Northridge Hospital Medical Center

2022 Community Health Implementation Strategy

Adopted November 2022

Dignity Health®
Northridge Hospital
Medical Center

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At-a-Glance Summary

Community Served	Northridge Hospital's service area is located in Service Planning Area 2 of Los Angeles County, which consist of the San Fernando and Santa Clarita Valleys. Our service area is home to over 1.5 million residents of multiple cultures and ethnic backgrounds. The total land area is 368.91 miles with a population density of 4,270.95 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 being addressed by strategies and programs are: 1 Mental Health 2 Substance Abuse 3 Diabetes 4 Oral Health 5 Access to Healthcare Services 6 Nutrition, Physical Activity & Weight 7 Respiratory Disease (COVID 19) 8 Heart Disease & Stroke
Strategies and Programs to Address Needs	The hospital intends to take several actions and to dedicate resources to these needs, including: 1 Mental Health - The Cultural Trauma Mental Health Resiliency Program to address behavioral health and mental well-being Trained staff and funded community partnerships with local mental health will continue to provide virtually and in person trainings of evidence-based Mental Health First Aid Adult and Youth and Question, Persuade, Refer (QPR) 2 Substance Abuse- Provide Medicated Assisted Treatment (MAT) Program to provide safe management of opioid addicted patients that present to the ED. A Nurse Practitioner with MAT waiver training will provide medication management, alternatives to opioids, community resources, and a warm handoff to drug treatment/detox centers. 3 Diabetes – Continue partnership with the California Department of Public Health Prevention Forward program to expanded diabetes programs to conduct Diabetes Self-Management and the National Diabetes Prevention Program for prediabetes. We will increase the capacity of other pharmacies and community based organizations that offer these sessions as well. 4 Oral Health – This is a newly identified need will be addressed through oral health education to be provided at parent centers and through the School based newsletter to better support oral health promotion. 5 Access to Healthcare Services – Continued financial assistance for the uninsured and under insured, continuation of providing access to recuperative care for those that are homeless and do not have a safe place to recover. The two COVID 19 projects set up pop up vaccine clinics in underserved communities of color to help alleviate health disparities related to lack access to vaccines. 6 Nutrition, Physical Activity, & Weight - Continued our commitment to the Community and School Wellness Initiative – Partnership with Los Angeles Unified School District to provide ongoing school wellness newsletter, nutrition

	education workshops, and added a physical activity session to some of the chronic disease workshops to encourage movement. We will continue to provide a once a month free produce distribution program in partnership with the American Heart Association as a way of providing healthy options. 7 Respiratory Disease (COVID 19) –The Northridge Hospital Center for Healthier Communities staff was funded in partnership with Los Angeles County Department of Public Health and the LA County of Health Services to continue to provide a massive COVID 19 Outreach and Engagement project to reduce the incidence of vaccine hesitancy and encourage the most vulnerable populations to become vaccinated incorporating social media outreach. Additionally, through early 2023 we will continue to provide pop-up vaccine clinic sites at schools, churches, preschools, and community based organizations. 8 Heart disease and stroke – Through our partnership with the California Department of Public Health Prevention Forward grant staff will continue to offer Activate your Heart prevention education and blood pressure self-monitoring programs.
Anticipated Impact	The strong focus on community-based universal and prevention education strategies that focus on the broad spectrum of needs identified from very disease specific programs addressing diabetes, heart disease, hypertension, and dental to those aimed at the broader complex issues such as mental health, substance abuse, and access to the health care system will provide the platform to work at the community level to change health behaviors to and improve health outcomes. Additionally, we will continue to grow our partnerships with other community based providers with like goals so that we are all utilizing our resources more effectively for each area of program implementation. At the individual level those participants in our health programs are improving their A1C counts, blood pressure, and cholesterol measures while those involved with our violence prevention programs show an increase in knowledge about what healthy relationships are, how to help others in non-healthy relationships, and know the resources available for seeking help.
Planned Collaboration	Northridge Hospital Medical Center has a long history of working in collaboration and is committed to serving an important role in our community through collaboration and partnerships with community partners in local capacity building and community building is significant and revolves around strong partnerships with residents, federally qualified health centers, political leaders and community and faith-based organizations. Collaboration Partnerships can be found in the Community Benefit Report as part of the Program Digest.

This document is publicly available online at the hospital's website. Written comments on this report can be submitted to the Dignity Health - Northridge Hospital Center for Healthier Communities at 8210 Etiwanda Ave, Reseda, CA 91335 or by e-mail to CHNA.NorthridgeHospital@DignityHealth.org.

Our Hospital and the Community Served

About the Hospital

Northridge Hospital Medical Center is a part of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 1,000 care sites in 21 states coast to coast, serving 20 million patients in big cities and small towns across America.

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

During FY 21 and FY 22 a dedicated COVID 19 unit continued to be in place as a result of the Omicron variant there was an ongoing need to dedicate space to service COVID 19 patients.

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.

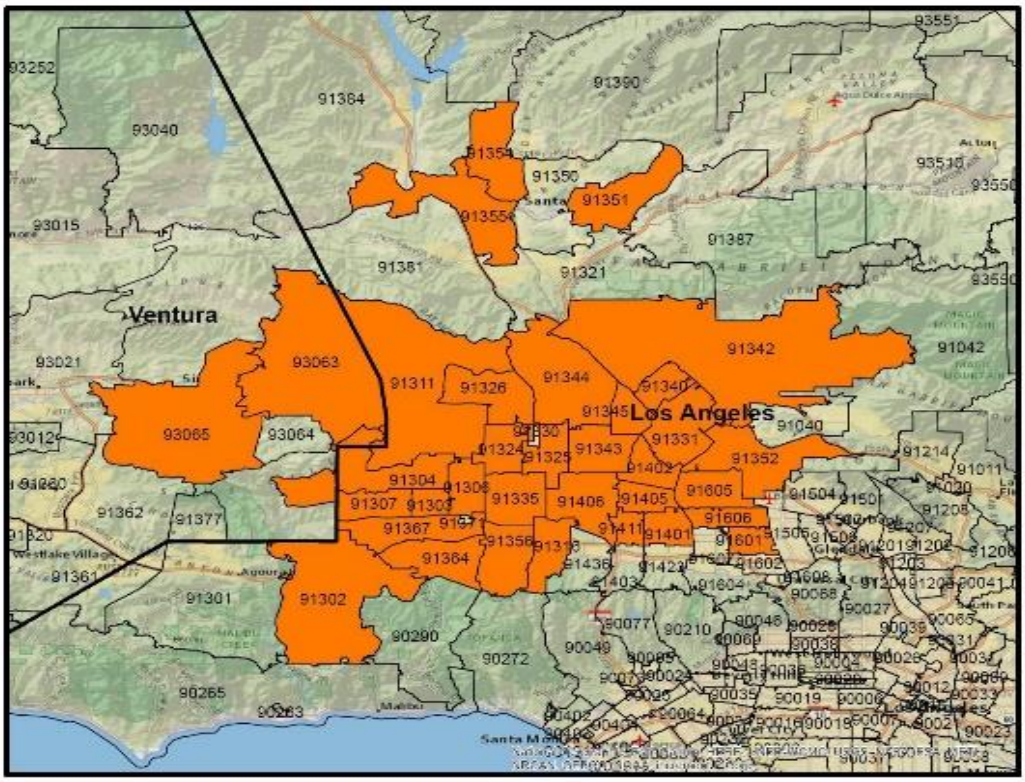
Financial Assistance for Medically Necessary Care

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 study area for the survey effort (referred to as the "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 (also see map below): 91302, 91303, 91304, 91306, 91307, 91311, 91316, 91324, 91325, 91326, 91331, 91335, 91340, 91342, 91343, 91344, 91345, 91351, 91352, 91354, 91355, 91356, 91364, 91367, 91401, 91402, 91405, 91406, 91411, 91601, 91605, 91606, 93063, and 93065.

The hospital's service region is located in Northern Los Angeles in Service Planning Area 2 (SPA 2 over 1.5 million residents), an urbanized valley that is surrounded by the Santa Susana Mountains on the northwest, Simi Valley to the west, the Santa Monica Mountains to the south, the Verdugo Mountains to the east, and the San Gabriel Mountains to the northeast. The most 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 region has higher income and middle class households juxtaposed by pockets of extreme poverty and ethnic mobility. The economy includes leading educational institutions (California State University, Northridge, Pierce and Mission community colleges), and Van Nuys airport. The areas of highest need and health care disparities are the 15 zip codes that are rated 4.2 and above by the Community Need Index. These communities have the highest number of people of color, lowest education attainment levels, English is a second language, and highest number of folks paying in excess of 45% of their income on housing.

COMMUNITY DEMOGRAPHICS	FY22
Total Population	1,528,095
Race	
Asian/Pacific Islander	11.1%
Black/African American - Non-Hispanic	3.8%
Hispanic or Latino	48.8%
White Non-Hispanic	32.2%
All Others	4.1%
Total Hispanic & Race	
% Below Poverty	9.0%
Unemployment	5.0%
No High School Diploma	19.3%
Medicaid	32.1%
Uninsured	8.9%
Source: Claritas Pop-Facts® 2022; *SG2 Market Demographic Module*	
SG2 Analytics Platform Reports:	
Demographics Market Snapshot	
Population Age 16+ by Employment Status	
Families by Poverty Status, Marital Status and Children Age	
Insurance Coverage Estimates (map data export)	

Community Assessment and Significant Needs

The health issues that form the basis of the hospital's community health implementation strategy and programs were identified in the most recent CHNA report, which was adopted in May 2022. The CHNA contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods;
- Presentation of data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available 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 table below, which also indicates which needs the hospital intends to address. Identified needs may include specific health conditions, behaviors and health care services, and also health-related social needs that have an impact on health and well-being.

Significant Health Need	Description	Intend to Address?
Mental Health	Mental health is a key driver of health status and was ranked as the highest priority by the community. Our goal will be to provide evidence-based trainings and social emotional learning workshops in school and youth settings to address this issue.	Yes
Substance Abuse	Substance abuse defined as "a maladaptive pattern of substance use leading to clinically significant impairment or distress results in repeated uses of drugs and alcohol. The major concern is the fentanyl that many drugs are laced with and the high rate of preventable death due to overdose.	Yes
Diabetes	Focus group and survey participants felt that diabetes is a major factor influencing the health of either themselves or a family member. One concern is the cost of insulin and the lack of education around self-management of the disease. The programs that will be implemented will address these issues.	Yes
Oral Health	Access to affordable dental care and limited knowledge regarding the importance of proper oral hygiene was listed as a concern by the community. Our goal around this issue will be to educate the community on the importance of a healthy mouth to prevent disease and help maintain good health.(Healthy eating, stop smoking/vaping, brush & floss)	Yes
Access to Healthcare Services	Community input suggest that health care access has now because a priority. Some of the barriers have been difficulty in getting appointments, having to stretch medication, unaffordable even with insurance, this includes mental health access.	Yes
Nutrition, Physical Activity, &Weight	This rose to the top as an issue due to inactive and weight gain during COVID, less food security due to high cost. The community does have an awareness of how nutrition and physical activity can affect cardiovascular health, diabetes, and obesity rates. Programs that are culturally relevant for the communities will be implemented to support overall health.	Yes
Respiratory Diseases (including COVID-19)	Our community saw an abundance of COVID 19 cases leading to long term and higher death rates than most of the nation. While this continues to be a hot topic issue we are still working with both federal and local government agencies to help reduce the disparities faced in some of our communities.	Yes
Heart Disease and Stroke	Respondents continue to be concerned and prioritize heart disease as a concern since they have an awareness that this is still the number one cause of death in our community. We will continue our partnership with the California Department of Public Health to address Heart Disease and stroke through primary prevention education and teaching of self-management skills.	Yes

Significant Needs the Hospital Does Not Intend to Address

The eight needs listed above were the ones prioritized as the most significant and the hospital plans to address all eight of those prioritized as most needed. The 2022 CHNA report also list cancer, Alzheimer's, and sexual health but they were not prioritized as significant needs. We do have programs for cancer and working in partnership with our local Alzheimer's Association.

2022 Implementation Strategy

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others on 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

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

Hospital and health system participants include Community Benefit, Mission and the Center for Healthier Communities Departments who continue to coordinate the community based programs with input from the community residents. Additionally, the foundation Director of Grants and team members from the Transitional Care team continue to support the delivery of the chronic disease and COVID 19 programs designed to meet the needs of the community.

Community input or contributions to this implementation strategy included input from the Community Grants Benefit Committee, who each year actively read and score the grants and then meet to provide input and guidance based on the most recent CHNA and make recommendations to support the best programs to include as part of our strategies. In addition, the feedback provided by the key informants of the 2022 CHNA are taken into consideration when deciding programs that need to continue to be part of the implementation strategy as well as strategies that need additional focus. As an example oral health

had not been identified in the 2019 CHNA as a concern but it has resurfaced as a need in our area so we will add oral health promotion and prevention education as a strategy in this plan.

The programs and initiatives described here were selected on the basis of the 2022 CHNA report conducted by PRC using the PRC Community Health Survey (input from community residents) and the PRC online Key Informant Survey. The community residents prioritized what they felt were the top eight priorities. The majority of the programs described in this document are existing programs that are evidence-based and have a history of success and have shown evidence as being an effective in helping to address the social determinants of health and reduce health inequities.

Community Health Strategic Objectives

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources and engagement of participants both inside and outside of the health care delivery system.

CommonSpirit Health has established four core strategic objectives for community health improvement activities. These objectives help to ensure that our program activities overall address strategic aims while meeting locally-identified needs.

Create robust alignment with multiple departments and programmatic integration with relevant strategic initiatives to optimize system resources for advancing community health.

Scale initiatives that complement conventional care to be proactive and community-centered, and strengthen the connection between clinical care and social health.

Work with community members and agency partners to strengthen the capacity and resiliency of local ecosystems of health, public health, and social services.

Partner, invest in and catalyze the expansion of evidence-based programs and innovative solutions that improve community health and well-being.

Strategies and Program Activities by Health Need

Health Need: Mental Health					
Anticipated Impact (Goal)	To reduce mental illness, suicidal tendencies and substance use among youth with emotional and major depressive disorders. Increase the skills, knowledge and awareness of local LAUSD staff, community organizations and residents to promote and instill mental health resiliency, especially among children and youth of color, along with the adults who care for them, in communities where significant health disparities exist. Implement the ACEs screening tool in Family Practice using a web-based referral platform to connect to resources. Positive Action will improve student self-concept and foster healthier relationships.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Cultural Trauma and Mental Health Resiliency Project	Project to address behavioral health and mental well-being of at-risk youth, through prevention and early intervention in Dignity Health's six Southern California hospitals most vulnerable areas. With a strong focus on funding community partnerships with local mental health providers to train and deliver evidence-based Mental Health First Aid, Youth Mental Health First Aid, and Question, Persuade Refer suicide prevention programs.	●	●	●	●
Adverse Childhood Experience Screening (ACEs Aware Network of Care)	As a Network of Care partner, family practice residents will screen for ACEs and respond to and help prevent toxic stress. In addition, we will work collaboratively to develop sustainable, community-informed, evidence-based services that treat and prevent toxic stress physiology and ACE-Associated Health Condition among Medi-Cal beneficiaries. Together we will work to build a sustainable workforce that supports ACE screening, and	●	●	●	●

Health Need: Mental Health					
	effective referrals utilizing the web-based platform One Degree				
Planned Resources	Staff and partners are certified trainers in to SAMSA recommended mental health programs so ongoing human resources to provide trainings. Financial resources available to continue to support the cost of training materials.				
Planned Collaborators	In partnership with National Alliance for Mental Illness (NAMI) and San Fernando Valley Community Mental Health, Inc. (SFVCMH), staff will be trained to build community capacity to deliver training of evidence-based programs Mental Health First Aid (MHFA Adult and Youth) and Question Persuade Refer (QPR). For ACEs Aware program the lead agency will be Northeast Valley Health Corporation and we will continue to be part of the San Fernando Valley Aces Aware Network which consist of San Fernando Valley Community Mental Health, 211, Strength Untied, Child Care Resource Center, and others)				
Positive Action	This program is being implemented 10 LAUSD middle and high schools. POSITIVE ACTION is an evidence-based curriculum that uses real-life concepts to foster social emotional learning and developing a positive self-concept. • The program emphasizes effective self-management, social skills, character, and mental health, as well as skills for setting and achieving goals. Positive Action teaches young people positive actions that help youth feel better about themselves and intrinsically motivates them. • Positive Action take a holistic and proactive approach toward improving teacher–student relations, parent and community involvement, instructional practices, and the development of the self-concept for all involved (students, teachers, parents, and community members).				

Health Need: Substance Abuse	
Anticipated Impact (Goal)	Our goals continue to be: 1) 80% of opioid patients will agree to MAT. 2) The Pain Management Team will

Health Need: Substance Abuse					
	provide counseling and education to 80% of identified patients. 3) 100% of patients will receive a warm hand-off. 4) Staff have completed MAT waiver training. In the first year of the program 713 individuals were served.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Pain Management and ED Collaborative for Medicated Assisted Treatment (MAT)	A program that provides safe management of opioid addicted patients that present to the ED and transition to the inpatient setting. A Nurse Practitioner with MAT waiver training will provide medication management, alternatives to opioids, community resources, and a warm handoff to drug treatment/detox centers.	●	●	●	●
Planned Resources	Staff consist of a Substance Abuse Navigator and trained clinicians to offer MAT education and warm hand offs to community based recovery services.				
Planned Collaborators	We partner with drug treatment centers including Tarzana Treatment Center, Discovery House, Cri-Help, ProWellness Academy, etc. for continuum of care including behavioral health services.				

Health Needs: Diabetes, Heart Disease & Stroke, and Nutrition, Physical Activity & Weight					
Anticipated Impact (Goal)	Prevention Forward is a grant funded public health program through CDPH that operates under the Chronic Disease Control Branch (CDCB). The main objective of the program is to implement evidence-based curriculums to prevent, manage, and treat cardiovascular disease, high blood pressure, high cholesterol, stroke, prediabetes, and Type 2 diabetes among patients 18-85 years old in the San Fernando Valley and Santa Clarita Valley. The primary impact the program will achieve is decreased rates of chronic diseases and complications from chronic diseases among program participants.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Prevention Forward Evidence-Based Education	Implement the following curricula: • ADCES 7: Diabetes Care and Education curriculum • National Diabetes Prevention Program • Blood Pressure Self-Monitoring Program • Diabetes Empowerment Education (DEEP)	●	●	●	●
Prevention Forward Community Workshops	• Activate Your Heart • Fall Prevention among Seniors, Mindfulness and Stress Management, Sleep Hygiene, and other health topics	●	●	●	●
Prevention Forward Program Recruitment	• Use the EHR System (Cerner) to identify pre-diabetes, and type 2 diabetes. • Identify a minimum of 100 patients per year who are eligible to participate in the PF Program. Recruit and maintain a minimum of 15 people per year to participate in NDPP or DSMES. • Implement strategies to increase enrollment in CDC-	●	●	●	●

Health Needs: Diabetes, Heart Disease & Stroke, and Nutrition, Physical Activity & Weight					
	recognized lifestyle change programs.				
Prevention Forward Capacity Building	• Work with Saint Mary's two pharmacies to secure ADA recognition • Support Clinicare pharmacy to secure ADA recognition	●	●	●	●
Prevention Forward Community Outreach	• Attend events hosted by other community organizations to provide free resources such as recipe books, program flyers, and demonstrate interactive My Plate food models to attendees. • Form partnerships with additional community based organizations.	●		●	●
Planned Resources	• Trainings provided by Right Care Initiative Virtual University of Best Practices and CDPH • EHR system for referrals • Transitional Care team to provide referrals, pharmacist assistance, and diabetes nurse practitioner • Partnerships with Comprehensive Community Health Centers, Clinicare, and faith based organizations • Program management support and community health worker				
Planned Collaborators	Dignity Health Northridge Hospital Medical Center Chronic Disease Transitional Care Team, CDPH, Comprehensive Community Health Centers, Clinicare, St Catherine of Siena Catholic Church, La Iglesia en El Camino, Hazeltine Avenue, Elementary School, Cleveland Charter High School, Pacoima Charter Elementary School.				

Health Need: Oral Health					
Anticipated Impact (Goal)	Oral Health is a newly identified need in the community our goal will be to work with two of our local federally qualified health centers (FQHCs) to support their ongoing dental programs. Additionally, we will add an Oral Health corner into the quarterly School Wellness Newsletter that is disturbed to 110 individuals in 34 schools. One oral health promotion/prevention education workshop will be established each school semester.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
LAUSD Oral Health Promotion Program	• Create quarterly oral health prevention/promotion articles for School Wellness Newsletter • Host one workshop per academic school term (2 per year) • Support oral health resource fairs at local FQHC sites offering dental services to youth and adults	●	●	●	●
Planned Resources	Provision of education and training materials, oral health promotion items, and CHC staff members to conduct workshops				
Planned Collaborators	We partner with LAUSD parent centers, Comprehensive Community Health Centers, and the San Fernando Community Health Center.				

Health Need: Access to Healthcare Services					
Anticipated Impact (Goal)	The hospital's initiatives to address access to healthcare are anticipated to result in early identification and treatment of youth's health issues, increase enrollment in public and/or private health plans if eligible, increased knowledge about how to access and navigate the health care system, and increase primary care medical homes through partnership with local FQHC's. Additionally, the hospital continues to provide charity care based on financial needs.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Healthy Families Initiative	Grant provided to Catholic Charities Guadalupe Center to provide access to care through enrollment into eligible programs.	●	●	●	●
ACEs Aware Network of Care Patient Navigation	As a Network of Care partner, we will screen for ACEs and respond to and help prevent toxic stress. In addition, we will work collaboratively to develop sustainable, community-informed, evidence-based services among Medi-Cal patients.	●	●	●	●
LEAP	Contribute to improving the social and health outcomes for older adults aged 60+ who are at-risk or have experienced elder abuse, exploitation, or self-neglect. • LEAP E-MDT brings together local experts from diverse disciplines to jointly respond to the needs of these older adults, develop best practices, and train our community to identify and intervene before an older adult is ever abused. • The team members review elder abuse cases, provide recommendations, referrals, and resources based on client needs and training to community members and healthcare professionals on the prevention of elder abuse.	●	●	●	●

Health Need: Access to Healthcare Services					
	• 2-3 Case Review's per month at monthly meeting • Review outstanding cases				
Planned Resources	Provision of education and training materials, oral health promotion items, and CHC staff members to conduct workshops and program management.				
Planned Collaborators	We partner with LAUSD parent centers, Comprehensive Community Health Centers, and the San Fernando Community Health Center. The LEAP- EMDT is a collaboration between Dignity Health - Northridge Hospital's Center for Healthier Communities and Center for Assault Treatment Services, and the Valley Care Community Consortium, Alzheimer's Association California Southland Chapter, ONEgeneration, Southern California Neuropsychology Group, Bet Tzedek Legal Services, WISE & Healthy Aging Long Term Care Ombudsman Program, Los Angeles County Adult Protective Services, the Office of the Public Guardian, a forensic accountant, a social isolation specialist and a Senior Real Estate Specialist.				

Health Need: Respiratory Disease (COVID 19)					
Anticipated Impact (Goal)	The goal of this program is to slow the spread of COVID-19 in the Northeast San Fernando Valley through outreach, education, and engagement efforts by encouraging preventive behaviors, providing up-to-date information, and dispelling myths and misinformation. Additionally, the HRSA Vaccinate LA Collaborative goal is to establish pop-up clinics at faith-based and community-based sites in areas of high vaccine hesitancy and low vaccine compliance neighborhoods to help reduce the health inequities caused by the pandemic.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
COVID 19 2.0 Community Outreach and Partnerships	• Active Engagements: 100 min activities per FTE • Passive Engagements: 8 min activities per month • Attend community events like vaccine clinics, resource events, and food pantries hosted by community based organizations and schools. • Participate in community coalitions • Conduct street outreach in at-risk areas • Drop offs to local community businesses • Bus Campaign and dissemination of PPE kits	●	●	●	●
COVID 19 2.0 Workshops	• Provide workshops on various topics including: healthy for the holidays, COVID-19 and youth, immigrant communities and covid-19.	●	●	●	●
COVID 19 2.0 Social Media	• Social Media engagements: 8 min activities per month • Repost LA County DPH and CDPH content pertaining to COVID-19 • Create content dispelling myths and misinformation	●	●	●	●

Health Need: Respiratory Disease (COVID 19)					
COVID 19 2.0 Mass Media Campaign	• Mass communication through radio PSA • Poster boards and banners to display COVID-19 messaging • Electronic Billboard campaign for three major holidays (Thanksgiving, Christmas, and Valentine's Day)	●	●	●	●
HRSA Vaccinate LA Collaborative	• Establish Pop Up Vaccine Clinics in areas of high vaccine hesitancy and low vaccine compliance rates	●	●	●	●
Planned Resources	• Support from marketing department • Partnerships with community based organizations • Outreach communications and accommodations				
Planned Collaborators	Assemblymember Adrin Nazarian, Boys & Girls Club, Broadus T Elementary School, Chicas Mom, Child Development Institute, Cleveland Charter High School, Community Equity Fund, Community Safety Partnership Bureau, Comprehensive Community Health Center, CSUN, Discovery Cube - Los Angeles, First United Methodist Church of Reseda, HACLA, Hazeltine Elementary School, LAPD Mission Hills, Los Angeles Valley College, Magnolia Science Academy Schools 2 & 7, MEND, M.I.T Alliance 6-12 Complex, N.E.W Academy Canoga Park, North Valley Caring Service, Northeast Valley Health Corporation, Pacoima Beautiful, Pacoima Charter School, Pueblo y Salud, Reseda Church of Christ, San Fernando Gardens, San Fernando Parks, Supervisor Sheila Kuehl, Valley Community Care Consortium, Zeus Vision				

	Health Need: Mental Health & Violence Prevention				
Anticipated Impact (Goal)	The BJA STOP school violence program focuses on preventing school violence. Through this program, NMHC is partnering with Los Angeles Unified School District and San Fernando Valley Community Mental Health Center Inc. to train educators in evidence-based violence prevention programs and expand their capacity to prevent all forms of violence on school campuses.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Safe Dates	• Train 9 middle and/or high schools in implementing the Safe Dates curriculum with youth throughout the campus. • Facilitate 9 sessions of Safe Dates with 60 student participants. • Reach a total of 120 students through Safe Dates	•		•	•
Positive Action	• Train 36 LAUSD personnel in Positive Action implementation. • Train 47 LAUSD Mental Health Professionals in Positive Action. • Reach 4603 students through Positive Action. • Host 12 awareness-raising events at school sites for bullying prevention and reach 527 students. • Host 1 conference and reach 75 LAUSD personnel to share best practices regarding evidence-based program implementation.	•		•	•

	**Health Need: Mental Health & Violence Prevention**				
Workshops	• Reach 110 parents and school staff/personnel in bullying, violence and suicide intervention (Question, Persuade, Refer) prevention workshops.	•		•	•
Counseling Services	• Connect 30 youth at risk for violence perpetration to mental health services through San Fernando Valley Community Mental Health Center Inc.	•	•	•	•
Planned Resources	This project is Federally funded by the Bureau of Justice Administration. 100% of the staff compensation and benefits are allocated by the funder. Additionally, all program materials and supplies are compensated by the funder. In addition to training school staff and personnel, the hospital will provide technical support to those implementing Safe Dates and/or Positive Action. Additionally, the hospital will partner with school parent centers to provide workshops to raise awareness on bullying prevention, teen dating violence prevention and suicide intervention/prevention (Question, Persuade, Refer trainings).				
Planned Collaborators	The hospital will partner with Los Angeles Unified School District Northwest & Northeast Division, San Fernando Valley Community Mental Health Center Inc., PUC Charter Schools, and the Los Angeles County Department of Children and Family Services.				