Northridge Hospital Medical Center

Community Benefit 2021 Report and 2022 Plan

Adopted November 2021

Dignity Health.
Northridge Hospital
Medical Center

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 2021 Report and 2022 Plan describes much of this work. This report meets requirements in California state law (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. Dignity Health hospitals in Arizona and Nevada voluntary 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 2021 (FY21), Northridge Hospital provided $37,296,549 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $39,206,181 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2021 Report and 2022 Plan at its November 9, 2021 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 to out to Joni Novosel, Director of Community Health, at 818-718-5936.

Paul Watkins
President, CEO

Steve Valentine
Chairperson, Community Board of Directors

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At-a-Glance Summary

Community Served	Northridge Hospital's service area is located in Service Planning Area 2 of Los Angeles County, which consist of the San Fernando and Santa Clarita Valleys. Our service area is home to over 1.9 million residents of multiple cultures and ethnic backgrounds. The geographic area is comprised of 25 cities with 34 ZIP codes which represent roughly 80% of patients seen at Northridge Hospital.
Economic Value of Community Benefit	$37,296,549 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $39,206,181 in unreimbursed costs of caring for patients covered by Medicare
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. Homelessness/Affordable Housing 2. Obesity/Overweight 3. Mental Health 4. Substance Abuse (Drug & Alcohol) 5. Diabetes 6. Child/Domestic and Sexual Abuse
FY21 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 – Participation in the Homeless Health Care Initiative. A navigator based in the Emergency Department to provide resources and warm handoffs, and connections to homeless services for those living on the street. 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. Had to move to virtual workshops Post COVID 19 conducted via ZOOM and offered to students and parents due to no outside guest permitted on school campuses throughout fiscal year 2021. 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 and virtually deliver evidence-based Mental Health First Aid Adult and Youth and Question, Persuade, Refer (QPR). Alzheimer's disease and Related Dementia

(ADRD) Program – A collaborative effort to improve the quality of respite and home-based services, case management and prevention.

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 virtually.

6 Child and Adult Violence Prevention programs were continued and newly implemented. In 2021 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, due to growing social injustice and violence increases during the COVID 19 pandemic we have implemented a STOP School Violence program, 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.

7 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 was funded in partnership with Los Angeles County Department of Public Health and the LA County of Health Services began to provide a massive COVID 19 Outreach and Engagement project to reduce the incidence of vaccine hesitancy and encourage the most vulnerable populations to become vaccinated incorporating social media outreach.

FY22 Planned Programs and Services

FY 21 Programs will continue with efforts to expand that outreach in addition to adding the following newly planned programs for FY22

1. Jade Lee Marasigan Charitable Fund. The fund directly assist adolescents and young adults as continuation of care for diagnosed cases of depression, anxiety, and other behavioral health conditions.
2. BJA Stop School Violence program focuses on preventing school violence. Through this program, NMHC is partnering with Los Angeles Unified School District and San Fernando Valley Community Mental Health Center to train educators in evidence-based violence prevention programs and expand their capacity to prevent all forms of violence on school campuses.
3. A new HRSA-Vax LA Collaborative project to provide vaccine hesitancy education and pop up vaccine clinics in areas of COVID-19 healthcare disparities using shared community based staffing model will start FY 22..
4. Monthly free drive through fresh produce giveaway with AHA.

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.

During FY 21 one unit was dedicated to a COVID 19 unit. However during the surges and with the onset of the Delta variant other units were closed and converted based on need for COVID 19 beds. Elective surgeries were delayed and visitation was severely restricted.

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

Northridge Hospital is dedicated to creating healthier communities by providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay. Advocating for the poor and vulnerable is both our mission and our passion. The hospital has financial assistance available to help pay for medically necessary services provided to those patients who meet certain income requirements. The financial assistance policy, a plain language summary of the policy, and a financial assistance application are on the hospital's web site.

Description of the Community Served

The hospital's service region is located in Northern Los Angeles in Service Planning Area 2 (SPA 2 over 2.1 million residents), an 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 populace region of Los Angeles County spans cities, communities, and incorporated areas in the San Fernando and Santa Clarita Valleys encompassing 34 zip codes. A summary description of the community is below. Additional details can be found in the CHNA report online.

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

Sg2 MARKET SNAPSHOT

Sg2 health care intelligence

Market Snapshot

Northridge PSA CY18

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Population and Gender	Market 2020 Population	Market 2020 % of Total	Market 2025 Population	Market 2025 % of Total	Market Population % Change	National 2020 % of Total
Female Population	682,722	50.54%	702,513	50.55%	2.90%	50.75%
Male Population	668,119	49.46%	687,148	49.45%	2.85%	49.25%
Total	1,350,841	100.00 %	1,389,661	100.00 %	2.87 %	100.00 %

Age Groups	Market 2020 Population	Market 2020 % of Total	Market 2025 Population	Market 2025 % of Total	Market Population % Change	National 2020 % of Total
00-17	305,261	22.60%	307,094	22.10%	0.60%	22.33%
18-44	509,859	37.74%	509,139	36.64%	(0.14 %)	35.65%
45-64	346,584	25.66%	350,645	25.23%	1.17%	25.39%
65-UP	189,137	14.00%	222,783	16.03%	17.79%	16.64%
Total	1,350,841	100.00 %	1,389,661	100.00 %	2.87 %	100.00 %

Ethnicity/Race	Market 2020 Population	Market 2020 % of Total	Market 2025 Population	Market 2025 % of Total	Market Population % Change	National 2020 % of Total
Asian & Pacific Is. Non-Hispanic	158,877	11.76%	171,585	12.35%	8.00%	5.98%
Black Non-Hispanic	58,588	4.34%	60,477	4.35%	3.22%	12.37%
Hispanic	685,433	50.74%	730,611	52.57%	6.59%	19.03%
White Non-Hispanic	408,335	30.23%	384,598	27.68%	(5.81 %)	59.33%
All Others	39,608	2.93%	42,390	3.05%	7.02%	3.29%
Total	1,350,841	100.00 %	1,389,661	100.00 %	2.87 %	100.00 %

Language*	Market 2020 Population	Market 2020 % of Total	Market 2025 Population	Market 2025 % of Total	Market Population % Change	National 2020 % of Total
Korean at Home	18,325	1.45%	19,289	1.48%	5.26%	0.56%
Only English at Home	549,436	43.36%	557,623	42.69%	1.49%	76.45%
Other Indo-European Lang at Home	73,492	5.80%	75,426	5.77%	2.63%	1.84%
Spanish at Home	520,230	41.06%	544,435	41.68%	4.65%	14.98%
Tagalog at Home	39,089	3.09%	40,893	3.13%	4.62%	0.80%
All Others	66,449	5.24%	68,544	5.25%	3.15%	5.37%
Total	1,267,021	100.00 %	1,306,210	100.00 %	3.09 %	100.00 %

Household Income	Market 2020 Households	Market 2020 % of Total	Market 2025 Households	Market 2025 % of Total	Market Households % Change	National 2020 % of Total
<$15K	34,007	8.15%	29,799	6.96%	(12.37 %)	9.97%
$15-25K	31,469	7.54%	28,645	6.69%	(8.97 %)	8.58%
$25-50K	76,465	18.33%	70,740	16.52%	(7.49 %)	20.73%
$50-75K	64,349	15.43%	62,106	14.50%	(3.49 %)	16.73%
$75-100K	52,627	12.62%	51,700	12.07%	(1.76 %)	12.44%
$100K-200K	110,137	26.41%	119,988	28.02%	8.94%	22.67%
>$200K	48,049	11.52%	65,193	15.23%	35.68%	8.87%
Total	417,103	100.00 %	428,171	100.00 %	2.65 %	100.00 %

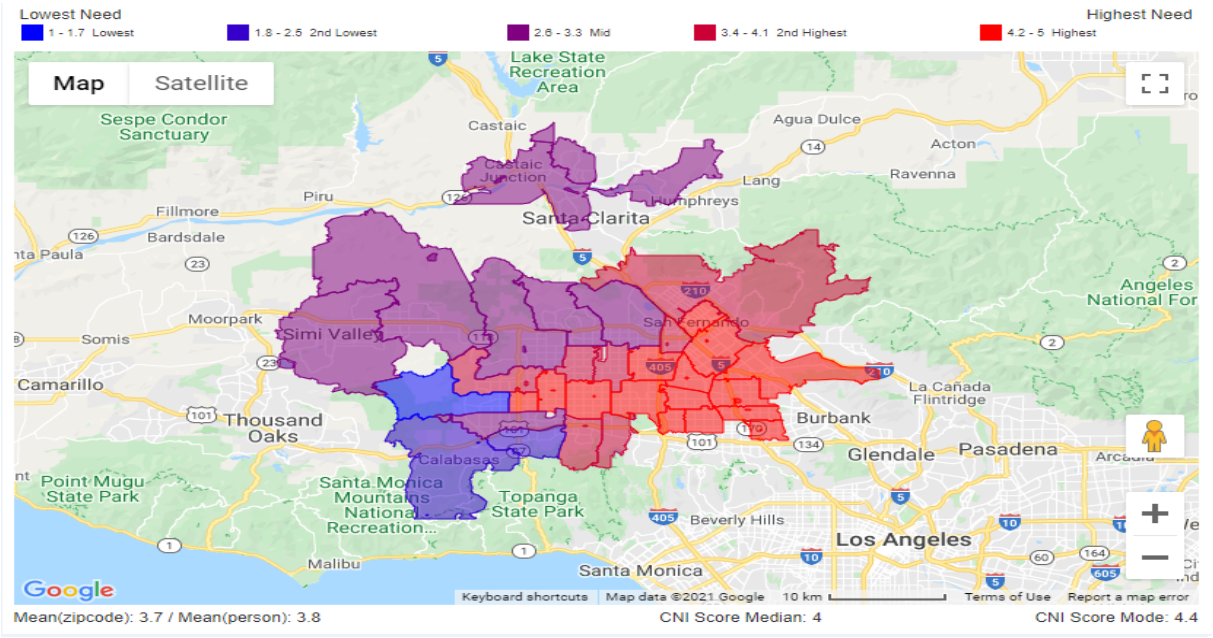
Education Level**	Market 2020 Population	Market 2020 % of Total	Market 2025 Population	Market 2025 % of Total	Market Population % Change	National 2020 % of Total
Less than High School	106,149	11.50%	110,842	11.50%	4.42%	5.21%
Some High School	78,271	8.48%	81,668	8.47%	4.34%	7.04%
High School Degree	208,393	22.58%	217,470	22.57%	4.36%	27.19%
Some College/Assoc. Degree	279,330	30.26%	291,550	30.25%	4.37%	31.01%
Bachelor's Degree or Greater	250,864	27.18%	262,120	27.20%	4.49%	29.55%
Total	923,007	100.00 %	963,650	100.00 %	4.40 %	100.00 %

*Excludes population age<5, **Excludes population age<25

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 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.



Mean(zipcode): 3.7 / Mean(person): 3.8 CNI Score Median: 4 CNI Score Mode: 4.4

Zip Code	CNI Score	Population	City	County	State
91302	2.4	27578	Calabasas	Los Angeles	California
91303	4.6	27973	Canoga Park	Los Angeles	California
91304	4	50515	Canoga Park	Los Angeles	California
91306	4.4	46889	Winnetka	Los Angeles	California
91307	1.6	24624	West Hills	Los Angeles	California
91311	3	38115	Chatsworth	Los Angeles	California
91316	3.6	27506	Encino	Los Angeles	California
91324	4	27985	Northridge	Los Angeles	California
91325	3.8	36317	Northridge	Los Angeles	California
91326	2.6	36809	Porter Ranch	Los Angeles	California
91331	4.4	106795	Pacoima	Los Angeles	California
91335	4.4	77115	Reseda	Los Angeles	California
91340	4.4	35756	San Fernando	Los Angeles	California
91342	3.8	96693	Sylmar	Los Angeles	California
91343	4.6	63139	North Hills	Los Angeles	California
91344	2.8	52457	Granada Hills	Los Angeles	California
91345	4	18347	Mission Hills	Los Angeles	California
91351	3.2	33476	Canyon Country	Los Angeles	California
91352	4.4	49156	Sun Valley	Los Angeles	California
91354	2.6	32283	Valencia	Los Angeles	California
91355	2.8	37778	Valencia	Los Angeles	California
91356	3.6	29979	Tarzana	Los Angeles	California
91364	2.4	25834	Woodland Hills	Los Angeles	California
91367	2.8	43056	Woodland Hills	Los Angeles	California
91401	4.6	39555	Van Nuys	Los Angeles	California
91402	4.8	73072	Panorama City	Los Angeles	California
91405	4.4	52249	Van Nuys	Los Angeles	California
91406	4.4	55829	Van Nuys	Los Angeles	California
91411	4.4	24194	Van Nuys	Los Angeles	California
91601	4.2	41019	North Hollywood	Los Angeles	California
91605	4.6	55889	North Hollywood	Los Angeles	California
91606	4.6	45226	North Hollywood	Los Angeles	California
93063	3	55838	Simi Valley	Ventura	California
93065	2.8	74416	Simi Valley	Ventura	California

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 May 2019.

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 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 the high cost 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 be out 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.
    - In 2018, of 7,478 homeless individuals, 74% of them are unsheltered.

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 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.

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.
    - In Los Angeles County, 8.6% of adults are diagnosed with current depression.

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

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.
    - In 2015, 9% of adults in SPA 2 were diagnosed with diabetes.
    - The 2017 Los Angeles County Health Survey indicated that 8.2% of the adults in SPA2 were diagnosed with diabetes.
    -
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.
    - Nationally, the rate of emergency room visits for intimate partner violence is 10 per 100,000 women, ages 18 and older.
    - In Los Angeles there were 674,000 victims of child abuse and neglect reported to child protective services (CPS) in 2017.
    - Nationally, about 1,720 children died from abuse or neglect in 2017.

An additional health need that could not have been foreseen in the 2019 report was the fact that a pandemic was looming called COVID 19 that would dominate our entire country and for most of 2020 and 2021.

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 including the COVID 19 planned actions.

2021 Report and 2022 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 FY21 and planned activities for FY22, with statements on anticipated impacts, planned collaboration, and patient financial assistance for medically necessary care. Program Digests provide detail on select programs' goals, measurable objectives, expenses and other information.

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 Community Benefit Plan

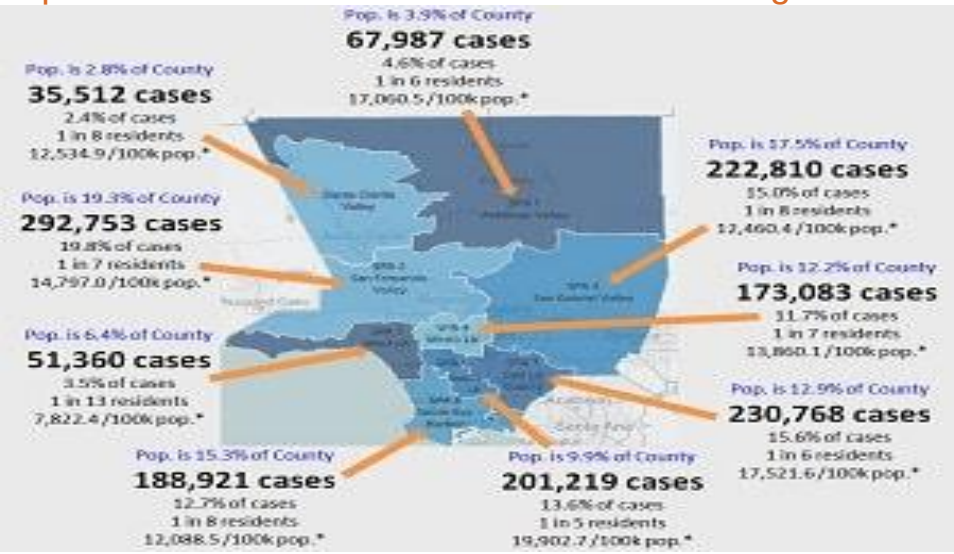
Northridge Hospital is dedicated to improving community health and delivering community benefit with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

Community input is obtained through being a member 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 are based on the needs identified in our 2019 Community Needs Assessment in addition to expanding and growing existing programs that have evidence of success. New programs were started in FY 21 and will continue through FY 22 to get as many community residents as possible the COVID 19 vaccines to create herd immunity to halt the spread of new COVID 19 variants.

New programs to assist with homelessness and mental health were added to the FY 22 plan as both of those issues rose to the top of the needs identified by community. Programs to address chronic disease self-management, cardiovascular health, and dating abuse prevention will be carried into 2022because of the evidence of success and impact it is having in our community but also because as a result of the "Stay at Home" orders many residents have gained weight and lead sedentary lifestyles. Staff training has occurred to increase the number of evidence-based programs, expanding our ability to continue to address immediate needs and increase our capacity to provide prevention and early intervention to reduce health disparities, and focus on upstream measures to address the social determinants of health including COVID 19. SPA 2 makes up over 21% of the population in Los Angeles County, so it is vital that we partner and engage in the community to control the spread of this deadly disease

Impact of the Coronavirus Pandemic in Los Angeles County by SPA



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An additional health need that could not be foreseen in the 2019 report was the fact that the COVID 19 dominated most of 2020 with first case in January and a public health emergency declared in February of 2020 and by March we were experiencing a pandemic. Soon after health care providers and residents began to think we were turning a corner on COVID 19 the surges hit at the end of the year creating chaos and a multitude of new cases and nonstop rising rates of deaths.

In addition to the needs we continued to work on the hospital added free vaccine clinics for the community as soon as they were approved, we received funding to outreach and educate those communities facing the greatest disparities, with increased food scarcity a once a week free produce distribution was planned for FY 22 in partnership with the American Heart Association, and a major effort to increase the capacity of vaccine clinics and outreach to the most hesitant to have access to vaccines in community to do our best to help control COVID 19.

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.

Affordable Housing and Homelessness

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
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, and assistance in enrollment of health plans.	☒	☒
LAHSA Hospital Liaison Program	• Linking individuals to homeless support services and resources through the coordinated entry system • Providing on-call information and support • Building capacity and knowledge • Tracking and documenting referred homeless	☒	☒
Partnership with the Homeless Health Initiative	Support integrated health care, behavioral health, safety, and wellness with housing and social services to improve health and advance social justice.	☐	☒
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.	☒	☒

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 Corporate supported local COVID 19 emergency housing for homeless infected with COVID 19 who needed to isolate.

Collaboration: Collaboration will be needed with Los Angeles Housing Services Authority (LASHA) and the SFSCVSC and all the homeless providers that belong to the coalition. Additionally, each year the Care Coordination Team at the hospital will update the Homeless Resource Directory to share with our homeless population, and with the assistance from the Center for Healthier Communities will continue to build partnerships to identify and connect to homeless service providers.

Obese and Overweight Adults and Children

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
School Wellness Initiative	• Parent Center Virtual Workshops with healthy diet, importance of exercise, stress management, and COVID 19 webinars offered at no cost • Preparation of Healthy Monthly School Newsletter shared with 32 schools	☒	☒
Prevention Forward Activate Your Heart 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 and provide base line and follow up screenings of BMI, cholesterol, and blood pressure. • 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.	☒	☒

Impact: Increased child and parent knowledge of importance of healthy diet and physical activity and COVID 19. Increases in the consumption of healthy food, building interdisciplinary collaborations to create healthier environments, and increased awareness in health promotion creating healthier families.

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 issues that could result in serious heart health issues.

Mental Health Services

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
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.	☒	☒
Creating Dementia Capable Health Systems	In partnership with ONE generation, 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).	☒	☒
Jade Lee Marasigan Charitable Fund	A legacy project created by her family in response to the passing of their daughter by suicide. The fund directly assist adolescents and young adults diagnosed cases of depression, anxiety, and other behavioral health conditions.	☒	☒

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 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.

Substance Use Disorders (Alcohol and Drug)

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
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.	☒	☒

Impact) 1)85% of opioid patients will agree to MAT. 2) 100% of patients will receive a warm hand-off. 3) A minimum of 12 staff (MD's, NP's, and PA's) completed MAT waiver training.

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

Diabetes

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Prevention Forward Diabetes Wellness including NDPP for prediabetes and DEEP for diabetic patients	• 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.	☒	☒

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.

Collaboration 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 external local pharmacies and FQHC clinics.

Child and Adult Abuse (domestic, physical, sexual, emotional, and neglect)

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
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.	☒	☒
Sexual and Domestic Violence Prevention Project	• An adolescent dating violence prevention program that will be conducted for middle and high school students • Beyond Trauma Support Group for survivors of Domestic Violence • Bringing in the Bystander	☒	☒
BJA STOP School Violence	• Train school personnel and educate students on preventing student violence • Train on evidence-based curriculums Positive Action and Safe Dates	☒	☒
Local Elder Abuse Prevention Enhanced Multidisciplinary Team LEAP EMDT	• Case review of Elder Abuse/Neglect Cases • Educate and train caregivers • Enhance care coordination, referrals, and resources provided	☒	☒

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. Over 80 Middle and High School students showed increase knowledge of what a healthy relationship is, and their ability to support and help a friend report abuse. Reduced violence and victimization of youth and adults. Provided case review to for population over 60.

Collaboration: Northridge Hospital's CATS program is co-located at the Family Justice Center. On-site partners include the Los Angeles Police Department, Strength United, Los Angeles City Attorney Victims Assistance Program, and Neighborhood Legal Services. We continue to work with the Boys and Girls Clubs, school sites, and youth service providers to implement programs virtually and on site. LEAP EMDT is a collaboration between Dignity Health - Northridge Hospital Center for Healthier Communities and Center for Assault Treatment Services, Valley Care Community Consortium, Alzheimer's Association California Southland Chapter, ONEgeneration, Southern California Neuropsychology Group, Bet Tzedek Legal Services, WISE & Healthy Aging Long Term Care Ombudsman Program, Los Angeles County Adult Protective Services, the Office of the Public Guardian, a forensic accountant, a social isolation specialist and a Senior Real Estate Specialist.

Community 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.

In FY21, the hospital awarded the grants below totaling $153,948. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Haven Hills	Core Programing for Domestic Violence Survivors	$38,487
LA Family Housing	Interim Housing and Supportive Services for Women Experiencing Homelessness	$38,487
ONE generation	Homeless Prevention & Mobile Food Bank	$38,487
San Fernando Valley Counseling Center COVID 19 Relief Funds	Low-Cost Affordable Metal Health Counseling to Community Members	$12,829
Triumph Foundation COVID 19 Relief Funds	Education and Support for those Living with Paralysis and Neuro disabilities	$12,829
Valley Women's Center COVID 19 Relief Funds	Operational Support to Continue to Provide Services	$12,829

Three of the grant awards were dedicated to small nonprofit organizations with annual operating budgets of $500,000 or less per year to assist them in continuation of programs during the pandemic.

UniHealth Matching Grant - The six hospitals in Dignity Health's SoCal Region continued the program in 2021 and will do so again for a third year in 2022. This collaboration is an unique opportunity to leverage 25% of each of their Community Grants funds for a joint proposal for a matching three-year grant from Dignity Health and the UniHealth Foundation for the Cultural Trauma and Mental Health Resiliency Project to deliver prevention and early intervention strategies to at-risk minority youth and families in the communities served by the SoCal hospitals. Northridge Hospital's 2021 contribution to this pool from their 2021 grant allotment of $205,264 was $51,316.

Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs. 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.

Homelessness and Affordable Housing Support Program	
Significant Health Needs Addressed	☑ Homelessness and Affordable Housing ❑ Obesity and Overweight Children and Adults ❑ Mental Health Services ❑ Substance Abuse Drugs and Alcohol ❑ Diabetes ❑ Violence (Child and Domestic Sexual etc.)
Program Description	• The Support Program consists of the ongoing 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. Creation of a new partnership with Los Angeles Housing Services Authority LAHSA) to pilot the Hospital Liaison Project. • Support the corporate Housing programs at the local level as needed
Community Benefit Category	Health Care Support Services and Community and Community Building
FY 2021 Report	
Program Goal / Anticipated Impact	Continued to provide systems to assist the homeless with safe discharge and create information into the electronic health record to be able to 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
Intervention Actions for Achieving Goal	Track distributions of weather appropriate clothing, meals, transportation, referrals, prescriptions, screenings, vaccines, and as needed assistance in eligible health plans through the electronic health record.

Collaboration	Member of the SFSCVHC which consist of over 100 homeless service providers and community based organizations. Continue to work with LAHSA.
Performance / Impact	Collaboration with
Hospital's Contribution / Program Expense	Provision of weather appropriate clothing to 72 people at cost of $849; meals provided to 320 people at a cost of $3,592; transportation vouchers supported 100 individuals at a cost of $3,524; and recuperative care beds to the homeless or uninsured - recuperative care cost serving 5 persons = $7,900
FY 2022 Plan	
Program Goal / Anticipated Impact	Continue systems to assist the homeless with safe discharge and create information into the electronic health record to be able to 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. While homelessness in the area continued to grow, we were able to see that through the Coordinated Entry System, a larger number of homeless individuals and families were connected to housing. Homelessness continues to be a concern in 2022 due to issues of a potential new crisis of low income folks that have had some CONIV 19 housing relieve and non-eviction status not being able to catch up past rent and pay new monthly fees and the rehousing of those affected by loss of housing due to COVID 19.
Measurable Objective(s) with Indicator(s)	Continue to provide the homeless with weather appropriate clothing, meals, and transportation to shelters and recuperative care. This data will be tracked in the patients electronic health record
Intervention Actions for Achieving Goal	• Linking individuals to homeless support services and resources through the coordinated entry system. • Providing on-call information and support • Building capacity and knowledge • Tracking and documenting referred homeless individuals and families
Planned Collaboration	Member of the SFSCVHC which consist of over 100 homeless service providers and community based organizations. Continue to work with LAHSA.

ED Collaborative Medicated Assisted Treatment (MAT)	
Significant Health Needs Addressed	☑ Homelessness and Affordable Housing ❑ Obesity and Overweight Children and Adults ☑ Mental Health Services ☑ Substance Abuse Drugs and Alcohol ❑ Diabetes ❑ Violence (Child and Domestic Sexual etc.)
Program Description	Continue + 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
FY 2021 Plan	
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, and 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.
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.
Performance / Impact	We will expand our MAT services by adding a part-time Social Worker to help patients with opioid use disorder post-discharge. We do not have enough Social Workers to assist patients with continuum of care. In FY 2020, 35% of MAT patients were Hispanic or Black. We currently have 12 clinicians (MD's NP's and PA's) who have their MAT X-Waiver and are initiating MAT, providing counseling on medication management, and alternatives to opioids.
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.

FY 2022 Plan	
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)	Physicians and clinical staff with a MAT X-Waiver will initiate Medicated Assisted Treatment in the Emergency Department and inpatient units, serving 125 patients of color annually/375 patients over 3 years. A Social Worker continues to serve as a 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.
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.

Cultural Trauma Mental Health Resiliency Project	
Significant Health Needs Addressed	☐ Homelessness/Affordable Housing ☐ Obesity/Overweight ☐ **Mental Health** ☐ Substance Abuse ☐ Diabetes ☐ Violence Child/Adult Domestic and Sexual Abuse and Assault
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.
Community Benefit Category	A1-a Community Health Education
FY 2021 Report	
Program Goal / Anticipated Impact	To provide prevention and early interventions that focus on children and youth of color, and the adults who care for them living in Los Angeles County, and in 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. This will be measured through attendance at training sessions and pre/post testing.
Intervention Actions for Achieving Goal	Provided funds and training to three local non-profit mental health organizations to deliver prevention and early intervention behavioral health strategies in a culturally and 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. All the community-based staff were trained and then received additional trainings along with our staff to be able to continue to provide all services virtually. During this time, five instructor certification training sessions were held, resulting in 87 trained instructors in either Adult Mental Health First Aid, Youth Mental Health First Aid, or Question, Persuade, Refer.
Collaboration	Collaboration at the local level will be with National Alliance for Mental Illness San Fernando Valley (NAMI-SFV), Tarzana Treatment Center (TTC), and San Fernando Valley Community Mental Health, Inc. (SFV-CMH, Inc.).
Performance / Impact	The COVID-19 pandemic continued to adversely affect the number of trainings and how we delivered those trainings; however we were able to meet our goals. Through Sept. 30, 2021, 69 training sessions were held and 1,195 professionals and community members were trained.
Hospital's Contribution / Program Expense	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. The hospital will provide $159,327 to our sub grantees to support their work.
FY 2022 Plan	
Program Goal / Anticipated Impact	Our objective is 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 teenagers (especially people of color and communities that are low-income and underserved). Our objective is to provide these courses in both English and Spanish.
Measurable Objective(s) with Indicator(s)	A goal has been set to conduct a at least 45 training sessions in our hospital area with staff and our partners to train 1,125 people
Intervention Actions for Achieving Goal	Hospital staff will conduct trainings in coordination with the three funded partners' to reach the goal of providing mental health awareness training and certification in Mental Health First Aid throughout the San Fernando Valley community (Service Planning Area 2 within Northridge Hospital Medical Center's service area). This goal will help to build awareness of the warning signs of mental health and substance use disorders so that those in need can be linked to appropriate support, services and treatment.
Planned Collaboration	Coordinate with the two funded partners (NAMI-SFV and SFV-CMHC, Inc.) and work with new or existing community partners that serve parents, youth and professionals working with those populations (ex. El Nido, Fire Dept., Northridge Hospital Medical Center staff, etc.).

	Prevention Forward (Diabetes Wellness and Active Your Heart)
Significant Health Needs Addressed	• Homelessness/Affordable Housing ▪ Obesity/Overweight • Mental Health • Substance Abuse ▪ Diabetes • Violence Child/Adult Domestic and Sexual Abuse and 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 Heart 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	A1-a Community Health Education
FY 2021 Report	
Program Goal / Anticipated Impact	Prevention Forward is a public health program launched by CDPH that operates under the Chronic Disease Control Branch (CDCB). 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. The primary impact the program will achieve is reduced rates of chronic diseases and complications from chronic diseases among program participants.
Measurable Objective(s) with Indicator(s)	Participants in FY2021 programs reported increased knowledge of nutrition and physical activity. NHMC Center for Healthier Communities conducted outreach and referral to evidence based classes for 748 community members in FY21. NHMC engaged 22 participants over the course of a year in the Prevention Forward Program.
Intervention Actions for Achieving Goal	Interventions include Diabetes Empowerment Education Program, National Diabetes Prevention Program, Activate Your Heart, and Healthy Heart Ambassador Blood Pressure Self-Monitoring Program.
Collaboration	Collaboration consisted of our Center for Healthier Communities, Chronic Disease Transitional Care Team, and CDPH.
Performance / Impact	58 individuals participated in virtual workshops and Activate Your Heart cohorts.

Hospital's Contribution / Program Expense	This program is a collaboration with CDPH providing funding for a portion of the staff and the hospital providing the staff time for four of the members of the team. This program served 251 people and the hospital expense was $68,814.89.
FY 2022 Plan	
Program Goal / Anticipated Impact	The program will achieve recruitment and maintain a minimum of 15 people per year to participate in NDPP or DSMES. We will improve access to and participation in American Diabetes Association (ADA)-Recognized/American Association of Diabetes Educators-Accredited Diabetes Self-Management Education/Support (DSMES) programs in underserved areas. We will increase engagement of pharmacists in the provision of medication management or DSMES for people with diabetes. Assist healthcare organizations in implementing systems to identify people with prediabetes and refer them to CDC-National Diabetes Prevention Program. Implement strategies to increase enrollment in CDC-recognized lifestyle change programs.
Measurable Objective(s) with Indicator(s)	Use the EHR System (Cerner) to identify pre-diabetes, and type 2 diabetes. 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
Intervention Actions for Achieving Goal	Initiate teaching of NDPP training/classes- 2 cohorts will be conducted (English and Spanish). Partner with community organizations that are NDPP recognized in order to link them to NDPP programs. Conducting 2 Diabetes Empowerment Education (DEEP) cohorts (English and Spanish). Conduct a training event to increase hypertension self-management skills of CHW and Promoters and share best SMBP practice resources with service area organizations to increase referrals and enrollment in lifestyle change programs. Conducting 2 Activate Your Heart Cohorts (English and Spanish)
Planned Collaboration	Pharmacies, and area Federally Qualified Health Centers. This project is a partnership with the California Department of Public Health

	**School Wellness Initiative (Community and School Wellness)**
Significant Health Needs Addressed	• Homelessness/Affordable Housing • Obesity/Overweight • Mental Health • Substance Abuse • Diabetes • Violence Child/Adult Domestic and Sexual Abuse and 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 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.
Community Benefit Category	A1-a Community Health Education
FY 2021 Report	
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.
Measurable Objective(s) with Indicator(s)	Create 4 School Wellness Newsletters for 34 schools. Facilitated the Great Kindness Challenge in 22 schools. Conduct educational workshops, as requested by school sites on nutrition, physical activity, and emotional health.
Intervention Actions for Achieving Goal	Continued to engage the schools through the School Wellness Newsletter that we create on a quarterly basis. We stay connected to the schools through relationships with school principals and parent center leaders. We assessed school workshop and education needs based on COVID-19 and developed more workshops on mental health topics such as Mindfulness for Kids.
Collaboration	Collaboration is with 34 LAUSD Title 1 schools located in the San Fernando Valley.
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. Due to the COVID-19 pandemic, there were challenges faced to engage the school community since students were learning virtually from home. We were able to conduct six workshops and reached 98 parents.
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 FY21 that equaled $7,268
FY 2022 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.

Measurable Objective(s) with Indicator(s)	We will measure our progress through assessments and interviews with key informants at schools to measure school-wide impact in areas like increases in physical activity, increases in knowledge of nutrition, and increases in awareness of socioemotional wellness and promotion among parents.
Intervention Actions for Achieving Goal	Engage the schools through the quarterly School Wellness Newsletters. Assess school workshop and education needs and build relationships with new school sites and school leaders. Facilitate a virtual Great Kindness Challenge to promote socio-emotional wellness to prevent bullying.
Planned Collaboration	Collaboration with our local LAUSD schools (34) and any new school sites we identify (ex. charter schools).

BJA STOP School Violence	
Significant Health Needs Addressed	• Homelessness/Affordable Housing • Obesity/Overweight • Mental Health • Substance Abuse • Diabetes • Violence Child/Adult Domestic and Sexual Abuse and Assault
Program Description	The BJA STOP school violence program focuses on preventing school violence. Through this program, NMHC is partnering with Los Angeles Unified School District and San Fernando Valley Community Mental Health Center to train educators in evidence-based violence prevention programs and expand their capacity to prevent all forms of violence on school campuses.
Community Benefit Category	A1-a Community Health Education
FY 2021 Plan Report	
Program Goal / Anticipated Impact	Achieve a measurable reduction in incidents of school-based violence among partner schools and increased capacity to implement evidence-based violence prevention Programs.
Measurable Objective(s) with Indicator(s)	Train 3 middle and/or high schools in implementing the Positive Action Curriculum with youth throughout the campus. Facilitate 3 sessions of Safe Dates with 60 student participants while training 21 educators to implement in the future. Train 60 parents in bullying and violence prevention. Connect 20 youth at risk for violence perpetration to mental health. Services through San Fernando Valley Community Mental Health Center. Train 9 LAUSD personnel in Positive Action implementation. Train 15 LAUSD Mental Health Professionals in Positive Action
Intervention Actions for Achieving Goal	Although we have faced delays in our program implementation due to the MOU process with our LAUSD partners, we have completed other process activities in preparation for the implementation phase (establish tracking materials and progress checklists, pre and posttest, physical curricula binders for staff, referral tracking protocol, strategy for awareness campaign, resource guide and newsletter, role guide for all partners, deliverables guide for all partner schools, program interest survey, and program training flyers) and purchased all

	curricula materials for the program (toolkits and manuals), as well as, begin planning for parent workshops with our selected school sites and charter schools.
Collaboration	Through our collaborative efforts, we have partnered with the San Fernando Valley Community Mental Health Center to conduct 60 short term counseling services to our student population. Additionally, we have partnered with the Los Angeles Unified School District to implement our programming in 12 school sites. Lastly, we have collaborated with local charter schools like Pomelo Charter and Magnolia Science Academy to deliver parent workshops.
Performance / Impact	Our program has experienced challenges related to partner contracts and implementation; nonetheless, we have continued to adapt to these challenges to ensure processes are in place once implantation can occur. Our MOU with our partnered school district is still pending review and has now been moved to a different department. This has caused delays in our implementation timeline. Upon approval and receipt of mutual MOUs, we will be prepared to move forward with the next steps. Furthermore, through planning discussions with LAUSD, we have encountered challenges regarding programming delivery and logistics. Due to the COVID-19 pandemic, new protocols have been established with third party staff that will be present on school campuses.
Hospital's Contribution / Program Expense	This project is Federally funded by the Bureau of Justice Administration. 100% of the staff compensation and benefits are allocated by the funder. Additionally, all program materials and supplies are compensated by the funder. The total amount of the award is $718,018. The hospitals contribution is the working space and administrative support required.
FY 2022 Plan	
Program Goal / Anticipated Impact	Achieve a measurable reduction in incidents of school-based violence among partner schools and increased capacity to implement evidence-based violence prevention Programs.
Measurable Objective(s) with Indicator(s)	Train 4 middle and/or high schools in implementing the Positive Action Curriculum with youth throughout the campus. Facilitate 4 sessions of Safe Dates with 80 student participants while training 24 educators to implement in the future. Train 90 parents in bullying and violence prevention. Connect 20 youth at risk for violence perpetration to mental health. Services through San Fernando Valley Community Mental Health Center. Train 13 LAUSD personnel in Positive Action implementation. Train 20 LAUSD Mental Health Professionals in Positive Action
Intervention Actions for Achieving Goal	Implement Safe Dates groups, Question, Persuade, Refer, training for educators and parents, workshops on violence prevention for educators and parents, and Positive Action Curriculum in classrooms and school Counseling sessions. Host 7 awareness-raising events and 1 conference to share best practices with additional educators.
Planned Collaboration	Los Angeles Unified School District Northwest Division San Fernando Valley Community Mental Health Center Inc. Cleveland Community of Schools Charter Schools in Local District Northwest

	Sexual and Domestic Violence Prevention
Significant Health Needs Addressed	• Homelessness/Affordable Housing • Obesity/Overweight ▪ Mental Health • Substance Abuse • Diabetes ▪ Violence Child/Adult Domestic and Sexual Abuse and Assault
Program Description	The Sexual and Domestic Violence Prevention project brings culturally relevant violence prevention training to community members and youth using evidence-based curriculum. A social worker, nurse practitioner, and program coordinator facilitate classes for youth, and support groups and workshops for adults on domestic and sexual violence prevention.
Community Benefit Category	A1-a Community Health Education
FY 2021 Report	
Program Goal / Anticipated Impact	Increase awareness of teen dating violence and domestic violence and strategies for supporting those who are at-risk for violence among parents, youth, and educators. Also, increase advocacy capacity of youth and parents through evidence-based curriculum and prevent future incidents of abuse by providing support groups.
Measurable Objective(s) with Indicator(s)	Safe Dates: 4 sessions (60 youth) BITB: 2 sessions (20 youth) Beyond Trauma Open & Closed Support Groups: Reach 25 collectively Workshops: 18 workshops, 200 community members
Intervention Actions for Achieving Goal	Hosted three Teen Dating Violence Workshop series for parents and school staff. Hosted twelve 1-hour educational workshops (English and Spanish) for community members. Hosted Beyond Trauma Support group sessions. Hosted 3 cohorts of Safe Dates and a two-part workshop series on Safe Dates core values. Hosted Bringing in the Bystander cohort, reaching 4 youth. Hosted monthly School Outreach Working Group meetings with school staff to champion Safe Dates curriculum.
Collaboration	Optimist Youth Homes & Family Services Northridge Middle School Sutter Middle School
Performance / Impact	Reached 30 parents and school staff through three Teen Dating Violence Workshop series Reached 111 community members through one-hour educational workshops. Reached 20 community members through Beyond Trauma Support Groups. Reached 45 youth through Safe Dates cohorts and two-part workshop series. Reached 4 youth through Bringing in the Bystander cohort.

Hospital's Contribution / Program Expense	This program served 233 people and the hospital expense was $95,651.32.
FY 2022 Plan	
Program Goal / Anticipated Impact	Continue increasing awareness of teen dating violence and domestic violence and strategies for supporting those who are at-risk for violence among parents, youth, and educators. Continue to increase advocacy capacity of youth and parents through evidence-based curriculum and prevent future incidents of abuse by providing support groups. Program concludes in August 2021. However, Center for Assault Treatment Services Outreach Coordinator continues to provide educational workshops to community members and agencies that work with sexual assault and domestic violence survivors.
Measurable Objective(s) with Indicator(s)	Safe Dates: 4 sessions (60 youth) BITB: 2 sessions (20 youth) Beyond Trauma Open & Closed Support Groups: Reach 25 collectively Workshops: 18 workshops, 200 community members School Outreach Working group
Intervention Actions for Achieving Goal	Reached a total of 21 community members through Beyond Trauma Support Groups. Reached a total of 70 youth through Safe Dates sessions. Reached 190 community members through educational workshops in English and Spanish. Hosted and concluded monthly meetings for the School Outreach Working Group.
Planned Collaboration	West Valley Boys and Girls Club Northridge Middle School Sutter Middle School

County Community COVID-19 Equity Fund	
Significant Health Needs Addressed	• Homelessness/Affordable Housing • Obesity/Overweight • Mental Health • Substance Abuse • Diabetes • Violence Child/Adult Domestic and Sexual Abuse and Assault ▪ COVID-19 Efforts
Program Description	The County Community COVID-19 Equity Fund is funded by the Los Angeles County Department of Public Health to provide COVID-19 outreach and education to the Northeast San Fernando Valley. Outreach and education is conducted through educational workshops, community events, monthly electronic newsletters, and social media posts.

Community Benefit Category	A1-a Community Health Education
FY 2021 Report	
Program Goal / Anticipated Impact	The goal of this program is to slow the spread of COVID-19 through outreach, education, and engagement efforts throughout the Northeast San Fernando Valley by promoting preventive behaviors, providing up-to-date information, and dispelling myths and misinformation. Program began in March 2021.
Measurable Objective(s) with Indicator(s)	Social Media engagements: min 8 activities per month Passive engagement: min 8 activities per month Active Engagements: min 100 interactions per FTE per month Develop PSA campaign and disseminate information Host small business webinar series on COVID-19 regulation
Intervention Actions for Achieving Goal	Interventions include hosting monthly educational workshops on relevant COVID-19 information and trends, participating in community health and resource events, tabling at vaccine clinics, participating in local coalitions, food pantries.
Collaboration	Valley Community Care Consortium, Northeast Valley Health Corporation, North Valley Caring Services, Los Angeles Department of Mental Health Promoters, and Cleveland Charter High School
Performance / Impact	During FY 2021, the COVID-19 Outreach and Education program has reached 1,257 community members in active engagements through 11 virtual workshops (English and Spanish), health and resource events, and food pantries.
Hospital's Contribution / Program Expense	This program served 1,257 people and the hospital expense was $60,830.76.
FY 2022 Plan	
Program Goal / Anticipated Impact	Continue promoting preventive behaviors, providing up-to-date information, and dispelling myths and misinformation. Program concludes in February 2022.
Measurable Objective(s) with Indicator(s)	Social Media engagements: min 8 activities per month Passive engagement: min 8 activities per month Active Engagements: min 100 interactions per FTE per month Develop PSA campaign and disseminate information Host small business webinar series on COVID-19 regulation
Intervention Actions for Achieving Goal	Work with Dignity Health marketing to develop a PSA campaign for the holidays to promote vaccination and safe, healthy holidays. We will work with small businesses in the Northeast San Fernando Valley to address their needs and concerns through a small business webinar series. Additionally, we will continue hosting educational workshops and participate in community events, vaccination clinics, and food pantries. Partner with schools for workshops and community events.
Planned Collaboration	Valley Community Care Consortium, Northeast Valley Health Corporation, North Valley Caring Services, Supervisor Sheila Keuhl, Assemblymember Adrin Nazarian, Chicas Mom, Magnolia Science Academy Schools 2 & 7 Child Development Institute, Reseda Church of Christ, First United Methodist Church, Pacoima Charter School, Los Angeles Valley College

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.
- **Fresh Produce Monthly Distribution Drive Through -** A partnership with the American Heart Association to provide free produce to those that are food insecure. Additionally, any leftover items are distributed to our local food pantries to support healthier items to be added to their distributions.
- **Helping Hands Holiday Jam** – COVID 19 may continue to affect the way we prepare for the 14th annual event. The Northridge Hospital Foundation has provided a Christmas wonderland for disadvantaged children from eight Title 1 LAUSD schools providing them with at times the only toys they may receive for Christmas. This is even more important this year.
- **Jade Lee Marasigan Charitable Fund** - A legacy project created by her family in response to the passing of their daughter by suicide. The fund directly assist adolescents and young adults diagnosed cases of depression, anxiety, and other behavioral health conditions.
- **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. This has moved to a virtual platform to continue to provide these sessions.
- **Health Education–** Virtual evidence–based workshops and training events on all topics to promote community health and education that includes chronic disease self-management, COVID 19 education and stress management skills, and domestic violence and child abuse prevention sessions.
- **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 prior to COVID 19, and then through COVID safe appointments and virtual appointments

In addition, we invest in community capacity to improve health –addressing the social determinants of health – through Dignity Health's Community Investment Program. Both programs below address the number one need identified in the 2019 Community Health Needs Assessment, homelessness

LA Family Housing Corporation (LAFH) - In March 2016 Dignity Health approved a 7-year $3,051,000 loan to LAFH, to support construction of a new facility to house formerly homeless individuals and families plus a new FQHC. LAFH's service model for this campus is of a service "home" that combines housing and supportive services under one roof. LAFH's mission is to help families transition out of homelessness and poverty through a continuum of housing enriched with supportive services.

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 in County of Los Angeles. . With Dignity Health's support, Abode has built affordable housing in Long Beach, Hollywood, and South and Central Los Angeles.

Economic Value of Community Benefit

341 Northridge Hospital Medical Center
Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2020 through 6/30/2021

	Persons	Expense	Revenue	Net Benefit	% of Expense
Benefits for Poor					
Financial Assistance	**8,611**	**6,449,751**	**0**	**6,449,751**	**1.4%**
Medicaid	**25,581**	**134,415,487**	**114,878,714**	**19,536,773**	**4.3%**
Community Services					
A - Community Health Improvement Services	5,006	1,485,235	598,451	886,784	0.2%
E - Cash and In-Kind Contributions**	6	562,189	990,196	0	0.0%
G - Community Benefit Operations	79	688,466	0	688,466	0.2%
Totals for Community Services	**5,091**	**2,735,890**	**1,588,647**	**1,147,243**	**0.3%**
Totals for Poor	**39,283**	**143,601,128**	**116,467,361**	**27,133,767**	**6.0%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	5,142	1,386,793	710,224	676,569	0.1%
B - Health Professions Education	1,578	7,950,360	1,023,640	6,926,720	1.5%
C - Subsidized Health Services	1,362	19,449,631	18,013,164	1,436,467	0.3%
E - Cash and In-Kind Contributions	300	132,553	38,576	93,977	0.0%
F - Community Building Activities	10,574	1,029,049	0	1,029,049	0.2%
Totals for Community Services	**18,956**	**29,948,386**	**19,785,604**	**10,162,782**	**2.2%**
Totals for Broader Community	**18,956**	**29,948,386**	**19,785,604**	**10,162,782**	**2.2%**
Totals - Community Benefit	**58,239**	**173,549,514**	**136,252,965**	**37,296,549**	**8.2%**
Medicare	**19,353**	**182,718,768**	**143,512,587**	**39,206,181**	**8.7%**
Totals with Medicare	**77,592**	**356,268,282**	**279,765,552**	**76,502,730**	**16.9%**

** Consistent with IRS instructions and CHA guidance, Cash and In-Kind Contributions is reported at $0 net Benefit because offsetting revenue was greater than expense in FY21. This was due to the return of a large Donation in the fiscal year. Net gain for cash and in-kind contributions is still included in the all “Totals” calculations, however.

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

Hospital Board and Committee Rosters

Maritza Artan
Retired

Dorothy Benveniste
Project Manager, BCA Customer Support
The Boeing Company

Christina Galstian
Chief Executive Officer
CCHCS, Los Angeles County

Arturo Jacinto
Retired

Felice L. Klein
Retired

Kirsten Mewaldt, MD
Emergency Room Physician

Barbra Miner
Independent Consultant

Jahandar Saleh, MD
Cardiologist, 2020-2022 NHMC Medical Staff President

Carol Stern
CEO
Pro Pharma Pharmaceutical Consultants

Steve Valentine
President
Valentine Health Advisers

Anil Wadhwani, M.D.
Radiologist

Paul Watkins
President/CEO
Northridge Hospital Medical Center

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