2025 Community Health Implementation Strategy and Plan

Adopted October 2025

Northridge Hospital Medical Center

Dignity Health®
A member of CommonSpirit

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At-a-Glance Summary

Community Served

Dignity Health - Northridge Hospital Medical Center's (NHMC) service area is located in Service Planning Area 2 of Los Angeles County, which consists of the San Fernando and Santa Clarita Valleys. The service area is home to over 1.5 million residents of multiple cultures and ethnic backgrounds. The total land area is 369 miles with a population density of 4,271 people per square mile.

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 the hospitals intends to address with strategies and programs are:

- Mental Health
- Diabetes
- Climate, Nature, and Health
- Substance Use
- Nutrition, Physical Activity, and Weight
- Access to Health Care Services
- DIsabling Conditions
- Heart Disease and Stroke
- Injury and Violence
- Sexual Health

Strategies and Programs to Address Needs

The hospital intends to take several actions and to dedicate resources to these needs, including:

Community Health Needs	Actions/Programs to Address the Need
Mental Health	Continue to offer the SFV Healing Project - Mental Health Awareness Training; Continue to offer the SFV Resourceful Adolescent Program; Continue to offer the Enhancing Youth Mental Health Well-Being Program; Continue to build community partnerships and provide grants focused on addressing mental health needs.
Diabetes	Implement the STEM (Screen, Test, Empower, and Manage) Diabetes Program.
Climate, Nature, and Health	Continue to offer the LISTOS California Program
Substance Use	Continue to offer the SFV Resourceful Adolescent Program.
Nutrition, Physical	Provide educational workshops and events

Activity, and Weight	focused on healthy nutrition and physical activity; Incorporate nutrition and physical activity topics into the HeartBeat and STEM Diabetes Programs,
Access to Health Care Services	Continue to offer the Community Health Worker for Sustainable Outreach & Navigation Program; Continue to offer financial assistance services to low-income and uninsured patients; Provide free transportation services to patients in need.
Disabling Conditions	Continue to offer the Local Elder Abuse Prevention Enhanced Multidisciplinary Team Program; Continue to offer the Cancer Navigation Program to low-income patients.
Heart Disease and Stroke	Continue to offer the HeartBeat California Program.
Injury and Violence	Continue to offer the Schools Against Violence - LA Program: Continue to offer CATS; Implement the AVAAS program focused on reducing community violence.
Sexual Health	Continue to offer the Schools Against Violence - LA Program; Continue to offer the CATS Program.

Planned resources and collaborators to help address these needs, as well as anticipated impacts of the strategies and programs, are described in the “Strategies and Program Activities by Health Need” section of the document.

This document is publicly available online at: https://www.dignityhealth.org/socal/locations/northridgehospital/about-us/community-benefit-reports

Written comments on this report can be submitted to the **Center for Healthier Communities- 8210 Etiwanda Avenue Reseda, CA 91335** or by e-mail to ron.sorensen@commonspirit.org.

Our Hospital and the Community Served

About the Hospital

Dignity Health - Northridge Hospital Medical Center is a part of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 2,200 care sites in 24 states coast to coast, serving patients in big cities and small towns across America.

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

- Hospital location- 18300 Roscoe Blvd., Northridge, CA.91328
- Description - Founded in 1955, Northridge Hospital is a non-profit facility that has a total of 394 beds, including 354 licensed beds for general acute care and 40 acute psychiatric beds. The hospital employs over 1,800 staff members and has 750 active physicians.

Major program and service lines

- Cancer Center Services
- Center for Healthier Communities
- Adult and Pediatric Trauma Centers
- STEMI Receiving Center
- Center for Assault Treatment Services (CATS)
- Neonatal ICU/Pediatrics
- Cardiovascular Center
- Family Birth Center
- Stroke Center

Our Mission

The hospital's dedication to assessing significant community health needs and helping to address them in conjunction with the community is in keeping with its 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.

Financial Assistance for Medically Necessary Care

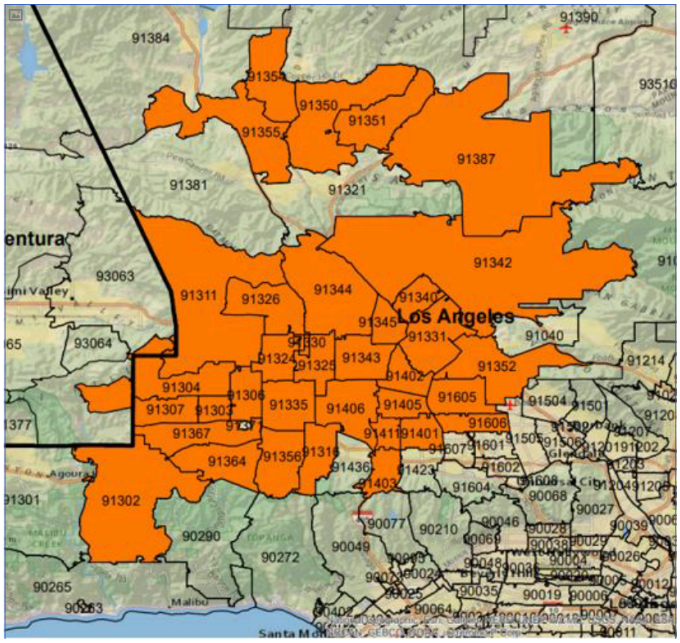
It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay.

This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.

Description of the Community Served

The hospital's service region is located in northern Los Angeles in Service Planning Area 2 (SPA 2) with over 1.5 million residents, and is 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 densely populated region of Los Angeles County spans cities, communities, and incorporated areas in the San Fernando and Santa Clarita Valleys. A summary description of the community is below, and additional details can be found in the CHNA report online.

The study area for the needs assessment (referred to as "NHMC Service Region" in this report) reflects communities throughout the San Fernando and Santa Clarita Valleys in Los Angeles, inclusive of the following ZIP Codes: 91302, 91303, 91304, 91306, 91307, 91311, 91316, 91324, 91325, 91326, 91330, 91331, 91335, 91340, 91342, 91343, 91344, 91345, 91350, 91351, 91352, 91354, 91355, 91356, 91364, 91367, 91387, 91401, 91402, 91403, 91405, 91406, 91411, 91605, and 91606. This community definition, determined based on the ZIP Codes of residence of recent patients of Dignity Health – Northridge Hospital Medical Center, is illustrated in the following map.



The San Fernando and Santa Clarita Valleys are predominantly suburban regions characterized by a diverse population and a mix of urban and residential communities. The San Fernando Valley, known for its rich cultural tapestry, is home to various ethnic groups, including significant Latino and immigrant populations. The Santa Clarita Valley, while more suburban and newer in development, also attracts diverse residents. Key economic drivers in

both areas include entertainment, retail, and healthcare sectors, with a growing emphasis on technology and education. Despite their economic advantages, these valleys face notable health disparities, particularly among disadvantaged and minority communities relying on public health services and community clinics. Community demographics are listed below:

2025 CHNA Zip Codes	FY25
Total Population	1,500,327
Race	
Asian/Pacific Islander	11.5%
Black/African American - Non-Hispanic	4.0%
Hispanic or Latino	47.8%
White Non-Hispanic	32.5%
All Others	4.2%
% Below Poverty (families)	13.2%
Unemployment	5.8%
No High School Diploma	18.9%
Medicaid	32.5%
Uninsured	9.4%

Community Assessment and Significant Needs

The health issues that form the basis of the hospital's community health implementation strategy and plan were identified in the most recent CHNA report, which was adopted in June 2025. The CHNA report includes:

- description of the community assessed consistent with the hospital's service area;
- description of the assessment process and methods;
- data, information and findings, including significant community health needs;
- community resources potentially available to help address identified needs; and
- impacts of actions taken by the hospital since the preceding CHNA.

Additional details about the needs assessment can be found in the CHNA report, which is publicly available on the hospital's website or upon request from the hospital, using the contact information in the At-a-Glance Summary.

Significant Health Needs

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

Significant Health Need	Description	Intend to Address?
Mental Health	Key informants interviewed for the CHNA identified mental health as a top concern in the community. Survey findings revealed needs related to treatment for mental health issues.	☑
Housing	Key informants for the CHNA identified social determinants of health (including and especially housing) as a top concern in the community. Survey findings revealed needs related to housing conditions.	☐
Diabetes	Key informants participating in the CHNA interviews identified this as a top concern in the community. Existing data revealed needs related to diabetes deaths and kidney disease deaths.	☑
Climate, Nature & Health	Key informants for the CHNA identified this as a major concern in the community. Roughly 85% of residents recognize a connection between climate and health risks. Key concerns regarding climate included changes in weather, the frequency and intensity of wildfires, and environmental health-related issues.	☑
Substance Use	CHNA key informants identified this as a growing concern in the community. Existing data revealed needs relative to alcohol-induced deaths and unintentional drug-induced deaths.	☑
Nutrition, Physical Activity & Weight	Key informants for the CHNA discussed the importance of more nutrition, exercise, and other programs to address the growing rates of obesity in the community.	☑
Access to Health Care Services	Access to care and other health services continue to remain an issue in the community. People have expressed concerns in their ability to afford health care services, pharmaceuticals, and dental care as insurance deductibles rise and some people have lost their coverage.	☑
Disabling Conditions	Focusing on dementia and Alzheimer's are essential due to their growing prevalence and significant impact on individuals and families. Focusing on early intervention strategies and education can improve the quality of life.	☑
Heart Disease and Stroke	CHNA participants identified heart disease and stroke as a major concern in the community. The disease is rampant in the local community and the mortality rate for heart disease is higher in the NHMC service area compared to the rest of L.A. County.	☑
Injury & Violence	Injury and violence remain a pressing concern among participants in the CHNA survey. There remain high rates of violence targeting vulnerable populations and issues of poverty and homelessness contribute to the issue.	☑

Significant Health Need	Description	Intend to Address?
Respiratory Disease	Key informants to the CHNA survey identified respiratory disease as a major concern in the community. Contributing factors to this ongoing concern include the low vaccination rates for many residents due to misinformation, and poor air quality in the San Fernando Valley.	☐
Sexual Health	Among informants participating in the CHNA, 65% felt that issues of sexual health were a moderate to major problem in the community. Rates of sexually transmitted diseases are on the rise. Some individuals attribute the problem to information and ideas shared through the mainstream media and internet.	☑

Significant Needs the Hospital Does Not Intend to Address

From the prioritized list of needs identified from the 2025 CHNA, Northridge Hospital Medical Center will not be focusing on housing or respiratory disease. While the hospital does not have the expertise in developing affordable housing, it will support organizations through grant funding and CommonSpirit's low cost loan program that are trying to address the number of unhoused individuals living in L.A.

As the COVID-19 pandemic has been brought under control, the hospital is redirecting its resources to focus on other priority needs. NHMC will continue to partner with community organizations and providers to be proactive in encouraging people to get vaccinated and follow appropriate preventive measures to prevent transmissible respiratory illness..

2025 Implementation Strategy and Plan

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years, including resources for and anticipated impacts of these activities.

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

Creating the Implementation Strategy

Hospital and health system participants included our NHMC Foundation staff, Mission Department, and the NHMC Wellness Committee. The Center for Healthier Communities Director and Program Manager worked collaboratively to create this implementation strategy. NHMC leadership and Center for Healthier Communities staff, along with the Center for Assault Treatment Services (CATS) Director and team, will deliver the programs shared in this report.

Community input or contributions to this community health improvement plan and NHMC community health programs have long involved departments beyond Community Health and Mission in our planning and operations. A major part of that has been our team members' involvement in the Wellness Committee and Diversity, Equity, Inclusion and Belonging Committee and partnering with behavioral health, transitional care, and care coordination. Additionally, we continue to leverage our membership in the Valley Care Community Consortium (VCCC). VCCC is the health and mental health collaborative of Service Planning Area 2 of Los Angeles County. Vital feedback from our community residents on how to improve and expand our existing programs strengthens their impact. Our partnerships with community-based organizations (such as ONEgeneration, MEND, American Heart Association, and Northeast Valley Health Corp.) offer insights into the key needs facing our local community. Once the needs were established, leadership from the Center for Healthier Communities and Mission discussed strategies for improving health equity.

The programs and initiatives described here were selected on the basis of the continuation of successful existing models and strong community partnerships, informed by our 2025 Community Health Needs Assessments. Other key criteria used to select these programs and initiatives include:

- Interventions with proven effective outcomes;
- Availability of resources and expertise to implement the program;
- Ability to make a measurable impact on the issue or problem identified;
- Addressing a key vital condition;
- Ability to positively impact urgent needs in the community.

Community Health Core Strategies

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources. CommonSpirit Health has established three core strategies for community health improvement activities. These strategies help to ensure that program activities overall address strategic aims while meeting locally-identified needs.

- **Core Strategy 1**: Extend the care continuum by aligning and integrating clinical and community-based interventions.
- **Core Strategy 2**: Implement and sustain evidence-informed health improvement strategies and programs.
- **Core Strategy 3**: Strengthen community capacity to achieve equitable health and well-being.

Vital Conditions and the Well-Being Portfolio

Community health initiatives at CommonSpirit Health use the Vital Conditions framework and the Well-Being Portfolio[1] to help plan and communicate about strategies and programs.

Investments of time, resources, expertise and collaboration to improve health and well-being can take different approaches. And usually, no single approach can fully improve or resolve a given need on its own.

One way to think about any approach is that it may strengthen "vital conditions" or provide "urgent services," both of which are valuable to support thriving people and communities. A set of program activities may seek to do one or both. Taken together, vital conditions and urgent services compose a well-being portfolio.

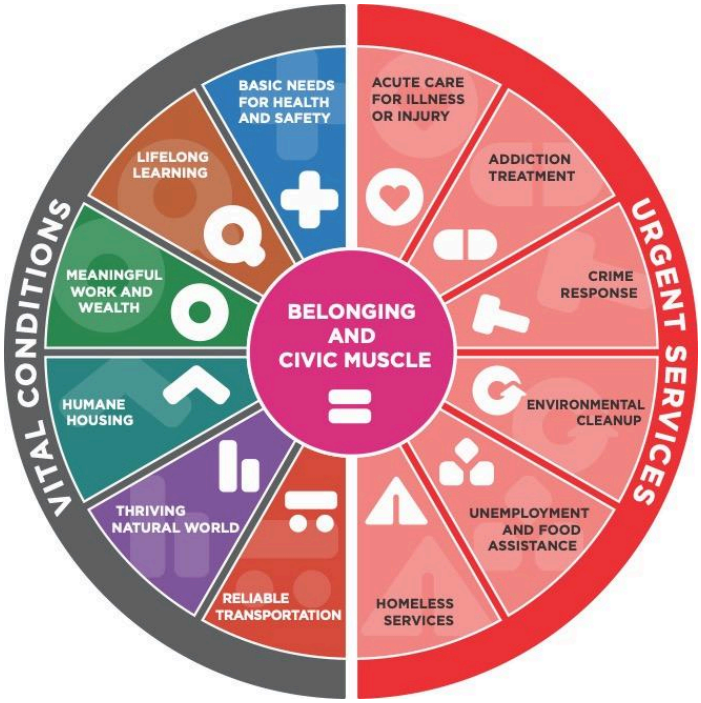
What are Vital Conditions?
These are characteristics of places and institutions that all people need all the time to be healthy and well. The vital conditions are related to social determinants or drivers of health, and they are inclusive of health care, multi-sector partnerships and the conditions of communities. They help create a community environment that supports health.

What are Urgent Services?
These are services that anyone under adversity may need temporarily to regain or restore health and well-being. Urgent services address the immediate needs of individuals and communities, say, during illness.

What is Belonging and Civic Muscle?
This is a sense of belonging and power to help shape the world. Belonging is feeling part of a community and valued for what you bring. Civic muscle is the power of people in a society to work across differences for a thriving future.

Well-Being Portfolio in this Strategy and Plan

The hospital's planned strategies and program activities that follow are each identified as aligning with one of the vital conditions or urgent services in this figure.



This helps to identify the range of approaches taken to address community needs, and also acknowledges that the hospital is one community resource and stakeholder among many that are dedicated to and equipped for helping to address these needs and improve health.

[1] The Vital Conditions Framework and the Well-Being Portfolio were created by the Rippel Foundation, and are being used with permission. Visit https://rippel.org/vital-conditions/ to learn more.

Strategies and Program Activities by Health Need

Health Need:	Mental Health				
Population(s) of Focus:	Youth, Adults, and Seniors				
Strategy or Program	**Summary Description**	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
SFV Healing Project - Mental Health Awareness Training (MHAT)	• MHAT provides evidence-based mental health educational training (Adult & Youth-Mental Health First Aid and Question, Persuade, Refer) to the general community and to professionals.	☐	☑	☑	Basic Needs for Health and Safety (VC)
Enhancing Youth Mental Health Well-Being	• The program offers evidence-based mental health education training (including Youth Mental Health First-Aid and Question, Persuade and Refer) to the general community.	☐	☑	☑	Basic Needs for Health and Safety (VC)
SFV Resourceful Adolescent Program	• The San Fernando Valley Resourceful Adolescent Program (SFV-RAP) will reduce health disparities in mental health outcomes through early intervention efforts targeting youth that are at high risk of poor behavioral health outcomes.	☐	☑	☑	Lifelong Learning (VC)
Community Health Improvement Grants to Nonprofit Partners	• Northridge Hospital Medical Center provides grants to community-based organizations providing mental health services to under-resourced residents of the community.	☐	☑	☑	Basic Needs for Health and Safety (VC)
Planned Resources:	Staff time, training materials, supplies, and financial resources				

Health Need:	Mental Health
Planned Collaborators	California Police Activities League, National Alliance on Mental Illness (NAMI), Los Angeles Police Dept., Center for Living and Learning, L.A. Family Housing, Magnolia Academy

Anticipated Impacts (overall long-term goals)	Measure	Data Source
The goals of these programs and financial support are to enhance emotional well-being, mental health awareness, and resilience among professionals, youth, and families through targeted training and supportive services.	Number of people trained in MHFA and QPR. Feedback on satisfaction surveys. Number and dollar amount of grants provided	Number of certificates granted Client surveys completed Number of MHFA and QPR trainings completed Grant database

Health Need:	Diabetes				
Population(s) of Focus:	Adults				
Strategy or Program	**Summary Description**	**Strategic Alignment**			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
STEM (Screen, Teach, Empower, and Manage) Diabetes Program	• The Stem (Screen, Teach, Empowerment, & Manage) Diabetes Program is a multi-pronged approach to addressing and managing diabetes within the Medical Center's service area. The program utilizes a team of trained professionals using evidence-based models to provide focused outreach, screening, and education to persons with diabetes or who are at high risk for the disease.	☐	☑	☑	Basic Needs for Health and Safety (VC) Lifelong Learning (VC)
Planned Resources:	Staff time, training materials, supplies				
Planned Collaborators:	4 faith-based institutions, California State University, Northridge (CSUN), ONEgeneration, St. Mary's Pharmacy, Valor Academy Community Center				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Screen 400 people in the community at-risk for diabetes over 3 years.	Individuals screened	Event tracking logs
Enroll 200 people in the Diabetes Empowerment Education Program (DEEP) over 3 years.	Individuals completing the multi-session program	DEEP workshop attendance sheets

Health Need:	Climate, Nature and Health				
Population(s) of Focus:	Children, Adults, and Seniors				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
LISTOS California Program	• The purpose of this program is to increase disaster literacy (including the impact of climate and natural disasters) to advance community emergency and disaster readiness within L.A. County.	☐	☑	☑	Thriving Natural World (VC)
Host a forum focusing on the impact that climate has on health	• Host two virtual forums targeting health care professionals that examines the key role that climate and nature have on health.	☐	☑	☑	Thriving Natural World (VC) Lifelong Learning (VC)
Planned Resources:	Staff time, supplies, educational materials, forum planning costs				
Planned Collaborators:	CSUN, New Horizons, Triumph Foundation, Disability Disaster Access and Resources (DDAR), L.A. County Dept. of Public Health, Emergency Department at Northridge Hospital Medical Center, State of California Governor's Office of Emergency Services				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
To offer educational programs and resources to the community to prepare for adverse climate-related (e.g. wildfires) and natural events (e.g. floods, earthquakes, etc.) that could negatively impact the health of the residents.	Workshop participants Number of community events attended Feedback on virtual forums Number of forum attendees	Class attendance logs Calendar of events Individuals reached at events Forum evaluation form

Health Need:	Substance Use				
Population(s) of Focus:	Children and Teens				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
SFV Resourceful Adolescent Program	• Reduce health disparities in mental health outcomes and risks for substance use through early intervention efforts targeting high risk youth.	☐	☑	☑	Basic Needs for Health and Safety (VC) Lifelong Learning (VC)
Planned Resources:	Staff time, training materials, supplies, food				
Planned Collaborators:	El Nido Family Services, Champions in Service, Assurance Learning, Boys and Girls Club of the West Valley				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
To reduce the risks for substance use/misuse among youth by addressing key factors contributing to drug and alcohol use and improving self-esteem among children/teens.	Number of youth attending the program Number of youth completing the multi-part training Number of parents/ guardians completing the training	Youth and parents enrolled in the RAP training session Youth receiving completion certificates Parents/guardians receiving completion certificates Course evaluations

Health Need:	Nutrition, Physical Activity and Weight				
Population(s) of Focus:	Children, Teens, Adults, and Seniors				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Community Education Workshops/Classes	• Offering free educational workshops, presentations, and classes that focus on how to eat better and develop more active lifestyles.	☐	☑	☑	Basic Needs for Health and Safety (VC) Lifelong Learning (VC)
HeartBeat CA and STEM Diabetes Programs	• These programs incorporate themes dealing with healthy eating, increasing levels of physical activity, and maintaining a healthy lifestyle	☐	☑	☑	Basic Needs for Health and Safety (VC) Lifelong Learning (VC)
Planned Resources:	Staff time, educational materials, supplies				
Planned Collaborators:	Faith-based organizations, schools, community partner sites				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
To reduce the incidence of chronic disease in the community and to help people live healthier lives.	Number of workshops and presentations provided in the community Number of participants in the workshops/ classes Evaluation of the quality of the workshops/classes	Calendar of confirmed workshops/events during the year Workshop attendance logs Participant evaluation forms

Health Need:	Access to Health Care Services				
Population(s) of Focus:	Youth, Adults, and Seniors				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Community Health Worker for Sustainable Outreach & Navigation (CHW/SON) Program	• Improve access to health and community services by providing resource referrals, and encourage immunizations with a focus on under-resourced communities.	☑	☐	☑	Unemployment and Food Assistance (US) Basic Needs for Health and Safety (VC)
Patient Financial and Transportation Assistance	• Provide financial assistance and free transportation to patients who are uninsured/underinsured needing medical care, transportation to/from the hospital, and recuperative care services.	☑	☐	☑	Acute Care for Illness/Injury (US) Reliable Transportation (VC) Homeless Services(US)
Planned Resources:	Staff time, supplies, financial resources				
Planned Collaborators:	Meet Each Need with Dignity (MEND), Los Angeles County Department of Public Health, Rising Communities, Hospital Departments, NHMC Medical Staff, ModivCare, Lyft				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Improve access to health care for under-resourced persons served by the hospital by offering assistance in connecting to medical and community resources, providing a patient financial assistance program, free transportation to the hospital to those who qualify, and recuperative care services to low-income patients.	Number of referrals made to community resources Number of transports provided Number of patients receiving financial help and dollar value of the accounts written off	Client referral database Patient transportation log Patient accounting system to track those receiving financial assistance

Health Need:	Disabling Conditions (Focusing on Dementia/Alzheimer's Disease and Cancer)				
Population(s) of Focus:	Adults and Seniors				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Local Elder Abuse Prevention Enhanced Multidisciplinary Team (LEAP)	• Promote awareness and education of elder abuse and financial exploitation (especially those with declining mental capacity) through prompt identification, appropriate responsiveness, and comprehensive coordinated support.	☐	☑	☑	Basic Needs for Health and Safety (VC) Humane Housing (VC)
Cancer Navigation Program	• This program serves low-income women by providing education, linkages to community resources, free mammogram screenings, and navigator services to patients dealing with cancer.	☑	☐	☑	Acute Care for Illness/Injury (US) Basic Needs for Health and Safety (VC)
Planned Resources:	Staff time, supplies, medical supplies, financial assistance, subcontractor fees				
Planned Collaborators:	Alzheimer's Association of So. California, Adult Protective Services, Bet Tzedeck, DLG, LL Accounting and Advisory Services, L.A. Police Department, Menorah Housing Foundation, ONEgeneration, Saahas for Cause, local cancer treatment programs, and various community services				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
To assist vulnerable persons (including those facing serious health issues such as dementia, Alzheimer's Disease, and cancer) with assistance in navigating the health care system and accessing important medical and community resources.	Number of referrals made to LEAP Number of successful LEAP client outcomes Number of patients referred to the Cancer Navigator	LEAP client database tracker Cancer Navigation patient tracker

Health Need:	Heart Disease and Stroke				
Population(s) of Focus:	Adults and Seniors				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
HeartBeat California	• Promote effective chronic disease management of high blood pressure and high blood cholesterol to reduce the risk and prevalence of heart disease.	☐	☑	☑	Basic Needs for Health and Safety (VC) Lifelong Learning (VC)
Planned Resources:	Staff time, educational materials, supplies, subcontractor fees				
Planned Collaborators:	American Heart Association, African American Leadership Organization, Abode Communities, Church of the Canyons, State of California Department of Public Health				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
To reduce the incidence of chronic disease in the community focusing on heart disease and stroke, and to assist those with these chronic illnesses to better manage their condition.	Recruit people to participate in the HeartBeat cohorts (120 people). Participate in community outreach events (min. of 32) to raise awareness about heart disease.	HeartBeat client database to identify who completed the cohorts Number of community events the program participated in and how many referrals were generated at those events.

Health Need:	Injury and Violence				
Population(s) of Focus:	Children, Teens, and Adults				
Strategy or Program	**Summary Description**	**Strategic Alignment**			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Schools Against Violence-Los Angeles Program (SAVe-LA)	• Reduce school-based violence related to bullying in the Los Angeles Unified School District Region North service area.	☐	☑	☑	Basic Needs for Health and Safety (VC)
Center for Assault Treatment Services (CATS)	• Provide compassionate, comprehensive care to victims of domestic and sexual assault and child victims of sexual abuse in a supportive and comforting environment.	☑	☑	☐	Basic Needs for Health and Safety (VC) Crime Response (US)
Addressing Violence Across the Ages Spectrum Project (AVAAS)	• Enhance community capacity across all ages within the San Fernando Valley to prevent all forms of violence. This goal will be accomplished through the implementation of protective solutions.	☐	☑	☑	Basic Needs for Health and Safety (VC) Lifelong Learning (VC)
Planned Resources:	Staff time, educational materials, supplies, medical supplies, subcontractor fees				
Planned Collaborators:	LAUSD Police Department, L.A. Trust for Children's Health, Los Angeles Police Department, Los Angeles District Attorney's Office, Medical Safe Haven, Family Justice Center, MEND, CSUN, Valor Academy Charter School				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
To be proactive in addressing violence in the community through education and prevention efforts and offering compassionate and caring services to victims of violence.	Number of presentations conducted Number of students reached Number of victims assisted with medical and counseling services	Calendar of scheduled presentations Attendance logs Patient database/medical records of victims served

Health Need:	Sexual Health				
Population(s) of Focus:	Youth and Adults				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Schools Against Violence-Los Angeles (SAVe-LA)	• Reduce school-based violence related to teen dating in the Los Angeles Unified School District Region North service area.	☐	☑	☑	Basic Needs for Health and Safety (VC)
Center for Assault Treatment Services (CATS)	• Provide compassionate, comprehensive care to victims of sexual assault and child victims of sexual abuse in a supportive and comforting environment. The program also provides outreach and education around topics related to sexual assault and preventive measures.	☑	☐	☑	Basic Needs for Health and Safety (VC) Crime Response (US)
Planned Resources:	Staff time, educational materials, supplies, medical supplies, subcontractor fees				
Planned Collaborators:	LAUSD Police Department, L.A. Trust for Children's Health, Los Angeles Police Department, Los Angeles District Attorney's Office, Medical Safe Haven, Family Justice Center, Meet Each Need with Dignity (MEND), CSUN, Valor Academy Charter School, Los Angeles Unified School District Middle and High Schools				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
To be proactive in addressing sexual abuse and violence in the community through education and prevention efforts and by offering compassionate and caring services to victims of sexual abuse.	Number of presentations conducted Number of students served Number of victims assisted with medical and counseling services	Calendar of scheduled presentations Attendance logs Patient database/medical records of victims served

Program Highlights

Addressing Violence Across the Ages Spectrum Project (AVAAS)

Program Description:

The AVAAS Project, started in fiscal year 2026 and funded by the United Against Violence Mission and Ministry Fund from CommonSpirit Health, is a multi-year United Against Violence initiative. The goal is to enhance community capacity across all ages within the San Fernando Valley to prevent violence.

Community Need Being Addressed:

The overarching goal of the AVAAS Project is to enhance community capacity across all ages within the San Fernando Valley to prevent all forms of violence. The program will accomplish this goal through the implementation of protective solutions like formative, general community, young adult, family, and older adult engagement. We will also engage in stakeholder involvement and participation, furthering the commitment to addressing violence in the community. Program activities will encompass varying levels of prevention across different levels of influence based on the socio-ecological model framework.

How Was the Need Determined?

Insights from the SoCal Anti-Violence Education Program Action Plan: A Goal-Setting Framework For Violence Prevention report showed that 56.9% of community survey participants, ranging from ages 11-65+, felt unsafe in their community within the last 12 months and 69.2% felt violence in their community had worsened. Additionally, the report's findings showed that concerns about violence within the community spanned across all age groups. Violence does not discriminate and affects all communities and age groups, and this is validated by the findings from the aforementioned report. That is why the project will support community members of all ages, especially those that feel unsafe in their communities.

Key Program Objectives:

Conduct 8 community voice listening sessions to reach 136 community members.
Implement Bringing in the Bystander workshops to reach 300 young adults.
Implement 3 Guiding Good Choices cohorts to reach 36 parents.
Conduct 12 situational awareness workshops to reach 144 older adults and their caregivers.
Participate in 10 community awareness events to reach 1,100 general community members.