ADVENTIST HEALTH GLENDALE

2022 COMMUNITY HEALTH IMPLEMENTATION STRATEGY

APPROVED APRIL 27, 2023

Adventist Health
Glendale

2022

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Purpose & Summary

Non-profit health systems, community-based organizations, and public health agencies across the country all share a similar calling: to provide public service to help improve the lives of their community. To live out this calling and responsibility, Adventist Health Glendale conducts a Community Health Needs Assessment (CHNA) every three years, with our most recent report completed in 2022. Now that our communities' voices, stories, and priority areas are reflected in the CHNA, our next step is to complete a Community Health Improvement Plan (CHIP), or as we refer to it in this report, a Community Health Implementation Strategy (CHIS).

The CHIS consists of a long-term community health improvement plan that strategically implements solutions and programs to address our health needs identified in the CHNA. Together with the Adventist Health Well-Being team, local public health officials, community-based organizations, medical providers, students, parents, and members of selected underserved, low-income, and minority populations, Adventist Health Glendale intentionally developed a strategic plan to address the needs of our community.

In this CHIS, you will find strategies, tactics, and partnerships that address the following health needs identified in the 2022 Adventist Health Glendale CHNA:

Access to Care

Health Conditions

Mental Health

We hope this report is leveraged by all local partners and community members, empowering them to own the potential of healthy living for all. This report was reviewed and approved by our Hospital Board as well as the Adventist Health System Board on April 27, 2023. The entire report is published online and available in print form by contacting community.benefit@ah.org.

What if . . .

It's not a prescription that changes your health?

Instead, it's a collaboration between you and your care providers?

And it's community-based organizations working together to support you?

Getting to know our Glendale CHNA service area*

Although largely known by its adjacent 'City of Angels' neighborhood, Glendale is its own unique community with shops, family-owned businesses, scenic Forest Lawn Memorial Park treks, and endless varieties of culturally diverse restaurants including well-known and local favorite Cuban bakery, Porto's.

The Glendale Hospital community is home to 314,658 residents and reflects a diverse culture with 33.08% being Hispanic, and the largest age group being 25-34.

The median household income is $72,109 of which 47.77% is spent on housing and transportation. Among this population, 16.74% of children live in poverty and 5.16% of students are unhoused, compared to the state average of 4.25% and national average of 2.77%.

For a more detailed look into community member comments, facts and numbers that are captured in the CHNA, please visit adventisthealth.org/about-us/community-benefit. The following pages provide a closer look into our community demographic as well as our approach to the CHIS.

This service area represents Adventist Health Glendale's primary service areas (PSA), accounting for 75% of hospital discharges. Additionally, we took a collaborative approach and expanded our PSA by inviting Steering Committee members to include the zip codes of those they serve, creating the Glendale CHNA service area.

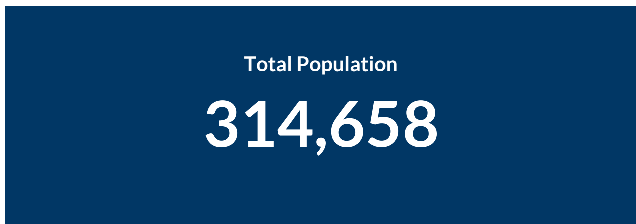
What if our community worked together and made life all-around better? What if we offered various pathways to meet our diverse needs, so every member of our community experienced better health, prosperity and longevity?

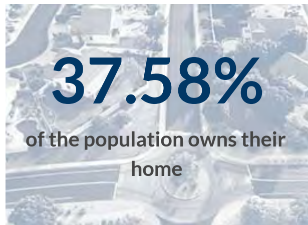
Who We Serve

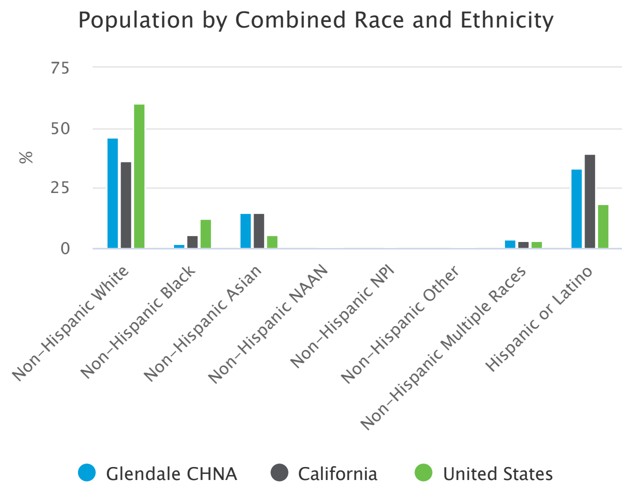
DEMOGRAPHIC PROFILE

The following zip codes represent Adventist Health Glendale's primary service area (PSA), accounting for 75% of hospital discharges. Additionally, we took a collaborative approach and expanded our PSA by inviting Steering Committee members to include the zip codes of those they serve.

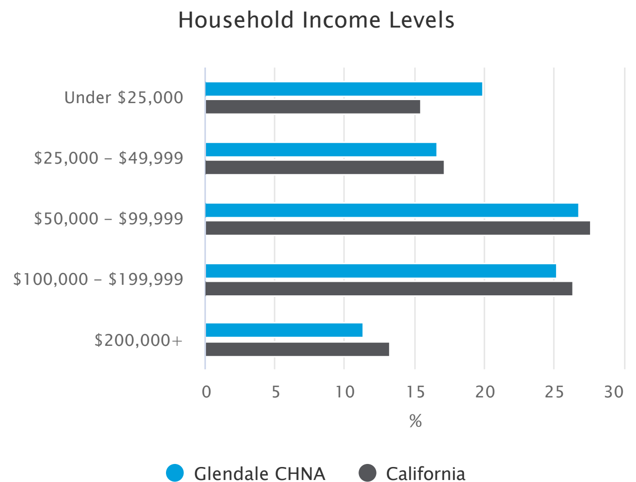
The Adventist Health Glendale CHNA market has a total population of 314,658 (based on the 2020 Decennial Census). The largest city in the service area is Glendale, with a population of 191,761. The service area is comprised of the following zip codes: 91020, 91201, 91206, 91203, 91205, 90065, 91207, 90041, 91204, 90042,91208, 91202.

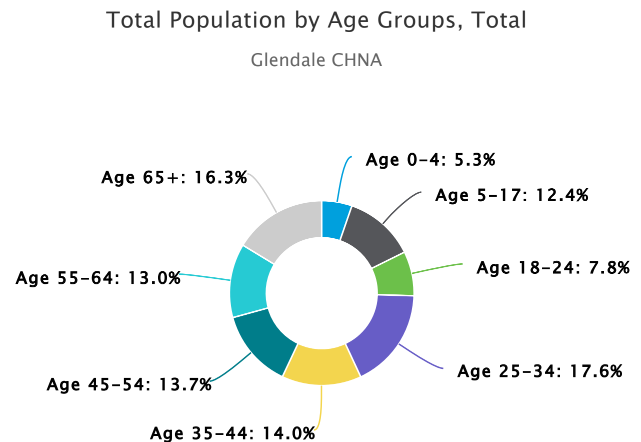






Note: NAAN = Native American or Alaska Native, NPI = Native Hawaiian or Pacific Islander.





About Us

Adventist Health Glendale

Located in the center of beautiful mountain ranges, Adventist Health Glendale is a 515-bed medical center and acts as an active and devoted leader in promoting a healthy lifestyle and the highest quality of medical care. Key services include our heart and vascular institute, neurology institute, spine institute and more. We are proud to serve a section of Los Angeles County.

Adventist Health

Adventist Health is a faith-inspired, nonprofit integrated health system serving more than 80 communities on the West Coast and Hawaii. Founded on Adventist heritage and values, Adventist Health provides care in hospitals, clinics, home care agencies, hospice agencies and joint-venture retirement centers in both rural and urban communities. Our compassionate and talented team of 34,000 includes associates, medical staff physicians, allied health professionals and volunteers driven in pursuit of one mission: living God's love by inspiring health, wholeness and hope. Together, we are transforming the American healthcare experience with an innovative, yet timeless, whole-person focus on physical, mental, spiritual and social healing to support community well-being.

Adventist Health's Approach to CHNA & CHIS

Adventist Health prioritizes well-being in the communities we serve across our system. We use an intentional, community centered approach when creating our hospital CHNA's to understand the health needs of each community. After the completion of the community assessment process, we address health needs such as mental health, access to care, health risk behaviors, and others through the creation and execution of a Community Health Implementation Strategy (CHIS) for each of our hospitals and their communities.

The following pages highlight the key findings the Adventist Health Glendale CHNA Steering Committee (see page 18 for a list of CHNA Steering Committee sector participants) identified as their top priority health needs, or as we refer to them in this report, their 'High Priority Needs'. The High Priority Needs are addressed in this Community Health Implementation Strategy.

High Priority Needs

The following pages highlight the High Priority Needs that will be addressed in this Community Health Implementation Strategy.

Access to Care

COMMUNITY VOICES

- People with inadequate insurance and who don't speak English as a first language struggle to access good quality care, interviewees noted.
- Residents will forgo some medical care if they can't afford it, with dental visits being one cited example.
- There is a strong desire by interviewees to ensure equal care regardless of insurance status.
- Community leaders said the inadequate number of providers makes it difficult for everyone to get appointments.
- Inconsistent access to care leads to chronic diseases becoming major medical problems, in the eyes of some.

Glendale offers the chance to explore local events and fun family activities. But day-to-day, the area's families have a very different perspective, facing challenges from finances to health to overall well-being.

Residents face numerous barriers to accessing health care when needed. Glendale has a limited number of mental health providers, about half that of California and the US, and 7.9% of the population is uninsured.

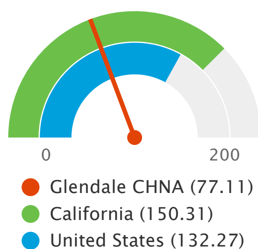
The number of adults in Glendale without a high school diploma (14.85%) is above that of the US (11.47%). Of children ages five and older, 28.57 percent of the population have limited English proficiency, creating barriers to healthcare access, provider communication and health literacy/education. This rate is significantly higher than that of California (17.41%) and the US (8.25%).

Residents provided input, noting the need for translation services and improved transit access, and frustration with the complicated rules of insurance and legal status.

Community voices have been heard. The challenge now is to take the next steps and move forward with new vision and new confidence.

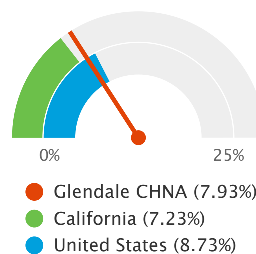
SECONDARY DATA INFOGRAPHIC STATS:

Mental Health Care Providers, Rate per 100,000 Population



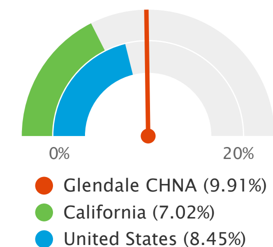
- Glendale CHNA (77.11)
- California (150.31)
- United States (132.27)

Uninsured Population, Percent



- Glendale CHNA (7.93%)
- California (7.23%)
- United States (8.73%)

Percentage of Households with No Motor Vehicle



- Glendale CHNA (9.91%)
- California (7.02%)
- United States (8.45%)

Health Conditions

COMMUNITY VOICES

- Poor health and dietary choices, often driven by expense, are seen as major contributors to health problems, noted community members.
- Social isolation, driven by COVID, has led some to avoid medical care, which will likely have long-term consequences. This was a concern expressed by community leaders.
- People reported increased consumption of processed foods, resulting in higher incidences of cardiac cases and diabetes.
- Increased rates of substance abuse are seen as drivers of poor health.

Glendale faces challenges, as residents struggle with poor food choices and chronic conditions are seen as major contributors to health concerns.

Residents shared concerns, including a focus on affordable fast food that can lead to diabetes, high cholesterol and higher incidences of cardiac cases. It was also shared that residents dealing with social isolation, driven by COVID, have avoided care, resulting in long-term consequences.

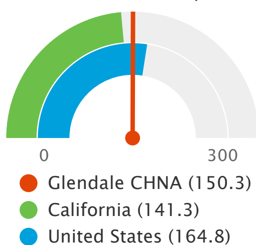
The death rate from health disease and stroke is 150.3 per 100k people. The percentage of adults with cancer (5.8%) is slightly elevated as well, from that of California (5.5%). The percentage of Medicare beneficiaries with Alzheimer's disease is 14.6%, which is higher than the California rate (10.5%) and the nation (10.8%).

Postponing care, and specialty care shortages, can mean some residents will be more ill when they begin treatment than they may have been otherwise. School closures limit sports participation, which can impact students' quality of life.

Yet, despite these genuine concerns, residents are eager to roll up their sleeves and find solutions to reduce the health conditions in their community. Together with the community, we can tackle these issues to ensure a future full of health, wholeness and hope.

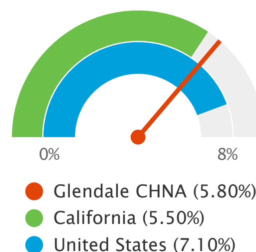
SECONDARY DATA INFOGRAPHIC STATS:

Heart Disease Mortality, Age-Adjusted Death Rate (Per 100,000 Pop.)



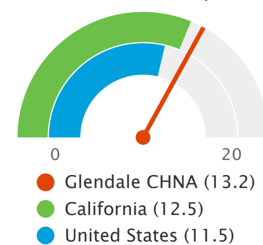
- Glendale CHNA (150.3)
- California (141.3)
- United States (164.8)

Percentage of Adults with Cancer



- Glendale CHNA (5.80%)
- California (5.50%)
- United States (7.10%)

Liver Disease Mortality, Age-Adjusted Death Rate (Per 100,000 Pop.)



- Glendale CHNA (13.2)
- California (12.5)
- United States (11.5)

Mental Health

COMMUNITY VOICES

- The limited socialization caused by COVID is seen as a driver of depression, especially in youth, per focus group participants.
- There are worries that housing instability and the high cost of living increases anxiety levels for many.
- Mental health services are seen as stigmatized, causing some not to seek services.
- Mental health issues are seen as taboo in some cultures, leading to less access to care.
- Teen mental health is seen as a large and growing problem.
- There is a deficiency in the number of mental health providers that are accessible for those who are uninsured or underinsured, an interviewee indicated.

Helpful research is opening doors on how to address mental health among residents of all ages.

Residents shared concerns regarding teen mental health; a growing problem made more concerning by the depression and isolation created by COVID. Overall, inadequate mental health care is seen as a major problem. The older adult population is another area of concern, due to the shortage of physical and mental health care.

Many residents receiving services are stigmatized, which causes some to avoid seeking care. Insurance status affects the ability to get mental health care and shortages of providers prevent residents from receiving needed care.

A survey indicated that 48 percent of residents feel their top health concern and their top concern overall is mental health. Access to mental health care providers is limited, with 77.11 mental health providers per 100k people, which is significantly less than the rate in California (150.31) and in the US (132.27). The violent crime rate is 488.3 per 100k people, higher than that of California (419.4) and the US (385.6).

With commitment, numbers can be replaced with healing and hope.

SECONDARY DATA INFOGRAPHIC STATS:

Violent Crime Rate

Report Area	Violent Crimes	Violent Crime Rate (Per 100,000 Pop.)
Glendale CHNA	1,556	**488.3**
Los Angeles County, CA	49,549	488.3
California	327,327	419.4
United States	2,445,671	385.6

Mental Health Care Providers, Rate per 100,000 Population

Report Area	Total Population (2020)	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
Glendale CHNA	314,462	36	242	**77.11**
Los Angeles County, CA	10,014,009	1,493	13,419	134.00
California	39,538,223	5,078	59,430	150.31
United States	334,735,155	56,424	442,757	132.27

Action Plan for Addressing High Priority Needs

Committee members drew upon a broad spectrum of expertise and possible strategies to improve the health and well-being of vulnerable populations within the community.

The following pages reflect the goals, strategies, actions, and resources identified to address each selected High Priority Need.

ADDRESSING HIGH PRIORITY: ACCESS TO CARE

GOAL	Increase the availability and placement of individuals and families with primary care providers.

Priority Area:	Access to Care	Sub-Category:	Availability	Defining Metric:	Primary Care Providers

Strategy:	Recruit, prepare, and place physician residents into family/primary care practice within the service area.
Population Served:	All residents of Glendale and surrounding communities
Internal Partners:	Director of Family Medicine Residency Program, Network Administrative Director
External Partners:	Glendale School District, City of Glendale, YMCA

Actions: Program/Activity/Tactic/Policy	**Organization**	**Lead**
Adventist Health Family Medicine Residency Program — training physician residents to specialize in family practice and serve in the Glendale community after completion. Training takes place in a range of locations both within and outside of the health system.	Adventist Health - Family Medicine Residency	Dr. Sirvard Khanoyan
	Glendale School District	Dr. Vivian Ekchian
	Adventist Health - Clinics	John Warda
	YMCA	George Saikali

YEAR ONE	YEAR TWO	YEAR THREE
Number of residents enrolled in program.	Number of residents that completed program.	Number of residents practicing in service area.

ADDRESSING HIGH PRIORITY: HEALTH CONDITIONS

GOAL	Reduce the rate of heart disease, related conditions, and risk factors.

Priority Area:	Health Conditions	Sub-Category:	Heart Disease & Stroke	Defining Metric:	Heart Disease and Related

Strategy:	Offer a range of education, screening, healthy lifestyle, condition management, and preventive services in the service area.
Population Served:	Residents of service area ages 18 to 55 years
Internal Partners:	Director of Finance, Director of HIM, Mobile Clinic Manager & Patient Registration Manager
External Partners:	Public Health, United Way, Ombudsman Society, Alliance on Aging & Food Bank

Actions: Program/Activity/Tactic/Policy	**Organization**	**Lead**
Go Heart Wellness Program — a free, community-based program offered by Adventist Health Glendale and a range of community partners. Includes a variety of fitness, nutrition, education, and other activities, through a range of events; with the intention of connecting individuals to local services for their ongoing needs.	Adventist Health - Go Heart	Monica Percich
	City of Glendale	Owning Bulanikian
	YMCA	George Saikali
	Local wellness businesses	Various

YEAR ONE	YEAR TWO	YEAR THREE
Program engagement, including enrollment, event attendance, and digital outreach.	Resource utilization, including wellness services and activities offered by local organizations.	Rates of clinical events and risk factors.

ADDRESSING HIGH PRIORITY: MENTAL HEALTH

GOAL	Improve mental health awareness, access to resources, and outcomes for different populations and needs.

Priority Area:	Mental Health	Sub-Category:	Risk Factors & Health Outcomes	Defining Metric:	Mental Health Status

Strategy 1:	Enhance student awareness and access by supporting school wellness centers, implementing a communications and engagement strategy, and connections to resources and services.
Population Served:	Middle and high school students in Glendale Unified School District
Internal Partners:	Behavioral Health Unit (BHU) Social Work Manager, VP of Foundation, Director of Family Medicine Residency
External Partners:	Glendale School District, Glendale Healthier Communities Coalition, National Alliance on Mental Illness (NAMI) Glendale

Actions: Program/Activity/Tactic/Policy	**Organization**	**Lead**
A partnership with Glendale Unified School District, which uses multiple forms of navigation to a) build awareness about mental health, and b) connect students to appropriate resources for their needs. The objectives are to improve student mental health knowledge, attitudes, experiences, and outcomes.	Adventist Health - BHU	Dr. Mya Little
	Adventist Health - Foundation	Louise Skosey
	Glendale School District	Dr. Vivian Ekchian
	Glendale Health Coalition	Vince Lucalano
	Family Medicine Residency	Dr. Sirvad Khonoyan
	NAMI Glendale	Jason Romero

YEAR ONE	YEAR TWO	YEAR THREE
Understand and report on knowledge and attitudes, as measured by standardized questionnaires.	Resource utilization, including event attendance, wellness center and counselor visits, and external services.	Health status and related factors: clinical conditions, risk behaviors, disciplinary actions, experiences.

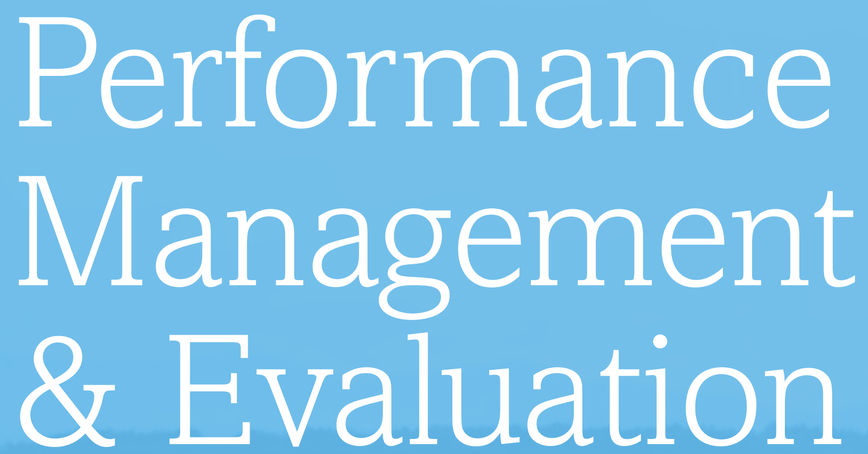
[ADVENTISTHEALTH:INTERNAL]

Strategy 2:	Homelessness/Housing Navigation program in Behavioral Health Unit.
Population Served:	Patients experiencing homelessness with serious mental illness.
Internal Partners:	BHU Social Work Manager, ED Substance Use Navigator
External Partners:	Ascencia, City of Glendale, National Health Foundation, Tarzana Treatment Center

Actions: Program(s)/Activity/Tactic/Policy	**Organization**	**Lead**
Care managers work with individual patients to assess their situations and connect them with a continuum of various community resources which best fit their specific needs.	Adventist Health - BHU	Dr. Mya Little
	Adventist Health - ED	Oscar Mendoza
	Ascencia	Tiffany Barrios
	City of Glendale	Arsine Isayan
	National Health Foundation	Marlene Smith
	Tarzana Treatment Center	Monica Davoodpour

YEAR ONE	YEAR TWO	YEAR THREE
Number of patients/clients enrolled in program.	Number places in temporary or permanent housing at hospital discharge.	Number remaining in housing at 60+ days after discharge.

[ADVENTISTHEALTH:INTERNAL]



We value the importance of measuring and evaluating the impact of our community programs.

Performance Management & Evaluation

Adventist Health will support the High Priority Need action plans identified in this CHIS by monitoring progress on an ongoing basis and adjusting the approach as needed over the course of the next three years. There are several resources in place to aid in this. All CHIS programs and initiatives will include a completed logic model to identify intended activities, outputs, and short and long-term outcomes. Establishing core metrics for each program or initiative will allow for the ongoing collection of performance management data. Actively tracking metric performance leads to the identification of strengths and challenges to the work, the local hospital, the Adventist Health Community Benefit team, and external consultants. Together, we will work to share successes and create performance improvement plans when necessary.

In addition, Adventist Health hospitals where High Priority Needs are shared will have the opportunity to join a collaborative held by the Adventist Health Well-Being team. The collaborative will be centered on building a common approach that aligns and maximizes community benefit, thus reducing the need to manage this work independently at each hospital. Along with that, where appropriate, evaluation activities designed to measure the overall strength and success of this work at the community level will be incorporated into performance management tracking.

CHIS Development

The development of the CHIS was directly built from the CHNA, whose goal focused on leveraging community stakeholders and data to address the most significant health needs of our community over the next three years. Members of the CHNA Steering Committee—comprised of healthcare, civic, public, and business leaders—led the process of identifying and addressing health needs for a healthier community, completing the final report in fall of 2022.

Collaborating with CHNA Steering Committee members again in early 2023, Adventist Health Community Well-Being Directors facilitated a multi-step process to outline goals and strategies for the CHIS that foster change and positive impact in each of the High Priority Need areas. Each community relied on existing programs and services, and, where necessary, identified new opportunities to pursue collectively.

Once an approach received a consensus, the Community Well-Being Directors worked with Adventist Health leadership and expert consultants to set major annual milestones for each approach, generating outputs and outcomes that allow for ongoing performance management of this work. For further information on how success will be tracked, refer to the Performance Management and Evaluation section above.

Finally, the CHIS was presented to Adventist Health local Hospital Boards for review and feedback. In addition to this collaborative effort, we also welcome feedback at community.benefit@ah.org.

Scan the QR code for the full Secondary Data Report

Significant Identified Health Needs

The Adventist Health Community Well-Being team and community partners collectively reviewed all relevant significant health needs identified through the CHNA process. Using a community health framework developed for this purpose, 12 significant health needs were initially considered. The list of significant needs are as follows:

- Access to Care
- Community Safety
- Community Vitality
- Education
- Environment & Infrastructure
- Financial Stability
- Food Security
- Health Conditions
- Health Risk Behaviors
- Housing
- Inclusion & Equity
- Mental Health

From this group of 12, several high priority health needs were established for Adventist Health Glendale. High priority health needs were chosen as they had demonstrated the greatest need based on severity and prevalence, intentional alignment around common goals, feasibility of potential interventions, and opportunities to maximize available resources over a three-year period.

Using the criteria mentioned above, we were able to determine which needs were high priority, as compared to those that were significant needs. The High Priority Needs are the focus of this CHIS. The remaining significant health needs are not addressed directly but will likely benefit from the collective efforts defined in this report. The following table provides additional information on all the significant health needs that were considered.

TABLE OF SIGNIFICANT IDENTIFIED HEALTH NEEDS

High Priority Needs	
Access to Care	**See Sections III.C - E**
Financial Stability	**See Sections III.C - E**
Housing	**See Sections III.C - E**
Lower Priority Needs	
Community Safety 211info.org/get-help/employment/	This community has higher rates of unemployed and out-of-school youth aged 16-19 than the state or the US, major vehicle crash mortality, and injury mortality.
Housing-Unhoused 211info.org/get-help/housing-shelter/	The limited number of available housing units and the overall high cost of living are critical drivers to homeless. 57% of those surveyed identified homelessness as a health need in the community.
Health Risk Behaviors 211info.org/get-help/mental-behavioral-health/	This community has higher rates of adulting smoking, teen birth rates, and low birthweight births than the rest of the state. There are concerns among interviewees that illicit drug use is a pervasive problem as well.
Health Conditions 211info.org/get-help/health-care/	The prevalence rates of diabetes, heart disease, and cancer are higher than the state average. Similarly, mortality rates for liver and lung disease are also elevated compared to Oregon as a whole.
Education 211info.org/get-help/education/	Difficulty recruiting and retaining teachers, coupled with limited afterschool options, hamper educational opportunities for students. Adequate and reasonably priced childcare access is also a problem for many families.
COVID 211info.org/get-help/health-care/	Around 60% of those surveyed identified COVID as a community health need.
Environment & Infrastructure 211info.org/get-help/transportation/	With limited public transportation in a rural area it is often difficult for many to access needed services. Land use also affects housing and recreational opportunities.
Mental Health 211info.org/get-help/mental-behavioral-health/	The need for mental health services has grown during COVID while the number of providers and the overall range of services has either been reduced or not matched the expanded need. Around 60% of those surveyed consider mental health a community health need.

Scan the QR code for the full Secondary Data Report

Community Health Financial Assistance for Medically Necessary Care Commitment

Adventist Health understands that community members may experience barriers in paying for the care they need. That is why we are committed to providing financial assistance to those who may need support in paying their medical expense(s).

Community members can find out if they qualify for financial aid in paying medical bills by completing a financial assistance application. Applications can be filled out at the time care is received or after the bill has been administered. To access the financial assistance policy for more information or contact a financial assistant counselor, please visit https://www.adventisthealth.org/patient-resources/financial-services/financial-assistance/.

Glossary of Terms

COMMUNITY ASSET

refers to community organizations, programs, policies, activities or tactics that improves the quality of community life.

DEFINING METRIC

this is the metric used to define the extent of the problem faced by the target population.

FUNDING

can be provided by (but not limited to) government agencies, public organizations, grants and philanthropic giving.

GOAL

there may be several overarching goals to address each prioritized health need. This is the overarching impact we want to achieve.

PARTNERS

describe any planned collaboration between the hospital and other facilities or organizations in addressing health needs.

POPULATION SERVED

who is included within the group to receive services of the program.

PRIORITIZED HEALTH NEED/ PRIORITY AREA/SIGNIFICANT HEALTH NEEDS

a health need that was identified in a community health needs assessment and was then selected by committee as a high priority need to be addressed.

STAKEHOLDER- INTERNAL

colleagues and or board members who work for or with the hospital.

STAKEHOLDER- EXTERNAL

community members or organizations who regularly collaborate with the hospital.

STRATEGY

a specific action plan designed to achieve the expected outcome.

SUB-CATEGORY

if needed, a more granular focus within the identified priority area may be called out.

Approval Page

2023 CHIS Approval

In response to the 2022 Community Health Needs Assessment, this Community Health Implementation Strategy was adopted on April 27, 2023 by the Adventist Health System/West Board of Directors.

The final report was made widely available on May 31, 2023.

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Thank you for reviewing our 2023 Community Health Implementation Strategy.
We are proud to serve our local community and are committed to making it a healthier place for all.

Alice Issai, MBA
Adventist Health Glendale

Adventist Health
Glendale