Northridge Hospital Medical Center

Community Benefit 2020 Report and 2021 Plan

Adopted November 2020

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 is conducted 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.

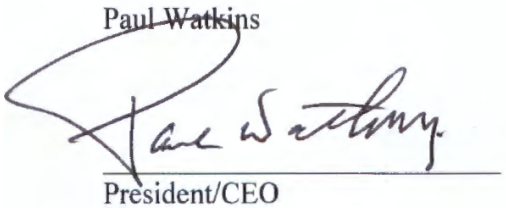
Northridge Hospital shares a commitment with others to improve the health of our community, and delivers programs and services to help achieve that goal. The Community Benefit 2020 Report and 2021 Plan describes much of this work. This report meets requirements in California state law (Senate Bill 697) 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 2020 (FY20), Northridge Hospital provided $52,574,985 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $42,043,616 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2020 Report and 2021 Plan at its November 10, 2020 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, Board of Directors

Table of Contents

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 26 cities with 40 ZIP codes which represent roughly 80% of patients seen at Northridge Hospital.
Economic Value of Community Benefit	$52,574,985 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $42,043,616 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
FY20 Programs and Services	The hospital delivered several programs and services to help address identified significant community health needs. Due to COVID -19 many of the programs were halted and transformed from live in-person to virtual and telephonic trainings, and coaching calls. These included: 1 Homelessness and Affordable Housing – 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. 2 Obesity/Overweight - Community and School Wellness Initiative – Partnership with Los Angeles Unified School District to implement physical activity, nutrition education, and parent education in community prior to April 2020. Post COVID 19 virtual workshops and trainings being conducted via ZOOM. 3 Mental Health – The Cultural Trauma Mental Health Resiliency Program to address behavioral health and mental well-being of at-risk youth, through prevention and early intervention in the most vulnerable areas. Fund community partnerships with local mental health providers to train and virtually deliver evidence-based Mental Health First Aid Adult/Youth, and the Question, Persuade, Refer suicide prevention programs.

	4 Substance Use - Medicated Assisted Treatment (MAT) Program 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. 5 Chronic Disease Wellness - expanded diabetes programs to conduct virtual evidence-based Diabetes Self-Management programs through the Prevention Forward project. Staff received online training to the offer CDC National Diabetes Prevention Program to population with pre-diabetes virtually. Cardiovascular health is 8 weeks of hypertension self-management, cardiovascular prevention education, physical activity, and stress management to reduce the risk of heart disease. 6 Center for Assault Treatment Services – Forensic interviews and medical exams for child and adult victims of sexual abuse/assault, domestic violence, child maltreatment, human trafficking, and dating abuse. Also includes outreach prevention education and mandated reporter training and teen dating abuse prevention curriculum designed to raise students' awareness of what constitutes healthy and abusive dating relationships. Escape Now, a violence prevention program for adults with developmental disabilities.
FY21 Planned Programs and Services 	FY20 programs above will continue, with the following new programs: 1) Participate with the Corporation for Supportive Housing on the Homeless Health Project that utilizes a navigator based in the Emergency Department to provide resources and warm handoffs, and connections to homeless services for those living on the streets. A homeless navigator for coordination of care will work with the most vulnerable. 2) Continue to build the Local Elder Abuse Prevention Enhanced Multidisciplinary Team (LEAP E-MDT) to reduce all types of abuse for those over 60 years old, and provide resources and awareness. 3) Community and School Wellness Initiative – Partnership with Los Angeles Unified School District to implement a school violence prevention program with the goal of reducing both school and community violence. 6) 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 of individuals including community-based education, outreach, and support to caregivers and workers caring for ADRD individuals.

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.

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Our Hospital and the Community Served

About Northridge Hospital

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

Northridge Hospital, a Dignity Health member, was founded in 1955 and is located at 18300 Roscoe Blvd., Northridge, CA. The facility has a total of 394 beds, licensed for 354 bed general acute care plus 40 acute psychiatric bed non-profit hospital facility. NHMC has over 1,840 employees and 750 active physicians. Major programs and services include Cancer Center with expanded Infusion Room, Center for Assault Treatment Services, Center for Healthier Communities, Cardiovascular Center, ER Online Waiting Service (In Quicker), Family Birth Center, Adult and Pediatric Trauma Centers, Stroke Center, STEMI Receiving Center and Neonatal ICU.

Our Mission

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

Our Vision

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

Financial Assistance for Medically Necessary Care

Northridge Hospital delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of our 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 on the hospital's web site.

Description of the Community Served

Northridge Hospital proudly serves approximately 1.9 million residents in the hospital's service area located in northern Los Angeles County. A summary description of the community is below. Additional details can be found in the CHNA report online.

The hospital's service region is located is Service Planning Area 2 (SPA 2), 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 region spans cities, communities, and incorporated areas in the San Fernando and Santa Clarita Valleys of Los Angeles County and Ventura County encompassing 40 zip codes. 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 17 zip codes that are rated 4.2 and above by the Community Need Index on the next page. 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.

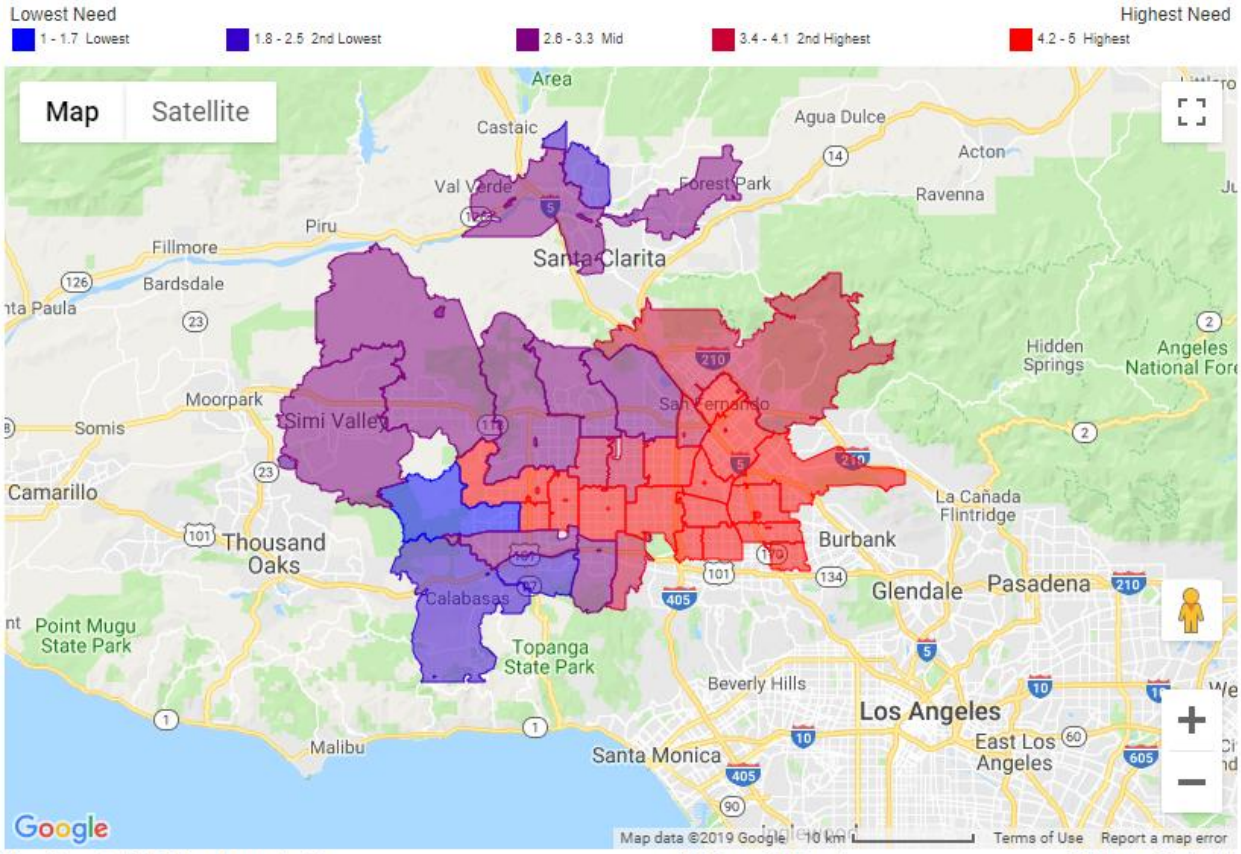
Total Population	1,575,710
Race	
White - Non-Hispanic	32.4%
Black/African American - Non-Hispanic	3.6%
Hispanic or Latino	49.6%
Asian/Pacific Islander	11.5%
All Others	2.9%
% Below Poverty	10.2%
Unemployment	5.8%
No High School Diploma	19.5%
Medicaid (household)	8.9%
Uninsured (household)	4.4%

Source: Claritas Pop-Facts® 2020; SG2 Market Demographic Module

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

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 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.

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.

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.

2020 Report and 2021 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 FY20 and planned activities for FY21, 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, they 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 will be 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 to assist with homelessness and mental health will be added to the FY 21 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 2021because of the evidence of success and impact it is having in our community. 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.

Impact of the Coronavirus Pandemic

The Coronavirus Pandemic has impacted our community due to the high volume of cases. At the hospital level to best support those seeking our services, the hospital developed a separate unit to isolate and care for COVID 19 patients. A command center was created to track ventilators and PPE so that our staff and patients were protected. The reduction of elective and non-emergent surgeries and hospital inpatient stays led to financial challenges. Patients continue to put off services and screenings that may potentially have a negative impact over time.

Northridge Hospital ramped up testing efforts in a number of ways including a partnership with the Los Angeles County Department of Public Health to set up a drive-by testing site for COVID-19. As for testing, as a current Cepheid Molecular customer when COVID 19 broke out, our lab was quickly identified as one of two (2) major accounts in the Los Angeles Market that would receive the first Cepheid test kits to be delivered to hospitals. Northridge Hospital Lab and USC Keck were the first hospitals able to do testing and greatly improved the TAT for identifying positive cases. Our allocations were cut due to demand around the nation and many of us had to start sending testing that could not be run in house due to short supply out to reference labs. Two additional testing platforms, the BD MAX and the Hologic Fusion were added to increase capacity. We are now doing all COVID 19 testing for Dignity Health's four LA hospitals and two San Bernardino hospitals. The hospital also participated in the COVID 19 positive plasma donation program.

In our area we have seen an increase in weight gain, higher rates of depression, higher rates of teen suicide, and higher rates of phone calls to crisis lines for domestic violence and child abuse. All of these areas are existing community needs that have been exacerbated by COVID 19. To address these concerns we have moved to providing individual and group coaching phone calls, mass mailings, support services development, and virtual presentations of targeted prevention education and depression prevention, self-care, stress management, diabetes, and cardiovascular and physical activity sessions. There has been a drastic increase in the number of telehealth appointments by physicians and mental health providers.

As a result of COVID 19, we support our community-based partners that are seeing greater need for meal home deliveries, loss of volunteers, and decreased staffing hours. We have increased our support to them financially through supporting their fundraising efforts and though grant making. This year a portion of our community benefit grants have been directed to support those non-profits most effected by COVID 19.

Moving forward into 2021 we will continue to provide COVID19 education and prevention tips through mass mailing, virtual workshops, creation of school based newsletters, funding support, and grant

making. Additionally, we will increase our efforts to conduct community outreach and engagement, COVID-19 prevention activities, and system navigation.

Report and Plan by Health Need

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

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

Health Need: Affordable Housing and Homelessness

Strategy or Program Name	Summary Description	Active FY20	Planned FY21
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.	☒	☒
LAHSA Hospital Liaison Pilot	• 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	☒	☒
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.	☒	☒

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

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.

Health Need: Obese and Overweight Adults and Children

Strategy or Program Name	Summary Description	Active FY20	Planned FY21
School Wellness Initiative	• Classroom nutrition classes for elementary school children including My Plate and Choose Water • Parent Center Virtual Workshops with 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.	☒	☐

Impact: Increased child and parent knowledge of importance of healthy diet and physical activity. Increases in the consumption/purchase 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.

Health Need: Mental Health Services

Strategy or Program Name	Summary Description	Active FY20	Planned FY21
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. Will fund community partnerships with local mental health providers to train and deliver	☒	☒

	evidence-based Mental Health First Aid and Question, Persuade, Refer teen suicide prevention.		
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	Active FY20	Planned FY21
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. 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)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.

Health Need: Chronic Disease (Diabetes)

Strategy or Program Name	Summary Description	Active FY20	Planned FY21
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 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 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 cardiovascular 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. 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 FY20	Planned FY21
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.	☒	☐

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. Increased awareness of over 300 people with cognitive and development disabilities to be able to self-identify and report when they are victims of abuse. Over 100 Middle and High School students through pre- and post-testing 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.

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. Will continue to work with the Boys and Girls Clubs, school sites, and youth service providers to implement programs virtually and on site when safe to do so.

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 FY20, the hospital awarded the grants below totaling $205,185. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Journey Out	Human Trafficking Continuum of Care Network: Sex Trafficking Response Team	$52,377
OneGeneration	Senior Enrichment Center Health and Housing Project	$52,377
Phoenix House California	Close to Nature-A new Approach to Teen Behavioral Health	$52,377
Community-Based Mental Health Partners National Alliance for Mental Illness (NAMI), San Fernando Valley Community Mental Health, Inc.(SFVCMH), and Tarzana Treatment Centers (TTC)	The Cultural Trauma and Mental Health Resiliency Project	$48,054
2020 Grant Making Total		$205,185

UniHealth Matching Grant - The six hospitals in Dignity Health's SoCal Region continued for Year 2, 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 2020 contribution to this pool from their original 2020 grant allotment of $205,065 was $48,054.

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.
Community Benefit Category	Health Care Support Services and Community and Community Building
FY 2020 Report	
Program Goal / Anticipated Impact	Establish 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 rise from 2019 – 2020, homelessness increased despite higher number of those housed showing sustained increases in the number of people housed. Of the 9,108 homeless in SPA 2, 27.4% are sheltered and 76.2% live on the streets.
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. CHC Program Manager has become more active on the committee by joining the hospital sector subcommittee member 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, 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 387 people at cost of $3,363; meals provided to 779 people at a cost of $9,350; transportation vouchers supported 466 individuals at a cost of $13,104; and recuperative care beds to the homeless or uninsured - recuperative care cost serving 39 persons = $149,434.
FY 2021 Plan	
Program Goal / Anticipated Impact	Establish 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. A huge concern and effort in 2021 will be to support 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.

Pain Management and 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	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
FY 2020 Report	
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 socioeconomic mobility through job training and job

	support in conjunction with the range of medical, substance abuse, and mental health 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)	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 will 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. He/she will provide a warm hand-off, help patients with barriers to care, and follow up with patients to keep them engaged in the program. Grant funds will be used to hire a part-time Social Worker (0.5 FTE per diem) and to provide transportation vouchers for patients to get to appointments
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 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	This ongoing 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 delivery of mental health awareness education.
Community Benefit Category	Community Health Education and Community Building
FY 2020 Report	

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, 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. An evaluator on the program will share evaluation reports with us with a first report expected by Jan. 2021.
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 provide all services virtually. There was a disruption and sometime lags due to the time it took for this second round of training to occur.
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).
Performance / Impact	COVID 19 adversely affected the number of training sessions and numbers of individuals reached due to the cancellation of sessions due to Stay at Home orders and no public meetings. Through Sept. 30th there were35 training sessions conducted educating 491 people.
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 with enrolling into programs. Hospital expense was $2,717.
FY 2021 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 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 65 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' goals. New partners will receive training including schools, LAPD, LAFD, probation officers, and jail Provide mental health awareness training and certification in Mental Health First Aid throughout the San Fernando Valley community to build awareness of the warning signs of mental health and substance use disorders so that those in need can be linked to appropriate treatment. Staff and TTC will provide Youth Mental Health First Aid (YMHFA) training to health and social service providers and other relevant community members, including teachers and parents/caregivers, in Service Planning Area 2 within Northridge Hospital Medical Center's service area.
Planned Collaboration	Staff with existing community partners Boys & Girls Clubs, YMCA, Libraries, Parks and Recreation Department, and more.

Prevention Forward (Diabetes Wellness and Active Your Heart)

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	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	Community Health Education

FY 2020 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 FY2020 programs reported increased knowledge of nutrition and physical activity. NHMC Center for Healthier Communities conducted outreach and referral to evidence based classes for 502 community members in FY20. NHMC engaged 30 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 Grocery Store Tours
Collaboration	In 2020 collaboration consisted of our Center for Healthier Communities, Chronic Disease Transitional Care Team, and CDPH.
Performance / Impact	In the first year of the program a cohort of 28 individuals participated in evidence-based self-management classes, grocery store tours, cooking demonstrations and virtual workshops.
Hospital's Contribution / Program Expense	This partnership began as a pilot project called Healthier Living in 2019 and 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. The program served 251 people and the hospital expense was $39,314.
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 for year two include increasing the 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. Additional objectives are to conduct one session of the National Diabetes Prevention Program for a minimum of 10 participants. Further objectives are to conduct four sessions of Activate Your Heart, and two sessions of DEEP in addition to monthly wellness workshops.
Intervention Actions for Achieving Goal	• Diabetes Empowerment Education Program • National Diabetes Prevention Program • Activate Your Heart • Grocery Store Tours • Monthly Wellness Workshop
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. CDPH has funded 12 partners so that this program can be implemented throughout the state. We are the Los Angeles County partners.

Community and School Wellness

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	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 hospitals Center for Healthier Communities staff.
Community Benefit Category	Community Health Improvement and Community Education

FY 2020 Report

Program Goal / Anticipated Impact	Increases child and parents knowledge in evidence-based health curriculums including My Plate and the value of nutrition. Enhance socio-emotional wellness in parents, children, and educators, and enhance adult's capacity to support children in coping with COVID-19 stressors.
Measurable Objective(s) with Indicator(s)	Created 10 School Wellness Newsletters for 34 schools. Facilitated the Great Kindness Challenge in 22 schools. Conducted 9 workshops at each school for nutrition, physical activity, and emotional health.
Intervention Actions for Achieving Goal	Continued to engage the schools through the School Wellness Newsletter that we create for them each month that school is in session. 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. We facilitated the Great Kindness Challenge with 22 schools and provided incentives for youth to engage in completing Kindness Checklists to promote socio-emotional wellness and prevent bullying.
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.

Hospital's Contribution / Program Expense	This program was support by the hospital in the amount of $7,268 for supplies. This program is primarily staffed by the Program Manager at the NHMC Center for Healthier Communities and supported by other staff members that are fully grant funded. We reached 20,420 children and their parents through workshops, and classroom and virtual presentations.
FY 2021 Plan	
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. 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 knowledge and awareness of socioemotional wellness promotion among parents. We plan to conduct 10 workshops throughout the year.
Intervention Actions for Achieving Goal	Nutrition workshops that will include My Plate and other evidence-based nutrition and exercise curriculums. We also plan to conduct a virtual version of the Great Kindness challenge and additional socioemotional wellness workshops.
Planned Collaboration	Collaboration with our local LAUSD schools (34). Additionally, we will plan to add some new charter schools.

Sexual and Domestic Violence Prevention

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	New program in 2020. 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-b Community Health Education - Public dissemination of materials and information
FY 2020 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.
Measurable Objective(s) with Indicator(s)	Trained 30 professionals on ways to recognize and prevent domestic violence in the midst of COVID-19.
Intervention Actions for Achieving Goal	Developed curriculum and training materials for school and parent violence prevention workshops. Hosted two 1-hour workshops (English and Spanish) for professionals on domestic violence prevention.
Collaboration	Bright Star Academy
Performance / Impact	Participants in workshops reported increased knowledge of strategies for preventing violence in the midst of COVID-19.
Hospital's Contribution / Program Expense	Costs for FY2020 amounted to $3979. There were no other costs as the grant became fully active in June 2020.
FY 2021 Plan	
Program Goal / Anticipated Impact	Continue 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)	Provide support groups and training workshops to approximately 200 educators and parents Conduct 10 violence prevention workshops Provide Safe Dates classes to 40 youth Provide Bringing in the Bystander classes to 20 youth
Intervention Actions for Achieving Goal	We will conduct monthly support groups using the Beyond Trauma curriculum, and we will conduct workshops for parents and educators two or more times a month. We will implement 4 Safe Dates classes and 2 Bringing in the Bystander Classes
Planned Collaboration	Optimist Youth Homes BrightStar Academy LAUSD Northwest District

STOP School Violence

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 STOP school violence programs focuses on preventing school violence in all forms including dating violence, bullying, and youth suicide. Through this program NMHC is partnering with the Los Angeles Unified School District and San Fernando Valley Mental Health Center to train educators in evidence based violence prevention programs and expand their capacity to prevent violence on campus.
Community Benefit Category	A1-b Community Health Education - Public dissemination of materials and information
FY 2020 Report	
Program Goal / Anticipated Impact	This is a new project to be implemented in FY 2021 that was not active in FY2020
Measurable Objective(s) with Indicator(s)	This is a new project to be implemented in FY 2021 that was not active in FY2020
Intervention Actions for Achieving Goal	This is a new project to be implemented in FY 2021 that was not active in FY2020
Collaboration	This is a new project to be implemented in FY 2021 that was not active in FY2020
Performance / Impact	This is a new project to be implemented in FY 2021 that was not active in FY2020
Hospital's Contribution / Program Expense	This is a new project to be implemented in FY 2021 most of the work will be grant funded, however some expenses are covered by the hospital including the Project Director and Project Manager whose time and expenses will be covered by the hospital.
FY 2021 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 3 middle and/or high schools in implementing the Positive Action curriculum with youth throughout the campus. Facilitate 3 sessions of Safe Dates while training 3 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 Inc. Train 40 LAUSD personnel in Positive Action implementation.
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 6 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.

Local Elder Abuse Prevention Enhanced Multidisciplinary Team (LEAP E-MDT)

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	Newly implemented in 2020 LEAP EMDT works to put an end to the mistreatment and exploitation of older adults and provide integrated services to seniors who are victimized or vulnerable. LEAP EMDT bring together local experts from diverse disciplines to jointly respond to the needs of these seniors, develop best practices, and train our community to identify and intervene before a senior is ever abused. LEAP-EMDT has unique access to a forensic accountant, geriatric neuropsychologists, and community legal services in addition to drawing on the expertise of disciplines including aging services, the financial industry, and local law enforcement. The team members review cases of elder abuse, provide recommendations, referrals, and resources based on client needs as well as training to community members and healthcare professionals on the prevention of elder abuse.
Community Benefit Category	A1-b Community Health Education - Public dissemination of materials and information
FY 2020 Report	
Program Goal / Anticipated Impact	Contribute to improving the social and health outcomes for older adults aged 60+ who are at-risk or have experienced elder abuse, exploitation, or self-neglect.
Measurable Objective(s) with Indicator(s)	• Conduct a Community Needs Assessment to evaluate the needs of the community, the resources available to address elder abuse, and the gaps in services that act as barriers to victims of elder abuse.

	• Provide elder abuse prevention education to families, caregivers, and medical professionals. Impact is measured through participant count. • Conduct elder abuse case review and provide integrated services, referrals, recommendations, and resources unique to each case. Impact is measured through case review count and conducting risk assessments to validate reduced risk for victimization on each completed case. • Raise community awareness of elder abuse and elder abuse prevention through awareness events. The impact is measured through how many community members were reached.
Intervention Actions for Achieving Goal	Conduct monthly elder abuse case review meetings for 4 cases. Evidenced-based elder abuse prevention education for families, caregivers, reaching over 315 individuals. One Community outreach event reaching over 300 residents
Collaboration	LEAP EMDT is a collaboration between Dignity Health - Northridge Hospital's Center for Healthier Communities and Center for Assault Treatment Services, and the 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, and a forensic accountant.
Performance / Impact	Reduced risk for victimization and re-victimization for older adults who are at-risk or have experienced elder abuse, exploitation, or self-neglect. Provide pathways to restorative justice for victims of elder abuse. Educate medical professionals on how to recognize lesser known symptoms of elder abuse, exploitation, and self-neglect Increase community awareness of elder abuse and how to prevent it from occurring.
Hospital's Contribution / Program Expense	This is a grant funded project so the hospital contribution is a small portion of the expense with the majority of the cost reimbursed by grant funds from the Office of Victims of Crimes within the Department of Justice. Hospital contribution was $35,465.
FY 2021 Plan	
Program Goal / Anticipated Impact	Continued monthly elder abuse case review for older adults who are at-risk or have experienced elder abuse, exploitation, and self-neglect. Increase elder abuse prevention education for families and caregivers. Begin elder abuse prevention education for medical professionals (social workers, case managers, physicians, and nurse practitioners.
Measurable Objective(s) with Indicator(s)	Conduct 32 elder abuse case reviews Provide 30 caregiver education workshops to reach 250 individuals Provide 4 medical professional CME trainings to reach 60 medical professionals.

	Conduct 3 community outreach events reaching 150 community residents.
Intervention Actions for Achieving Goal	We will conduct 12 monthly meetings to review cases of elder abuse, host more than 100 workshops for caregivers, provide 4 sessions of CME training to medical professionals, and host 3 outreach events.
Planned Collaboration	Dignity Health Northridge Hospital's Center for Healthier Communities and Center for Assault Treatment Services, and the 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, and a forensic accountant. We will also collaborate as needed with law enforcement, and the District Attorney's office on criminal cases.

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
  - **COVID-19 Drive By Testing Site –** In partnership with Los Angeles County Department of Public Health created and staffed a free drive up testing site for the community residents with COVID 19 symptoms.
  - **Helping Hands Holiday Jam** – COVID 19 may affect the way we prepare for the 13th 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.
  - **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. They are the largest provider of housing and homeless services in the San Fernando Valley.

Abode Communities (Abode) - In 2019 Dignity Health approved a 3-year $2,000,000 line of credit to fund acquisition and predevelopment costs related to new development projects. A partner of Dignity Health since 2010, Abode is considered a thought leader in the affordable housing industry and since 2012, has placed in service 500 affordable housing units within the County of Los Angeles, with another 900 affordable units currently under construction and expected to be placed in service over the next several years. 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 7/1/2019 through 6/30/2020

	Persons	Net Benefit	% of Expenses
Benefits for Poor			
Financial Assistance	4,539	8,085,163	1.9%
Medicaid	33,511	32,435,319	7.6%
Means-Tested Programs	**30**	**466,560**	**0.1%**
Community Services			
A - Community Health Improvement Services	25,741	924,068	0.2%
E - Cash and In-Kind Contributions*	3	0	0.0%
G - Community Benefit Operations	79	587,875	0.1%
Totals for Community Services	**25,823**	**1,511,943**	**0.4%**
Totals for Poor	**63,903**	**42,498,985**	**9.9%**
Benefits for Broader Community			
Community Services			
A - Community Health Improvement Services	14,641	725,598	0.2%
B - Health Professions Education	2,025	7,958,042	1.9%
C - Subsidized Health Services	0	1,354,308	0.3%
E - Cash and In-Kind Contributions	386	38,052	0.0%
Totals for Community Services	**17,052**	**10,076,000**	**2.4%**
Totals for Broader Community	**17,052**	**10,076,000**	**2.4%**
Totals - Community Benefit	**80,955**	**52,574,985**	**12.3%**
Medicare	**22,303**	**42,043,616**	**9.8%**
Totals with Medicare	**103,258**	**94,618,601**	**22.1%**

*Cash and in-kind contributions reported at $0 net benefit due to return of a large donation in the fiscal year.

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 Roster

July 2020

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

Summary Of Financial Assistance Programs

Dignity Health's Financial Assistance Policy describes the financial assistance programs available to uninsured or underinsured patients who meet certain income requirements to help pay for medically necessary hospital services provided by Dignity Health. An uninsured patient is someone who does not have health coverage, whether through private insurance or a government program, and who does not have the right to be reimbursed by anyone else for their hospital bills. An underinsured patient is someone who has health coverage, but who has large hospital bills that are not fully covered by their insurance.

Free Care

- If you are uninsured or underinsured with a family income of up to 250% of the Federal Poverty Level you may be eligible to receive hospital services at no cost to you.

Discounted Care

- If you are uninsured or underinsured with an annual family income between 250-350% of the Federal Poverty level, you may be eligible to have your bills for hospital services reduced to the highest amount reasonably expected to be paid by a government payer, which is usually the amount that Medicare would pay for the same services.
- If you are uninsured or underinsured with an annual family income between 350-500% of the Federal Poverty level you may be eligible to have your bills for hospital services reduced to the Amount Generally Billed, which is an amount set under federal law that reflects the amount that would have been paid to the hospital by private health insurers and Medicare (including co-pays and deductibles) for the medically necessary services.

If you are eligible for financial assistance under our Financial Assistance Policy you will not be required to pay more than the Amount Generally Billed described above. If you qualify, you may also request an interest-free extended payment plan.

You will never be required to make advance payment or other payment arrangements in order to receive emergency services.

Free copies of the hospital's Financial Assistance Policy and financial assistance application forms are available online at your hospital's website listed below or at the hospital Admitting areas located near the main entrance. (Follow the signs to "Admitting" or "Registration"). Copies of these documents can also be mailed to you upon request if you call Patient Financial Services at the telephone number listed below for your hospital.

Traducción disponible: You may also obtain Spanish and other language translations of these documents at your hospital's website, in your hospital's Admitting area, or by calling your hospital's telephone number.

Dignity Health Financial Counselors are available to answer questions, provide information about our Financial Assistance Policy and help guide you through the financial assistance application process. Our staff is located in the hospital's Admitting area and can be reached at the telephone number listed below for your hospital.

California Hospital Medical Center 1401 South Grand Ave, Los Angeles, CA 90015 | **Financial Counseling** 213-742-5530
Patient Financial Services 888-488-7667 | www.dignityhealth.org/californiahospital/paymenthelp

Community Hospital of San Bernardino 1805 Medical Center Dr, San Bernardino, CA 92411
Financial Counseling 909-806-1317 | **Patient Financial Services** 909-806-1281
www.dignityhealth.org/san-bernardino/paymenthelp

Glendale Memorial Hospital 1420 South Central Ave, Glendale, CA 91204 | **Financial Counseling** 818-502-2305
Patient Financial Services 888-488-7667 | www.dignityhealth.org/glendalememorial/paymenthelp

Northridge Hospital Medical Center 18300 Roscoe Blvd, Northridge, CA 91328 | **Financial Counseling** 818-885-5368
Patient Financial Services 888-488-7667 | www.dignityhealth.org/northridgehospital/paymenthelp

St. Bernardine Medical Center 2101 N. Waterman Ave, San Bernardino, CA 92404
Financial Counseling 909-883-8711 ext 4408 | **Patient Financial Services** 909-881-4418
www.dignityhealth.org/stbernardinemedical/paymenthelp

St. Mary Medical Center 1050 Linden Ave, Long Beach, CA 90813 | **Financial Counseling** 562-491-7078
Patient Financial Services 888-488-7667 | www.dignityhealth.org/ stmarymedical/paymenthelp

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