Dignity Health.
Northridge Hospital
Medical Center

Dignity Health – Northridge Hospital Medical Center

Community Benefit 2016 Report and 2017 Plan

Dignity Health
Northridge Hospital
Medical Center

A message from:

Saliba H. Salo, president and CEO of Dignity Health – Northridge Hospital, and William Watkins, Chair of the Dignity Health – Northridge Hospital Community Board.

Dignity Health's comprehensive approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments that we conduct with community input, including from the local public health department. Our multi-pronged initiatives to improve community health include financial assistance for those unable to afford medically necessary care, arrange 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 to improve the health of our community, and delivers programs and services to achieve that goal. The Community Benefit 2016 Report and 2017 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 produces these reports and plans for all of its hospitals, including those in Arizona and Nevada. 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 2016 (FY16), Northridge Hospital provided $53,456,796 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, and other community benefits. Including the unreimbursed costs of caring for patients covered by Medicare, the hospital's total community benefit expense was $79,526,296.

Dignity Health's Northridge Hospital Board of Directors reviewed approved and adopted the Community Benefit 2016 Report and 2017 Plan at its November 8, 2016 meeting.

Thank you for taking the time to review our report and plan. If you have any questions, please contact us at 818-718-5936.

Saliba H. Salo
President/CEO

William Watkins
Chairperson, Board of Directors

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EXECUTIVE SUMMARY

This report covers community benefit activities for Dignity Health – Northridge Hospital fiscal year 2016. According to the 2016 Community Health Needs Assessment report, we proudly serve over 1.6 million residents of the hospital's service area. The hospital is located in Service Planning Area 2 (SPA 2) of Los Angeles County which consists of the San Fernando and Santa Clarita Valleys. Its population is roughly 16% of Los Angeles County's and 4% of California's total population. Community demographics vary significantly between the 26 cities with 36 zip codes that represent 90% of the hospital's catchment area. Highest need zip codes are those with CNI scores higher than 4.2 in our hospital area 13 of those zip codes fall into the highest needs category as ranked by Dignity Health's Community Need Index (CNI) scores. Our leadership team is focused on transforming health care to improve quality and make a positive impact in our community.

The significant community health needs that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA), which is publicly available at http://www.dignityhealth.org/northridgehospital/who-we-are/community-benefit-reports. Additional detail about identified needs, data collected, community input obtained, and prioritization methods used can be found in the CHNA report.

The top ten significant community health needs identified are:

1. Diabetes
2. Obesity/Overweight (Children and Adults)
3. Mental Health (Mainly Depression)
4. Heart Disease and Stroke
5. Affordable Housing/Homelessness
6. Cancer (All types)
7. Hypertension/High Blood Pressure
8. Dental Health
9. Child/Domestic Abuse (Including Sexual Assault)
10. Substance Abuse (Drugs and Alcohol)

In FY16, Northridge Hospital Medical Center took numerous actions to help address identified needs. These included:

11. Diabetes Wellness RX program
12. Chronic Disease Transitional Care Program
13. School Wellness Initiative
14. Emergency Room Initiative
15. Welcome Baby Program
16. Family Medicine and Residency Program
17. Center for Assault Treatment Services (C·A·T·S)
18. Choose Health LA Kids
19. Activate Your Heart
20. Human Trafficking Task Force

For FY17, the hospital plans to continue the following successful programs including Chronic Disease Transitional Care Program, School Wellness Initiative, Welcome Baby, Family Medicine and Residency

Program, C·A·T·S, Choose Health LA Kids and Human Trafficking Task Force. Additionally, new programs that began in FY 17 include the Diabetes Wellness RX program and grant funded programs including a greater focus on dental care. The Activate your Heart program will be expanded. We have plans to increase our partnerships and alliances with community-based non-profit organizations to advocate for healthy outcomes for all residents. In FY 17 we will address Dental Health through collaborative efforts with a free clinic (Meet Each Need with Dignity) MEND and West Coast University to offer an eight hour Saturday session creating increased capacity for 36 dental patients per month.

The economic value of community benefit provided by Northridge Hospital Medical Center in FY16 was $53,456,796, excluding unpaid costs of Medicare in the amount of $26,069,500.

This document is publicly available at http://www.dignityhealth.org/northridgehospital/who-we-are/community-benefit-reports . This report is widely distributed with printed copies made available to the community and portions of the report can be found in foundation (Impact) and hospital (the Insider) newsletter publications.

Written comments on this report can be submitted to the Dignity Health Northridge Hospital Medical Center for Healthier Communities at 8210 Etiwanda Ave, Reseda, CA 91335 or by e-mail to CHNA.NorthridgeHospital@DignityHealth.org.

MISSION, VISION AND VALUES

Our Mission

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

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

Our Vision

A vibrant, national health care system known for service, chosen for clinical excellence, standing in partnership with patients, employees, and physicians to improve the health of all communities served.

Our Values

Dignity Health is committed to providing high-quality, affordable healthcare to the communities we serve. Above all else we value:

Dignity - Respecting the inherent value and worth of each person.

Collaboration - Working together with people who support common values and vision to achieve shared goals.

Justice - Advocating for social change and acting in ways that promote respect for all persons.

Stewardship - Cultivating the resources entrusted to us to promote healing and wholeness.

Excellence - Exceeding expectations through teamwork and innovation.

Hello humankindness

After more than a century of experience, we've learned that modern medicine is more effective when it's delivered with compassion. Stress levels go down. People heal faster. They have more confidence in their health care professionals. We are successful because we know that the word "care" is what makes health care work. At Dignity Health, we unleash the healing power of humanity through the work we do every day, in the hospital and in the community.

Hello humankindness tells people what we stand for: health care with humanity at its core. Through our common humanity as a healing tool, we can make a true difference, one person at a time.

OUR HOSPITAL AND OUR COMMITMENT

Northridge Hospital, a Dignity Health member, was founded in 1955 and is located at 18300 Roscoe Blvd., Northridge, CA. The facility is a 409 bed non-profit site located in a residential area of the San Fernando Valley, in Service Planning Area 2 (SPA 2) of Los Angeles County. The facility proudly serves approximately 1.6 million residents of the hospital's service area in northern Los Angeles County and a portion of the cities of Simi Valley in Ventura County, and parts of the Santa Clarita Valley. The facility has approximately 2,000 employees, 800 affiliated physicians, and over 400 volunteers. Major programs and services include cancer center, center for assault treatment services, center for healthier communities, cardiovascular center, ER Online Waiting Service (In Quicker), Family Birth Center, Pediatric Trauma Center, Stroke Center, and a new Neonatal ICU.

Some significant hospital accomplishments in 2016 included the expansion of the chemotherapy infusion center, women's cancer center, and the completion of phase one of the emergency room redesign and the start of phase 2 to allow for increased capacity.

Rooted in Dignity Health's mission, vision and values, Northridge Hospital is dedicated to improving community health and delivering community benefit with the engagement of its management team and Community Board. The board is composed of community members who provide stewardship and direction for the hospital as a community resource.

The Community Board, hospital President/CEO, community residents, public health experts, community based organizations and the Center for Healthier Communities management team are involved in community health/community benefit reports with the understanding that better health outcomes can only be achieved by going beyond the walls of the hospital into the community to improve the health and wellbeing of residents where they live, work, play, and pray.

The role and responsibilities, for representing the community needs, of the Community Board, of which the hospital CEO is a member, includes:

- Oversight and adoption of the CHNA, Implementation Strategy, and Community Benefit Report
- Participate in the process of establishing priorities plans and programs with the Center for Healthier Communities.
- List of the current Community Board members and officers with affiliations can is located under Appendix A roster of board and committee members

Joni Novosel, Director of Community Health, is responsible for the Center for Healthier Communities which consist of community benefit reporting, creation of community health needs assessment and implementation strategy, grant writing, community and school based programs and oversight of key staff. There are three key staff members, in addition to one full-time and one part-time health educator, one full time and nine per-diem staff at the Center for Assault Treatment Services. Key staff and roles.

Key Employee and Title	Key Role
Priscilla Lomeli – Office Coordinator (CHC)	CIBSA input and monitoring and support staff
Barbara Gonzalez – Program Coordinator (CHC)	Oversight of Heart, Diabetes, and School Wellness programs
MaryAnn Lague – Program Manager (CATS)	Oversight of all staff Center for Assault Treatment Services

Northridge Hospital's community benefit program includes financial assistance provided to those who are unable to pay the cost of medically necessary care, unreimbursed costs of Medicaid, subsidized health services that meet a community need, and community health improvement services. Additionally, $325,067 community benefit for MD Continuing Education is provided through opening up the education sessions to community based MD's providing the ability for 3,166 health professionals to expand their education and research knowledge. Our community benefit also includes monetary grants we provide to not-for-profit organizations that are working together to improve health on significant needs identified in our Community Health Needs Assessment. In 2016 a total of $155,392 was provided to six non-profit agencies. Many of these programs and initiatives are described in greater detail in this report. Agencies funded include:

1. Coalition to Abolish Slavery and Trafficking (CAST)- Addresses sexual and labor trafficking
2. SOS Mentor Programs – Anti bullying and childhood obesity program.
3. Tarzana Treatment Centers – Emergency Department reduction program through connection to primary care medical homes, substance abuse and mental health treatment.
4. Meet Each Need with Dignity (MEND) – Diabetes and obesity health education program.
5. Mid Valley YMCA – Cardiovascular health education and physical activity program.
6. Triumph Foundation – Assist those with spinal cord injuries, financial constraints and inadequate medical insurance with equipment, supplies, and services.

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

LA Family Housing Corporation

In March 2016 Dignity Health approved a $3,051,000 loan to the LA Family Housing Corporation (LAFH), to support construction of a new facility to house formerly homeless individuals and families, and a new Federally Qualified Health Center. 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.

Valley Economic Development Center
(Based in Los Angeles; conducts business in California and Nevada)
In June 2016 Dignity Health approved a $1,000,000 loan to the Valley Economic Development Center (VEDC), to supply access to capital services to African-American entrepreneurs in low- and moderate-income business communities. This investment will provide lending capital for 30 African-American entrepreneurs to expand their business in California, Nevada, and nationally. VEDC established a dedicated loan fund to provide African-American entrepreneurs with affordable small business loans between $35,000 and $250,000. The fund helps to close the gap between African American small business ownership (7% of the total) and access to capital (2% of loan approvals in the Small Business Administration's 7(a) program.

These investments in community, specifically the LA Family Housing Corporation addresses one of the top five concerns of affordable housing/homelessness which has grown over 30% in our hospital service area between 2015 and 2016.

DESCRIPTION OF THE COMMUNITY SERVED

Northridge Hospital Medical Center's (NHMC) service region spans cities, communities, and unincorporated areas in the San Fernando and Simi Valleys of Los Angeles County and Ventura County. The region is bordered to the north by the Santa Susana Mountains, the 5 freeway and parkways, and the cities of Chatsworth, Porter Ranch, Granada Hills and Sylmar; to the east by the communities of Sun Valley, North Hollywood and Lake Balboa, the San Gabriel Mountains and the Pacoima wash; to the south by the communities of Studio City, Sherman Oaks, Encino, Tarzana and Woodland Hills, and the Santa Monica Mountains; and to the west by the community of West Hills in Los Angeles County and Simi Valley in Ventura County.

The geographic area is comprised of 26 cities with 37 ZIP codes which represent roughly 90% of the total patients served at Northridge Hospital Medical Center in fiscal year 2014-2015. Northridge Hospital's primary service area is comprised of 20 ZIP codes in Canoga Park, Chatsworth, Granada Hills, North Hills, North Hollywood, Northridge, Pacoima, Panorama City, Reseda, Sylmar, Valley Village, Van Nuys, Winnetka and Woodland Hills. These 20 zip codes represent roughly 77% of NHMC patients.

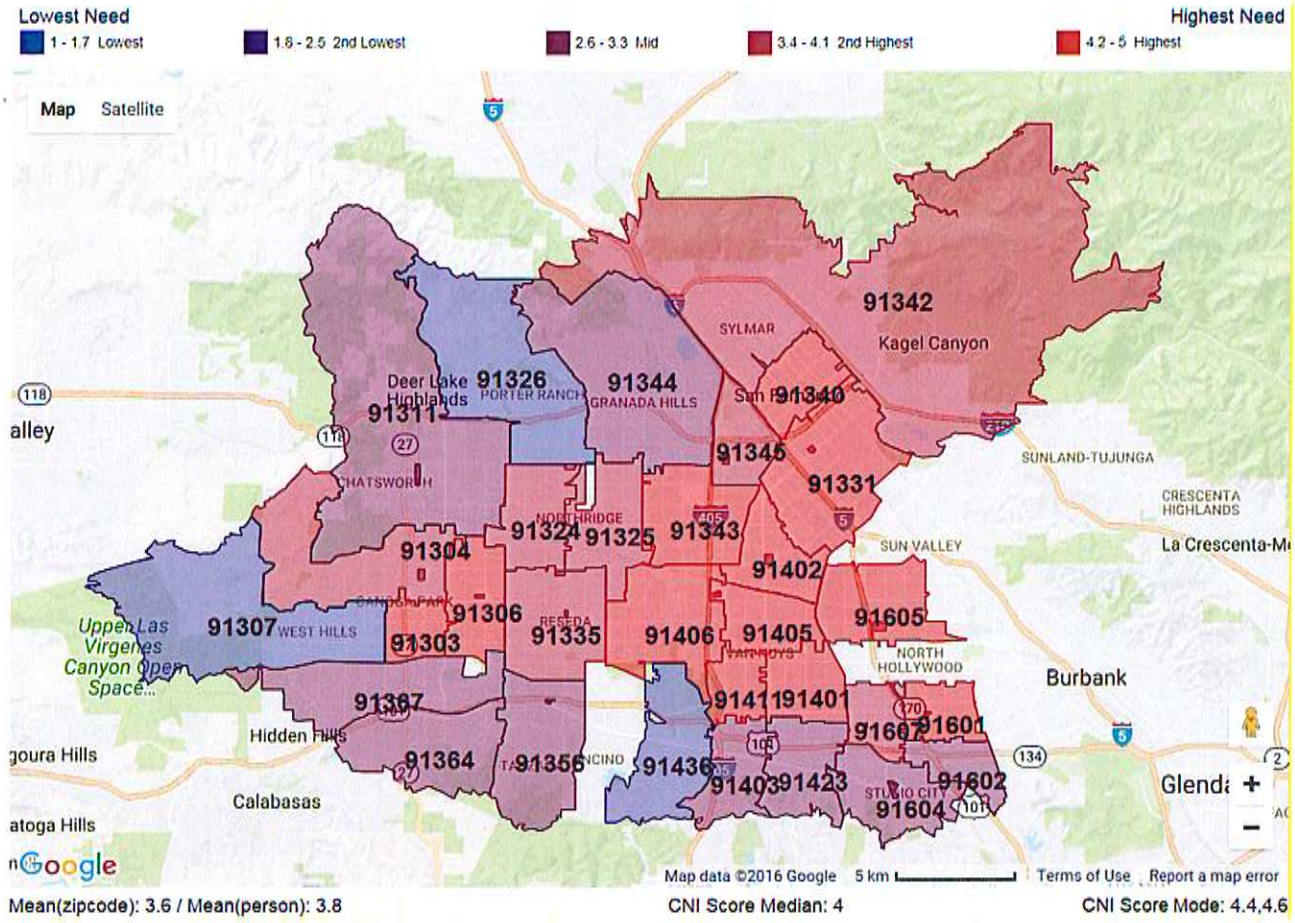
The region served by the hospital has pockets of extreme poverty. Thirteen of the zip codes fall into the highest needs category (4.2 to 5) using Dignity Health's Community Need Index (CNI) scores. CNI score is an average of five barriers including income, culture, education, insurance, and housing. Income levels vary drastically with 14% of population that lives in poverty (household income < 100% of the Federal Poverty Level) where the median income is $62,668. Latino's make up 48.6% of the areas ethnicity however we have eight zip codes where 60% to 92% of the population is Latino where health disparities including higher rates of diabetes and obesity are evident. Lack of education and income has been cited as major indicators of poor health. According to the Los Angeles Homeless Services Authority count homelessness in our area has increased over 30% between 2015 and 2016 compared to an increase of homeless of 12% in Los Angeles County. A summary description of the community is below, and additional community facts and details can be found in the CHNA report.

Northridge Hospital Medical Center Service Area Demographics

Total Population	1,341,223
Race	
White - Non-Hispanic	33.7%
Black/African American - Non-Hispanic	4.1%
Hispanic or Latino	48.6%
Asian/Pacific Islander	10.8%
All Others	2.8%
Total Hispanic & Race	100.0%
Median Income	$62,668
Unemployment	7.2%
No High School Diploma	21.7%
Medicaid *	30.4%
Uninsured	6.0%

* Does not include individuals' dually-eligible for Medicaid and Medicare.

Source: © 2016 The Nielsen Company, © 2016 Truven Health Analytics Inc.



Mean(zipcode): 3.6 / Mean(person): 3.8 CNI Score Median: 4 CNI Score Mode: 4.4,4.6

One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and Truven Health Analytics. 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.

COMMUNITY BENEFIT PLANNING PROCESS

The hospital engages in multiple activities to conduct its community benefit and 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; using five core principles to guide planning and program decisions; measuring and tracking program indicators; and engaging the Community Board members and other stakeholders in the development of the annual community benefit plan and triennial Implementation Strategy.

Community Health Needs Assessment Process

Northridge Hospital Medical Center conducted a comprehensive 2016 community health needs assessment (CHNA) and hospital and community asset mapping process to identify the most significant health needs in the hospital's catchment area and assess the resources available to address those needs. The CHNA was approved and adopted by the board in May of 2016. A copy of the CHNA and Community Resource Directory are posted on hospital's website.

The 2016 CHNA was completed mainly in house with support of a statistical consultant, C M Schaeffer, and limited collaboration with the Valley Care Community Consortium (VCCC), the health planning collaborative for the San Fernando and Santa Clarita Valleys. Center for Healthier Communities staff and hospital leadership met with consultant and VCCC to determine service area, indicators, participates in prioritization process, and to establish the timeline for primary data collection.

Data and information used in the CHNA report began with a review of common indicators. Indicators included consist of demographic data, social and economic factors, risky health behaviors, public safety, and environmental data. The report includes primary data and secondary data comprised of demographics, health behavior, and health outcome data publically available from the United States Census Bureau, California Department of Public Health, Los Angeles Department of Public Health, UCLA Center for Health Policy Research, Los Angeles Police Department, Los Angeles Homeless Services Authority, and Dignity Health Community Needs Index (CNI) in partnership with Truven Health Analytics Inc.

Secondary data were collected from the above noted resources and descriptive statistics were prepared. For cities that were represented by more than one ZIP code, the city level data was derived as a weighted average of the statistics for the component ZIP codes, the weights being the population count for each of the ZIP codes; similarly statistics for the service region were computed as a weighted average of the statistics for all 37 ZIP codes in the service region. When appropriate and when data were available, proportions were compared to those comparable for the service area as a whole, Los Angeles County and/or California.

Primary data, which is new data collected directly from first-hand experience, was collected through 36 key-informant interviews and 313 paper and online surveys through Survey Monkey and Turning Point. Additionally, 5 focus groups and 3 community forums (public health experts, physicians' staff and business members) representing community members (elementary schools and Mid-Valley YMCA), health professionals and business members were scheduled across the hospital's catchment area. A variety of community settings (schools, hospital, Mid-Valley YMCA, local businesses) were selected with a special emphasis on those persons and areas most impacted by health disparities. Staff used the

Health Research & Educational Trust eight-step Assessment and Implementation Pathway model to engage community residents in the CHNA process.

A copy of the 2016 CHNA and completed asset inventory, Community Resource Guide, can be found on the Northridge Hospital website at; https://www.dignityhealth.org/northridgehospital/who-we-are/serving-the-community/community-needs-assessment.

The 2016 Community Health Needs Assessment report was disseminated to the community via mailings, posting on the hospital's website, and upcoming distribution at community forums.

CHNA Significant Health Needs

Each of the primary methods included brainstorming sessions to identify health needs, health risk factors/behaviors, resources, and gaps. These methodologies led to multiple lists of health needs that varied from concerns about community blithe to income levels, and health concerns. Following the identification of health needs, the methodology used for prioritization consisted of each group being presented with the following criteria and asked to prioritize the list into top ten highest needs based on:

1. How severe is the problem (burden) (i.e. meeting benchmarks, leads to premature death)?
2. Is the issue getting worse over time (severity of problem)?
3. How does the community rank the issue over other issues (community importance)?
4. Are there reasonable solutions to the issues (hospital capacity)?

Participants were then asked to rank what they consider to be the 10 most significant health needs for their community. This approach was effective for condensing a long list into a more compact list of major health needs. Participants varied in age, economic status, education levels, community residents, public health, and providers of care to vulnerable populations. Results were tabulated at the end of each event and all items were entered into an excel spreadsheet, where they were assigned a point value. The top ten priority needs were assessed based on highest to lowest need of the cumulative input.

The 10 most identified health needs that rose to the top based on the prioritization process were: (from highest to lowest priority)

1. Diabetes – The vast majority of community members and providers listed diabetes as the top concern. Diabetes is one of the top leading causes of death in our primary service area. In 2011, 9.0% of adults in hospital service area were diagnosed with diabetes

2. Obesity/Overweight (Children and Adults) - Many parents participating in focus groups stated that fast food and lack of formal physical education and nutrition in schools are creating children who are at greater risk of obesity. According to the data from the 2015 Los Angeles County Health Survey, in SPA 2, nearly 20% of adults are obese and an additional 37% are considered overweight.

3. Mental Health (Mainly Depression) - Mental health issues were a concern of community residents stating that many of the homeless population and teenagers in the community are dealing with mental health and substance use. In SPA 2, 12.5% of the adult population was diagnosed with depression at some point. Currently, 8.0% of the population in SPA 2 is diagnosed with depression.

4. Heart Disease and Stroke –Cardiovascular disease is the leading cause of death in the primary service area. In SPA 2, coronary heart disease is the second cause of premature death in females and the first cause of premature death in males.

5. Affordable Housing/Homelessness – The largest increase of homelessness between 2015 and 2016 occurred in our service area, where an increase of 35% was noted by the Los Angeles Homeless Services Agency (LAHSA). In 2015, of the 5,215 homeless individuals, 73% of which are unsheltered.

6. Cancer (All Types) - The majority of focus groups participants stated Cancer was a great concern, with many participants stating that this is a disease that has affected them personally or they are in the process of assisting a family member or friend. Breast cancer is the first leading cause of death among females in SPA 2.

7. Hypertension/High Blood Pressure – Death rates due to stroke continues to be in the top five leading causes of death. In 2015, 23.7% of the adults in SPA 2 were diagnosed with hypertension at some point.

8. Dental/Oral Health – Parents at focus groups in Title 1 schools stated that lack of access to affordable dental care prevented them from seeking treatment. In SPA 2, 49 % of adults and 22% of children do not have dental insurance, and 30 % of adults and 10% of children did not obtain dental care in the past year because they could not afford it.

9. Child/Domestic Abuse (Including Sexual Assault) In fiscal year 2016 the Center for Assault Treatment Services treated 1,102 victims of sexual and domestic violence over 50% of those victims were children.

10. Substance Abuse (Drugs & Alcohol) In SPA 2, drug overdose is the third cause of premature death in people before the age of 75. In our service area 15% of adults reported binge drinking in the past month.

The overall health status of the community is the result of many inter-related factors. The overall consensus was that many issues including chronic diseases and concerns routing from lack of resources could be the result of stress that emerges from being part of the "working poor" population.

The Hospital Community Board voted to accept the 2016 Community Health Needs Assessment and address the ten highest prioritized needs. Prioritized needs will be addressed by the hospital through hospital-based programing or by funding non-profit agencies with Community Benefit Grants to address identified needs.

Creating the Community Benefit Plan

As a matter of Dignity Health policy, the hospital's community health and community benefit programs are guided by five core principles. All of our initiatives relate to one or more of these principles:

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

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

Once the needs were established leadership from the Center for Healthier Communities and the Foundation discussed strategies for building new partnerships and developing funds to address the identified health needs. Many of the projects in place to address needs were in their second and third year of funding so continuation of successful programs remained in place. Vital feedback from our community residents on how to improve and expand our existing programs strengthens their impact. Additionally through asset mapping we were able to identify existing programs in the community with evidence of success and community trust. We have provided financial support through building partners into grant request that have the appropriate skills to address unmet needs such as school based health clinics in areas with high population of uninsured residents.

Planning for the Uninsured/Underinsured Patient Population

Northridge Hospital seeks to deliver compassionate, high quality, affordable health care and to advocate for those who are poor and disenfranchised. In furtherance of this mission, the hospital offers financial assistance to eligible patients who may not have the financial 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 hospital's Financial Assistance Policy is in Appendix C. The amount of financial assistance provided in FY16 is listed in the Economic Value of Community Benefit section of this report.

Northridge Hospital notifies and informs patients about the Financial Assistance Policy by offering a paper copy of the plain language summary of the Policy to patients as part of the intake or discharge process. At the time of billing, each patient is offered a conspicuous written notice containing information about the availability of the Policy.

Notice of the financial assistance program is posted in locations visible to the public, including the emergency department, billing office, admissions office, and other areas reasonably calculated to reach people who are most likely to require financial assistance from the hospital. The hospital provides brochures explaining the financial assistance program in registration, admitting, emergency and urgent care areas, and in patient financial services offices.

The Financial Assistance Policy, the Financial Assistance Application, and plain language summary of the Policy are widely available on the hospital's web site, and paper copies are available upon request and without charge, both by mail and in public locations of the hospital. Written notices, posted signs and brochures are printed and available online in appropriate languages.

2016 REPORT AND 2017 PLAN

This section presents the programs and initiatives that the hospital staff provides or cash is given. As a local non-profit hospital, giving back by creating healthier communities is essential in designing the plan to meet the community needs. Below are the community benefit and community health programs and initiatives operated or substantially supported by the hospital in FY16, and those planned to be delivered in FY17.

The strategy and plan 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.

Strategy and Program Plan Summary

The list is in order for the top 10 identified highest needs and include projects funded through our Community Grants Program to organizations that work to address identified community health needs.

1. **Diabetes** – As the number one concern of community residents the hospital's Center for Healthier Communities has received grant funding to create the Diabetes Wellness RX program. Two staff members have received training to become certified trainers in the evidence based Diabetes Self-Management Program and the Diabetes Empowerment Education Program. Ten sessions of this program will be conducted in FY17. Meet Each Need with Dignity (MEND) (Community Benefit Grant) supports a team based approach for the care of diabetic and obese patients and diabetic health management through diet and exercise.

2. **Obesity/Overweight (Children and Adults)** – Because obesity is a main factor in many chronic diseases two hospital based programs and one program funded through the community benefit grants program are in force to address this community need; 1) Choose Health LA Kids (CHLA) is a collaborative place-based initiative working in 8 high-need areas in partnership with Los Angeles County Department of Public Health funded by First 5. The overall goal of CHLA Kids is to reduce obesity among families with young children prenatal through age five using nutrition education, restaurant engagement, food demonstrations, grocery store tours, and parenting workshops. 2) School Wellness Initiative- focuses on nutrition and physical activity and is designed to combat obesity in students and their parents attending 34 low-income Los Angeles Unified School District Title 1 schools. 3) SOS Mentor Healthy Kids Kindness Challenge (Community Benefit Grant) funding provided to for a program with themes and activities throughout the school year related to improving health, reduce bullying, nutrition education, and physical activity and healthy messaging.

3. **Mental Health (Mainly Depression)**- Emergency Department Initiative – A collaboration between Northridge Hospital and Tarzana Treatment Center to reduce health disparities among uninsured/underinsured with alcohol and/or chemical dependency and/or mental health conditions through connections to primary care medical home, detox, and mental health/substance abuse services. Addresses multiple identified health needs.

4. **Heart Disease and Stroke** –Activate your Heart (AYH)– A collaborative effort between Northridge Hospital and the Mid Valley YMCA providing ten 8 week community based

education and exercise program focuses on cardiovascular health and provides participants information on how to manage their high blood pressure, lower their risks of blood pressure, healthy eating and stress management. The AYH program engages participants in an interactive market tour and food demonstrations. Community Cholesterol Screenings – Northridge Hospital Cardiology Department staff conducts screening and provides education on heart disease at community based locations including schools, churches, and low income housing units.

5. **Affordable Housing/Homelessness** – Financial Assistance for the Uninsured – The hospital provides discounted and free health care to qualified individuals, following Dignity Health's Financial Assistance Policy. Additionally, staff participates on the San Fernando/Santa Clarita Homeless Coalition a collaborative of over 50 agencies that focuses on ending homelessness by 2025. In March 2016 Dignity Health approved a $3,051,000 loan to the LA Family Housing Corporation (LAFH), to support construction of a new facility to house formerly homeless individuals and families, and a new Federally Qualified Health Center. 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.

6. **Cancer (All Types)** – The Harold & Carole Pump Foundation supports Screening Fairs and patient support offering free mammograms to uninsured women over 40 years old. Additionally the Patient Navigator Program provides outreach and educational presentations at schools, churches, health fairs, support groups, smoking cessation workshops and more to inform women about risk factors, early detection, self-exams, screening guidelines, and the importance of scheduling an annual mammogram.

7. **Hypertension/High Blood Pressure** – The Family Medicine Center & Residency Program– This clinic provides primary and specialty medical services for the underserved. Shape-Up Your Heart (Community Grant Program) A collaborative effort with the Mid Valley YMCA, and Valley Care Community Consortium to address high blood pressure through physical activity and nutrition education for underserved Latino families

8. **Dental/Oral Health** – In 2016 Northridge Hospital facilitated an arrangement between the Meet Each Need with Dignity (MEND) Dental Clinic and West Coast University Dental Program to establish a once a week free clinic creating capacity for an additional 36 free adult dental appointments per month.

9. **Child/Domestic Abuse** – Center for Assault Treatment Services (C·A·T·S) – The only 24-hour/7-day-per-week designated Sexual Assault Response Team in the San Fernando and Santa Clarita Valleys. C·A·T·S provides the highest level of medical evidentiary examinations and forensic interviews for child and adult victims of sexual abuse and domestic violence in a supportive and comforting environment through a coordinated collaborative effort at no cost to the victim. Additionally the hospital provided a Community Benefit Grant to the Coalition to Abolish Slavery and Trafficking for the On Our Watch: Building Our Community Capacity to Serve Survivors of Human Trafficking to serve survivors of labor and sex trafficking through improved and expanded access to appropriate, specialized health care services for survivors or trafficking. Benefits to the target population include increased access to treatment of

serious injuries or sexually transmitted diseases, improved detection and diagnosis of diseases and conditions, increased knowledge of health issues, and the ability to access care and protection.

10. **Substance Abuse (Drugs & Alcohol)** – Emergency Department Initiative, as described under Mental Health, is a collaboration between Northridge Hospital and Tarzana Treatment Center to reduce health disparities among uninsured/underinsured with alcohol, chemical dependency and/or mental health conditions. Onsite case manager works in the emergency department to assist patients' needs including connections to primary care medical homes, detox, and mental health/substance abuse services. Addresses multiple identified health needs.

Anticipated Impact

The anticipated impacts of specific, major program initiatives, including goals and objectives, are stated in the program digests on the following pages. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to care; and help create conditions that support good health. The hospital is committed to monitoring key initiatives to assess and improve impact. The hospital executive leadership, Community Board, and Dignity Health receive and review program updates. The hospital creates and makes public an annual Community Benefit Report and Plan, and evaluates impact and sets priorities for its community health program by conducting Community Health Needs Assessments every three years.

Planned Collaboration

Northridge Hospital Medical Center has a long history of working in collaboration and is committed to serving an important role in our community through collaboration and partnerships with community partners in local capacity building and community building is significant and revolves around strong partnerships with residents, federally qualified health centers, political leaders and community and faith-based organizations, most notably but not limited to:

American Diabetes and Heart Associations	California State University, Northridge
Coalition to Abolish Slavery and Trafficking	Department of Child and Family Services
Department of Parks and Recreation	Healthcare Partners
LA Family Housing	Los Angeles Police Department
Los Angeles City and District Attorney	Los Angeles County Department of Public Health
Los Angeles Unified School District	Meet Each Need with Dignity
Mid Valley YMCA	Neighborhood Legal Services
Parent Institute for Quality Education	Network for a Healthy California
SOS Mentor	Tarzana Treatment Center
Strength United	Valley Care Community Consortium

Community wide collaboration is prevalent with various staff members participating in community wide collaboration. Staff members participate on community-wide collaborations including: VCCC Chronic Diseases Committee, San Fernando and Santa Clarita Homeless Coalition, VCCC Board of Directors, participate on boards of other local organizations.

Program Digests

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

Diabetes Wellness RX	
Significant Health Needs Addressed	☒ Diabetes ☐ Obesity/Overweight ☐ Mental Health ☐ Heart Disease and Stroke ☐ Affordable Housing Homelessness ☐ Cancer ☐ Hypertension/High Blood Pressure ☐ Dental Health ☐ Child/Domestic Abuse include Sexual Assault ☐ Substance Abuse
Program Emphasis	☐ Focus on Disproportionate Unmet Health-Related Needs ☒ Emphasize Prevention ☒ Contribute to a Seamless Continuum of Care ☐ Build Community Capacity ☒ Demonstrate Collaboration
Program Description	This project will expand the evidence based Diabetes Self-Management Program (DSMP) to underserved Latino adults with Type 2 diabetes at 10 community sites to reduce diabetes. Program consist of free 6 week program that will meet twice a week and include education, exercise, discounted YMCA membership, healthy food demonstrations, grocery store tours and follow up.
Community Benefit Category	Community Health Improvement Services
FY 2016 Report	
Program Goal / Anticipated Impact	Expand access to diabetes self-management health education.
Measurable Objective(s) with Indicator(s)	60% of Diabetic Type 2 will Decrease glucose levels by 10% 70% of participants will lower cholesterol by 5% 70% of participants will increase knowledge of diabetes management, nutrition, and fitness
Intervention Actions for Achieving Goal	Evidence based diabetes education sessions will be conducted
Planned Collaboration	This project is a collaborative effort with the funder Medtronic, YMCA and hospital Cardiology team conducting baseline and follow up measurements.
Program Performance / Outcome	Evidence based program implemented at one school based site providing education and supplemental activities to 15 Diabetic Type 2 residents.
Hospital's Contribution / Program Expense	Project Director, Project Coordinator and Health Educator will provide oversight, training, and implementation of the program.
FY 2017 Plan	
Program Goal / Anticipated Impact	Build capacity of community based free diabetic education to provide appropriate behavior modifications so that participants can manage their diabetes.
Measurable Objective(s) with Indicator(s)	At the end of 3 months 75% of participants will increase knowledge of diabetes management, nutrition, and fitness this will be measured by pre/post test.
Intervention Actions for Achieving Goal	Education component includes 2 ½ hours of culturally sensitive workshops, support groups will be available, 30 minute exercise sessions and health fairs.
Planned Collaboration	Will continue to partner with Medtronic, YMCA and other agencies as needed.

Emergency Department Initiative ED	
Significant Health Needs Addressed	☐ Diabetes ☐ Obesity/Overweight ☒ Mental Health ☐ Heart Disease and Stroke ☒ Affordable Housing Homelessness ☐ Cancer ☐ Hypertension/High Blood Pressure ☐ Dental Health ☐ Child/Domestic Abuse include Sexual Assault ☒ Substance Abuse
Program Emphasis	☒ Focus on Disproportionate Unmet Health-Related Needs ☒ Emphasize Prevention ☒ Contribute to a Seamless Continuum of Care ☐ Build Community Capacity ☒ Demonstrate Collaboration
Program Description	A partnership between Northridge Hospital Medical Center (NHMC) and Tarzana Treatment Center (TTC) to coordinate patient care through education, assessment and case management with a primary goal of linking under insured and uninsured residents into a primary care medical home and or to substance/mental health services as needed. Under this project, hospital personnel providing discharge services refer eligible patients to an on-site TTC case manager who works with patients requiring case management services. This includes intake and assessment, individualized case planning, case conferencing, coordinating with other coordinators of client care or services, referral to ambulatory care, mental health care, substance abuse treatment, housing, vocational services, distribution of transportation vouchers and follow-up. Data collection and tracking also take place.
Community Benefit Category	Community Health Improvement Services and Community Building
FY 2016 Report	
Program Goal / Anticipated Impact	Reduce health care disparities among populations with disproportionate unmet health-related needs utilizing the emergency room for service better delivered in primary care.
Measurable Objective(s) with Indicator(s)	Track the number of ED patients that is currently receiving TTC case management services Track the percentage of ED visits and/or hospital admissions three months post TTC intervention Track the percentage of patients linked into primary care services, substance abuse and housing
Intervention Actions for Achieving Goal	• Educate ED staff regarding appropriate referrals • TTC to provide case management for referred program participants • Case manager to provide follow-up services to program participants Data collection and analyzes
Planned Collaboration	Collaboration continues to be with TTC and the patients. No one else allowed on site
Program Performance / Outcome	Program responds to the needs of the underserved population by facilitating access to primary care to patients with substance abuse and behavioral health

	conditions.
Hospital's Contribution / Program Expense	This project is provided through a community benefit grant to TTC in the amount of $40,000 for providing staff to cover the projects
FY 2017 Plan	
Program Goal / Anticipated Impact	The Northridge Hospital ED and TTC collaborate on reducing recidivism in the ED. The objective of the collaboration is to reduce health disparities among populations with disproportionate unmet health-related needs, specifically individuals with alcohol and/or chemical dependency and mental health conditions. Additionally, the focus is on those patients who are uninsured or underinsured. Referrals are made to the TTC Case Manager by an MD. The TTC Case Manager provides an assessment, individualized plan of care and assistance in establishing follow-up services
Measurable Objective(s) with Indicator(s)	• Increase knowledge of 80% of clients that interact with case manager of community resources available to address primary care, substance abuse, and mental health needs • Increase the proper use of healthcare service agencies for 80% of clients accessing the healthcare system to increase their satisfaction and health outcomes through receiving care in the proper site. Reduce inappropriate use of the ED by a minimum of 31%
Intervention Actions for Achieving Goal	TTC Case Manager to receive access to EHR to better track all aspects of patients care
Planned Collaboration	Hospital will continue to collaborate with TTC

Center for Assault Treatment Services (CATS)	
Significant Health Needs Addressed	☐ Diabetes ☐ Obesity/Overweight ☐ Mental Health ☐ Heart Disease and Stroke ☐ Affordable Housing Homelessness ☐ Cancer ☐ Hypertension/High Blood Pressure ☐ Dental Health ☒ Child/Domestic Abuse include Sexual Assault ☐ Substance Abuse
Program Emphasis	☒ Focus on Disproportionate Unmet Health-Related Needs ☒ Emphasize Prevention ☒ Contribute to a Seamless Continuum of Care ☒ Build Community Capacity ☒ Demonstrate Collaboration
Program Description	CA TS expert team of forensic examiners, under the direction of the Clinical Manager and Medical Director, provides medical evidentiary examinations and forensic interviews of adult and child victims of sexual assault/abuse, human trafficking, witness interviews, and domestic violence in a safe, comforting and private environment that preserves the dignity of the victims. CATS also provides child abuse prevention education to professionals in the San Fernando Valley and surrounding areas who work with children and elder adults and are therefore mandated by law to report any reasonable suspicion of abuse. More recently reports of youth sex trafficking in the area have been noted and CATS staff has joined a task force along with local City Councilmember Nury Martinez, CAST, Law Enforcement, and the District Attorney's office. Northridge Hospital supports CATS by providing staffing and funding.
Community Benefit Category	Community Health Improvement
FY 2016 Report	
Program Goal / Anticipated Impact	Provide clinical forensic medical exams and interview service to child and adult victims of sexual assault and abuse, domestic violence, child abuse, and human trafficking victims. Provide education to mandated reporters on how to identify, prevent, and report child/elder abuse prevention.
Measurable Objective(s) with Indicator(s)	• By June 30, 2016 provided 1107 medical evidentiary examinations and forensic interviews for child and adult victims of sexual, human trafficking, and domestic violence, with a 19% increase from fiscal year 2015. In addition provided follow up and post –abuse care and participated as expert witness at court. • Continue to build strategic partnerships at the Family Justice Center a unique team of professionals co-located under one roof, dedicated to the prevention of child maltreatment, domestic violence and sexual abuse.
Intervention Actions for Achieving Goal	• Conducted medical evidentiary exams for victims of sexual/domestic assault/abuse of all ages • Conducted forensic interviews • Work closely with child protective services, law enforcement and the District Attorney's office to assist in the investigation process • Work closely with partner agencies at Family Justice Center

	• Outreach to public and private organizations including schools, hospitals, clinics, and other community based organizations • Develop training materials and conduct trainings
Planned Collaboration	Strength United, Coalition to Abolish Slavery and Trafficking (CAST), Jewish Family Service Family Violence Project, Los Angeles City and County Attorneys, Los Angeles Police Department, Major Assault Crimes, Department of Child and Family Services, and Neighborhood Legal Services,
Program Performance / Outcome	• CATS provided medical evidentiary exams and forensic interview to 1107 victims of sexual abuse and assault. • In partnership with Strength United case management/counseling was provided to all victims at no cost • Reputation for program excellence is leading law enforcement from inside and outside the area to increase usage of the CATS facility. • 2015 Victory for Victims Walk Run helped to raise funds in the amount of $127,961 to offset the cost of the program.
Hospital's Contribution / Program Expense	Total program expense for CATS clinical $1,189,183 and outreach $224,176. Offsetting revenue from LAPD payments and fundraising activities $650,560. In FY 16 hospital contributed $762,799 to support salaries and equipment.
FY 2017 Plan	
Program Goal / Anticipated Impact	Provide high quality clinical forensic service to victims of sexual assault, sexual abuse, human trafficking, and domestic violence and child/elder abuse prevention education to mandated reporters.
Measurable Objective(s) with Indicator(s)	Cases of sexual and domestic violence are rising in the area. By June 30, 2016 include high quality clinical forensic services to more than 1100 victims of sexual and domestic violence. By June 30, 2016 provide community outreach education on how to identify and report child/elder abuse to 21600 mandated reporters. Continue to be a member of the Sexual Assault Response Team and Domestic Assault Response Team, and Human Traffick Task Force.
Intervention Actions for Achieving Goal	• Support and purchase additional equipment to keep current as technology improves. • Provide continuing education through webinars, classes, and conferences to keep staff current in the field to maintain status as expert witnesses in court • Continue to work with all partners at the Family Justice Center • Work closely with law enforcement and the District Attorney's Office • Conduct roll call trainings at local law enforcement precincts/divisions • Conduct medical evidentiary examinations and forensic interviews. • Review and update training materials for community outreach • Continue to conduct CATS Victory for Victims Walk/Run to promote awareness of child/adult sexual and domestic abuse and to raise funds to offset cost of the program • Increase staff to keep up with increase in volume to help prevent burn out Network with local agencies to find potential donors
Planned Collaboration	Coalition to Abolish Slavery and Trafficking (CAST), Jewish Family Service Family Violence Project, Los Angeles City and County Attorneys, Los Angeles Police Department, Major Assault Crimes, Department of Child and Family Services, Neighborhood Legal Services, and Strength United.

Family Practice Residency Program	
Significant Health Needs Addressed	☒ Diabetes ☒ Obesity/Overweight ☒ Mental Health ☒ Heart Disease and Stroke ☐ Affordable Housing Homelessness ☒ Cancer ☒ Hypertension/High Blood Pressure ☐ Dental Health ☐ Child/Domestic Abuse include Sexual Assault ☐ Substance Abuse
Program Emphasis	☒ Focus on Disproportionate Unmet Health-Related Needs ☒ Emphasize Prevention ☒ Contribute to a Seamless Continuum of Care ☒ Build Community Capacity ☐ Demonstrate Collaboration
Program Description	The Northridge Hospital Family Medicine Residency Program, in conjunction with the faculty group, provides both inpatient and outpatient care to many of the underserved in the community. They are an integral part of providing care in the San Fernando Valley. Care provided ranges from prenatal to pediatric to adult and geriatric medicine. Over the years, the FPC has extended its services to comprehensive diabetes management, breast and cervical cancer screenings, family planning, counseling, and patient education, to the uninsured and under-insured in the community. Ongoing health outreach, prevention, and education are a part of FPC's efforts to engage and serve its community. FPC responds to the community's need for chronic disease self-management for adults.
Community Benefit Category	Community Health Improvement Services and Subsidized Health Services
FY 2016 Report	
Program Goal / Anticipated Impact	To provide a safety net for patients in our community both in the hospital and in the ambulatory setting, with emphasis on becoming an integral part of the local neighborhood and continued outreach and prevention education efforts. Services were provided to 42,533 children, adults, and elderly population.
Measurable Objective(s) with Indicator(s)	Measure number of indigent patients receiving inpatient services Measure number of patients seen through Medi-Cal and managed Medi-Cal. Measure number of patients seen through state funded programs including CHDP, CCS, and Family PACT
Intervention Actions for Achieving Goal	• Provided Family Medicine coverage of admissions through the hospital emergency department including involvement with the obstetrical and surgical panel coverage. • Provided outpatient services. • Contracted with Medi-Cal HMO's as the State of California continues to move additional patients into managed Medi-Cal. • Maintain "Diabetes Indigent Program." Ongoing community partnerships and outreach prevention education efforts, including health education for the youth, high school sports coverage, obesity and diabetes prevention in children and adults, general health screenings, and senior center screenings.
Planned Collaboration	UCLA Residency Program, CSUN Family Focus Resource Center, Northeast

	Valley Health Corporation FQHC clinics
Program Performance / Outcome	The Northridge Hospital Family Medicine Residence Program provided: inpatient and outpatient services to 42,533 people. • Ongoing community partnerships and outreach programs: o Sutter Middle School Health Education Program o Northridge Middle School "Aim High Childhood Obesity" project engaged eighth grade students, parents, teachers and residents in using photo diaries to increase awareness of food choices. o High school football games coverage for Monroe High School, as their Team Physician. o Partnership with Partners in Care's Disease Prevention and Health Promotion Program at local senior centers. Local Screening Health Fairs and community presentations.
Hospital's Contribution / Program Expense	UCLA Residency Program, CSUN Family Focus Resource Center, Northeast Valley Health Corporation FQHC clinics .
FY 2017 Plan	
Program Goal / Anticipated Impact	Continue to provide a safety net for patients in our community both in the hospital and in the ambulatory setting, with emphasis on becoming an integral part of the local neighborhood and continue outreach prevention education efforts.
Measurable Objective(s) with Indicator(s)	• Measure number of indigent patients receiving inpatient services • Measure number of patients seen through Medi-Cal and managed Medi-Cal • Measure number of patients seen through all state-funded service programs for low-income patients such as CHDP, CCS, PACT • Measure number of indigent patients seen in Family Practice Center including Specialty Clinics • Continuation and expansion of partnerships and outreach prevention education efforts with local schools, senior centers, can community agencies
Intervention Actions for Achieving Goal	• Continue Family Medicine coverage of admissions through the hospital emergency department including involvement with the obstetrical and surgical panel coverage. • Continue and expand hospital inpatient service at Northridge Hospital Medical Center. • Contract with Medi-Cal HMO's as the State of California continues to move additional patients into managed Medi-Cal. • Maintain "Diabetes Indigent Program." Maintain community partnerships and outreach prevention education efforts, including health education for the youth, high school sports coverage, obesity and diabetes prevention in children and adults, general health screenings, and senior center screenings.
Planned Collaboration	UCLA Residency Program, CSUN Family Focus Resource Center, Northeast Valley Health Corporation FQHC clinics.

Community and School Wellness Initative	
Significant Health Needs Addressed	☒ Diabetes ☒ Obesity/Overweight ☐ Mental Health ☒ Heart Disease and Stroke ☐ Affordable Housing Homelessness ☒ Cancer ☒ Hypertension/High Blood Pressure ☒ Dental Health ☐ Child/Domestic Abuse include Sexual Assault Substance Abuse
Program Emphasis	☒ Focus on Disproportionate Unmet Health-Related Needs ☒ Emphasize Prevention ☐ Contribute to a Seamless Continuum of Care ☐ Build Community Capacity ☐ Demonstrate Collaboration
Program Description	Community and school Wellness Initiative programs are designed to improve health and wellness with a focus on cardiovascular and diabetes health, nutrition and physical activity promotion, obesity and chronic disease prevention. School Wellness programs include 34 public schools in collaboration with LAUSD and community partners. Choose Health LA Kids focuses on parents and caregivers of children ages 0 to 5 in eight low-income San Fernando Valley communities. In FY 16 the Community and School Wellness Imitative consists of three programs that are supported by the hospital and with offsetting grant revenues. Programs included are Choose Health LA Kids, Activate your Heart, and School Wellness Healthier Living Programs: The evidence-based Chronic Disease and Diabetes Self-Management Programs are designed to help people gain self-confidence in their ability to control their symptoms and learn how their health problems affect their lives. Small-group, highly interactive workshops are six weeks long, meeting once a week for 2 ½ hours.
Community Benefit Category	Community Health Improvement and Community Building
FY 2016 Report	
Program Goal / Anticipated Impact	Increase physical activity and improve nutrition with the ultimate goals of reducing obesity rates in children and adults and reducing the onset of chronic diseases that are linked to obesity including hypertension, cardiovascular disease, diabetes, cholesterol and cancers. In FY 16 there were 24,727 children and adults received health education and or physical activity instruction.
Measurable Objective(s) with Indicator(s)	NHMC staff conducted informative sessions at CDI Learning Center, Casa Esperanza and Park Parthenia involving a total of 18 participants. NHMC facilitated the Diabetes Self-Management Program at Napa Elementary School involving 17 participants. NHMC facilitated the Chronic Disease Self-Management Program at NH Family Practice involving 7 participants. NHMC presented an overview of the Chronic Disease Self-Management Program for 20 physicians at Valley Community Healthcare.

	NHMC staff conducted the Chronic Disease Self-Management Program engaging 12 participants. NHMC staff provided newsletter and health related handouts for 68 Principals and Parent Center Directors in 32 schools.
Intervention Actions for Achieving Goal	• Offer program and assistance to principals at each school. • Identify partners to work with each school. • Coordinate partner's involvement in addressing schools' needs. • Conduct cooking demonstrations and grocery store tours • Implement grant-funded programs at schools. • Monitor progress. • Evaluate results
Planned Collaboration	Northridge Hospital's Cardiology Department, Los Angeles Unified School District (34 schools in the San Fernando Valley), Food for Less, Super King, Los Angeles County Department of Public Health, School-based Health Clinics, Parent Center Directors and Parent Facilitators; American Heart Association, California State University, Northridge–Department of Dietetic Internship and Department of Kinesiology, Enrichment Works, Health Net, Mid-Valley YMCA, Valley Care Community Consortium (VCCC) .
Program Performance / Outcome	Community health fair and events: Staff participated and provided information on healthy eating, sugary beverages, the effect of sodium, Center for Assault Treatment Services events, and conducted an interactive spin the wheel game. Disseminated health information at North Hills Neighborhood Hite (124 participants), Park Parthenia Apartments Health Fair (20 participants), Valley Care Community Consortium Diabetes Expo (150 participants), Northwest Fest at Reseda High School (275 participants), Iglesia Poder de Dios (120 participants) totaling to 689. The Great Kindness Challenge: The campaign is one school week devoted to performing as many acts of kindness as possible during the last week of January. School Anti-bullying campaign NHMC hosted a Great Kindness Challenge Breakfast for 33 Los Angeles Unified School District Principals and Support Staff. As a result NHMC engaged 19,650 school staff and students from 22 schools to promote kindness. Walking Groups: School-based walking groups designed to improve cardiovascular health and prevent and/or manage chronic conditions. Walking groups took place in school grounds or around the community. NHMC staff, CSUN public health and kinesiology students conducted walking groups at Hart (21), Gault (8), Langdon (7) Liggett (6), Limerick (8), Napa (28), and Noble (5) involving a total of 83 participants. Turnip the Nutrition Presentations: CSUN interns conducted a 30 minute presentation for students at Gault Elementary Schools engaging 450 students. Mindful Eating: The 1 hour presentation cover the main pillar of a healthy lifestyle such as healthy eating, physical activity, sleep, stress management, and a positive social life engaging 23 participants. **Activate Your Heart** Activate Your Heart: The 8 week program focuses on cardiovascular health and

provides participants information on how to manage their high blood pressure, lower their risks of blood pressure, healthy eating and stress management. The AYH program engages participants in an interactive market tour and food demonstrations.

- NHMC staff conducted the Activate Your Heart program at 4 sites involving a total of 156 participants which attended at least one class and 92 who were tracked. A tracked participants is a person who has one baseline measurement and a second measurement. Measurements were: cholesterol, glucose, blood pressure, body mass index and knowledge survey.
- NHMC staff conducted informative session for 5 YMCA Wellness Coaches.
- CSUN interns participated and promoted the AYH program in the Nury Martinez Egg Hunt and Health Fair (75 participants), Partnerships to Uplift Communities Health Fair (130 participants), Mid-Valley YMCA Kids Day (339), and YMCA Fundraiser Breakfast (100 participants) involving a total of 649 participants.

Choose Health LA Kids is designed to prevent early childhood obesity by providing:

1. Nutrition Education: Designed in collaboration between First 5 LA and DPH, The *Healthy Parenting Workshops* is a series of six, 90-minute workshops that engage parents in a social learning environment designed to foster effective parenting skills and implement healthful parenting, sleep, nutrition, and physical activity routines into their lives.
o NHMC provided nine Healthy Parenting workshop cycles, graduating 101 parents during the project period.

2. Restaurant Engagement: the DPH Choose Health LA Restaurant program is promoted in the community and directly with local restaurants through in-person outreach. DPH, in turn, promotes the Choose Health LA Restaurant program citywide. o NHMC engaged eight restaurants as partners in the Choose Health LA Restaurant program during the project period.

3. Food Demonstrations: interactive skill-building workshops are provided at community-based locations, where parents learn healthy recipes. o NHMC conducted 94 food demonstrations, involving 1,352 participants.

4. Grocery Store Tours: Health Educators provided a "learning by doing" experience through walking the perimeter of the store with parents (where fresh foods are placed); ingredients from the food demonstration recipe(s) were highlighted in order to tie the two activities together. o NHMC conducted 45 grocery store tours, involving 325 participants during the project period.

5. Parent Collaborative: the parents of young children are empowered as community leaders through a variety of facilitated skill-building and "learning by doing" activities. Parent Collaborative groups were established at Noble Elementary and Hazeltine Elementary Schools. The major accomplishments included: o collaboration with local supermarkets (Super King and Food 4 Less)

	to develop a Healthy Kids Club o NHMC enrolled 151 families in the Food 4 Less Healthy Kids Club o VCCC enrolled 110 families in the Super King Healthy Kids Club 6. Community Assistance Programs: Health Educators disseminated information about the Women, Infants and Children (WIC) nutritional assistance program and Cal Fresh program (formerly known as Food Stamps) to the community. NHMC distributed 2,346 informational materials to the community during the course of the program.
Hospital's Contribution / Program Expense	The hospital's Center for Healthier Communities provided the staff and contracted with a local university and their professors to make community benefit projects part of community service work. Additionally grant funding was secured and grants funding is being sought to continue the level of services in community. For FY 16 program expenses were $714,922 with $399,121 in offsetting grant revenues the hospital contributed $315,801
FY 2017 Plan	
Program Goal / Anticipated Impact	Program goal is to continue work in schools and community to provide the services listed above. We will establish a strong foundation to help reduce access to vital nutrition and health messaging, free physical activity opportunities, and effectively engaging parents in promoting their children's health as well as the whole family. The anticipated impact is that as children and adult learn how to have a healthy life they will make better healthcare decisions which can lead to better health outcomes.
Measurable Objective(s) with Indicator(s)	• By Dec 2017 conduct three 6-week parenting workshops • By June 2017 conduct wellness campaigns in 34 schools. • By June 2017 500 students and adults will increase hours engaged in in physical activity • By June 2017 increase students' knowledge of good nutrition pre/post test. • By June 2017 continue to recruit new partners.(3 new partners) • By June 2017 provide 10 grocery store tours and food demonstrations • By June 2017 conduct eight 10 week Activate your Heart Sessions
Intervention Actions for Achieving Goal	Develop flyers and a promotional plan to engage schools and community residents in no cost programs to reduce obesity and reduce the risk of the many chronic diseases that were listed as concerns by the community in our 2016 Community Health Needs Assessment.
Planned Collaboration	Northridge Hospital's Cardiology Department, Los Angeles Unified School District (34 schools in the San Fernando Valley), Food for Less, Super King, Los Angeles County Department of Public Health, School-based Health Clinics, Parent Center Directors and Parent Facilitators; American Heart Association, California State University, Northridge–Department of Dietetic Internship and Department of Kinesiology, Enrichment Works, Health Net, Mid-Valley YMCA, Valley Care Community Consortium (VCCC) .

ECONOMIC VALUE OF COMMUNITY BENEFIT

Northridge Hospital Medical Center
Complete Summary - Classified Including Non Community Benefit (Medicare and Bad Debt)
For period from 7/1/2015 through 6/30/2016

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses
Benefits for Living in Poverty					
Financial Assistance	3,584	5,524,008	0	5,524,008	1.4
Medicaid	37,453	136,438,850	104,960,663	31,478,187	8.1
Community Services					
A - Community Health Improvement Services	29,824	2,011,393	890,166	1,121,227	0.3
C - Subsidized Health Services	42,533	11,082,063	129,488	10,952,575	2.8
E - Cash and In-Kind Contributions	18	1,055,732	0	1,055,732	0.3
G - Community Benefit Operations	0	712,650	0	712,650	0.2
Totals for Community Services	72,375	14,861,838	1,019,654	13,842,184	3.6
Totals for Living in Poverty	113,412	156,824,696	105,980,317	50,844,379	13.1
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	10,768	506,506	279,386	227,120	0.1
B - Health Professions Education	4,110	2,299,802	0	2,299,802	0.6
E - Cash and In-Kind Contributions	546	79,533	0	79,533	0.0
F - Community Building Activities	11	5,962	0	5,962	0.0
Totals for Community Services	15,435	2,891,803	279,386	2,612,417	0.7
Totals for Broader Community	15,435	2,891,803	279,386	2,612,417	0.7
Totals - Community Benefit	128,847	159,716,499	106,259,703	53,456,796	13.8
Medicare	16,087	96,019,633	69,950,133	26,069,500	6.7
Totals with Medicare	144,934	255,736,132	176,209,836	79,526,296	20.5

Northridge Hospital Medical Center utilizes decision support clinical cost accounting methodology.

APPENDIX A: COMMUNITY BOARD AND COMMITTEE ROSTERS

NORTHRIDGE HOSPITAL MEDICAL CENTER
COMMUNITY BOARD
July, 2016

Justin Ako
Chair, Dept. of Health Administration
West Coast University — ako.justin@gmail.com

Jacob Bustos
Market Manager
Panera Bread — jacobbustos@mc.com

Barbra Miner
Consultant — barbraminer.cominfo@barbraminer.com

Shawki Saad, M.D. — saadshawki@yahoo.com
Northridge Hospital

Saliba Salo
President
Northridge Hospital Medical Center — saliba.salo2@dignityhealth.org

Hooshang Semnani, M.D.
C/o PICU
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Carol Stern
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Steve Valentine
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William Watkins
V.P. Student Affairs
CSUN — william.watkins@csun.edu

Enrique Wong
Regional Manager
Marcus & Millichap — Enrique.wong@maarcusmillichap.com
Board Chair

APPENDIX B: OTHER PROGRAMS AND NON-QUANTIFIABLE BENEFITS

The hospital delivers a number of community programs 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.

- **Angie's Spa** – Free therapeutic massages are provided to men and women undergoing inpatient and outpatient cancer treatment at our Leavey Cancer Center. The therapeutic massages decrease stress, anxiety, pain and alleviate some of the side effects of traditional medical treatments. This unique service provides cancer patients with extra support and comfort.
- **Helping Hands Holiday Jam** - For over ten years, the Northridge Hospital Foundation has provided a Christmas wonderland for disadvantaged children from eight Title 1 LAUSD school children
- **Great Kindness Challenge** – For the second year we engaged 22 schools for participation in a week long anti-bullying event providing over 5,000 acts of kindness to our community.
- **Community Grant - Triumph Foundation** – The Keep Moving Forward program provides paralyzed spinal cord injury individuals with financial constraints and inadequate medical insurance access to wheelchairs and other necessary equipment, supplies and services.
- **Community Room Use** – Free use of conference rooms, classrooms, and auditoriums are provided to community based non-profit groups that conduct support groups, meetings, seminars, etc.
- **MD Continuing Education** – Classes offered to physicians on the medical staff and outside the medical staff on various topics of importance to build knowledge base and increase quality of care.
- **Health Education and Support Groups** – Community education that includes community classes/seminars, support groups, health fairs, outreach events.
- **Administrative Intern Program** - A collaboration with the local California State University, Northridge where hospital leadership staff provide mentorship and internship opportunities to health administration and public health students for their future roles in healthcare.
- **Nursing Students** – A program precepting and mentoring for nursing students at both a staff and leadership level. Include room use for RN to BSN, BSN, and MSN students from multiple local colleges and universities.
- **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.
- **Wheelchair Sports** – In partnership with Los Angeles Recreation and Parks Therapeutic Services (over the line tournament) financial and human resources are supplied to allow disabled individuals to participate in a wide variety of wheelchair sports. Goal is to increase participation in community sporting events by physically disabled wheelchair bound community residents.

APPENDIX C: FINANCIAL ASSISTANCE POLICY SUMMARY

Dignity Health's Financial Assistance Policy describes the financial assistance programs available to uninsured or under-insured 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 200% 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 200-350% 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.

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