 Interventions and Outcomes

- Since its implementation, the GAMC chapter of Choose Health LA Kids has within the short time frame of six months:
  - Conducted 19 store tours with over 600 members participating (307 adults, 291 children 0-5, 10 children 5+)



- Conducted 27 food demonstrations with 1,237 members participating (596 adults, 642 children 0-5, 6 children 5+)
  - Facilitated 8 parent collaborative meetings with 141 members participating (59 adults; 78 children 0-5, 4 children 5+)
  - Conducted 7 physical activity events with 83 members participating (46 adults, 31 children 0-5, and 6 children 5+)
  - Have participated in 8 large scale community health fairs
  - Given 22 presentations on Choose Health LA Kids and the Choose Health LA Restaurant Program.
- While conducting our key informant interviews for the CHLAKids Community Needs Assessment, many women shared that they felt the community could be more supportive of mothers who are nursing by creating spaces where moms can breastfeed. Upon hearing this, the GAMC chapter of CHLAKids partnered with a local business, Bellies, Babies and Bosoms, to create a mobile breastfeeding unit replete with supplies for nursing mothers. The mobile breastfeeding unit debuted at Glendale's Cruise Night, and it was extremely well received and supported.
  - As a result of creating collaborative participatory relationships with local grocers and markets; GAMC-CHLAKids grocery store tours have been extremely successful. As a result of combining nutrition education and incentives we've seen a continued increase in participation. For example, in September 2014 one of our store tours had 80 attendees.
  - In October of 2014 GAMC-CHLAKids hosted a Harvest BBQ to kick-off the holiday season and mark the end of our regularly scheduled food demonstrations. We felt it important to give back to the parents who support and participate in our CHLAKids events, close to one hundred participants came and we fostered relationships with parents who were previously unaware of the CHLAKids program.
  - GAMC-CHLAKids coordinated the ribbon cutting ceremony for the John Stauffer Mobile Medical Unit, where free health screenings were provided to program participants, there were over 120 CHLAKids parents in attendance.
  - Through GAMC-CHLAKids staff outreach efforts, Que Ricos Tacos joined the Choose Health LA Restaurant Program, and has agreed to incorporate healthier children's meal options and make smaller portion sizes available to patrons.

### 2015 Interventions and Outcomes

- Conducted 15 store tours with 206 members of the community participating (93 adults, 62 children 0-5, 51 children 5+).
- Conducted 16 food demonstrations with 644 community members participating (247 adults, 214 children 0-5, 183 children 5+).
- Facilitated 12 parent collaborative meetings and participated in 1 Glendale Healthier Community Coalition meeting with 221 community members participating (126 adults, 58 children 0-5, 37 children 5+).
- Conducted 4 cycles of 6-week Healthy Parenting Workshops with 87 community members participating.
- Gave 22 presentations on Choose Health LA Kids and the Choose Health LA Restaurant program with 86 community members participating and distributed 168 CHLA Restaurants brochures and postcards.

- Enrolled 12 restaurants to the CHLA Restaurants program.
- Participated in 53 community events and meetings, with outreach to 2,464 participants.
- Promoted WIC and CalFresh by passing out 1,042 brochures and information packets to families who may need financial assistance and are unaware of the resources available to them.
- Compiled a comprehensive list, a Community Resource Guide, of local family resources, services, businesses, organizations, and family-friendly locations for the community in English, Spanish, and Armenian and distributed 264 physical copies to the community and posted electronic copies on 3 partner websites.
- Collaborated with 6 local media outlets to promote the CHLA Kids program: television interview with Mundo Fox, news article in GAMC Source, television interview with Fern Leaf Media, news article in Epoch Times, television interview with New Tang Dynasty, and communications with Univision Communications.
- Over 1,000 community members screened
- 50% have been identified as at-risk for diabetes and 18% for cardiovascular disease
- DCEP has conducted 49 outreach events.
- All program staff have been certified to conduct and facilitate either the Stanford Model or DEEP model Diabetes Self- Management workshops.
- Five DSMP workshops have been successfully completed thus far; four in English, one in Spanish.
- DCEP staff have referred over 170 community members to DSMP workshops, there has been a 35% enrollment rate and of that, a 59% participation and completion rate.
- DCEP engaged 49 community partners
- DCEP has held 10 HbA1c free testing clinics in partnership with GAMC's lab since July 14th; there have been 76 total participants; of those 76, 27% fell in the diabetes range, and .05% were diagnosed as diabetic.
- Those identified as at risk for CVD have been referred to GAMC's Heart and Vascular Institute for clinical follow-up for a total cholesterol point of care test. Patients also receive health education and counseling by a registered RN.
- Those patients who do not have a medical home or a PCP have been referred to All for Health, Health for All, a community based FQHC.
- With the support of GAMC-CHLA Kids, the Healthy Kids/Healthy Lives Parent Collaborative presented their PhotoVoice project at Glendale's Cesar Chavez event. They showcased photos they took of healthy and unhealthy items and venues they would like improved in their community. The event was attended by over 175 community members, City Council members, and other city officials. The attention and reception the presentation received encouraged the collaborative members to pursue a Healthy Vending Policy to enforce guidelines regarding vending machine options found in Glendale's parks and recreation facilities. In a few short months, 400 public opinion surveys were collected from the community. 94% of the residents surveyed would support and purchase healthier snack and beverage options in vending machines and over 83% would be in favor of removing the unhealthy snacks and beverages. As a result, the Healthy Kids/Healthy Lives Parent Collaborative proposed a draft of the Healthy Vending Policy to Glendale's City Manager, Scott Ochoa.
- In November 2015, members of the Healthy Kids, Healthy Lives Parent Collaborative

attended the “We Own the Health of Our Community” Impact Initiative event, a coalition of local organizations, businesses, and community members taking ownership of the community’s health. The collaborative was presented to the coalition as a community-based collaborative of local parents and caregivers who share the common purpose of creating a healthy environment for their families. The collaborative voiced their interest and intent on working with other members of the coalition to create a healthier Glendale.

- In 2015, GAMC-CHLAKids completed 4 cycles of 6-session workshops with 87 participants. These workshops are meant to engage parents and caregivers of children under the age of five in a social learning environment to foster effective parenting skills and implement healthful parenting, sleep, nutrition, and physical activity routines. In workshop evaluations, participants praised the curriculum and requested a second workshop to continue their education. The popularity of the workshops has grown and participation continues to increase.
- The GAMC-CHLAKids staff was trained as Facilitators in a Diabetes Self- Management course, a workshop designed to educate the community on how to self-manage diabetes. This equipped the staff with the knowledge and tools to facilitate the Diabetes Self-Management curriculum with the intention of helping those with diabetes or those who care for a person with diabetes better manage their lifestyle.
- In collaboration with the Glendale Parks and Recreation department, the GAMC- CHLAKids staff has facilitated eight afterschool nutrition classes with Glendale Unified School District students participating in afterschool sports. These classes introduced over 160 elementary school students to basic nutrition facts and emphasized the importance of a balanced diet in conjunction with their active lifestyle.
- In 2015, GAMC initiated a school-based Asthma Education program, in collaboration with Glendale Unified School District, to decrease school nurse visits from 10 to 7 per school year, and to deliver 10 education sessions with 50 parent and students per year, thus impacting diabetes risk factors and other quality of life indicators.

## 2016 Interventions and Outcomes

- In 2016, the GAMC chapter of Choose Health LA Kids has:
  - Conducted 8 store tours with 126 members of the community participating (59 adults, 66 children 0-5, 1 children 5+).
  - Conducted 7 food demonstrations with 254 community members participating (118 adults, 125 children 0-5, 11 children 5+).
  - Facilitated 11 parent collaborative meetings with 234 community members participating (109 adults, 113 children 0-5, 13 children 5+).
  - Conducted 7 cycles of 6-week Healthy Parenting Workshops with 62 community members participating.
  - Gave 7 presentations on Choose Health LA Kids and the Choose Health LA Restaurant program with 79 community members participating and distributed 87 CHLA Restaurants brochures and postcards.
  - Participated in 12 community events and meetings, with outreach to 707 participants.

- Facilitated 2 ribbon cutting events for local restaurants who joined the CHLA Restaurants program.
- Promoted WIC and CalFresh by passing out 1,042 brochures and information packets to families who may need financial assistance and are unaware of the resources available to them.
- Compiled a comprehensive list, a Community Resource Guide, of local family resources, services, businesses, organizations, and family-friendly locations for the community in English, Spanish, and Armenian and distributed 788 physical copies to the community and posted electronic copies on 3 partner websites.
- Collaborated with 5 local media outlets to promote the CHLAKids program and its' various messages: media coverage by Telemundo, interview with Estrella TV, news article in GAMC Source, article in LA Times, and article in Glendale News Press.
- Collaborated with Healthy Kids, Healthy Lives Parent Collaborative to pass a Citywide Healthy Vending Policy.
- In March 2016, with the support of GAMC-CHLA Kids, the Healthy Kids, Healthy Lives Parent collaborative brought forward a Citywide Healthy Vending Policy to the Glendale City Council. The Healthy Vending Policy was unanimously approved by all members of City Council. With the passing of the Healthy Vending Policy, starting in 2018 vending machines on Glendale city property, will only be allowed to include healthy snacks and beverages that follow specific nutrition standards. The new vending standards, which are more stringent than current vending standards, include sodium and sugar limits on snacks, any juice offered must be 100% fruit juice, and sodas and sports drinks are no longer allowed. Also, included in the vending policy is that at least half of the beverage options must be water.
- In 2016, GAMC-CHLA Kids facilitated 2 ribbon cutting events for restaurants (El Ruby and Que Ricos) that joined the CHLA Restaurant Program. By being a member of CHLA Restaurants, these restaurants will now offer smaller portion sizes, healthy side options, and new children's menus to their customers. Both of these ribbon-cutting ceremonies were attended by LA County DPH officials and local media, with the Que Ricos ceremony being attended by representatives from the local chamber of commerce, as well as representatives from City and State congressional council members.
- In 2016, GAMC-CHLA Kids continued to offer healthy parenting workshops, which have been met with positive responses from the community. In 2016, 7 cycles of 6-session workshops were conducted with 62 community members participating. These workshops are meant to engage parents and caregivers of children under the age of five in a social learning environment to foster effective parenting skills and implement healthful parenting, sleep, nutrition, and physical activity routines.
- In collaboration with the Glendale Parks and Recreation and the One Glendale Foundation, GAMC-CHLA Kids staff has facilitated 20 afterschool nutrition classes across 8 different Glendale Unified School District elementary schools, for students participating in afterschool sports. These classes introduced over 500 elementary school students to basic nutrition facts and emphasized the importance of nutrition and water consumption in conjunction with their active lifestyle.
- In November 2016, GAMC-CHLA Kids participated in the Glendale Health Festival, where staff disseminated information about the importance of increasing water consumption and

- decreasing the consumption of sugary beverages to over 100 community members.
- Over 3,000 community members screened
  - 30% have been identified as at-risk for diabetes and 14% for cardiovascular disease
  - DCEP has conducted 91 outreach events since the initiative began in February 2015.
  - All program staff have been certified to conduct and facilitate either the Stanford Model or DEEP model Diabetes Self- Management workshops.
  - 14 DSMP workshops have been successfully completed thus far; 10 in English, 2 in Armenian, 1 in Spanish.
  - DCEP staff have referred over 200 community members to DSMP workshops.
  - DCEP has engaged 56 community partners to date
  - DCEP has held 14 HbA1c free testing clinics in partnership with GAMC's lab; there have been 85 total participants; 27% fell in the diabetes range, and .01% were diagnosed as diabetic.
  - Those identified as at risk for CVD have been referred to GAMC's Heart and Vascular Institute for clinical follow-up for a total cholesterol point of care test. Patients also receive health education and counseling by a registered RN.
  - Those patients who do not have a medical home or a PCP have been referred to All for Health, Health for All, a community based FQHC.

## Priority Area 4 Evaluation: Wellness and Support for Patients Diagnosed with Cancer

### Goal

Increase access to cancer screenings within GAMC's primary service area.

### 2014 Interventions and Outcomes

- The National Comprehensive Cancer Network (NCCN) approved guidelines for low dose CT for lung cancer screening. Cancer Services, in conjunction with the GAMC Radiology Department, agreed to adopt these guidelines and offer this service at an affordable price to our community. A marketing plan directed to our medical staff and community was developed and implemented to announce the offering of this lifesaving service as of February 1, 2014. Patients with positive findings will be referred to Cancer Services for appropriate navigation to timely diagnosis, treatment and follow up care.
- There were three prostate screenings during 2014. The initial prostate screening occurred on June 12, 2014 for the Senior Program. Nineteen seniors were screened for prostate cancer, with four men that were found to have abnormal PSAs. Patients were referred for follow up. The second screening was held on October 16, 2014 at GAMC, as a Glendale community event. Eighty-five men attended, with sixteen abnormal PSA findings. The third prostate screening was held on November 15, 2014 at the Glendale Community Health Fair. Of the thirty-seven participants, two had abnormal PSAs.
- Developed an outpatient and inpatient massage therapy program.

### 2015 Interventions and Outcomes

- Held cancer screening event for community members.



**OUR MISSION:**  
Living God's love by inspiring health,  
wholeness and hope

- Held continuing medical education events for providers.

#### **2016 Interventions and Outcomes**

- Held cancer screening event for community members.
- Held continuing medical education events for providers.



## Strategic Partner List

- A.D.A.M. Tools
- All for Health, Health for All – FQHC
- American Association of Neuroscience Nurses (AANN)
- American Cancer Society
- American College of Cardiology
- American Heart/Stroke Association
- American Red Cross
- Armenian American Medical Association
- Armenian American Nurses Association
- Armenian Relief Society
- Armenian Senior Services
- ARTN for TV shows
- Ascencia Homeless Services
- Association of Clinical Research Professional (ACRP)
- Bellies, Babies, and Bosoms
- Bethel Latino Temple United
- Cancer Care Guild through the GAMC Foundation
- Center for Neuro Skills
- Cerritos Elementary School
- CHLAKids and CHLA Restaurants
- Christian Books and Veggie Foods
- Christian Outreach for Armenians Church
- Churches Without Walls
- CINCO
- City of Glendale Community Services
- City of Glendale Fire Department
- City of Glendale Parks and Recreation
- Coffey Communications for HQ community newsletter
- Comprehensive Community Health Center – FQHC
- Consortium of Safety Net Providers
- Covered California Small Business Outreach (CCHC)
- CPM Healthgrades
- Crescenta Valley Adventist School
- Crescenta Valley Alliance
- Da Juice Bar
- Department of Motor Vehicles
- Department of Social Services – CalFresh
- Didi Hirsch
- Eagle Rock Seventh Day Adventist Church
- Edison Elementary School
- El Ruby Café
- eOrthopod for online education
- Eruptr for online Search Engine Marketing
- Facebook
- Family Medicine Center/Family Practice Residency
- Filipino Seventh Day Adventist Church
- GAMC chapter of CHLAKids
- GAMC Laboratory - Thomas Paw
- GAMC Senior Live Well Center
- Genentech
- Glendale Chamber of Commerce
- Glendale City Church
- Glendale City Manager Scott Ochoa
- Glendale Communitas Initiative
- Glendale Community College
- Glendale Free Clinic
- Glendale Healthier Community Coalition
- Glendale Healthy Kids
- Glendale Homeless Coalition
- Glendale Memorial Medical Center
- Glendale Merchants Association
- Glendale News-Press
- Glendale Religious Leader Association
- Glendale Senior Center
- Glendale Senior Community Services Supervisor Moises Carillo
- Glendale Unified School District
- Glendale WIC
- Glendale YMCA
- Glendale YWCA
- Golden Farm

- Health Steering Response Committee of So. California
- Healthy Kids, Healthy Lives Parent Collaborative
- Heart and Vascular Institute
- Holy Family Catholic Church
- Horace Mann Elementary School
- HSAG - Health Services Advisory Group
- Incarnation Catholic Church
- Influence Health for website management
- Ingeborg Zeme Foundation
- Jon's
- JosyInn Center - Burbank
- La Cañada YMCA
- Latino Business Association
- LinkedIn
- Living Stones Seventh Day Adventist Church
- Los Angeles County Department of Health and Human Services
- Los Angeles County Department of Public Health – CHLAKids and CHLA
- Los Angeles Stroke Coordinator's Network (LASCN)
- Lutheran Church of the Foothills
- Marshall Elementary School
- MedSeek
- Medtronic Minimally Invasive Therapies
- National Junior Charity League
- National Stroke Association
- Pacific Avenue Education Center
- Pacific Clinics Head Start, Early Start
- Pacific Park
- PAREXEL International
- Parish Nurse of Glendale
- Participating physicians for HealthLine TV show
- Partners in Care Foundation
- Que Ricos
- Ralphs
- Rapid Urgent Care Clinic - La Cañada/Montrose
- Salem Church
- Salvation Army
- Smart & Final
- Society for Interventional Radiology
- Society of Chest Pain Centers
- Solheim Lutheran Home
- Spanish Seventh Day Adventist Church
- St. Gregory Armenian Catholic Church
- St. Ignatius of Loyola
- St. Matthews Church
- StayWell for online health education
- Toshiba
- Trader Joe's
- Twitter
- UCLA pre-hospital admissions department
- Vallejo Church
- Valley Nonprofit Resources
- Verdugo Hills Hospital for cardiac rehab
- Vons
- West Hollywood SDA
- Women with Wings
- YouTube



## Community Benefit Inventory

Health is a precious resource. People from every community want their families to be healthy, and not only have access to health services, but also to healthy food, safe parks and green spaces for recreation and play, and homes that are safe, well maintained, and affordable. Ensuring our communities are free of violence requires employment and opportunities for everyone to learn and succeed. Below you will find an inventory of additional interventions that are apart of creating a healthy community.

### Year 2016 – Inventory

Activities	Number of People Served
<b>Medical Care Services</b>	
<p>Glendale Adventist Medical Center and Adventist Health have an extensive charity care policy, which enables the Medical Center to provide discounted care and charity assistance for financially qualified patients. Financial counselors are available to help patients determine eligibility for charity assistance and manage medical bills. This assistance is available for both emergency and non--emergency health care.</p> <p>Charity care does not include: <b>1)</b> bad debt or uncollectible charges that the hospital recorded as revenue but wrote--off due to failure to pay by patients, or the cost of providing such care to such patients; <b>2)</b> the difference between the cost of care provided under Medicaid or other means--tested government programs and the revenue derived there from; or <b>3)</b> contractual adjustments with any third--party payers.</p>	

**Community Health Improvement**

Coalition building - Glendale Healthier Community Coalition, established in 1990 and the Health Information Exchange (HIE) Task Force meetings. The Glendale Healthier Community Coalition plans and implements projects that promote disease prevention, health education, clean and safe environments, adequate housing, affordable and quality education, and community revitalization. The GHCC mission statement embraces a broad definition of health which includes the wider spectrum of environmental influences impacting the community's well-being.

GHCC has brought together 52 organizational and individual community members including 14 from health care, nine from city government, two from education, seven from business/media, 11 from non-profit agencies, several clergy, and the balance made up of other community stakeholders.

Behavioral Health patient transportation to attend: Partial Hospitalization/intensive Outpatient Services (PHP/IOP)

**Cancer Center Services:**

- Positive Image Center Classes
- Health Screenings/Community Outreach/events

**Cardiology Services:**

- Acute Coronary Syndrome Banners
- Cardiac Education Rehab Group
- Sidewalk CPR: Blood pressure screenings Chaplains'

**Dept./Beyond Loss Bereavement Ministry:**

- Beyond Loss Bereavement Newsletters
- Beyond Loss Bereavement Support Groups
- Beyond Loss Holiday Gathering of Remembrance
- Beyond Loss 25th Anniversary Celebration

**Chaplains' Dept.: CINAHL:**

- Diabetes Support Group

A total of 159 participants.

- o GHCC coalition building meetings included: HIE Task Force meetings, Executive Committee meetings, General meetings, Care Transitions CEO Physician Dinner meeting, Population Health Simulation Event and Home Health/SNF's Collaborative meeting to reduce readmissions.

Community Building – LAACHA (Los Angeles County Alliance for Community Health and Aging) – Quarterly meetings – participants unknown.

- 61,157 non-unique participants

- **6,301 total participants**
- 1,492 participants
- 4,809 participants

- 1,000 served
- 200 served
- **1,351 total participants**

- 900 served
- 128 served
- 100 participants
- 120 participants

- 520 participants - Weekly spiritual care support groups at GAADS

<p>CINCO:</p> <ul style="list-style-type: none"> <li>• Choose Health LA (CHLA) Kids PACT to Quit Tobacco Cessation</li> <li>• Tobacco Control Program</li> </ul> <p>Clinical Research:</p> <p>Maternity Tour:</p> <p>Senior Program:</p> <p>Marketing Dept:</p> <ul style="list-style-type: none"> <li>• Blood Drives</li> <li>• Health Quarterly Newsletters</li> <li>• Healthline &amp; Dr. Arutyounian Show</li> </ul> <p>Neuroscience institute:</p> <ul style="list-style-type: none"> <li>• Stroke Support Group:</li> </ul> <p>Heart Failure follow up:</p> <ul style="list-style-type: none"> <li>• Pharmaceuticals for Medically Indigent</li> </ul> <p>Hospital information services:</p> <p>Respiratory:</p> <ul style="list-style-type: none"> <li>• Easy Breathers lung disease support group</li> <li>• School--based parent/child asthma education</li> </ul> <p>Women &amp; Children’s Services:</p> <ul style="list-style-type: none"> <li>• Infant Safety &amp; CPR Classes (Monthly)</li> <li>• Play to Learn developmental delays screening</li> </ul>	<ul style="list-style-type: none"> <li>• 2,307 participants</li> <li>• 4,385 participants</li> <li>• 95 participants</li> <li>• 430 participants</li> <li>• 11,229 participants</li> <li>• 297 participants</li> <li>• 260,000 participants</li> <li>• 3,840,000 viewers</li> <li>• 180 participants, held monthly groups</li> <li>• 268 recipients</li> <li>• 21 support group participants</li> <li>• Unknown number of participants</li> <li>• 209 participants</li> <li>• 55 participants</li> </ul>
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Health Professions Education	
<p><b>Educational programs and training for physicians, nurses and support staff</b></p> <p>Beyond Loss Bereavement Ministry:</p> <ul style="list-style-type: none"> <li>• Complexities of Suicide &amp; Grief Training</li> <li>• Certified Bereavement Facilitator Training</li> </ul> <p>CINAHL:</p> <ul style="list-style-type: none"> <li>• MonitorTechClasses-Education/PT Student Clinical Rotation –</li> </ul> <p>Emergency Dept.:</p> <ul style="list-style-type: none"> <li>• EMS Update 2016</li> <li>• Field Care Audits</li> <li>• MICN CE</li> <li>• MICNRide--along/ClinicalTime</li> </ul> <p>Healthy Heart Program:</p> <ul style="list-style-type: none"> <li>• Early Heart Attack Care Education</li> </ul> <p>Infection Prevention Facility Orientation:</p> <p>Occupational Medicine, Mobile Unit Student Health: Play to Learn/Pediatric Therapy: Pharmacy Dept., University Students on Rotation:</p>	<ul style="list-style-type: none"> <li>• 24 students</li> <li>• 79 students</li> <li>• 46 students</li> <li>• 27 students</li> <li>• 80 students</li> <li>• 3 students</li> <li>• 15 students</li> <li>• 1,000 served</li> <li>• 435 students</li> <li>• 21 students</li> <li>• 55 students</li> <li>• 99 students</li> </ul>

USC Spine & Orthopedic Institute:

- Student Education & P/T Internship

Stroke Awareness:

- City of Glendale- Stroke Awareness w/ Michelle Jocson

The Wellness Center:

Radiology Dept. Student Externship:

Volunteer Resources, interns/students registered:

**Train and support quality improvement teams** Quality and Patient Safety Measures describe the journey the Medical Center has been on providing world class care:

- Mortality Rate
- Core Measures Composite Score (Inpatient Psychiatric Measures, Stroke, Venous Thromboembolism, Elective Delivery prior to 39 weeks and Flu Immunization)
- Infection Prevention – Evidence based best practice
- Patient Falls
- GAMCs 'Overall rating of the Hospital'
- Hospital Acquired Conditions (HAC/PSI 90):

- 8 students

- 50 participants

- 6,109 served

- 359 students

- 4,087 participants

- Outperformed expected rates (decreased) in 2016.
- 96.8% (thru October 2016)

- Outperforming target (SIR 1.0) in CLABSI, Knee, Hysterectomies, C Diff, MRSA
- 7% reduction in falls
- HCAHPS percentile score 81.1 in 2016. Outperforming NRC 75th percentile rating.

- HAC cases not subject to any reduction (2016); GAMC PSI 90 is better than value based purchasing achievement threshold and better than the benchmark

All Cause Hospital Readmissions:

Awards 2016:

- 22% reduction
- CMS Star Ratings for Overall Quality of Care: 4 out of 5 stars (top 20% of CA Hospitals)
- Best Therapy and Wellness Center – Los Angeles Daily News
- Best Hospital in California (24th of 347) – U.S. News
- Gold Plus Award – Get with the Guidelines Stroke
- Leapfrog Hospital Safety Score/Grade: A
- GAMC will continue on this quality journey and is dedicated to providing world class care to the community we serve

Subsidize Health Services	
<p>ASSIST Care – Medications for discharged patients</p> <p>Pharmacy Dept.</p> <ul style="list-style-type: none"> <li>• Med Mgmt for Heart Failure Pts</li> <li>• Vaccines provided for Senior Living</li> <li>• PassMeds Dispensed Upon discharge</li> <li>• Insulin provided to Glendale Free Clinic</li> <li>• Drugs provided to Camp Cedar Falls Adventist Youth Camp</li> <li>• Drug purchases for Pathway to Health</li> <li>• Drugs Requested by Dr. Cunningham - Family Medicine Center</li> </ul> <p>SOS Thrift Shop</p> <ul style="list-style-type: none"> <li>• Food Bank Program</li> <li>• Court Referral Hours</li> <li>• Senior Job Training Program</li> </ul> <p>Transportation/Bus Tokens, Cab Fare, etc. –</p> <ul style="list-style-type: none"> <li>• Transportation for Behavioral health pt's to attend PHP/IOP</li> <li>• Nursing Taxi Service</li> </ul>	<ul style="list-style-type: none"> <li>• 92 indigent patients</li> <li>• 268 served</li> <li>• 180 served</li> <li>• 49 served</li> <li>• 323 served</li> <li>• 100 served</li> <li>• 100 served</li> <li>• 100 served</li> <li>• 2222 served</li> <li>• 146 hours</li> <li>• 7 served</li> <li>• 600 served at a cost of \$61,157</li> <li>• 1347 served at a cost of \$39,634</li> </ul>

Charitable Events	
<p>Glendale Fire Awards Luncheon                      Soroptimist Program                      Bras for a Cause Event                      Cancer Care Guild Laugh 4 a Cause at Alex Theatre</p>	<ul style="list-style-type: none"> <li>• 450 participants</li> <li>• 1221 participants</li> <li>• 175 participants</li> <li>• 1000 participants</li> </ul>
Community Benefit & Economic Value for Prior Year	
<ul style="list-style-type: none"> <li>• Choose Health LA</li> <li>• Tobacco Control</li> <li>• Champion for Change</li> <li>• Unihealth (Diabetes)</li> <li>• LA Care</li> <li>• Total Contributions</li> </ul>	<p>\$252,031.50</p> <p>\$97,600.00</p> <p>\$6,268.20</p> <p>\$308,655.00</p> <p>\$63,750.00</p> <p>\$728,304.70</p>



## Connecting Strategy and Community Health

As hospitals move toward population health management, community health interventions are a key element in achieving the overall goals of reducing the overall cost of health care, improving the health of the population, and improving access to affordable health services for the community both in outpatient and community settings. The key factor in improving quality and efficiency of the care hospitals provide is to include the larger community they serve as a part of their overall strategy.

Health systems must now step outside of the traditional roles of hospitals to begin to address the social, economic, and environmental conditions that contribute to poor health in the communities we serve. Bold leadership is required from our administrators, healthcare providers, and governing boards to meet the pressing health challenges we face as a nation. These challenges include a paradigm shift in how hospitals and health systems are positioning themselves and their strategies for success in a new payment environment. This will impact everyone in a community and will require shared responsibility among all stakeholders.

Population health is not just the overall health of a population but also includes the distribution of health. Overall health could be quite high if the majority of the population is relatively healthy—even though a minority of the population is much less healthy. Ideally such differences would be eliminated or at least substantially reduced.

Community health can serve as a strategic platform to improve the health outcomes of a defined group of people, concentrating on three correlated stages:

- 1) The distribution of specific health statuses and outcomes within a population;
- 2) Factors that cause the present outcomes distribution; and
- 3) Interventions that may modify the factors to improve health outcomes.

Improving population health requires effective initiatives to:

- 1) Increase the prevalence of evidence-based preventive health services and preventive health behaviors,
- 2) Improve care quality and patient safety and
- 3) Advance care coordination across the health care continuum.

Our mission as a health system is to share God's love by providing physical, mental and spiritual healing and we believe the best way to re-imagine our future business model with a major emphasis of community health is by working together with our community.



**OUR MISSION:**  
Living God's love by inspiring health,  
wholeness and hope

## Financial Assistance Policies

Glendale Adventist Medical Center and Adventist Health have an extensive charity care policy, which enables the Medical Center to provide discounted care and charity assistance for financially qualified patients. Financial counselors are available to help patients determine eligibility for charity assistance and manage medical bills. This assistance is available for both emergency and non-emergency health care.

The purpose of this policy is to enact and ensure a fair, non-discriminatory, consistent, and uniform method for the review and completion of charitable emergency and other Medically Necessary care for individuals of our community who may be in need of Financial Assistance.

More can information can be found by accessing our link,

<https://www.adventisthealth.org/glendale/pages/patients-and-visitors/financial-assistance.aspx>

## Community Benefit & Economic Value for Prior Year

Our community benefit work is rooted deep within our mission, with a recent recommitment of deep community engagement within each of our ministries.

We have also incorporated our community benefit work to be an extension of our care continuum. Our strategic investments in our community are focused on a more planned, proactive approach to community health. The basic issue of good stewardship is making optimal use of limited charitable funds. Defaulting to charity care in our emergency rooms for the most vulnerable is not consistent with our mission. An upstream and more proactive and strategic allocation of resources enables us to help low-income populations avoid preventable pain and suffering; in turn allowing the reallocation of funds to serve an increasing number of people experiencing health disparities.

### Valuation of Community Benefit

Year 2016

<b>GLENDALE ADVENTIST MEDICAL CENTER</b>		
<b>Charity Care and Other Community Benefit</b>	<b>Net Community Benefit</b>	<b>% of Total Cost</b>
Traditional charity care	8,799,039	2.20%
Medicaid and other means-tested government programs	42,683,992	10.67%
Community health improvement services	3,234,144	0.81%
Health professions education	5,591,677	1.40%
Subsidized health services	-	-
Research	-	-
Cash and in-kind contributions for community benefit	(14,242)	0.00%
Community building activities	3,797,232	0.95%
<b>TOTAL COMMUNITY BENEFIT</b>	<b>64,091,842</b>	<b>16.03%</b>
<b>Medicare</b>	<b>Net Cost</b>	<b>% of Total Cost</b>
Medicare shortfall	-	-
<b>TOTAL COMMUNITY BENEFIT WITH MEDICARE</b>	<b>64,091,842</b>	<b>16.03%</b>

## Appendices

### Glossary of terms

#### Medical Care Services (Charity Care and Un-reimbursed Medi-Cal and Other Means Tested Government Programs)

Free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are thereby deemed unable to pay for all or portion of the services. Charity Care does not include: a) bad debt or uncollectible charges that the hospital recorded as revenue but wrote-off due to failure to pay by patients, or the cost of providing care to such patients; b) the difference between the cost of care provided under Medicaid or other means-tested government programs, and the revenue derived there from; or c) contractual adjustments with any third-party payers. Clinical services are provided, despite a financial loss to the organization; measured after removing losses, and by cost associated with, Charity Care, Medicaid, and other means-tested government programs.

#### Community Health Improvement

Interventions carried out or supported and are subsidized by the health care organizations, for the express purpose of improving community health. Such services do not generate inpatient or outpatient bills, although there may be a nominal patient fee or sliding scale fee for these services.

Community Health Improvement – These activities are carried out to improve community health, extend beyond patient care activities and are usually subsidized by the health care organization. Helps fund vital health improvement activities such as free and low cost health screenings, community health education, support groups, and other community health initiatives targeting identified community needs.

*Subsidized Health Services* – Clinical and social services that meet an identified community need and are provided despite a financial loss. These services are provided because they meet an identified community need and if were not available in the area they would fall to the responsibility of government or another not-for-profit organization.

*Financial and In-Kind Contributions* – Contributions that include donations and the cost of hours donated by staff to the community while on the organization's payroll, the indirect cost of space donated to tax-exempt companies (such as for meetings), and the financial value (generally measured at cost) of donated food, equipment, and supplies. Financial and in-kind contributions are given to community organizations committed to improving community health who are not affiliated with the health system.

*Community Building Activities* – Community-building activities include interventions the social determinants of health such as poverty, homelessness, and environmental problems.



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### Health Professions Education and Research

Educational programs that result in a degree, certificate, or training that is necessary to be licensed to practice as a health professional, as required by state law; or continuing education that is necessary to retain state license or certification by a board in the individual's health profession specialty. It does not include education or training programs available exclusively to the organization's employees and medical staff, or scholarships provided to those individuals. Costs for medical residents and interns may be included.

Any study or investigation in which the goal is to generate generalized knowledge made available to the public, such as underlying biological mechanisms of health and disease; natural processes or principles affecting health or illness; evaluation of safety and efficacy of interventions for disease such as clinical trials and studies of therapeutic protocols; laboratory-based studies; epidemiology, health outcomes and effectiveness; behavioral or sociological studies related to health, delivery of care, or prevention; studies related to changes in the health care delivery system; and communication of findings and observations (including publication in a medical journal)

# Community Health Needs Assessment and Community Health Plan Coordination Policy

**Entity:**

- System-wide Corporate Policy**
- Standard Policy**
- Model Policy**

**Corporate Policy**  
**Department:**  
**Category/Section:**  
**Manual:**

**No. AD-04-006-S**  
**Administrative Services**  
**Planning**  
**Policy/Procedure Manual**

**POLICY SUMMARY/INTENT:**

This policy is to clarify the general requirements, processes and procedures to be followed by each Adventist Health hospital. Adventist Health promotes effective, sustainable community benefit programming in support of our mission and tax-exempt status.

**DEFINITIONS**

1. **Community Health Needs Assessment (CHNA):** A CHNA is a dynamic and ongoing process that is undertaken to identify the health strengths and needs of the respective community of each Adventist Health hospital. The CHNA will include a two document process, the first being a detailed document highlighting the health related data within each hospital community and the second document (Community Health Plan or CHP) containing the identified health priorities and action plans aimed at improving the identified needs and health status of that community.

A CHNA relies on the collection and analysis of health data relevant to each hospital's community, the identification of priorities and resultant objectives and the development of measurable action steps that will enable the objectives to be measured and tracked over time.

2. **Community Health Plan:** The CHP is the second component of the CHNA and represents the response to the data collection process and identified priority areas. For each health need, the CHP must either: a) describe how the hospital plans to meet the identified health need, or b) identify the health need as one the hospital does not intend to specifically address and provide an explanation as to why the hospital does not intend to address that health need.
3. **Community Benefit:** A community benefit is a program, activity or other intervention that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of these objectives:
  - Improve access to health care services
  - Enhance the health of the community
  - Advance medical or health care knowledge
  - Relieve or reduce the burden of government or other community efforts

Community benefits include charity care and the unreimbursed costs of Medicaid and other means-tested government programs for the indigent, as well as health professions' education, research, community health improvement, subsidized health services and cash and in-kind contributions for community benefit.

**AFFECTED DEPARTMENTS/SERVICES:**

Adventist Health hospitals

## **POLICY: COMPLIANCE – KEY ELEMENTS**

### **PURPOSE:**

The provision of community benefit is central to Adventist Health's mission of service and compassion. Restoring and promoting the health and quality of life of those in the communities served, is a function of our mission "To share God's love by providing physical, mental and spiritual healing." The purpose of this policy is: a) to establish a system to capture and report the costs of services provided to the underprivileged and broader community; b) to clarify community benefit management roles; c) to standardize planning and reporting procedures; and d) to assure the effective coordination of community benefit planning and reporting in Adventist Health hospitals. As a charitable organization, Adventist Health will, at all times, meet the requirements to qualify for federal income tax exemption under Internal Revenue Code (IRC) §501(c)(3). The purpose of this document is to:

1. Set forth Adventist Health's policy on compliance with IRC §501(r) and the Patient Protection and Affordable Care Act with respect to CHNAs;
2. Set forth Adventist Health's policy on compliance with California (SB 697), Oregon (HB 3290), Washington (HB 2431) and Hawaii State legislation on community benefit;
3. Ensure the standardization and institutionalization of Adventist Health's community benefit practices with all Adventist Health hospitals; and
4. Describe the core principles that Adventist Health uses to ensure a strategic approach to community benefit program planning, implementation and evaluation.

### **A. General Requirements**

1. Each licensed Adventist Health hospital will conduct a CHNA and adopt an implementation strategy to meet the community health needs identified through such assessment.
2. The Adventist Health *Community Health Planning & Reporting Guidelines* will be the standard for CHNAs and CHPs in all Adventist Health hospitals.
3. Accordingly, the CHNA and associated implementation strategy (also called the Community Health Plan) will initially be performed and completed in the calendar year ending December 31, 2013, with implementation to begin in 2014.
4. Thereafter, a CHNA and implementation strategy will be conducted and adopted within every succeeding three-year time period. Each successive three-year period will be known as the Assessment Period.
5. Adventist Health will comply with federal and state mandates in the reporting of community benefit costs and will provide a yearly report on system wide community benefit performance to board of directors. Adventist Health will issue and disseminate to diverse community stakeholders an annual web-based system wide report on its community benefit initiatives and performance.
6. The financial summary of the community benefit report will be approved by the hospital's chief financial officer.
7. The Adventist Health budget & reimbursement department will monitor community benefit data gathering and reporting for Adventist Health hospitals.

### **B. Documentation of Public Community Health Needs Assessment (CHNA)**

1. Adventist Health will implement the use of the Lyon Software CBISA™ product as a tool to uniformly track community benefit costs to be used for consistent state and federal reporting.

2. A written public record of the CHNA process and its outcomes will be created and made available to key stakeholders in the community and to the general public. The written public report must include:
  - a. A description of the hospital's community and how it was determined.
  - b. The process and methods used to conduct the assessment.
  - c. How the hospital took into account input from persons who represent the broad interests of the community served.
  - d. All of the community health needs identified through the CHNA and their priorities, as well as a description of the process and criteria used in the prioritization.
  - e. Existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.
3. The CHNA and CHP will be submitted to the Adventist Health corporate office for approval by the board of directors. Each hospital will also review their CHNA and CHP with the local governing board. The Adventist Health government relations department will monitor hospital progress on the CHNA and CHP development and reporting. Helpful information (such as schedule deadlines) will be communicated to the hospitals' community benefit managers, with copies of such materials sent to hospital CFOs to ensure effective communication. In addition, specific communications will occur with individual hospitals as required.
4. The CHNA and CHP will be made available to the public and must be posted on each hospital's website so that it is readily accessible to the public. The CHNA must remain posted on the hospital's website until two subsequent CHNA documents have been posted. Adventist Health hospitals may also provide copies of the CHNA to community groups who may be interested in the findings (e.g., county or state health departments, community organizations, etc.).
5. For California hospitals, the CHPs will be compiled and submitted to OSHPD by the Adventist Health government relations department. Hospitals in other states will submit their plans as required by their state.
6. Financial assistance policies for each hospital must be available on each hospital's website and readily available to the public.

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**Corporate Initiated Policies: (For corporate office use)**

**References:** Replaces Policy: AD-04-002-S  
**Author:** Administration  
**Approved:** SMT 12-9-2013, AH Board 12-16-2013  
**Review Date:**  
**Revision Date:**  
**Attachments:**  
**Distribution:** AHEC, CFOs, PCEs, Hospital VPs, Corporate AVPs and Directors





## 2017 Community Health Plan

This community health plan was adopted on April 20, 2017, by the Adventist Health System/West Board of Directors. The final report was made widely available on May 15, 2017.

### **CHNA/CHP contact:**

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Director of Community Services

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Request a copy, provide comments or view electronic copies of current and previous community health needs assessments: <https://www.adventisthealth.org/pages/about-us/community-health-needs-assessments.aspx>