Northridge Hospital Medical Center

Community Benefit 2022 Report and 2023 Plan

Adopted November 2022

A message from

Paul Watkins, President and CEO of Dignity Health – Northridge Hospital Medical Center, and Steve Valentine, Chair of the 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 2022 Report and 2023 Plan describes 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 voluntarily produce these reports and plans, as well. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report to our community.

In fiscal year 2022 (FY22), Northridge Hospital provided $53,209,781 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $19,999,607 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 2022 Report and 2023 Plan at its November 8, 2022 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 at 818-718-5936.

Paul Watkins President	Steve Valentine Chairperson, Board of Directors

Table of Contents

At-a-Glance

Summary **Page 4**

Our Hospital and the Community Served **Page 6**

About the Hospital Page 6
Our Mission Page 6
Financial Assistance for Medically Necessary Care Page 6
Description of the Community Served Page 6

Community Assessment and Significant Needs **Page 8**

Community Health Needs Assessment Page 8
Significant Health Needs Page 8

2022 Report and 2023 Plan **Page 10**

Creating the Community Benefit Plan Page 10
Community Health Strategic Objectives Page 11
Report and Plan by Health Need Page 11
Community Health Improvement Grants Program Page 16
Program Highlights Page 17
Other Programs and Non-Quantifiable Benefits Page 24

Economic Value of Community Benefit **Page 25**

Hospital Board and Committee Rosters **Page 26**

At-a-Glance Summary

Community Served	Northridge Hospital's service area is located in Service Planning Area 2 of Los Angeles County, which consist 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	$53,209,781 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $19,999,607 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). 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
FY22 Programs and Services	The hospital delivered several programs and services to help address identified significant community health needs. These included: 1 Homelessness and Affordable Housing – Continuation of providing safe discharge of homeless patients through care coordination, provision of weather appropriate clothing, meals, transportation, referrals, prescriptions, screenings, vaccines, and as needed assistance in eligible health plans. Provide recuperative care for those that needed post discharge care. 2 Obesity/Overweight – Continued our commitment to the Community and School Wellness Initiative – Partnership with Los Angeles Unified School District to provide ongoing school wellness newsletter. Conducted virtual workshops Post COVID 19 conducted no outside guest permitted on school campuses throughout fiscal year 2022. Just completed our first year of a free drive through produce program in partnership with the American Heart Association to provide healthy food options to the food insecure the program. 3 Mental Health - The Cultural Trauma Mental Health Resiliency Program to address behavioral health and mental well-being funded community partnerships with local mental health providers to train folks on evidence-based Mental Health First Aid Adult and Youth and Question, Persuade, Refer (QPR). Additionally, the Jade Lee Marasigan Charitable Fund was created to assist adolescents and young adults receive continuation of care when diagnosed with behavioral health conditions. 4 Substance Use - Medicated Assisted Treatment (MAT) Program Implemented a program to provide safe management of opioid addicted patients that present to the ED. A Nurse Practitioner with MAT waiver training will provide medication management, alternatives to opioids, community resources, and a warm handoff to drug treatment/detox centers. 5 Diabetes and other Chronic Disease Wellness Programs - expanded diabetes programs to conduct virtual evidence-based Diabetes Self-Management programs through the

	Prevention Forward project and continued the Activate your Heart program and added Blood Pressure Self-Monitoring education. 6 Child and Adult Violence Prevention programs were continued and newly implemented. In 2022 the Center for Assault Treatment Services –Continued to provide Forensic interviews and medical exams for child and adult victims of sexual abuse/assault, domestic violence, child maltreatment, human trafficking, and dating abuse .Additionally, we are in year three of our STOP School Violence program, we increased membership in the Local Elder Abuse Prevention Elder Abuse Multidisciplinary Team (LEAP-EMDT), and added a Domestic Violence Prevention Program with virtual prevention education and peer support. Due to the COVID 19 Pandemic and the high rates of infection and death in Los Angeles. The Northridge Hospital Center for Healthier Communities staff continues to provide extensive COVID 19 Outreach and Engagement to reduce the incidence of vaccine hesitancy and encourage the most vulnerable populations to become vaccinated incorporating social media outreach. This funding was extended into a second year and additional funding was received form the Health Resources and Services Administration (HRSA) to establish pop up vaccine clinics that began in late 2021 through January 2023.
FY23 Planned Programs and Services	The hospital intends to continue the programs listed above in collaboration with our community partners and grantees with expanded efforts including: 1. Mental Health – Additional staff will be trained to educate those working with youth and their parents on Question, Persuade, Refer (QPR) so that more providers are skilled in caring for those dealing with mental health issues. Positive Action is an evidence-based curriculum that uses real-life concepts to foster social emotional learning and developing a positive self-concept that will be used in LAUSD sites. 2. Substance Abuse – Continue the Medicated Assisted Treatment (MAT) program. 3. In addition to providing evidence-based diabetes and pre diabetes self-management sessions we will build the capacity of local pharmacies to also begin to implement diabetes workshops and support their accreditation and recognition process. This continues to be in partnership with the California Department of Public Health. 4. Recently partnered with a local FQHC clinic that provides dental care and screening for benefits we will support those efforts while also providing oral health education to parent centers and through articles in the school based newsletter to better support oral health promotion. 5. Access to Healthcare Services – Continued financial assistance for the uninsured and under insured, continuation of providing access to recuperative care for those that are homeless and do not have a safe place to recover. Continue to set up pop up vaccine clinics to help alleviate health disparities related to lack of resources. 6. Nutrition, Physical Activity, & Weight- Continued partnership with LAUSD additionally, staff will begin to add a physical activity session to some of our chronic disease workshops to encourage movement. Continue free produce program. 7. Respiratory disease (COVID 19) Continue working with our partners to provide education, mask, COVID 19 test kits, and pop up vaccine clinics. 8. Heart disease and stroke- Continue the Activate your Heart program and added blood pressure self-monitoring program. .

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 Dignity Health - 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 bed general acute care plus 40 acute psychiatric bed non-profit hospital facility. NHMC has over 1,840 employees and 750 active physicians. Major programs and services include Cancer Center with expanded Infusion Room, Center for Assault Treatment Services, 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

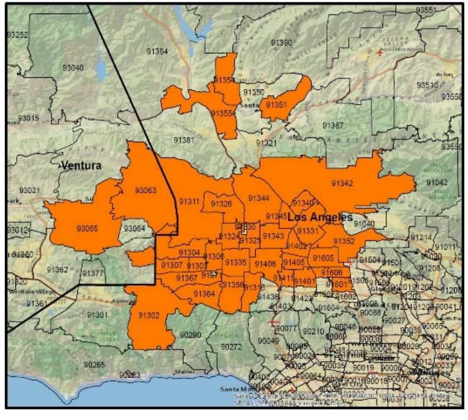
A healthier future for all – inspired by faith, driven by innovation, and powered by our humanity.

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

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

	FY22
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%
Total Hispanic & Race	
% Below Poverty	9.0%
Unemployment	5.0%
No High School Diploma	19.3%
Medicaid	32.1%
Uninsured	8.9%
Source: Claritas Pop-Facts® 2022; *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 Coverage Estimates (map data export)	

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 2022 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 detail 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. Below are the areas of opportunities identified through the assessment

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 trainings 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

Significant Health Need	Description	Intend to Address?
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 around self-management of the disease. The programs that will be implemented will address these issues.	Yes
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.(Healthy eating, stop smoking/vaping, brush & floss)	Yes
Access to Healthcare Services	Community input suggest that health care access has now because a priority. Some of the barriers have been difficulty in getting appointments, having to stretch medication, unaffordable even with insurance, this includes mental health access.	Yes
Nutrition, Physical Activity, &Weight	This rose to the top as an issue due to inactive and weight gain during COVID, less food security due to high cost. The community does have an awareness of how nutrition and physical activity can affect cardiovascular health, diabetes, and obesity rates. Programs that are culturally relevant for 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 a hot topic issue we are still working with both federal and local government agencies to help reduce the disparities faced in some of our 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 teaching of self-management skills.	Yes

Significant Needs the Hospital Does Not Intend to Address

The eight needs listed above were the ones prioritized as the most significant and the hospital plans to address all eight of those prioritized as most needed. The 2022 CHNA report also list cancer, Alzheimer's, and sexual health but they were not prioritized as significant needs. We do have programs for cancer and working in partnership with our local Alzheimer's Association.

2022 Report and 2023 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 FY22 and planned activities for FY23, 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 benefit with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

Hospital and health system participants included our hospital foundation staff, mission department, wellness committee, and the transitional care team all of whom will work collaboratively to improve the health outcomes of the communities we serve.

Community input or contributions to this community benefit plan include leveraging our membership of the Valley Care Community Consortium (VCCC). VCCC is the health and mental health collaborative of Service Planning Area 2 of Los Angeles County that NHMC services. The consortium consists of other hospitals, FQHC clinics, faith-based and community-based organizations along with community members. Semi-annual meetings are held where community input is gathered to determine needed programs and services to assist with the social determinants of health. 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

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. New COVID 19 programs were started in FY 21 and 22 and will continue through FY 23 because the community residents has prioritized this issue in their top eight community health needs concerns and we continue to work with our federal and state partners to halt the spread of new COVID 19 variants to

reduce the disparities faced in underserved areas with this ongoing pandemic. The Center for Healthier Communities is dedicated to the goal of health promotion, primary, secondary, and tertiary health prevention and in helping to address the social determinants of health that remain evident in some of the communities we serve.

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.

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

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

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

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

Strategy or Program	Summary Description	Active FY22	Planned FY23
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.	☒	☒
ACE's Aware Network of Care	As a Network of Care partner, we will screen for ACEs and respond to and help prevent toxic stress. In addition, we will work collaboratively to develop sustainable, community-informed, evidence-based services among Medi-Cal patients.	☐	☒
Positive Action	Positive Action is an evidence-based curriculum that uses real-life concepts to foster social emotional learning and developing 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, along with the adults who care for them, in communities where significant health disparities exist. ACE's goal will be to identify youth that score 4 or higher on the screening to and utilize a web-based referral process to link them to needed resources to promote healing. Positive Action will be to improve youth self-concept.

Collaborators: In partnership with five other Dignity Health Hospitals, 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 of evidence-based programs. The ACE's Network of Care team consist 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, Savaye LLC, Department of Children and Family Services (DCFS), and San Fernando Valley Community Mental Health Center (SFVCMHC). Positive Action will be implemented in 10 LAUSD schools.

Health Need: Substance Use Disorders (Alcohol and Drug)

Strategy or Program	Summary Description	Active FY22	Planned FY23
ED Collaborative for Medicated Assisted Treatment (MAT)	Implement a program to provide safe management of opioid addicted patients that present to the ED. A Nurse Practitioner with MAT waiver training will provide medication management, alternatives to opioids, community resources, and a warm handoff to drug treatment/detox centers.	☒	☒

Goal and Impact: To reduce the death rate of those living with addition by providing 100% of the patients admitting to the ED a warm hand off to staff to encourage a minimum of 85% to work with one of the MAT licensed providers in our ED.

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

Strategy or Program	Summary Description	Active FY22	Planned FY23
Prevention Forward Diabetes Wellness including NDPP for prediabetes and DEEP for diabetic patients	• Continue our multi-disciplinary team based approach • Implement Diabetes Education and Empowerment Program (DEEP) for diabetes patients • Provide 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 capacity to local pharmacy to become recognized as ADA provider increasing access to free diabetes self-management education	☒	☒

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. Increased use of community health worker to support pre-diabetes patients. 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: The hospital will partner with California Department of Public Health that will target low-income community residents with pre-diabetes, diabetes, heart disease, high blood pressure, stroke, and high cholesterol patients to enroll in evidence-based classes and case management with pharmacist, community health worker, and MD to self-manage their chronic conditions. We will also partner with two Saint Mary's pharmacies and an FQHC clinic (Comprehensive Community Health Centers).

Health Need: Oral Health

Strategy or Program	Summary Description	Active FY22	Planned FY23
LAUSD Oral Health Promotion Program	• Provide oral health promotion workshops to parent centers in LAUSD schools • Create an Oral Health Section to 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 hospitals promotion and prevention education sessions will be to increase knowledge and encourage more frequent brushing and flossing. Too 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 targeted oral health promotion and prevention education.

Collaborators: The hospital will partner 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 Care

Strategy or Program	Summary Description	Active FY22	Planned FY23
Healthy Families Initiative	Provided a community benefit grant to Catholic Charities Guadalupe Center that will support this program covering FY 22 and FY 23. This program offers physical and mental health awareness workshops with a “meet the doctor” program and offer referrals to services as needed.	☒	☒
ACE’s Aware Promise Grant	This program was in the planning phase in FY 22 and is now active in FY23. Youth are screened for Adverse Childhood Experiences and through coordinated web based referral platform called One Degree all youth regardless of ability to pay will be connected to the appropriate resources.	☐	☒
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 provide by the hospital.	☒	☒

Goal and Impact: The hospital’s initiatives to address access to care are anticipated to result in: early identification and treatment of health issues through free local prevention programs and increased knowledge about how to access and navigate the health care system; and increased primary care “medical homes” among those identified through the ACEs Aware program and those seeking care from our primary care partner FQHC clinics. In FY22 $7,969,434 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 assure that individuals are connected to a medical home. In addition, the hospital will continue to provide in-kind services through the patient Financial Assistance Program.

Nutrition, Physical Activity & Weight

Strategy or Program Name	Summary Description	Active FY22	Planned FY23
School Wellness Initiative	For over a decade we have partnered with LAUSD Parent Centers to offer in person and virtual workshops on healthy diet, importance of exercise, stress management, at no cost. Additionally, our staff is responsible for the preparation of Quarterly School Wellness Newsletter.	☒	☒
Prevention Forward Program	The prevention forward program focuses on chronic disease management of diabetes, pre diabetes, cardiovascular, blood pressure, cholesterol, and stroke prevention. All of these programs mentioned elsewhere in this report emphasis education on nutrition, exercise, stress management, and self-monitoring.	☒	☒

Monthly Produce Distribution	In partnership with the American Heart Association this program offers free produce on the last Thursday of each month through a drive up pick up model, so folks can stay in their cars and volunteers will load the care in a safe and efficient manner.		

Impact: Increased child and parent knowledge of importance of healthy diet and physical activity and stress management. Increases in the consumption of healthy food, building interdisciplinary collaborations to create healthier environments, and increased awareness in health promotion creating healthier families. Approximately 350 families will have access to free produce each month.

Collaboration: Continued partnership with Los Angeles Unified School District Principals and Parent Center Leaders. Prevention Forward is a partnership with the California Department of Public Health that 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 chronic health issues. Continue the joint partnership Free Produce program with the American Heart Association.

Health Need: Respirator Diseases (Including COVID-19)

Strategy or Program	Summary Description	Active FY22	Planned FY23
COVID 19 Equity Project	Provide accurate outreach and education about COVID 19 to those living in the highest impact areas which is most cases are low income communities with a high population of people of color facing health inequities. Additionally, to provide PPE equipment to residents living in designated zip codes that were dealing with higher rates of COVID 19 infection rates.	☒	☒
San Fernando Valley Vaccine Collaborative	This federally funded program was tasked with providing accurate COVID 19 information to those communities with the highest vaccine hesitancy rates and lowest vaccine rates. Increase capacity by creating a community-based workforce with multiple partners to offer pop-up vaccine clinics in the communities of greatest need.	☒	☒

Goal and Impact: In collaboration with the Los Angeles County Department of Public Health (LA DPH) and other community based organizations we are working to reduce the disproportionate impact of COVID 19 by creating a community-centered system of care to deliver coordinated community-based services. As reported in the 2022 Community Health Needs Assessment The COVID 19 Outreach and Education team reached 1,257 community members through 11 virtual workshops, health and resource events and food pantries. Additionally, the HRSA team hosted 89 pop up vaccine clinics that vaccinated 4,866 individuals as of this report that number has increased to over 7,000 with over 300,000 individuals receiving COVID 19 prevention education and testing kits.

Collaborators: Partners in this effort include HRSA, LADP, Meet Each Need with Dignity (MEND), Pacoima Beautiful, Northeast Valley Health Corporation, Valley Care Community Consortium, San Fernando Community Health Center, ONEgeneration, North Valley Caring Services and Community Partners

Health Need: Heart Disease & Stroke

Strategy or Program	Summary Description	Active FY22	Planned FY23
Prevention Forward Activate Your Heart and Blood Pressure Self-Monitoring Program	Conduct eight-week 2-hour sessions of evidence-based heart disease prevention classes including 20 minutes of stress management and 40 minutes of an exercise 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 stokes.	☒	☒

Goal and Impact: The hospitals promotion and prevention education sessions will be to increase knowledge and encourage more frequent brushing and flossing. Too 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 targeted oral health promotion and prevention education.

Collaborators: The hospital will partner 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. Continue our ongoing partnership with California Department of Public Health.

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 FY22, the hospital awarded the grants below totaling $296,863. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Catholic Charities	Healthy Families Initiative	$52,510
Journey Out	Long Term Support Services to Assist Human Trafficking Victims with Social Reintegration	$52,510
San Fernando Valley Community Mental Health Inc.	Building Capacity for ACEs Aware Trauma Informed Network of Care	$52,510
National Alliance of Mental Illness	Cultural Trauma Mental Health Resiliency Funds	$89,033
San Fernando Valley Community Mental Health Inc.	Cultural Trauma Mental Health Resiliency Funds	$50,300

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 six Dignity Health Southern California Hospital 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 target to school teachers, school social workers, 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 2022 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 22 staff and partner sites offered 55 Mental Health First Aid training sessions and reached a total of 738 individuals. Additionally, 24 QPR sessions were conducted by staff and NAMI training 559 individuals.
Hospital's Contribution / Program Expense	The majority of the program expenses are covered through shared grant funding with the hospital contributing $139,333 to NAMI and SFVCMH. Additionally, the hospital provided a second Community Benefit grant to SFVCMH to develop their work with the ACEs Aware planning process in the amount of $52,510 to support staff and technology.
FY 2023 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.

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

Significant Health Needs Addressed	Substance Abuse Mental Health Access to Healthcare Services
Program Description	Continue MAT program to provide safe management of opioid addicted patients that present to the ED and transition to the inpatient setting. A Nurse Practitioner with MAT waiver training will provide medication management, alternatives to opioids and community resources.
Population Served	Individuals dealing with an opioid addiction
Program Goal / Anticipated Impact	Continue to support the Substance Abuse Navigator in the ED with the resources needed to be able to connect drug addicted individuals presenting in ED with a warm handoff to drug treatment/detox centers.
FY 2022 Report	
Activities Summary	MAT trained clinicians and the Substance Abuse Navigator work to get 80% or more of the opioid patients to agree to participate in MAT. The Pain Management team supports this process through provision of counseling and education of these patients and provide warm hand off for continuation of care.
Performance / Impact	Staff was able to serve 713 addicts and connect them to drug treatment centers including Tarzana Treatment Center, Discovery House, Cri-Help and ProWellness Academy for continuum of care services.

Hospital's Contribution / Program Expense	The services we provide, in partnership with SFVCMH, will enhance opportunities for support in conjunction with the range of medical, substance abuse, and mental health services. Additionally, the hospital supports the time for staff to participate in MAT waiver training.
FY 2023 Plan	
Program Goal / Anticipated Impact	Physicians and clinical staff with a MAT X-Waiver will initiate Medicated Assisted Treatment in the Emergency Department and inpatient units, serving a minimum of 125 patients of color annually/375 patients over 3 years. A Social Worker continues to serve as a Substance Abuse Navigator to assist patients with post-discharge treatment plans by identifying and referring to treatment facilities that specialize in MAT, substance abuse, and/or mental health.
Planned Activities	Staff and Partners planned activities for FY 23 1) Provision of counseling and education for patients identified as abusing drugs with a strong focus on opioid addiction. 2) Continue partnership with existing partners listed above and add new treatment providers including behavioral health partners.

	Prevention Forward
Significant Health Needs Addressed	Diabetes Nutrition, Physical Activity & Weight Heart Disease & Stroke
Program Description	Prevention Forward is a grant funded public health program through CDPH that operates under the Chronic Disease Control Branch (CDCB). The main objective of the program is to implement evidence-based curriculums to prevent, manage, and treat cardiovascular disease, high blood pressure, high cholesterol, stroke, prediabetes, and Type 2 diabetes.
Population Served	18-85 year olds with one or more of the following health conditions that reside in the San Fernando Valley and Santa Clarita Valley: • High blood pressure • High blood cholesterol • Type 2 diabetes • Prediabetes • Cardiovascular disease • Stroke
Program Goal / Anticipated Impact	The primary impact the program will achieve is decreased rates of chronic diseases and complications from chronic diseases among community members.

FY 2022 Report	

Activities Summary	• Implemented the following evidenced based curriculums:
	  ◦ ADCES 7: Diabetes Care and Education curriculum
	  ◦ National Diabetes Prevention Program
	  ◦ Blood Pressure Self-Monitoring Program
	  ◦ Diabetes Empowerment Education (DEEP)
	• Workshops including Activate Your Heart and Fall Prevention among Seniors, Mindfulness and Stress Management, Sleep Hygiene, and other health topics
	• Implement strategies to increase recruitment and enrollment in evidence-based lifestyle change programs.

Performance / Impact	• Identified 369 patients during FY22 who meet qualifications for the PF Program. • Recruited 22 people during FY22 and maintained a minimum of 15 people during FY22 to participate in NDPP or DSMES. • Identified St. Mary's Pharmacy as partner to achieve ADA recognition • Participate in a minimum of 4 cultural humility trainings to improve high burden population referrals to NDPP and DSMES • Identified 16 local pharmacies within 5 miles of Contractor to promote PF services and pharmacy survey
Hospital's Contribution / Program Expense	• Trainings provided by Right Care Initiative Virtual University of Best Practices and CDPH • EHR system for referrals • Transitional Care team to provide referrals, pharmacist assistance, and diabetes nurse practitioner • Program management support and community health worker
FY 2023 Plan	
Program Goal / Anticipated Impact	Identify a minimum of 100 patients per year who meet qualifications for the PF Program. Recruit and maintain a minimum of 15 people per year to participate in NDPP or DSMES. Partner with one other agency to achieve ADA recognition Annually participate in 2-4 cultural humility trainings to improve high burden population referrals to NDPP and DSMES Identify 15 local pharmacies within 5 miles of Contractor and engage 3-5 pharmacies in PF DSMES patient coordination
Planned Activities	• Continue to implement the evidenced based curriculums we did in FY22 and assist St Mary's Pharmacy and Clinicare to achieve ADA accreditation • Partner with Comprehensive Community Health Centers to establish NDPP at Sunland location • Partner with other community based organizations and faith based organizations to provide health education workshops and support PF recruitment • Implement strategies to increase recruitment and enrollment in evidence-based lifestyle change programs.

Community and School Wellness Initiative	
Significant Health Needs Addressed	• Nutrition, Physical Activity and Weight • Mental Health • Substance Abuse • Oral Health • Diabetes • Heart Disease and Stroke
Program Description	Community and School Wellness Initiative program is designed to improve the physical and mental health and wellness with a focus on nutrition, physical activity promotion, obesity, and chronic disease management through on site workshops and classroom lessons at 34 local Los Angeles Unified School District Title 1 schools in our area. Both children and adults are impacted by the health promotion and education provided by the hospital Center for Healthier Communities staff.
Population Served	Students and parents being served by Los Angeles Unified School District (LAUSD) Northeast and Northwest Title 1 schools.
Program Goal / Anticipated Impact	Increases child and parents knowledge in healthy living and evidence-based health curricula. Enhance socio-emotional wellness in parents, children, and educators, and enhance adults' capacity to support children in coping with COVID-19 stressors.
FY 2022 Report	
Activities Summary	Created 4 School Wellness Newsletters for 34 schools. Facilitated the Great Kindness Challenge in 14 schools. Conduct educational workshops, as requested by school sites on nutrition, physical activity, and emotional health.
Performance/Impact	Many of the parents and children in Title 1 schools fall below or within 200% of the Federal Poverty Level. Due to immigration status some of them do not have broad access to health education that is provided in their own language by trained public health educators or community health workers. We provide all health education and promotional materials in a culturally and linguistically appropriate way.
Hospital's Contribution / Program Expense	This program is primarily staffed by the Program Manager at the NHMC Center for Healthier Communities and supported by other interns or staff members that are grant funded to address the prevention of chronic disease, which always includes healthy diet and nutrition. The hospital contributes the cost of all supplies for this program and in FY22 that equaled $38,036
FY 2023 Plan	
Program Goal / Anticipated Impact	Continuation of all existing strategies reaching new students and parents each year to promote healthy lifestyles to decrease the risk of obesity/overweight youth and adults through nutrition education and maintaining an active lifestyle and increasing the level of physical activity for those that are currently not meeting the federal guidelines. In addition

	we will continue our focus on socio-emotional wellness through workshops on mindfulness, mindful movement, and support mental health in youth and children.
Planned Activities	Continue to create and distribute quarterly School wellness newsletters to 34 schools. Add an Oral Health Section to the newsletter to promote oral health. Conduct 6 workshops per semester to LAUSD parent centers which will include two workshops dedicated to Oral Health Prevention.

	DPH County COVID-19 Community Equity Fund 2.0
Significant Health Needs Addressed	Respiratory Disease (COVID 19)
Program Description	The goal of this program is to slow the spread of COVID-19 in the Northeast San Fernando Valley and surrounding areas through outreach, education, and engagement efforts by encouraging preventive behaviors, providing up-to-date information, and dispelling myths and misinformation.
Population Served	Individuals living in the Northeast San Fernando Valley. This program targets schools, community based organizations, local businesses, faith based organizations, and community centers.
Program Goal / Anticipated Impact	Increase knowledge surrounding COVID-19, dispel myths and misinformation, provide the most-up-to-date County information through community outreach and education. • Active Engagements: 100 min activities per FTE • Passive Engagements: 8 min activities per month • Social Media: 8 posts per month
FY 2022 Report	
Activities Summary	• Attend community events like vaccine clinics, resource events, and food pantries hosted by community based organizations and schools. • Participate in community coalitions • Conduct street outreach in at-risk areas • Drop offs to local community businesses • Bus Campaign and dissemination of PPE kits • Conduct COVID-19 workshops on various topics like: healthy for the holidays, COVID-19 and Youth, Immigrant Communities and COVID-19 • Collaborate with small businesses in the Northeast San Fernando Valley to meet their needs and concerns by facilitating a small business webinar series.
Performance / Impact	• Active Engagements: 100 min activities per FTE • Passive Engagements: 8 min activities per month • Social Media: 8 posts per month
Hospital's Contribution / Program Expense	• Program management, 2 Community Health workers • Partnerships with community based organizations • Outreach communications and accommodations (i.e mileage)
FY 2023 Plan	

Program Goal / Anticipated Impact	Increase knowledge surrounding COVID-19, dispel myths and misinformation, and provide the most-up-to-date County information through community outreach and education in target areas including Sun Valley, Pacoima, and Arleta. • Active Engagements: 110 min activities per FTE • Passive Engagements: 8 min activities per month • Social Media: 8 posts per month
Planned Activities	Our staff planned activities include: • Attend community events like vaccine clinics, resource events, and food distribution hosted by community based organizations and schools • Participate in community coalitions that cater to our targeted population • Conduct street outreach in Sun Valley, Arleta, Pacoima and surrounding areas in the San Fernando Valley • Drop off informational packages to local businesses, schools, and community centers • Bus Campaign and dissemination of hand sanitizers, masks, and at-home testing kits • Radio Campaign lasting 6 weeks with messaging related to COVID-19 and protective measures • Conduct COVID-19 workshops on various topics like LA County Vaccine Guidelines, booster information, and how to keep children protected against COVID-19

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.

- **Cancer Center** Free mammogram screenings, ultrasounds, biopsies, and consults for community for the under-served and non-insured.
- **Center for Assault Treatment Services –** This program is entering its 26th year as a member of the Sexual Assault Response Team (SART) and Domestic Assault Response Team (DART) and provides compassionate, comprehensive medical examinations and forensic interviews to child and adult victims of sexual assault, domestic violence, child maltreatment, and human trafficking victims at no cost to the victim.
- **Helping Hands Holiday Jam** –Northridge Hospital Foundation has provided a Christmas wonderland for disadvantaged children from eight Title 1 LAUSD schools providing toys.
- **MD Continuing Education –** Classes offered to physicians on the medical staff and for community medical providers on various topics of importance to build knowledge base and increase quality of care.
- **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.
- **STOP School Violence Program-** Train school personnel and educate students on preventing and reducing school violence using Positive Action and Safe Dates curriculum.
- **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.

In addition, we invest in community capacity to improve health –addressing the social determinants of health – through Dignity Health's Community Investment Program.

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.

Corporation for Supportive Housing (CSH) -In June 2016 Dignity Health approved a 7-year $3,000,000 loan to CSH to further this CDFI's work in creating supportive housing geared toward preventing and ending homelessness. CSH has been a close partner with Dignity Health hospitals particularly in Santa Cruz, Los Angeles and Las Vegas, working to reduce length of stays by frequent users (mostly homeless) of the hospitals' ER.

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.

Economic Value of Community Benefit

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.

341 Northridge Hospital Medical Center
Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2021 through 6/30/2022

	Persons	Expense	Offsetting Revenue	Net Benefit	% of Expenses
Benefits For Poor					
Financial Assistance	**11,161**	**7,969,434**	**0**	**7,969,434**	**1.8%**
Medicaid	**34,169**	**129,060,069**	**98,546,149**	**30,513,920**	**6.8%**
Community Services					
A - Community Health Improvement Services	9,704	1,964,077	633,438	1,330,639	0.3%
E - Cash and In-Kind Contributions	3	386,030	0	386,030	0.1%
G - Community Benefit Operations	34	667,928	0	667,928	0.1%
Totals for Community Services	**9,741**	**3,018,035**	**633,438**	**2,384,597**	**0.5%**
Totals for Poor	**55,071**	**140,047,538**	**99,179,587**	**40,867,951**	**9.1%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	16,249	1,523,292	953,185	570,107	0.1%
B - Health Professions Education	1,996	11,120,060	1,005,447	10,114,613	2.3%
C - Subsidized Health Services	0	15,959,515	15,163,813	795,702	0.2%
E - Cash and In-Kind Contributions	306	167,960	47,235	120,725	0.0%
F - Community Building Activities	7,190	1,444,164	703,481	740,683	0.2%
Totals for Community Services	**25,741**	**30,214,991**	**17,873,161**	**12,341,830**	**2.7%**
Totals for Broader Community	**25,741**	**30,214,991**	**17,873,161**	**12,341,830**	**2.7%**
Totals - Community Benefit	**80,812**	**170,262,529**	**117,052,748**	**53,209,781**	**11.9%**
Medicare	**20,532**	**99,870,438**	**79,870,831**	**19,999,607**	**4.5%**
Totals with Medicare	**101,344**	**270,132,967**	**196,923,579**	**73,209,388**	**16.3%**

Hospital Board and Committee Rosters

Maritza Artan
Retired Community Resident

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Law Offices of Daren Schlecter

Steve Valentine
Valentine Health Advisers

Anil Wadhwani, M.D.
Radiologist

Paul Watkins
President, Northridge Hospital Medical Center

Farrell Webb
Dean, College of Health & Human Development
California State University, Northridge