Northridge Hospital Medical Center

Community Benefit 2023 Report and 2024 Plan

Adopted November 2023

Dignity Health.
Northridge Hospital
Medical Center

A message from

Paul Watkins, President and CEO of Dignity Health Northridge Hospital Medical Center, and Daren Schlecter, Chair of the Dignity Health Northridge Hospital Community Board.

Dignity Health's approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments that we conduct with community input, including from the local public health department. Our initiatives to deliver community benefit include financial assistance for those unable to afford medically necessary care, a range of prevention and health improvement programs conducted by the hospital and with community partners, and investing in efforts that address social determinants of health.

Northridge Hospital shares a commitment with others to improve the health of our community and delivers programs and services to help achieve that goal. The Community Benefit 2023 Report and 2024 Plan describe much of this work. This report meets requirements in California (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. Dignity Health hospitals in Arizona and Nevada also voluntarily produce these reports and plans. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and we are pleased to report to our community.

In fiscal year 2023 (FY23), Northridge Hospital provided $53,559,686 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, and other community benefits. The hospital also incurred $13,644,533 in unreimbursed costs of caring for patients covered by Medicare fee-for-service.

The hospital's Community Board reviewed, approved, and adopted the Community Benefit 2023 Report and 2024 Plan at its November 14, 2023 meeting.

Thank you for taking the time to review our report and plan. We welcome any questions or ideas for collaborating that you may have, by reaching out to Joni Novosel, Director of Community Health 818-718-5936 or joni.novosel@commonspirit.org.

Paul Watkins
President CEO

Daren Schlecter
Chair, Community Board of Directors

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At-a-Glance Summary

Community Served	Northridge Hospital's service area is located in Service Planning Area 2 of Los Angeles County, which consists of the San Fernando and Santa Clarita Valleys. Our service area is home to over 1.5 million residents of multiple cultures and ethnic backgrounds. The total land area is 368.91 miles with a population density of 4,270.95 people per square mile.
Economic Value of Community Benefit	$53,559,686 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants, and other community benefits $13,644,533 in unreimbursed costs of caring for patients covered by Medicare fee-for-service
Significant Community Health Needs Being Addressed	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). The needs being addressed by strategies and programs are: 1 Mental Health 2 Substance Abuse 3 Diabetes 4 Oral Health 5 Access to Healthcare Services 6 Nutrition, Physical Activity & Weight 7 Respiratory Disease (COVID 19) 8 Heart Disease & Stroke 9 Violence Prevention
FY23 Programs and Services	The hospital delivered several programs and services to help address identified significant community health needs. These included: 1. Mental Health – Educate those working with youth and their parents on Question, Persuade, Refer (QPR) and Mental Health First Aid Youth. This will support two programs the Mental Health Awareness Program and the Cultural Trauma Mental Health Resiliency Program. Use Positive Action an evidence-based curriculum to foster social-emotional learning and develop a positive self-concept. 2. Substance Abuse – Continue the Medicated Assisted Treatment (MAT) program which helps patients with substance abuse disorder in the Emergency Department. A Social Worker/Substance Use Navigator (SUN) performs a psychosocial assessment, counseling, and connects patients to treatment facilities. 3. Diabetes – Our Prevention Forward program focuses on providing evidence-based diabetes and pre-diabetes self-management sessions we built the capacity of 2 local pharmacies to become ADA recognized. 4. Oral Health – Staff provided ongoing Oral Health promotion and prevention articles through articles in the LAUSD school-based newsletter to better support oral health. Additionally, we invited local dental service providers to attend the community health promotion events. 5. Access to Healthcare Services – Continued financial assistance for the uninsured and underinsured, continuation of providing access to recuperative care for those who are unhoused. 6. Nutrition, Physical Activity, & Weight - Community and School Wellness Initiative program is designed to improve health and wellness with a focus on nutrition, physical activity promotion, obesity, and chronic disease management through on-site workshops and classroom lessons. 7. Respiratory disease (COVID-19) Continue working with our partners to provide education, PPE items such as hand sanitizer, masks, COVID-19 test kits, and pop-up vaccine clinics at multiple community sites.

	8. Heart disease and stroke- Partner with the CA Department of Public Health Prevention Forward Program to provide evidence-based Self-Management Blood Pressure workshops to increase hypertension self-management skills. 9. Violence prevention – Continued multiple projects that focused on violence prevention including the BJA STOP school violence program focuses on preventing school violence. Our Center for Assault Treatment Services (CATS) provides services to child and adult victims of sexual assault, domestic/partner violence and child maltreatment. Our Local Elder Abuse Prevention Enhanced Multidisciplinary Team (LEAP E-MDT) focuses on age 60 and older victims of sexual, physical, emotional, neglect, self-neglect and financial abuse.
FY24 Planned Programs and Services	1. Mental Health – In 2024 we will continue to provide the Mental Health Awareness Program and the Cultural Trauma Mental Health Resiliency Program. Additionally, the Stop School Violence Program continues to use Positive Action to foster social-emotional learning and develop a positive self-concept at Los Angeles Unified District middle and high school sites. 2. Substance Abuse – Continue the Medicated Assisted Treatment (MAT) program in the Emergency Department. A Social Worker/Substance Use Navigator (SUN) performs a psychosocial assessment, counseling, and connects patients to treatment facilities for additional care. 3. Diabetes – Continue to provide evidence-based diabetes and pre-diabetes self-management. Conduct National Diabetes Prevention Program (NDPP) and the ADCES Diabetes Care and Education. 4. Oral Health – Continue Oral Health promotion and prevention articles in the LAUSD school-based newsletter 5. Access to Healthcare Services – Continue financial assistance for the uninsured and underinsured, continuing to provide access to recuperative care for those who are unhoused. Provide pop-up vaccine clinics for free Monkeypox to help alleviate health disparities in the LGBTQI+ community. 6. Nutrition, Physical Activity, & Weight – Continue to provide nutrition, physical activity promotion, obesity, and chronic disease management through on-site workshops. 7. Respiratory disease (COVID-19) Continue working with our partners to provide education, PPE items such as hand sanitizer, masks, COVID-19 test kits, and pop-up vaccine clinics at multiple community sites. 8. Heart disease and stroke- Provide Self-Management Blood Pressure workshops to increase hypertension self-management skills of community residents and organizations to increase referrals and enrollment in lifestyle change programs. 9. Violence prevention – Continue the BJA STOP school violence program, Center for Assault Treatment Services program, and LEAP E-MDT focusing on elder abuse. Additionally, in 2024 we will be working on a United Against Violence Action plan which will include conducting community based surveys, focus groups, and outreach events to gather the community voice for violence prevention programs and strategies to reduce community and individual violence.

This document is publicly available online at http://www.dignityhealth.org/northridgehospital/who-we-are/community-benefit-reports

Written comments on this report can be submitted to the Northridge Hospital Center for Healthier Communities at 8210 Etiwanda Ave, Reseda, CA 91335, or by e-mail to CHNA.NorthridgeHospital@DignityHealth.org.

Our Hospital and the Community Served

About Northridge Hospital

Northridge Hospital is a member of Dignity Health, which is a part of CommonSpirit Health.

Northridge Hospital, a Dignity Health member, was founded in 1955 and is located at 18300 Roscoe Blvd., Northridge, CA. The facility has a total of 394 beds, licensed for 354 beds of general acute care plus 40 acute psychiatric beds non-profit hospital facility. NHMC has over 1,800 employees and 750 active physicians. Major programs and services include a Cancer Center, the Center for Assault Treatment Services, a Center for Healthier Communities, Cardiovascular Center, ER Online Waiting Service (In Quicker), Family Birth Center, Adult and Pediatric Trauma Centers, Stroke Center, STEMI Receiving Center and Neonatal ICU.

Our Mission

As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Our Vision

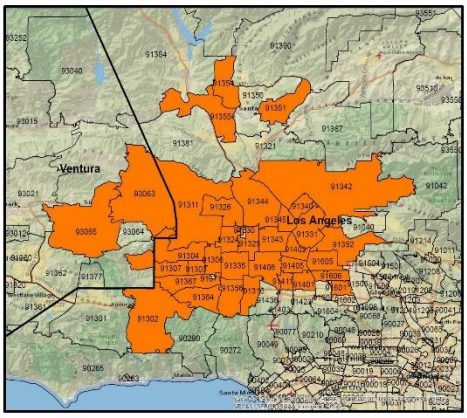
A healthier future for all – inspired by faith, driven by innovation, and powered by our humanity.

Financial Assistance for Medically Necessary Care

It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay. This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary, and related materials are available in multiple languages on the hospital's website.

Description of the Community Served

The study area for the survey effort (referred to as the "NHMC Service Region" in this report) reflects communities throughout the San Fernando and Santa Clarita Valleys in Los Angeles, inclusive of thirty-four ZIP Codes (see map below):



The hospital's service region is located in northern Los Angeles in Service Planning Area 2 (SPA 2) over 1.5 million residents), and urbanized valley that is surrounded by the Santa Susana Mountains on the northwest, Simi Valley to the west, the Santa Monica Mountains to the south, the Verdugo Mountains to the east, and the San Gabriel Mountains to the northeast. The most densely populated region of Los Angeles County spans cities, communities, and incorporated areas in the San Fernando and Santa Clarita Valleys. A summary description of the community is below, and additional details can be found in the CHNA report online.

The region has higher income and middle class households juxtaposed by pockets of extreme poverty and ethnic mobility. The economy includes leading educational institutions (California State University, Northridge, Pierce and Mission Community Colleges), and Van Nuys airport. The areas of highest need and health care disparities are the 15 zip codes that are rated 4.2 and above by the Community Need Index. These communities have the highest number of people of color, lowest education attainment levels, English is a second language, and highest number of folks paying in excess of 45% of their income on housing. Community demographics are listed below

2022 CHNA zip codes	FY23
Total Population	1,528,095
Race	
Asian/Pacific Islander	11.1%
Black/African American - Non-Hispanic	3.8%
Hispanic or Latino	48.8%
White Non-Hispanic	32.2%
All Others	4.1%
% Below Poverty (families)	9.0%
Unemployment	5.0%
No High School Diploma	19.3%
Medicaid	30.5%
Uninsured	7.2%
Source: Claritas Pop-Facts® 2023; *SG2 Market Demographic Module*	
SG2 Analytics Platform Reports:	
Demographics Market Snapshot	
Population Age 16+ by Employment Status	
Families by Poverty Status, Marital Status and Children Age	
Insurance Forecast	

Community Assessment and Significant Needs

The hospital engages in multiple activities to conduct its community health improvement planning process. These include, but are not limited, to conducting a Community Health Needs Assessment with community input at least every three years, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities, and measuring program indicators.

Community Health Needs Assessment

The health issues that form the basis of the hospital's community benefit plan and programs were identified in the most recent CHNA report, which was adopted in November 2022.

This document also reports on programs delivered during fiscal year 2023 that were responsive to needs prioritized in the hospital's previous CHNA report.

The CHNA contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods;
- Presentation of data, information, and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

Additional details about the needs assessment process and findings can be found in the CHNA report, which is publicly available at https://www.dignityhealth.org/socal/locations/northridgehospital/about-us/community-benefit-reports or upon request at the hospital's Community Health office.

Significant Health Needs

The CHNA identified the significant needs in the table below, which also indicates which needs the hospital intends to address. Identified needs may include specific health conditions, behaviors and health care services, and also health-related social needs that have an impact on health and well-being.

Significant Health Need	Description	Intend to Address?
Mental Health	Mental health is a key driver of health status and was ranked as the highest priority by the community. Our goal will be to provide evidence-based mental health awareness training and social-emotional learning workshops in school and youth settings to address this issue.	Yes
Substance Abuse	Substance abuse defined as "a maladaptive pattern of substance use leading to clinically significant impairment or distress results in repeated uses of drugs and alcohol. The major concern is the fentanyl that many drugs are laced with and the high rate of preventable death due to overdose.	Yes
Diabetes	Focus group and survey participants felt that diabetes is a major factor influencing the health of either themselves or a family member. One concern is the cost of insulin and the lack of education about the self-management of the disease.	Yes

Significant Health Need	Description	Intend to Address?
	The programs that we will be implement will address these issues.	
Oral Health	Access to affordable dental care and limited knowledge regarding the importance of proper oral hygiene was listed as a concern by the community. Our goal around this issue will be to educate the community on the importance of a healthy mouth to prevent disease and help maintain good health.	Yes
Access to Healthcare Services	Community input suggests that healthcare access has now become a priority. Some of the barriers have been difficulty in getting appointments, and having to stretch medication that is unaffordable even with insurance, this includes mental health access.	Yes
Nutrition, Physical Activity, &Weight	In the 2022 CHNA report this issue rose higher due to inactivity and weight gain during the COVID-19 pandemic, and less food security due to high cost. Programs that are culturally relevant to the communities will be implemented to support overall health.	Yes
Respiratory Diseases (including COVID-19)	Our community saw an abundance of COVID-19 cases leading to long-term and higher death rates than most of the nation. While this continues to be an issue we are still working to provide outreach and education and partnering with our local Federally Qualified Health Centers to provide pop-up vaccine clinics in communities.	Yes
Heart Disease and Stroke	Respondents continue to be concerned and prioritize heart disease as a concern since they have an awareness that this is still the number one cause of death in our community. We will continue our partnership with the California Department of Public Health to address Heart Disease and stroke through primary prevention education and blood pressure self-management education.	Yes
Violence Prevention	We have a history of working with victims of violence and have more recently placed a strong emphasis of violence prevention education and creating violence-free communities.	Yes

Significant Needs the Hospital Does Not Intend to Address

All of the needs identified as high priority will be addressed through charity care, no-cost community-based health promotion, and prevention education along with strong collaboration and partnership with other community-based organizations that have a strong focus on the social determinants of health.

2023 Report and 2024 Plan

This section presents strategies and program activities the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It summarizes actions taken in FY23 and planned activities for FY24, with statements on impacts and community collaboration. Program Highlights provide additional detail on select programs.

Planned activities are consistent with current significant needs and the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.

Creating the Community Benefit Plan

The hospital is dedicated to improving community health and delivering community benefits with the engagement of its management team, board, clinicians, staff, and in collaboration with partners.

Hospital and health system participants included our hospital foundation staff, mission department, wellness committee, Center for Healthier Communities manager, and the Center for Assault Treatment Services team all of whom work collaboratively to improve health outcomes of the community we serve.

Community input or contributions to this community benefit plan and Northridge's community health programs have long involved departments beyond Community Health and Mission in our planning and operations. A major part of that has been our team members' involvement in the Wellness Committee and Cultural Heritage Committees and partnering with behavioral health, transitional care, and care coordination. Additionally, we continue to leverage our membership in the Valley Care Community Consortium (VCCC). VCCC is the health and mental health collaborative of Service Planning Area 2 of Los Angeles County. The consortium consists of other hospitals, FQHC clinics, faith-based and community-based organizations, and community members. Vital feedback from our community residents on how to improve and expand our existing programs strengthens their impact. Once the needs were established leadership from the Center for Healthier Communities and the Hospital's Foundation discussed strategies for building new partnerships and developing funds to address the identified health needs

The programs and initiatives described here were selected on the basis of existing programs with evidence of success and solid community-based partnerships. Additionally, the existing programs that will be continued and or expanded are based on the needs identified in our 2022 Community Needs Assessment. COVID-19 programs were started in FY 21 and have been in place through FY 23 and continue to be in place during FY24 due to the community residents having continued concerns to halt the spread of new

COVID-19 variants to reduce disparities faced in underserved areas with this ongoing pandemic. With the increase of violence in FY 23 community members have once again stated that this is a top concern, therefore we are conducting focus groups, surveys, and key informant interviews to create action plans based on community voices to address violence issues. The Center for Healthier Communities is dedicated to the goal of health promotion, primary, secondary, and tertiary health prevention, and helping to address the social determinants of health that remain evident in some of the communities we serve therefore we will continue to expand the use of multiple evidence-based programs to address chronic disease, violence prevention, and social emotional learning.

Community Health Strategic Objectives

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources and engagement of participants both inside and outside of the health care delivery system.

CommonSpirit Health has established four core strategic objectives for community health improvement activities. These objectives help to ensure that our program activities overall address strategic aims while meeting locally identified needs.

Advance Community Health Alignment and Integration

Create robust alignment with multiple departments and programmatic integration with relevant strategic initiatives to optimize system resources for advancing community health.

Expand Clinical - Community Partnerships and Linkages

Scale initiatives that complement conventional care to be proactive and community-centered, and strengthen the connection between clinical care and social health.

Build Capacity for More Equitable Communities

Work with community members and agency partners to strengthen the capacity and resiliency of local ecosystems of health, public health, and social services.

Inspire, Innovate and Scale High Impact Initiatives

Partner, invest in and catalyze the expansion of evidence-based programs and innovative solutions that improve community health and well-being.

Report and Plan by Health Need

The tables below present strategies and program activities the hospital has delivered or intends to deliver to help address significant health needs identified in the community health needs assessment.

They are organized by health need and include statements of strategy and program impact and any collaboration with other organizations in our community.

Health Need: Mental Health - Significant Community Health Need 1

Strategy or Program	Summary Description	Active FY23	Planned FY24
ACES Promise Program (Adverse Childhood Experiences Screening)	This program promotes screening of ACEs in children 0-5 years old during well-child clinic visits and responding to ACEs through referrals to community resources and services. The Center for Healthier Communities partnered with Dignity Health Family Medicine to conduct ACEs screenings and a program navigator would connect with families and link them to services based on their ACEs score	☒	☒
San Fernando Valley Healing Project-Mental Health Awareness Training (MHAT)	MHAT is a public health program funded through the Substance Abuse and Mental Health Service Administration (SAMHSA) The main objective of the program is to implement evidence-based curricula to improve the mental health outcomes for individuals with mental illness who are homeless or experience housing instability within Service Planning Area (SPA) 2 of Los Angeles County.	☒	☒
UniHealth Cultural Trauma and Mental Health Resiliency Project	Project to address behavioral health and mental well-being of at-risk youth, and adults Funds community partnerships with local mental health providers to train and deliver evidence-based Mental Health First Aid Youth/ Adults and Question, Persuade, Refer to recognize signs and refer to services.	☒	☒
Positive Action	Positive Action is an evidence-based curriculum that uses real-life concepts to foster social-emotional learning and develop a positive self-concept.	☒	☒

Goal and Impact: To reduce mental illness, suicidal tendencies, and substance use among youth with emotional and major depressive disorders. Increase the skills and awareness of local community organizations and residents to promote and instill mental health resiliency, especially among children and youth of color, and those serving the unhoused who are dealing with mental health and where significant health disparities exist. ACE's goal will be to identify youth who score 4 or higher on the screening and utilize a web-based referral process to link them to resources to promote healing. Positive Action will be to improve self-concept.

Collaborators In partnership with five other Dignity Health Hospitals, the National Alliance for Mental Illness (NAMI), and San Fernando Valley Community Mental Health, Inc. (SFVCMH), staff will be trained to build community capacity to deliver training in evidence-based programs. The ACE's Promise team consists of a local FQHC clinic-Northeast Valley Health Corporation (NEVHC) as the lead agency with Northridge Hospital, Child Care Resource Center, The Help Group, 211 of Los Angeles County, Department of Children and Family Services (DCFS), and San Fernando Valley Community Mental Health Center (SFVCMHC). Positive Action is conducted in multiple LAUSD schools.

Health Need: Substance Abuse - Significant Community Health Need 2

Strategy or Program	Summary Description	Active FY23	Planned FY24
Emergency Department (ED) Medicated Assisted Treatment (MAT) Program	Our MAT program is part of CA Bridge which helps patients with substance abuse disorders. A Social Worker/Substance Use Navigator (SUN) performs a psychosocial assessment, counseling, and connects patients to treatment facilities for additional care. In collaboration with ED physicians, patients are given medicated assisted treatment (MAT) for withdrawal symptoms.	☒	☒

Goal and Impact: To reduce the death rate of those living with addiction by providing 100% of the patients admitted to the ED a warm handoff to staff to encourage a minimum of 85% to work with one of the MAT licensed providers in our ED. Staff served 752 patients with substance abuse through the ED and inpatient units.

Collaborators: Partnerships continue with drug treatment centers including Tarzana Treatment Center, Discovery House, Cri-Help, ProWellness Academy, etc. for behavioral health services

Health Need: Diabetes - Significant Community Health Need 3

Strategy or Program	Summary Description	Active FY23	Planned FY24
Prevention Forward Diabetes Wellness including NDPP for prediabetes and DEEP for diabetic patients	• Implement Diabetes Education and Empowerment Program (DEEP) for diabetes patients • Provide a National Diabetes Prevention Program (NDPP) to those individuals identified as pre-diabetic and provide case management with a community health worker to follow for one year to support self-management and education to prevent from becoming a diabetic • Expand the capacity of local pharmacies to become recognized as ADA providers increasing access to free diabetes self-management education	☒	☐
Diabetes Self-Management Program for those diagnosed with diabetes and prediabetes	• Continue our multi-disciplinary team-based approach to address diabetes through the provision of ADCES Diabetes Care and Education Curriculum • Conduct community-based educational workshops	☐	☒

Goal and Impact: Anticipated results include increased knowledge in diabetes self-management with reductions in glucose levels, cholesterol, and A1C levels; reduced rates of morbidities due to uncontrolled diabetes; and increased rates of annual foot and eye screenings. Use of Community Health Educators to support pre-diabetes patients.

Collaborators: The hospital will partner with community-based organizations that serve low-income community residents with pre-diabetes and diabetes to enroll in evidence-based ADCES classes at LAUSD parent centers and local churches.

Health Need: Oral Health - Significant Community Health Need 4			
Strategy or Program	**Summary Description**	**Active FY23**	**Planned FY24**
School Wellness Initiative LAUSD Oral Health Promotion Program	• Provide oral health promotion workshops to parent centers in LAUSD schools • Create an Oral Health Section for the Quarterly School Wellness Newsletter that is distributed to 110 schools • Support the work of local FQHC clinics providing oral health services to youth	☒	☒
Goal and Impact: The hospital promotion and prevention education sessions will be to increase knowledge and encourage more frequent brushing and flossing. To be successful we will build relationships with two clinics providing dental health. Since many oral health issues are preventable and this is a leading cause of absence in school-aged children our goal will target oral health promotion and prevention education.			
Collaborators: The hospital will partner with LAUSD and two local federally-qualified health centers Comprehensive Community Health Centers and San Fernando Community Health Center to promote oral health. Through a series of prevention education workshops.			

Health Need: Access to Healthcare Services - Significant Community Health Need 5			
Strategy or Program	**Summary Description**	**Active FY23**	**Planned FY24**
Healthy Families Initiative	We proudly awarded a community grant to Catholic Charities Guadalupe Center for providing an exceptional physical and mental health awareness program. This included workshops and a "meet the doctor" program, along with referrals to necessary services.	☒	☐
San Fernando Valley Integrated Health Access Collaborative Program	Comprehensive Community Health Center received a community benefit grant to implement an integrated health access program in partnership with the hospital and other community-based organizations.	☒	☒
ACE's Aware Promise Grant	This program became active in FY23. Youth are screened for Adverse Childhood Experiences and through a coordinated web-based referral platform called One Degree all youth regardless of ability to pay will be connected to the appropriate resources.	☒	☒
Recuperative Care Support	Recuperative care expenses for patients discharged from the hospital who would benefit from a non-acute setting in which to continue recovering, and who are homeless or do not have insurance coverage or other means to pay. Financial assistance to reduce health inequity.	☒	☒

Financial Assistance for the uninsured and underinsured	Financial assistance to the uninsured or underinsured patients who meet certain income requirements to help pay for medically necessary hospital services provided by the hospital	☒	☒

Goal and Impact: The hospital has implemented several initiatives to improve access to healthcare services, which is expected to result in early identification and treatment of health issues. The programs that are aimed at prevention are free and available locally, making it easier for people to access and navigate the healthcare system. As a result, there is an expected increase in the number of referrals for those identified through the ACEs Promise program. In the fiscal year 2023, a total of $9,630,426 worth of charity care was provided.

Collaborators: The hospital will partner with Northeast Valley Health Corporation, Comprehensive Community Health Services, and the San Fernando Valley Community Health Center (all FQHC) clinics to ensure that individuals are connected to a medical home. We continue to partner with Harbor Care and other recuperative care sites for our unhoused population to continue recovery after discharge from the hospital. In addition, the hospital will continue to provide in-kind services through the patient Financial Assistance Program

Health Need: Nutrition, Physical Activity& Weight - Significant Community Health Need 6

Strategy or Program	Summary Description	Active FY23	Planned FY24
School Wellness Initiative	We have been collaborating with LAUSD Parent Centers for more than a decade to provide both in-person and virtual workshops. Our workshops cover topics such as healthy eating, the significance of exercise, and stress management. The best part is that these workshops come at no cost to participants. Moreover, our team is responsible for creating the Quarterly School Wellness Newsletter.	☒	☒
Monthly Produce Distribution	This program is a partnership with the American Heart Association and provides free produce on the last Thursday of every month using a drive-up pickup model. Participants can stay in their cars and volunteers will load the produce safely and efficiently. Additionally, make the community aware of local food pantries and monthly produce distribution sites	☒	☒

Goal and Impact: As a result of our efforts, both children and parents have gained knowledge about the significance of maintaining a healthy diet, engaging in physical activity, and stress management. This has resulted in an increase in the consumption of healthy food, the establishment of interdisciplinary collaborations to create healthier environments, and an overall improvement in health promotion, leading to healthier families. As part of our initiative around 350 families are now able to access free produce each month.

Collaborators: Continued partnership with Los Angeles Unified School District Principals and Parent Center Leaders for school wellness. Ongoing partnership with the American Heart Association to offer free produce monthly.

Health Need: Respiratory Disease (COVID-19) - Significant Community Health Need 7

Strategy or Program	Summary Description	Active FY23	Planned FY24
COVID-19 Community Health Outreach, Education, and Vaccine Clinics	Through county, federal, and sub-award funding, the Center for Healthier Communities carried out activities to provide outreach and education regarding COVID-19, collaborate with local partner organizations and host COVID-19 pop-clinics to promote access to and uptake of the COVID-19 vaccine using a shared community-based staffing model.	☒	☒

Goal and Impact: In partnership with the Los Angeles County Department of Public Health (LA DPH), three local Federally Qualified Health Centers (FQHCs) have joined forces to reduce the unfair impact of COVID-19. Together, we are developing a community-centered approach to providing vaccines to those in need. The COVID-19 Outreach and Education team continued to provide workshops, attend health and resource events, and provide pop up vaccine clinics in communities with higher rates of COVID-19 and vaccine hesitancy rates.

Collaborators Partners in this effort include HRSA, LADPH, Meet Each Need with Dignity (MEND), Northeast Valley Health Corporation, San Fernando Community Health Center, and Comprehensive Community Health Centers in addition to the community sites that host us which include churches, community-based organizations, and parks.

Health Need: Heart Disease & Stroke - Significant Community Health Need 8

Strategy or Program	Summary Description	Active FY23	Planned FY24
Prevention Forward Activate Your Heart will be under a new name Heart Beat CA	Provided Activate Your Heart curricula in community settings to reduce the risk of heart disease and stroke in 2023. Currently in the planning stages of preparing for a new project in partnership with California Department of Public Health on a National Cardiovascular Health project to start the new Heart.	☒	☒
Blood Pressure Self-Monitoring Program	Includes a train-the-trainer model to train Community Health Workers and residents how to accurately self-monitor their blood pressure to reduce hypertension and the risk of heart attack and strokes.	☒	☒

Goal and Impact: Increased knowledge of what leads to cardiovascular disease and how to prevent and manage existing heart disease. Reduce the risk of new-onset cardiovascular disease. Increased screening rates. Additionally, increases awareness of risk factors for stroke and diabetic disease.

Collaborators: Continued partnership with Los Angeles Unified School District Principals and Parent Center Leaders. Continue our partnership with the California Department of Public Health which will target low-income community residents with, heart disease, high blood pressure, stroke, and high cholesterol patients to enroll in evidence-based classes and to learn how to self-manage issues that could result in serious heart health issues.

Health Need: Violence Prevention - Significant Community Health Need 9			
Strategy or Program	**Summary Description**	**Active FY23**	**Planned FY24**
Los Angeles School Empowerment Program and the Schools Against Violence Los Angeles Program	Provide schools with the tools they need to recognize, respond quickly to, and help prevent acts of violence. This will be accomplished through community partnerships, evidence-based classes, workshops, student counseling, anti-bullying campaigns, school professional training, and engagement and training of school law enforcement.	☒	☒
SoCal Anti-Violence Education and Survivor Advocate Program (SAVE-ASAP)	This program aims to implement a trauma-informed, culturally sensitive anti-violence initiative that will engage community input. This will be accomplished through focus groups, key informant interviews, community surveys, coalition meetings, and a culminating action report.	☐	☒
Center for Assault Treatment Services (CATS)	• Provides compassionate, comprehensive medical examinations and forensic interviews to victims of sexual assault, domestic/partner violence, child maltreatment, and human trafficking. • Conducts community outreach and education to mandated reporters on how to report abuse, the signs and symptoms of abuse, and the short and long-term consequences of abuse. • Provides expert witness testimony in court	☒	☒
Medical Safe Haven	A program of Family Practice Medicine Residents to identify and treat victims of Human Trafficking in the clinic in partnership with a Journey Out Survivor Advocate to help remove victims from the lifestyle	☒	☒
Local Elder Abuse Prevention Enhanced Multidisciplinary Team LEAP EMDT	• Case review of Elder Abuse/Neglect Cases • Educate and train caregivers • Enhance care coordination, referrals, and resources provided to victims of elder abuse	☒	☒
Goal and Impact: Increased capacity to serve victims of sexual and domestic abuse and assault, child maltreatment, and human trafficking victims. Deliver coordinated community response, and enhance awareness and expertise of service providers and community groups around domestic violence, sexual assault, and human trafficking. Reduced violence and victimization of youth and older adults.			
Collaborators: Los Angeles Police Department, Strength United, Los Angeles City Attorney Victims Assistance Program, and Neighborhood Legal Services. We continue to work with the Boys and Girls Clubs, school sites, and youth service providers to implement programs virtually and on-site. Alzheimer's Association, ONEgeneration, Southern California Neuropsychology Group, Bet Tzedek Legal Services, WISE & Healthy Aging Long Term Care Ombudsman Program, Los Angeles County Adult Protective Services, the Office of the Public Guardian, 211 LA County, a Forensic Accountant, a Social Isolation Specialist, and a Los Angeles Police Department Domestic Violence Detective.			

Community Health Improvement Grants Program

One important way the hospital helps to address community health needs is by awarding financial grants to non-profit organizations working together to improve health status and quality of life. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations related to CHNA priorities.

In FY23, the hospital awarded the grants below totaling $216,220. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Coalition to Abolish Slavery and Trafficking (CAST)	Housing Assistance and Support Services to Survivors of Human Trafficking in Los Angeles County	$31,220
Comprehensive Community Health Centers	San Fernando Valley Integrated Health Access Collaborative Program	$50,000
Harbor Care Foundation	Recuperative Care Center	$35,000
Journey Out	Survivor Advocate Program	$50,000
ONEgeneration	Senior Enrichment Center Behavioral Health Project	$50,000

Program Highlights

The following pages describe a sampling of programs and initiatives listed above in additional detail, illustrating the work undertaken to help address significant community health needs.

Cultural Trauma Mental Health Resiliency Project

Significant Health Needs Addressed	Mental Health Access to Healthcare Services
Program Description	This ongoing joint project is between Dignity Health Southern California Hospitals to increase the awareness, skills, and capacity of local community organizations and community members to identify mental distress, address the impacts of trauma, reduce stigma, and increase resiliency, via delivery of mental health awareness education.
Population Served	Training programs are targeted to school teachers, school social workers, and community and faith-based organizations working with youth, older adults, and the homeless population. Additionally, we are training staff from the Department of Child and Family Services in the Question, Persuade, and Refer (QPR) curriculum. We are reaching Title 1 schools and underserved communities.
Program Goal / Anticipated Impact	Increase the ability to recognize depression, anxiety, and suicidal ideation of children and young adults that have been affected by health

	disparities, especially those affected by poverty, racism, adverse childhood experiences (ACEs), and violence.
FY 2023 Report	
Activities Summary	Staff in partnership with NAMI and SFVCMH continued to offer Mental Health First Aid, Youth Mental Health First Aid, and Question, Persuade and Refer to parents and adults who interact with children and young adults (especially in communities that are underserved).
Performance / Impact	In FY 23 staff and partner sites offered 57 Mental Health First Aid training sessions and reached a total of 965 individuals. Additionally, 37 QPR sessions reached 649 individuals. The overwhelming majority of respondents said they agree or strongly agree that they are now able to recognize the signs of mental illness and distress, reach out to someone who needs help, engage directly with a person, refer to services utilizing the ALGEE approach, and assist someone in crisis.
Hospital's Contribution / Program Expense	The majority of the program expenses are covered through shared grant funding with the hospital contributing $155,077 to NAMI and SFVCMH.
FY 2024 Plan	
Program Goal / Anticipated Impact	The goals of both Mental Health 1st Aid and QPR curriculum are to teach those working with children and young adults in underserved communities how to identify warning signs and assess for risk of harm and suicide. By teaching the importance of listening nonjudgmentally providing factual information and encouraging appropriate professional help. The anticipated impact for FY 24 will be to increase the number of individuals working with children and young adults to be trained in these evidence-based curriculums to help reduce the risk of suicide and promote better mental health outcomes.
Planned Activities	Staff and Partners planned activities for FY 24 1) Continue expansion of outreach to deliver virtual and in-person MHFA trainings. Average of 2 presentations per month for a combined total of 24 new trainings 2) Continue expansion of outreach to deliver virtual and in-person QPR trainings. Goal 15 additional training sessions. We expect to reach the target population of adults who interact with Children and young adults. The goal will be to train 500 individuals.

San Fernando Valley Healing Project-Mental Health Awareness Training (MHAT)	
Significant Health Needs Addressed	Mental Health Access to Healthcare Services
Program Description	MHAT is a public health program funded by the Substance Abuse and Mental Health Service Administration (SAMHSA) that operates. The main objective of the program is to implement evidence-based curricula to improve the mental health outcomes for individuals with mental illness who are homeless or experience housing instability within Service Planning Area (SPA) 2 of Los Angeles County. The program goals are

	to: 1. Increase the capacity and ability of local homeless services providers, security offers, health and mental health professionals and support staff to recognize the signs and symptoms of mental disorders, safely respond to those with Adverse Mental Illness, Severe Mental Illness or Serious Emotional Disturbances in this high-risk population, and refer them to resources that promote mental health. 2. Increase the ability of parents, families, caregivers, and community-based service providers to identify signs of potential AMI, SMIs and SEDs in this high-risk population and enhance awareness of and increasing referrals to available local resources.
Population Served	Professionals such as Law Enforcement, First Responders and support staff of community-based organizations that service people at-risk or experiencing homelessness and families, parents, and caregivers at risk or experiencing homelessness in Los Angeles County's SPA-2 area.
Program Goal / Anticipated Impact	• Conduct 60 Question Persuade and Refer (QPR) training sessions (including orientation to the One Degree and or 211 referral platform) for 590 participants. • Conduct 66 Mental Health First Aid (MHFA) and Youth Mental Health First Aid (YMHFA) training sessions (including orientation to the One Degree and or 211 referral platform) reaching 748 mental health professionals.
FY 2023 Report	
Activities Summary	• Conduct Question Persuade and Refer (QPR) training sessions (including orientation to the One Degree and or 211 referral platform). • Conduct Mental Health First Aid (MHFA) and/or Youth Mental Health First Aid (YMHFA) training sessions (including orientation to the One Degree and or 211 referral platform).

Performance / Impact	• Implemented evidence-based curriculums: Mental Health First Aid (MHFA) and Question, Persuade and Refer (QPR).
	• Orient individuals to One Degree and 211 resources.
	• Established partnerships with organizations.
	• Disseminated educational information via Social Media
	  • Instagram posts- 1683
	  • Facebook posts-524
	• Participated in 7 Outreach and Educational Activities reaching 359 individuals.
	• Hosted 3 MHFA reaching 17 individuals.
	• Hosted 1 QPR reaching 8 individuals.

Hospital's Contribution / Program Expense	• Program management support donated to the project, leadership and grant financial analyst paid through community benefit.
FY 2024 Plan	
Program Goal / Anticipated Impact	• Conduct 60 Question Persuade and Refer (QPR) training sessions (including orientation to the One Degree and or 211 referral platform) for 590 participants.

	• .Conduct 66 Mental Health First Aid (MHFA) and Youth Mental Health First Aid (YMHFA) training sessions (including orientation to the One Degree and or 211 referral platform) reaching 748 mental health professionals.
Planned Activities	• Conduct Question Persuade and Refer (QPR) training sessions (including orientation to the One Degree and or 211 referral platform). • Conduct Mental Health First Aid (MHFA) and/or Youth Mental Health First Aid (YMHFA) training sessions (including orientation to the One Degree and or 211 referral platform).

Emergency Department (ED) Medicated Assisted Treatment (MAT) Program

Significant Health Needs Addressed	Substance Abuse Mental Health Access to Healthcare Services
Program Description	Our MAT program is part of CA Bridge, which helps patients with substance abuse disorder in the Emergency Department (ED). A Social Worker/Substance Use Navigator (SUN) performs a psychosocial assessment, counseling, and connects patients to treatment facilities for additional care. In collaboration with ED physicians, patients are given medicated assisted treatment (MAT) such as buprenorphine or sub Oxone for withdrawal symptoms and those at high risk of overdose are given naloxone.
Population Served	Individuals dealing with opioid addiction.
Program Goal / Anticipated Impact	• Decrease barriers to obtaining MAT • Reduce drug use and overdose events • Promote recovery among individuals with opioid use disorders.
FY 2023 Report	
Activities Summary	• SUN and ED physicians provide support, counseling, and MAT to opioid patients • Patients are either admitted to our hospital's Behavioral Health Unit, inpatient units, or connected to a substance abuse or mental health treatment facility. • Patients are given community resources.

Performance / Impact	• Staff served 752 patients with substance abuse through the ED and inpatient units.
	• A warm handoff was made to various treatment facilities
	  ○ Tarzana Treatment Facility
	  ○ ProWellness Academy

	○ Miracles Detox ○ Sober Living, Restore Recovery Center ○ White Oak Recovery, etc.
Hospital's Contribution / Program Expense	An ED Physician Champion spends time working with our SUN, educating the ED staff on prescribing MAT, and participating in CA Bridge training.
FY 2024 Plan	
Program Goal / Anticipated Impact	• SUN and physicians will continue helping patients with substance abuse and initiate MAT in the ED and inpatient units. • SUN will continue to connect patients to treatment facilities for the continuum of care.
Planned Activities	• Provide counseling and education for substance abuse patients with a strong focus on opioid addiction. • Expand referrals to substance abuse and mental health treatment facilities.

ACEs Promises

Significant Health Needs Addressed	Mental Health Access to Healthcare Services
Program Description	The Adverse Childhood Experiences (ACEs) Promise Program is focused on promoting screening of ACEs in children 0-5 years old during well-child clinic visits and responding to ACEs through referrals to community resources and services. The Center for Healthier Communities collaborated with Dignity Health Family Medicine to conduct ACEs screenings and our program navigator would connect with families to provide referrals and link them to services based on their ACE score. Additionally, through this program, we will be involved in a Network of Care Collaborative with other ACE screening and ACE serving organizations.
Population Served	Our target population is children 0-17 Years Old who are referred to our Community Patient Navigator after scoring a 4 or above on the PEARLS screening tool.
Program Goal / Anticipated Impact	• Screen children 0-5 years old for ACEs • Refer and connect families with ACEs to community resources and services to respond to ACEs and toxic stress • Participate in a Network of Care Collaborative to share best practices for ACEs screenings and services

FY 2023 Report	

Activities Summary	• Dignity Health Family Medicine conducting screenings for children 0-5 for ACEs using a standardized screening tool.
	• Navigator conducts training for Family Medicine staff on ACEs screenings and the program.
	• Identified ACEs will be contacted by Community Navigator.
	  ○ Assess families needed resources and services
	  ○ Create referrals to local organizations for needed resources and services
	  ○ Follow-up on referrals
	• Participate in Network of Care Collaborative monthly meetings.
	• Attend local health fairs/community events to promote awareness of ACEs and connect with local community organizations.

Performance / Impact	• 538 Well-Child Visits conducted in Family Medicine
	  ○ 128 Children 0-5 screened for ACEs
	  ▪ 4 ACE screening declinations
	  ▪ 116 Negative ACE screenings identified
	  ▪ 8 Positive ACE screenings Identified
	• Navigator connected with 9 children with identified ACEs.

Hospital's Contribution / Program Expense	Dignity Health Family Medicine is not a grant-funded partner and their Behavioral Health Coordinator provides in-kind time and effort on this project and participates in bi-weekly program meetings. In-kind time and effort are also provided by the Director and Program Manager of the Center for Healthier Communities.
FY 2024 Plan	
Program Goal / Anticipated Impact	This was a one-year implementation project that received funding to support a Patient Navigator through November 30, 2023 thereafter the program will be supported by the Dignity Health Family Practice Clinic residence under the guidance of Dr. Warnesky. From July 2023-November 2023 the Patient Navigator will continue to: • Screen children 0-5 years old for ACEs. • Refer and connect families with ACEs to community resources and services to respond to ACEs and toxic stress. • Participate in a Network of Care Collaborative to share best practices for ACEs screenings and services. Family Medicine is still committed to conducting ACEs screenings and making referrals as necessary to positively identify ACEs and now has the capacity to bill insurance for such services.
Planned Activities	• Dignity Health Family Medicine conducting screenings for children 0-5 for ACEs using a standardized screening tool • Refer and connect families with ACEs to community resources and services to respond to ACEs and toxic stress.

Prevention Forward

Significant Health Needs Addressed	Diabetes Nutrition, Physical Activity & Weight Heart Disease & Stroke
Program Description	Prevention Forward Healthy Lifestyles Program, which is funded through the California Department of Public Health (CDPH) aims to empower community members to put their health first and learn how to effectively prevent or manage chronic diseases through evidence-based health education programs and curricula.
Population Served	18-85 year olds residing in the San Fernando and Santa Clarita Valley with one or more of the following health conditions: • High blood pressure • High blood cholesterol • Type 2 diabetes • Prediabetes • Cardiovascular disease • Stroke
Program Goal / Anticipated Impact	• Recruit and retain community members for one year • Conduct evidence-based classes • Host educational workshops • Engage local pharmacies to provide Diabetes self-management education and support (DSMES) services.
FY 2023 Report	

Activities Summary	• Recruit/enroll community members into the program.
	• Offered the following evidence-based curricula:
	  • ADCES 7: Diabetes Care and Education
	  • National Diabetes Prevention Program
	  • Blood Pressure Self-Monitoring Program
	  • Diabetes Empowerment Education (DEEP)
	• Offered educational workshops on the following topics:
	  • Heart Health
	  • Mindfulness
	  • Stress Management
	  • Healthy Shopping
	  • Healthy Living
	• Partnered with local pharmacies to apply for American Diabetes Association recognition.

Performance / Impact	• Identified and contacted 524 patients during FY23 who meet qualifications for the PF Program. • Enrolled 53 individuals during FY23 and maintained a minimum of 15 people during FY23 to participate in NDPP or DSMES. • Hosted 5 ADCES 7: Diabetes Care and Education cohorts reaching 29 individuals, 3 Blood Pressure Self-Management

	cohorts reaching 37 individuals, 1 NDPP cohort, and enrolled 8 individuals. • Facilitated 8 Activate Your Heart workshops (cardiovascular disease prevention) reaching 61 individuals and 3 additional health workshops reaching 29 individuals. • Partnered with St Mary Pharmacy and Clinicare to achieve their ADA recognition. • Participated in at least 4 cultural humility trainings to improve high-burden population referrals to NDPP and DSMES.
Hospital's Contribution / Program Expense	• Trainings provided by Right Care Initiative Virtual University of Best Practices and CDPH • EHR system for referrals • Location/classroom space for in-person classes • Transitional Care team to provide referrals, pharmacist assistance, and diabetes nurse practitioner • Program management support and community health worker
FY 2024 Plan	
Program Goal / Anticipated Impact	Continuation of diabetes and cardiovascular education through evidence based curriculum to community residents.
Planned Activities	• Host a minimum of 2 DSMES and/or cardiovascular cohorts to reach a minimum of 20 participants at a local school or community center. • Continue to partner with community-based organizations, schools, and faith-based organizations to provide health education workshops and support diabetes and cardiovascular disease prevention efforts, as needed.

COVID-19 Community Health Outreach, Education and Vaccine Clinics

Significant Health Needs Addressed	Respiratory Disease (COVID-19) Access to Healthcare Services
Program Description	Through county, federal, and sub-award funding, the Center for Healthier Communities carried out activities to provide outreach and education regarding COVID-19, collaborate with local partner organizations (ex. Federally Qualified Health Centers) and host COVID-19 pop-clinics to promote access to and uptake of the COVID-19 vaccine using a shared community-based staffing model.
Population Served	Residents living in the San Fernando and Santa Clarita Valley.
Program Goal / Anticipated Impact	• Conduct Outreach and Education on COVID-19

	• Dispel myths and misconceptions regarding COVID-19 and COVID-19 vaccine through active and passive engagements, social media posts, and marketing. • Provide up-to-date COVID-19 and COVID-19 vaccine information from credible sources. • Conduct educational presentations on COVID-19 and vaccine information at local community agencies. • Distribute COVID-19 personal protective equipment (PPE) to residents and local businesses. • Promote local COVID-19 pop-up clinics. • Host local community pop-up vaccine clinics • Vaccinate residents for 1st, 2nd or booster COVID-19 vaccines and/or flu vaccines at local community based organizations and in collaboration with local community partner organizations and federally qualified health centers.
FY 2023 Report	
Activities Summary	• Participated in community events for COVID-19 outreach and education. o Locations included: vaccine clinics, community resource events/health fairs, and food pantries locations at community based organizations and schools. • Participated in community collaboratives to share COVID-19 outreach and education best practices. • Promoted local COVID-19 pop-up clinics. • Conducted street outreach with high vaccine hesitancy rates. • Conducted active and passive engagements. o 1-1 two-way engagement o Social media posts o Electronic newsletters o Media Campaigns (bus and radio campaigns) o Handout drop-offs at local businesses • Disseminated PPE items. o COVID-19 testing kits o Masks o Hand sanitizers • Conducted COVID-19 educational workshops. • Hosted COVID-19 vaccine pop-up clinics in community hubs. o Distributed vaccine gift card incentives.
Performance / Impact	• Conducted 7,682 active engagements: • Conducted 246 passive engagements • Posted 160 social media posts • Reaching 5,721 accounts • Hosted 17 Pop-up Clinics • Vaccinating a total of 191 people

Hospital's Contribution / Program Expense	In-kind time and effort by Director and Program Manager of the Center for Healthier Communities.
FY 2024 Plan	

Program Goal / Anticipated Impact	FQHC clinic partnerships will continue during FY 24.
	• Conduct Outreach and Education on COVID-19
	  • Dispel myths and misconceptions regarding COVID-19 and COVID-19 vaccines through active and passive engagements, social media posts, and marketing.
	  • Provide up-to-date COVID-19 and COVID-19 vaccine information from credible sources.
	  • Conduct educational presentations on COVID-19 and vaccine information at local community agencies.
	  • Distribute COVID-19 personal protective equipment (PPE) to residents and local businesses.
	  • Promote local COVID-19 pop-up clinics.
	• Host local community pop-up vaccine clinics
	  • Vaccinate residents for 1st, 2nd, or booster COVID-19 vaccines and/or flu vaccines at local community-based organizations and in collaboration with local community partner organizations and federally qualified health centers.

Planned Activities	• Participate in community events for COVID-19 outreach and education. • Participate in community collaboratives to share COVID-19 outreach and education best practices. • Promote local COVID-19 pop-up clinics. • Conduct street outreach with high vaccine hesitancy rates. • Conduct active and passive engagements. • Disseminate PPE items • Conduct COVID-19 educational workshops • Host COVID-19 vaccine pop-up clinics in community hubs ○ Distributed vaccine gift card incentives

Los Angeles School Empowerment Program

Significant Health Needs Addressed	Mental Health Access to Healthcare Services
Program Description	The Los Angeles School Empowerment Program and the Schools Against Violence Los Angeles Program (SAVe LA), funded through the Bureau of Justice Assistance (BJA) aim to provide schools with the tools they need to recognize, respond quickly to, and help prevent acts of violence. This will be accomplished through community partnerships,

	evidence-based classes, educational workshops, student counseling, anti-bullying campaigns, school professional training and engagement and training of school law enforcement.
Population Served	Middle and high school students as well as school resource officers, school staff/school mental health staff from LAUSD school, and parents and community members within the San Fernando Valley.
Program Goal / Anticipated Impact	Reduce incidents of school-based violence at partner schools and increase the capacity of school staff to implement evidence-based violence prevention classes. Improve awareness and knowledge of parents to prevent or identify various forms of school violence.
FY 2023 Report	

Activities Summary	• Safe Dates Program
	  ○ Conduct Safe Dates cohorts at school sites for students
	  ○ Training School and School Mental Health Staff to implement program
	• Positive Action
	  ○ Training school and school mental health staff to implement activities
	• Parent/Community Workshops
	  ○ Teen Dating Violence Prevention
	  ○ Cyberbullying
	  ○ Question, Persuade, Prefer Suicide Intervention
	• Anti-Bullying Awareness Campaigns
	• Counseling services provided in partnership with San Fernando Valley Community Mental Health Center, Inc. to students

Performance / Impact	• Hosted 10 cohorts of Safe Dates and reached 161 students • Hosted 6 Safe Dates trainings and trained 73 school staff • 2642 students reached through Positive Action • Hosted 4 Positive Action trainings and trained 64 school staff • Hosted 8 Anti-Bullying Awareness Campaigns and reached 582 students • Hosted 23 workshops and reached 249 parents/community members • 46 referrals received for counseling of which 22 received services with San Fernando Valley Community Mental Health Center, Inc.
Hospital's Contribution / Program Expense	In-kind time and effort by the Director, Program Manager, and Grant Financial Analyst of the Center for Healthier Communities.
FY 2024 Plan	
Program Goal / Anticipated Impact	The goals of both Mental Health 1st Aid and QPR curriculum is to teach those working with children and young adults in underserved communities how to identify warning signs and assess for risk of harm and suicide. By teaching the importance of listening nonjudgmentally and providing factual information and encouraging appropriate professional help. The anticipated impact for FY 23 will be to increase the number of individuals working with children and young adults to be

	trained in these evidence-based curriculums to help reduce the risk of suicide and promote better mental health outcomes.
Planned Activities	Staff and Partners planned activities for FY 23 1) Continue expansion of outreach to deliver virtual and in-person MHFA trainings. Average of 4 presentations per month for a combined total of 48 new trainings 2) Continue expansion of outreach to deliver virtual and in-person QPR trainings. Goal 30 additional training sessions. We expect to reach the target population of adults who interact with Children and young adults, especially people of color residing in underserved communities. Overall goal will be to train 1,200 individuals.

Local Elder Abuse Prevention-Enhanced Multidisciplinary Team (LEAP-EMDT)	
Significant Health Needs Addressed	Mental Health Access to Healthcare Services Violence Prevention
Program Description	LEAP E-MDT, which is a grant-funded program funded by the Office for Victims of Crime (OVC) aims to improve the provisioning of services for victims of elder abuse using evidence-based methodology, increase awareness of how to identify, report, and respond to incidence of elder abuse for professionals and social service providers, and to improve knowledge and implementation of best practices when addressing resource gaps within a team-based environment.
Population Served	Older adults 60+ who are at risk or are victims of elder abuse or financial exploitation, their caregivers and older adult serving professionals within Los Angeles County.
Program Goal / Anticipated Impact	• Review and coordinate services for 60 elder abuse cases over the course of 30 case review meetings. • Conduct 60 caregiver education workshops to reach a total of 500 medical professionals with the aid of our community partners • Lead 6 community awareness events intended to reach at least 150 community residents.
FY 2023 Report	
Activities Summary	• Review and coordinate services for elder abuse cases through case review meetings. • Conduct caregiver education workshops to reach medical professionals with the aid of our community partners • Lead community awareness events intended to reach community residents.
Performance / Impact	• Reviewed and coordinated services for 20 elder abuse cases over the course of 8 case review meetings.

	• Conducted 129 caregiver education workshops to reach a total of 1,073 medical professionals/caregivers with the aid of our community partners. • Lead 2 community awareness events and reached a total of 227.
Hospital's Contribution / Program Expense	In-kind time and effort by the Program Manager of the Center for Healthier Communities.
FY 2024 Plan	
Program Goal / Anticipated Impact	The LEAP-EMDT program is set to conclude effective September 2023. New funding through the Office of Victims for Crime (OVC) was secured to continue our efforts through the new program LEAP-Los Angeles EMDT from October 2023 to September 2026. • Increase the capacity of caregivers, professionals, law enforcement and the general community to identify, report, and respond to incidents of elder abuse. • Improve prevention and intervention services for victims of elder abuse using evidence-based methodology (closed-loop referral and enhanced multidisciplinary team approach). • Increase involvement as a community stakeholder in elder abuse prevention & intervention services. • Promote best practices
Planned Activities	• Review and coordinate elder abuse cases across EMDT working group meetings. • Add new EMDT members to participate in EMDT working group meetings. • Reach professionals/caregivers/general community through workshops. • Reach community members through elder abuse community awareness events. • Train and provide resources to law enforcement officers.

Cancer Center	
Significant Health Needs Addressed	Access to Healthcare Services Cancer
Program Description	The *Navigator Program* is a breast cancer screening program serving women who are uninsured in the San Fernando community and beyond. The program provides free mammogram screenings and navigation services. Navigation facilitates the follow-up process for patients who must complete diagnostic imaging and procedures. The Patient Navigator eliminates barriers to care by providing education, guidance, and support as patients navigate the healthcare system. The program collaborates with local organizations to provide breast cancer education in a variety of community settings.
Population Served	Breast cancer and breast health education is provided to all women in the community regardless of age or insurance status.

	Free breast cancer screenings are available to those who qualify. Eligibility requirements; women with no health insurance who are 40 years of age and over.
Program Goal / Anticipated Impact	• Improve access to breast cancer screenings for women in the community who are uninsured. • Support patients by providing education, guidance, and support to all women with abnormal imaging findings. • Ensure that patients diagnosed with breast cancer are connected to a treatment center. • Provide free screenings • Increase breast cancer and breast health education • Establish new partnerships with community organizations and agencies • Connect newly diagnosed breast cancer patients to a cancer treatment center.
FY 2023 Report	

Activities Summary	• 12 outreach health fairs
	  ○ Held on the second Friday of the month
	  ○ Free mammogram screenings are provided by appointment
	• Outreach coordinator attended 17 community events

Performance / Impact	• *Community Education:* 3,115 Individuals educated on breast cancer and breast health • *Mammogram Screenings:* 242 uninsured women were provided with free education and breast cancer screenings • Connected patient diagnosed with breast cancer to a treatment center in FY 2023.
Hospital's Contribution / Program Expense	Outreach and Education Supplies FY 23 - $1,629.11 Breast Cancer Screening Costs for FY 23 - $112,795.81
FY 2024 Plan	
Program Goal / Anticipated Impact	• *Community Outreach and Education:* Educate 3,500 individuals in the community regarding breast cancer and breast health • *Mammogram Screenings:* Provide 350 free screening mammograms. • Engage existing collaborating organizations and conduct additional staff and clinician education. • Collaborate in a minimum of 4 brand new community events and in doing so establish new community partnerships.
Planned Activities	• Educate individuals in the community regarding breast cancer and breast health • Provide free screening mammograms. • Engage existing collaborating organizations • Conduct additional staff and clinician education. • Collaborate in community events. ○ Establish new community partnerships.

Other Programs and Non-Quantifiable Benefits

The hospital delivers community programs, services, and non-quantifiable benefits in addition to those described elsewhere in this report. Like those programs and initiatives, the ones below are a reflection of the hospital's mission and its commitment to improving community health and well-being.

- **Helping Hands Holiday Jam** –Northridge Hospital Foundation has provided a Christmas wonderland for disadvantaged children from eight Title 1 LAUSD schools providing a day of celebration with food, fun, and a bag of toys for the holidays.
- **Listos California –**A one-year grant-funded program by the California Governor's Office of Emergency Services (CAL OES). This program aims to provide culturally competent education to prepare all older adults and their caregivers for wildfire, flood, earthquake, drought, heatwave, and other disasters.
- **Medical Safe Haven -** Family Practice Medicine Residents to identify and treat victims of Human Trafficking in the clinic in partnership with a Journey Out Survivor Advocate.
- **Reduce Disparities in Monkeypox (Mpox) Vaccination Project –** This program aims to increase knowledge of Mpox, reduce Mpox vaccine hesitancy, and increase uptake of the Mpox vaccine within the LGBTQ+IA community.
- **Welcome Baby –** A free maternal-child home visitation program that provides support to mothers during their pregnancy and throughout the baby's first nine months.

Abode Communities (Abode) - In 2019 Dignity Health approved a 3-year $2,000,000 line of credit to fund acquisition and predevelopment costs related to new development projects. A partner of Dignity Health since 2010, Abode is considered a thought leader in the affordable housing industry and since 2012, has placed in service 500 affordable housing units within the County of Los Angeles, with another 900 affordable units currently under construction and expected to be placed in service over the next several years. The line of credit was renewed in 2022 and will provide 431 units of housing. With Dignity Health's support, Abode has built affordable housing in Long Beach, Hollywood, South and Central Los Angeles. The line of credit was renewed in 2022 and will provide 431 units of housing in Coachella Valley / Indian Wells, Berkeley (Workforce Housing), and Los Angeles.

Genesis LA Economic Growth Corporation - Founded in 1998, this is a Community Development Financial Institution (CDFI) with over $42 million in total assets, making it the fourth largest CDFI headquartered in Los Angeles (LA) County. In September 2018, Dignity Health approved a 7-year $1,000,000 loan to Genesis for lending capital in Genesis' GCIF that focuses on investments in community development projects, affordable housing, and microloans to residents living in the underserved, economically distressed communities of LA County.

United Way of Greater Los Angeles - United Way of Greater Los Angeles is a Los Angeles, California, nonprofit organization whose mission is to permanently break the cycle of poverty for the most vulnerable individuals, supporting low-income families, students, veterans, and people experiencing homelessness. The organization administers an annual fundraising campaign in Los Angeles County, California, and uses those funds to support a variety of human services. UWGLA is focused on providing long-term solutions in three interconnected areas that the organization believes are the root causes of poverty, which include low-income individuals having a home, quality education and career, and access to economic resources and opportunities to thrive. Loan proceeds approved in 2023 will be used to support UWGLA's new Affordable Housing Initiative Fund which was started in 2020 to finance the creation and preservation of up to 2000 affordable homes through 60 developments (Predominantly minority-owned or BIPOC developers), with a focus in the Greater Los Angeles area.

Economic Value of Community Benefit

341 Northridge Hospital Medical Center					
Complete Summary - Classified (Programs) Including Non Community Benefit (Medicare)					
For period from 07/01/2022 through 06/30/2023					
	Persons	**Expense**	**Offsetting Revenue**	**Net Benefit**	**% of Expenses**
Benefits for Poor					
Financial Assistance	**12,858**	**$9,630,426**	**$0**	**$9,630,426**	**2.0%**
Medicaid	**38,085**	**$212,703,196**	**$183,029,691**	**$29,673,505**	**6.0%**
Community Services					
A - Community Health Improvement Services	27,712	$1,615,379	$876,258	$739,121	**0.2%**
E - Cash and In-Kind Contributions	4	$673,095	$0	$673,095	**0.1%**
G - Community Benefit Operations	102	$905,975	$0	$905,975	**0.2%**
Totals for Community Services	**27,818**	**$3,194,449**	**$876,258**	**$2,318,191**	**0.5%**
Totals for Benefits for Poor	**78,761**	**$225,528,071**	**$183,905,949**	**$41,622,122**	**8.5%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	20,745	$1,458,903	$1,088,830	$370,073	**0.1%**
B - Health Professions Education	2,463	$12,866,159	$2,507,844	$10,358,315	**2.1%**
C - Subsidized Health Services	Unknown	$14,477,953	$13,292,148	$1,185,805	**0.2%**
E - Cash and In-Kind Contributions	383	$46,251	$9,550	$36,701	**0.0%**
F - Community Building Activities	1,789	$283,189	$296,519	$0	**0.0%**
Totals for Community Services	**25,380**	**$29,132,455**	**$17,194,891**	**$11,937,564**	**2.4%**
Totals for Broader Community	**25,380**	**$29,132,455**	**$17,194,891**	**$11,937,564**	**2.4%**
Totals - Community Benefit	**104,141**	**$254,660,526**	**$201,100,840**	**$53,559,686**	**10.9%**
Medicare	**30,499**	**$101,372,741**	**$87,728,208**	**$13,644,533**	**2.8%**
Totals Including Medicare	**134,640**	**$356,033,267**	**$288,829,048**	**$67,204,219**	**13.7%**
**Consistent with IRS instructions and CHA guidance, Community Building ACtivities are reported at $0 net benefit because offsetting revenue was greater than expense in FY23. Net gain for Community Building Activities is still included in all "Totals" calculations, however.					

The economic value of all community benefit is reported at cost. Patient financial assistance (charity care) reported here is as reported to the Office of Statewide Health Planning and Development in Hospital Annual Financial Disclosure Reports, as required by Assembly Bill 204. The community benefit of Medicaid and other means-tested programs is calculated using a cost-to-charge ratio to determine costs, minus revenue received for providing that care. Other net community benefit expenses are calculated using a cost accounting methodology. Restricted offsetting revenue for a given activity, where applicable, is subtracted from total expenses to determine net benefit in dollars.

Hospital Board and Committee Rosters

Daren Schlecter - Board Chair
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Retired Community Resident

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Radiologist

Paul Watkins
President, Northridge Hospital Medical Center