Northridge Hospital Medical Center

2019 Community Health Implementation Strategy

Adopted November 2019

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At-a-Glance Summary

<table>
<tr><td>Community Served
 </td><td>Northridge Hospital Medical Center's (NHMC) service region spans cities, communities, and unincorporated areas in the San Fernando and Santa Clarita Valleys in Los Angeles County, including two zip codes in Simi Valley and Ventura County.
The geographic area is comprised of 26 cities with 40 ZIP codes which represent roughly 80% of the total patients seen at Northridge Hospital in fiscal year 2018. Northridge Hospital's primary service area is comprised of 24 ZIP codes in Canoga Park, Chatsworth, Granada Hills, North Hills, North Hollywood, Northridge, Pacoima, Panorama City, Reseda, Sylmar, Van Nuys, Winnetka and Woodland Hills. The remaining 16 zip codes make up our secondary service. The NHMC service region is comprised of nearly 1.9 million residents</td></tr>
<tr><td>Significant Community Health Needs Being Addressed
 </td><td>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:
• Homelessness and Affordable Housing
• Obesity/Overweight (Children and Adults)
• Mental Health
• Substance Abuse (Drug & Alcohol)
• Diabetes
• Child/Domestic Abuse</td></tr>
<tr><td>Strategies and Programs to Address Needs
 </td><td>The hospital intends to take several actions and to dedicate resources to these needs, including:
1) Continued participation in the San Fernando and Santa Clarita Valley Homeless Coalition to increase partnerships to support the homeless. Annual updates to the Homeless Resource Guide to support linkages for homeless patients to needed social support services and housing providers.
2) Incorporate our Diabetes Wellness RX program and Activate your Heart Program into a new Prevention Forward Program – In partnership with the CA Department of Public Health. The focus of the program is to implement evidence-based interventions to prevent, manage, and treat cardiovascular disease, high blood pressure, high cholesterol, stroke, prediabetes, and diabetes among patients 18-85 years old.
3) Center for Assault Treatment Services – Continue 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. Outreach prevention education and mandated reporter training.
4) Family Medicine Residency Program – In conjunction with the UCLA faculty group provide education and training to residents who then provide both inpatient and outpatient care to many of the underserved in the community.</td></tr>
</table>

	5) Community and School Wellness Initiative – Partnership with Los Angeles Unified School District to implement #VictoriousKids Running program to reduce childhood obesity. 6) The Cultural Trauma and Mental Health Resiliency Project is designed to help young people, particularly youth of color, identify mental distress, address the impacts of trauma, reduce stigma, and increase resiliency. 7) Safe Dates and Escape Now– Evidence-based programs provided to West Valley Boys and Girls Club sites (2 middle schools and 4 high schools) is an adolescent dating abuse prevention curriculum designed to raise students' awareness of what constitutes healthy and abusive dating relationships. Escape Now's violence prevention program is for adults with developmental disabilities at New Horizons. 8) Alzheimer's Disease and Related Dementia (ADRD) Program – A collaborative effort to improve the quality of respite and home-based services and case management to Alzheimer's Disease and Related Dementia individuals including community-based education, outreach, and support to caregivers and workers caring for ADRD individuals. 9) Pain Management and ED Collaborative Medicated Assisted Treatment (MAT) a program to increase referrals for opioid addicted population.
Anticipated Impact	Programs being continued, expanded and newly implemented will address the top six needs identified by community residents as significant health needs. The anticipated impacts of specific, major program initiatives, including goals and objectives, are stated in the program digests on the following pages. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to care; and help create conditions that support good health. The hospital is committed to monitoring key initiatives to assess and improve health outcomes in community.
Planned Collaboration	Northridge Hospital Medical Center has a long history of working in collaboration and is committed to serving an important role in our community through collaboration and partnerships with community partners in local capacity building and community building is significant and revolves around strong partnerships with residents, federally qualified health centers, political leaders and community and faith-based organizations. Collaboration Partnerships can be found in the Community Benefit Report as part of the Program Digest.

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 Medical Center (NHMC)

NHMC 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.

For more than 60 years, NHMC has proudly served our community. WE are committed to ensure patient safety, while our medical experts provide compassionate, technologically advanced care. We house an Emergency and Trauma Center, as well as a Cardio Vascular Center, Cancer Center, Advanced Primary Stroke Center, Behavioral Health, Women's and Children's Services, Rehabilitation, Center for Healthier Communities and the Center for Assault Treatment Services.

Our Mission

We are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

- Delivering compassionate, high-quality, affordable health services;
- Serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community to improve the quality of life.

Financial Assistance for Medically Necessary Care

Northridge Hospital Medical Center delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services.

A plain language summary of the policy is at the end of this report. The financial assistance policy and plain language summary are also on the hospital's web site, dignityhealth.org/northridgehospital.

Description of the Community Served

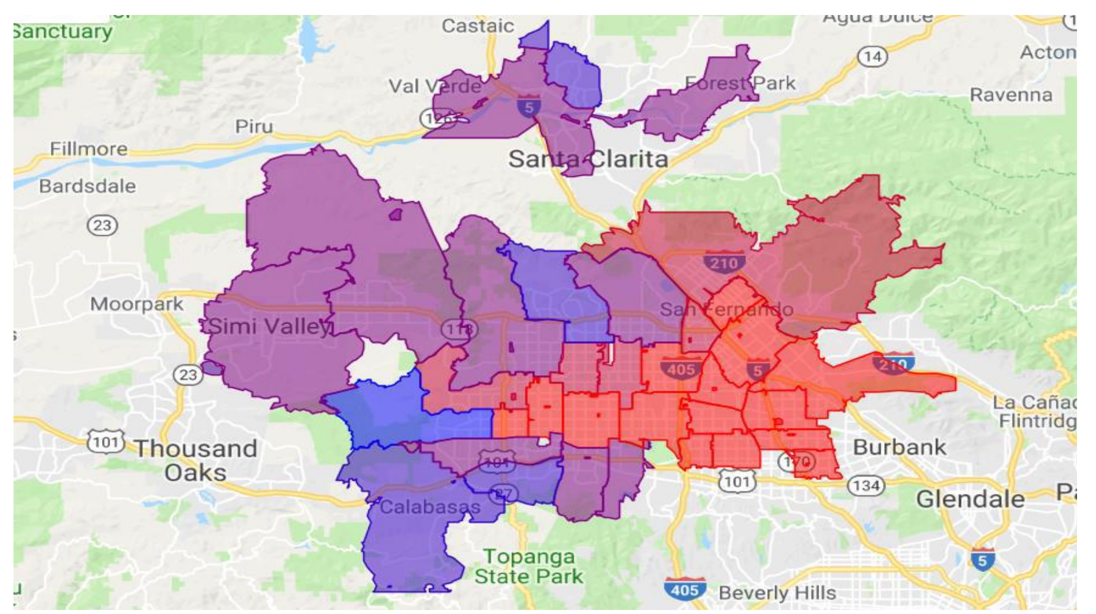
Northridge Hospital Medical Center proudly serves approximately 1.9 million residents of the hospital's service area located in northern Los Angeles County and a portion of the cities of Simi Valley in Ventura County, and parts of the Santa Clarita Valley. A summary description of the community is on page 7. Additional details can be found in the CHNA report online.

Description of Community Served (cont.)

NHMC's service area population is roughly 18% of Los Angeles County's and 4.5% of California's total population. The largest cities based on population count are Van Nuys, Northridge, North Hollywood, Canoga Park, and Simi Valley, each representing between 6% and 9% of the service region. Mission Hills, Calabasas, Encino, and Tarzana each represent less than 2% of the service region. The median age in the NHMC service region increased from 35.9 years in the 2016 CHNA report to 37.5 years. The racial composition of residents in the NHMC service region is 48.6% Latino, 33.5% White, 11.4% Asian/ Pacific Islander, 3.6% African American, and 2.9% other races. In comparison, Los Angeles County has fewer White residents (26%), and more Latino, and African Americans residents (49% and 8%).[1] In the Los Angeles County, 2% of the population identifies itself as "other" race.

Community Need Index

One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and IBM Watson Health. The CNI analyzes data at the zip code level on five factors known to contribute to or be barriers to health care access: income, culture/language, education, housing status, and insurance coverage.
Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zip code in the community. Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores.



	Lowest Need
	1-1.7
	1.8-2/5
	2.6-3.3
	3.4-4.1
	4.2-5
	Highest Need

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 triennial CHNA report, which was adopted in May 2019.

The process to identify and prioritize the significant health needs included steps to identify the needs, the factors and conditions contributing to those needs, the groups or populations most affected by needs, barriers and challenges to addressing needs, and the strategies and resources to address those needs. To assist in the identification of significant health needs, the following criteria was used:

- Severity – How severe is the problem considering morbidity and mortality?
- Magnitude – How many people are affected by the problem?
- Community Importance – How important is this issue to the community?
- Hospital Capacity – Does the hospital have the adequate resources to address the issue?

This document also reports on programs delivered during fiscal year 2019, which are linked 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
- 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 2019 CHNA report, which is publicly available at http://www.dignityhealth.org/northridgehospital/who-we-are/community-benefit-reports or upon request at the hospital's Community Health office.

Significant Health Needs

The most recent community health needs assessment identified the following significant community health needs:

1. Homelessness and Affordable Housing – The majority of community residents and public health experts described this as a top concern. Many expressed that the high costs of rent/mortgage are affecting their health and mental health. Additionally, many participants expressed concern about how homeless families and individuals receive the help they need to move out of that situation.

- In 2018, the total homeless count for SPA 2 was 7,478, and in 2015 the total homelessness count for SPA 2 was 5,215 which is roughly a 70% increase in the last three years. Additionally, of 7,478 homeless individuals, 74% are unsheltered. [14, 15]

2. Obesity/Overweight (Children and Adults) - Parents, community leaders, and public health professionals expressed a continuing concern about the obesity epidemic in their local communities. Food deserts and food swamps were issues identified as negatively affecting people's health. Some community members expressed the connection between obesity and chronic diseases, lack of nutrition education, and availability of unhealthy food options.
   - According to the data from the 2017 Key Indicators of Health, in Los Angeles County, 19.8% of adults are obese and an additional 37% are considered overweight. [2]

3. Mental Health - Mental health issues were a concern of community members who expressed the national political climate is affecting the decisions families make in accessing mental health services. Additionally, a surge in suicides and suicide attempts among teenagers has many parents alarmed and questioning why this occurs.
   - In SPA 2, 8% of the adult population is currently diagnosed with depression. [2]
   - In Los Angeles County, 8.6% of adults are diagnosed with current depression. [2]

4. Substance Abuse (Drugs & Alcohol) – Substance use disorders was a constant concern with many expressing alarm about the opioid epidemic and how the legalization of marijuana impacts young people.
   - The average age for prescription pain killer first-time use was 21.2 years of age in the past year.[27]
   - National statistics show in 2017 there were 66.6 million binge drinkers, and another 16.7 million heavy drinkers in the surveyed month. [26]

5. Diabetes – Diabetes remains a key concern with community members in how it affects so many individuals in the region, and disproportionally affects communities of color. Participants cited the connection between diabetes and the food they eat.
   - The 2017 Los Angeles County Health Survey indicated that 8.2% of the adults in SPA2 were diagnosed with diabetes. [2]

6. Child/Domestic Abuse (Including Sexual Assault) – Child and domestic abuse was citied a concern for community members as it relates to overall community health.
   - In Los Angeles there were 674,000 victims of child abuse and neglect reported to Child Protective Services (CPS) in 2017.[34]
   - Nationally about 1,720 children died from abuse or neglect in 2017.[36]

The hospital intends to take actions to address all of the prioritized significant health needs in the CHNA report, both through its own programs and services, and with community partners. Lists and descriptions of those planned actions are included in this report.

2019 Implementation Strategy

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years. It summarizes planned activities with statements on anticipated impacts and planned collaboration. Program Digests provide additional detail on select programs.

This report specifies planned activities consistent with the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in community assets and resources directed to those needs may merit refocusing the hospital's limited resources to best serve the community.

The anticipated impacts of the hospital's activities on significant health needs are summarized below, and for select program initiatives are stated in Program Digests. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to needed and beneficial care; and help create conditions that support good health. The hospital works to evaluate impact and sets priorities for its community health programs in triennial Community Health Needs Assessments.

Creating the Implementation Strategy

NHMC 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.

As a matter of the NHMC Center for Healthier Communities, the hospital's community benefit programs are guided by five core principles. All of our initiatives relate to one or more of these principles:

1) Focus on Disproportionate Unmet Health-Related Needs: Seek to address the needs of communities with disproportionate unmet health-related needs.
2) Emphasize Prevention: Address the underlying causes of persistent health problems through health promotion, disease prevention, and health protection.

3) Contribute to a Seamless Continuum of Care: Emphasize evidence-based approaches by establishing operational linkages between clinical services and community health improvement activities.
4) Build Community Capacity: Target charitable resources to mobilize and build the capacity of existing community assets.
5) Demonstrate Collaboration: Work together with community stakeholders on community health needs assessments, health improvement program planning and delivery to address significant health needs.

Once the needs were established leadership from the Center for Healthier Communities and the Foundation discussed strategies for building new partnerships and developing funds to address the identified health needs. Many of the projects in place to address needs were in their second and third year of funding so continuation of successful programs remained in place. Vital feedback from our community residents on how to improve and expand our existing programs strengthens their impact. Additionally through asset mapping we were able to identify existing programs in the community with evidence of success and community trust. We have provided financial support through Community Benefit Grants that address social determinants of health such as building capacity for housing to address upstream issues that can improve health outcomes of a community if we can reduce or prevent homelessness, which is the number one identified health need in our 2019 report.

Strategy by Health Need

The tables below present strategies and program activities the hospital intends to deliver to help address significant health needs identified in the CHNA report.

They are organized by health need and include statements of the strategies' anticipated impact and any planned collaboration with other organizations in our community.

Health Need: Affordable Housing and Homelessness

Strategy or Program Name	Summary Description		
Support of SB1152 Homeless Patient Discharge	• Assuring safe discharge of homeless patients through care coordination and provision of weather appropriate clothing, meals, transportation, referrals, prescriptions, screenings,		

	vaccines as needed, and assistance in enrollment for eligible health plans.		
Participation in the San Fernando and Santa Clarita Homeless Coalition (SFSCVHC)	Serve as a member of the SFSCVHC which advocates for the social needs of the community through strong partnerships, enhanced service collaborations, empowered service providers, and best practices to address underlying factors causing and exacerbating homelessness. Collaborate with a vision to prevent and end homelessness in SPA 2.		
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.		
LA Family Housing Campus Health Center			

Impact: Support the SFSCVHC to help create a regional plan to prevent and reduce the number of people in SPA 2 that are currently homeless and through referral process assist with recuperative care beds, emergency housing, temporary housing, and permanent supportive housing where capacity permits.

Health Need: Obese and Overweight Adults and Children

Strategy or Program Name	Summary Description		
School Wellness Initiative	• Classroom nutrition classes for elementary school children including My Plate and Choose Water • Parent Center Workshops A healthy diet, label reading, cooking on a budget, and grocery store tours • Preparation of Healthy Monthly School Newsletter shared with 32 schools		
#Victorious Kids	Childhood obesity project aimed at increasing physical activity for 100 youth at Primary Academy for Success School, a Title 1 school. A 20-week program, the first 10 weeks addresses strength training and safe running, and the second 10 weeks is a running program.		

Impact: 100 or more K-5th graders will participate in the program each Monday during their structured activity time.

Collaboration: Our collaborative partner for #VictoriousKids is with two Students from the Kinesiology Department at California State University, Northridge.

Health Need: Poor Mental Health

Strategy or Program Name	Summary Description
UniHealth Cultural Trauma and Mental Health Resiliency Project	• Project to address behavioral health and mental well-being of at-risk youth, through prevention and early intervention in Dignity Health's six Southern California hospitals most vulnerable areas. With a strong focus on funding community partnerships with local mental health providers to train and deliver evidence-based Mental Health First Aid, Youth Mental Health First Aid, and Question, Persuade Refer suicide prevention programs.
Creating Dementia Capable Health Systems	In partnership with ONEgeneration, we are working to provide training to families, para-professionals, and other care providers that will enhance the quality of life of individuals living with Alzheimer's Disease and related dementia (ADRD).

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. Creating Dementia Capable Health Systems will promote understanding of ADRD symptoms, reduce isolation, and improve access to ADRD services.

Collaboration: In partnership with National Alliance for Mental Illness (NAMI), Tarzana Treatment Centers (TTC), and San Fernando Valley Community Mental Health, Inc. (SFVCMH), staff will be trained to build community capacity to deliver training of evidence-based programs. Training of health care providers will provide families and caregivers with greater understanding of ADRD and behavioral symptom management.

Health Need: Substance Use Disorders (Alcohol and Drug)

Strategy or Program Name	Summary Description
Pain Management and ED Collaborative for Medicated Assisted Treatment (MAT)	• Implement a 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, community resources, and a warm handoff to drug treatment/detox centers.

Impact: Our goals: 1) 80% of opioid patients will agree to MAT. 2) The Pain Management Team will provide counseling and education to 80% of identified patients. 3) 100% of patients will receive a warm hand-off. 4) A minimum of 8 staff (MD's, NP's, PA's) will complete MAT waiver training.

Collaboration: We partner with drug treatment centers including Tarzana Treatment Center, Discovery House, Cri-Help, ProWellness Academy, etc. for continuum of care including behavioral health services.

Diabetes

Strategy or Program Name	Summary Description
Prevention Forward Diabetes Wellness including NDPP for prediabetes and DEEP for diabetic patients	Implement one of two evidence-based Stanford Model programs - Diabetes Self-Management (target audience low-income Latino population) and Diabetes Education and Empowerment Program (DEEP) Provide National Diabetes Prevention Program 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 and reverse so that they do not become diabetic. Components include support group discussions, physical activity, grocery store tours, food demonstrations, bi-lingual speakers specializing in diabetes care, and clinical measurements for evaluation
Prevention Forward Activate Your Heart	Conduct 4 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 with grocery market tours, food demos, and nutrition education. Provide base line and follow up screenings of BMI, glucose, cholesterol, and blood pressure.

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 cardio vascular disease. Increased screening rates. Additionally, increases awareness of risk factors for stroke and diabetic disease.

Collaboration: Prevention Forward is a partnership with the 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.

Child and Domestic Abuse (physical, sexual, emotional, and neglect)

Strategy or Program Name	Summary Description
Center for Assault Treatment Services (CATS)	Member of Sexual Assault Response Team (SART) and Domestic Assault Response Team (DART) that provides compassionate, comprehensive medical examinations and forensic interviews. Conducts community outreach and education to mandated reporters on how to report abuse, signs and symptoms of abuse, and the short and long-term consequences of abuse. Provides expert witness testimony in court
Medical Safe Haven	Expansion of Dignity Corporate program to provide training of Family Practice Medicine Residents to identify and treat victims of Human Trafficking in the clinic in partnership with Journey Out Survivor advocates to help remove victims from the lifestyle.
Safe Dates Program	An adolescent dating violence prevention program that will be conducted for middle and high school students at community-based organizations such as the Boys and Girls Club. A minimum of four 8-week sessions will be conducted.
Escape Now	Provide an evidence-based six-week program to persons with cognitive and developmental disabilities to prevent and empower them to not become victims of sexual, physical, verbal, emotional, or financial abuse.
California State University, Northridge Foundation (CSUN)	CSUN Campus Care Advocate Program (CCA) – Provided Community Benefit grant to fund a full time advocate on the CSUN campus to advocate for victims of sexual assault, sexual harassment, stalking and domestic violence to protect the 25% of women and 15% of men that report being victims of crime while on campus. Advocate served 48 students in 2018.

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. Reduce violence and victimization of youth and adults.

Collaboration: Northridge Hospital's CATS program is co-located at the Family Justice Center so each assault victim served is referred to a patient advocate. Additional on-site partners include the Los Angeles Police Department, Los Angeles City Attorney Victims Assistance Program, Neighborhood Legal Services, and Strength United.

Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs in the most recent CHNA report. The digests include program descriptions and intervention actions, statements of which health needs are being addressed, any planned collaboration, and program goals and measurable objectives.

Homeless and Affordable Housing Support Program	
Significant Health Needs Addressed	x Homelessness and Affordable Housing ❑ Obesity and Overweight Children and Adults ❑ Mental Health Services ❑ Substance Abuse Drugs and Alcohol ❑ Diabetes ❑ Child and Domestic Abuse including sexual assault
Program Description	Provision of safe discharge of the 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 are not ready for discharge back into homelessness. Continue participation in the local San Fernando Santa Clarita Valley Homeless Coalition.
Community Benefit Category	Health Care Support Services and Community and Community Building
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Grow the systems to assist the homeless with safe discharge and through the electronic health record to be able track and monitor what is being provided to the homeless population. Through participation in the coalition build strong partnerships to enhance service collaboration to reduce homelessness.
Measurable Objective(s) with Indicator(s)	Continue to build strong partnerships to provide effective referrals for the homeless. The SFSCVHC has become more formalized and has just created a new charter where there will be voting members and non-voting members. The CHC will assign a staff member to become more active on the committee as a voting member to assist in the reduction of homelessness in our service area.
Intervention Actions for Achieving Goal	Track distributions of weather appropriate clothing, meals, transportation, referrals, prescriptions, screenings, and vaccines and as needed assistance in eligible health plans through the electronic health record.

Planned Collaboration	Member of the SFSCVHC which consist of over 100 homeless service providers and community based organizations.

Community and School Wellness

Significant Health Needs Addressed	□ Homelessness and Affordable Housing X Obesity and Overweight Children and Adults ❑ Mental Health Services ❑ Substance Abuse Drugs and Alcohol X Diabetes ❑ Child and Domestic Abuse including sexual assault
Program Description	Community and School Wellness Initiative program is designed to improve the health and wellness with a focus on nutrition, physical activity promotion, obesity and chronic disease management through on site workshops and class room 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 hospitals Center for Healthier Communities staff.
Community Benefit Category	Community Health Improvement and Community Education

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	Continuation of all existing strategies reaching new students and parents each year 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.
Measurable Objective(s) with Indicator(s)	We can measure the increase in knowledge through pre and post-test at workshops with a goal of increasing 90% of those in attendance at each workshop. To measure an increase in physical activity logs will be provided so that children and parents can track the time they spend doing physical activity. We will also focus on reducing screen time for youth so that they will have more time to be physical.
Intervention Actions for Achieving Goal	Nutrition workshops that will include My Plate, Choose Water, Red Light, Yellow Light, Green Light Foods and Increasing Physical Activity Workshops
Planned Collaboration	Collaboration with our local LAUSD schools (34). Additionally, we will plan to add some new charter schools that we have not worked with in the past. California State University, Northridge Public Health Interns and the Department of Kinesiology.

The Cultural Trauma and Mental Health Resiliency Project

Significant Health Needs Addressed	□ Homelessness and Affordable Housing ❑ Obesity and Overweight Children and Adults X Mental Health Services X Substance Abuse Drugs and Alcohol ❑ Diabetes ❑ Child and Domestic Abuse including sexual assault
Program Description	New three year joint project 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 deliver of mental health awareness education.
Community Benefit Category	Community Health Education and Community Building
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	To provide prevention and early interventions that focuses on children and youth of color and the adults who care for them living in Los Angeles County. The hospital service areas with high health disparities, especially those affected by poverty, racism, adverse childhood experiences (ACEs), and violence.
Measurable Objective(s) with Indicator(s)	Youth who have experienced trauma, homelessness, foster care placement, juvenile justice involvement, and ACEs experience higher risk factors for mental health and substance use disorders. This project will increase the capacity of adults to recognize and assist youth with enrolling into programs.
Intervention Actions for Achieving Goal	Provide funds and training to local non-profit organizations to deliver prevention and early intervention behavioral health strategies in a culturally ad linguistically responsive manner. Deliver Mental Health First Aid, Youth Mental Health First Aid, and or Question, Persuade and Refer (QPR) curricula to individuals and community organizations. The staff of successful applicant organizations will receive train-the trainer sessions and materials for these evidence-based interventions at no cost..
Planned Collaboration	Collaboration at the local level will be with National Alliance for Mental Illness San Fernando Valley (NAMI), Tarzana Treatment Center (TTC), and San Fernando Valley Community Mental Health, Inc. (SFVCMH).

Pain Management and ED Collaborative Medicated Assisted Treatment (MAT)

Significant Health Needs Addressed	X Homelessness and Affordable Housing ❑ Obesity and Overweight Children and Adults X Mental Health Services X Substance Abuse Drugs and Alcohol ❑ Diabetes ❑ Child and Domestic Abuse including sexual assault
Program Description	Implement a 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, community resources, and a warm handoff to drug treatment/detox centers
Community Benefit Category	Community-Based Clinical Services and Health Are Support Services
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Implement a 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, community resources, and a warm handoff to drug treatment/detox centers
Measurable Objective(s) with Indicator(s)	Objectives include 1) 80% of opioid patients will agree to MAT. 2) The Pain Management Team will provide counseling and education to 80% of identified patients. 3) 100% of patients will receive a warm hand-off. 4) A minimum of 8 staff (MD's, NP's, PA's) will complete MAT waiver training.
Intervention Actions for Achieving Goal	Provision of counseling and education for patients identified as abusing drugs with a strong focus on opioid addiction.
Planned Collaboration	We partner with drug treatment centers including Tarzana Treatment Center, Discovery House, Cri-Help, ProWellness Academy, etc. for continuum of care including behavioral health services.

Prevention Forward (Diabetes Wellness and Activate Your Heart)

Significant Health Needs Addressed	□ Homelessness and Affordable Housing ❑ Obesity and Overweight Children and Adults □ Mental Health Services □ Substance Abuse Drugs and Alcohol

	X Diabetes ❑ Child and Domestic Abuse including sexual assault
Program Description	To continue and expand our Diabetes Wellness program including Diabetes Empowerment Education Program (DEEP), National Diabetes Prevention Program (NDPP), and Activate Your Health program into a combined project in partnership with the California Department of Public Health to reduce the rate of pre-diabetics from becoming diabetic and to education the community on the importance of self-management.
Community Benefit Category	Community Health Education
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Implement a 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, community resources, and a warm handoff to drug treatment/detox centers
Measurable Objective(s) with Indicator(s)	• Diabetes Management & Type 2 Diabetes Prevention (Year one) o Assess/ increase use of health care reporting systems to identify and report standard clinical quality measures, and/ or refer patients with chronic conditions to nationally recognized lifestyle change programs. o Identify policies and procedures within health care organizations to identify, manage, and prevent chronic conditions. o Assess/ increase use of team-based models to manage, monitor, and refer patients with chronic conditions to nationally recognized lifestyle change programs. o Complete CDPH contract – related duties. • Cardiovascular Disease Prevention and Management o Assess/ increase use of health care reporting systems to identify and report standard clinical quality measures, and/ or refer patients with chronic conditions to nationally recognized lifestyle change programs. o Identify policies and procedures within healthcare organizations to identify, manage, and prevent chronic conditions. o Assess use of team-based models to manage, monitor, and refer patients with chronic conditions to nationally recognized lifestyle change programs. o Complete CDPH contract-related duties. • Diabetes Management and Type 2 Diabetes Prevention (Year 2) o Assess/increase use of health care reporting systems to identify and report standard clinical quality measures,

	and / or refer patients with chronic conditions to nationally recognized lifestyle changes programs. o Identify policies and procedures within health care organizations to identify, manage, and prevent chronic conditions. Assess/ increase use of team – based models to manage, monitor, and refer patients with chronic conditions to nationally recognized lifestyle change programs.
Intervention Actions for Achieving Goal	• Diabetes Empowerment Education Program • National Diabetes Prevention Program • Activate Your Heart • Grocery Store Tours • Podiatrist foot exam • Ophthalmologist for eye care • Dentist for dental health care • Dermatologist skin health management
Planned Collaboration	We are in the process of working with our local Federally Qualified Health Centers to establish contracts to share patients and conduct the evidence based trainings on site at the clinics. We are also providing sessions at a local low income housing unit, and church. CDPH has funded 12 partners so that this program can be implemented throughout the state. We are the Los Angeles County partners.

Center for Assault Treatment Services (CATS)

Significant Health Needs Addressed	☐ Homelessness and Affordable Housing ❑ Obesity and Overweight Children and Adults ❑ Mental Health Services ❑ Substance Abuse Drugs and Alcohol ❑ Diabetes ❑ X Child and Domestic Abuse including sexual assault
Program Description	Provide compassionate, comprehensive medical examinations and forensic interviews Community outreach and education about prevention of abuse, identifying abuse, consequences of abuse and how to report Provide expert witness testimony in court.
Community Benefit Category	Community Health Education and Community Based Clinical Services

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	CATS' expert team of forensic examiners, under the direction of the Program Manager and Medical Director, provides medical evidentiary examinations and forensic interviews of adult and child victims of sexual assault/abuse, human trafficking, witness interviews, and domestic violence in a safe, comforting and private environment that preserves the dignity of the victims. CATS also provides child abuse prevention education to professionals in the San Fernando Valley and surrounding areas who work with children and elder adults and are therefore mandated by law to report any reasonable suspicion of abuse. Northridge Hospital supports CATS by providing staffing and funding. Anticipated impact that approximately 1,000 child/adult victims of abuse will received forensic interviews and as needed medical evidentiary exams.
Measurable Objective(s) with Indicator(s)	By June 30, 2020 include high quality clinical forensic services to more than 1000 victims of sexual and domestic violence. By June 30, 2020 provide community outreach education on how to identify and report child/elder abuse to 1,500 mandated reporters and an additional 3,000 community individuals at the Victory for Victims Walk/Run and community based health fairs and events to help Break the Silence and Stop the Abuse. By June 30, 2020 provide at least 4 eight week sessions of Safe Dates to middle and high school aged children Continue to be a member of the Sexual Assault Response Team and Domestic Assault Response Team, and Human Trafficking Task Force. By June 30, 2020 provide at least 10 12 week sessions of Escape Now to adults with developmental disabilities
Intervention Actions for Achieving Goal	• Support and purchase additional equipment to keep current technology • Provide continuing education through webinars, classes, and conferences to keep staff current in the field to maintain status as expert witnesses in court • Continue to work with all partners at the Family Justice Center • Work closely with law enforcement and the District Attorney's Office • Conduct roll call trainings at local law enforcement precincts/divisions • Conduct medical evidentiary examinations and forensic interviews. • Review and update training materials for community outreach • Continue to conduct CATS Victory for Victims Walk/Run to promote awareness of child/adult sexual and domestic abuse and to raise funds to offset cost of the program • Increase staff to keep up with volume to help prevent burn out Network with local agencies to find potential donors
Planned Collaboration	Coalition to Abolish Slavery and Trafficking (CAST), Jewish Family Service Family Violence Project, Los Angeles City and County Attorneys, Los Angeles Police Department, Major Assault Crimes,

	Department of Child and Family Services, Neighborhood Legal Services, Journey Out and Strength United.

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