Dignity Health.
Northridge Hospital
Medical Center

# Northridge Hospital Medical Center

## Community Benefit 2018 Report and 2019 Plan

Dignity Health
Northridge Hospital
Medical Center

# A message from

Julie Sprengel, interim President and CEO of Dignity Health – Northridge Hospital and Carol Stern, Chair of the Dignity Health - Northridge Hospital Community Board.

Dignity Health's approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments that we conduct with community input, including from the local public health department. Our multi-pronged initiatives to improve community health include financial assistance for those unable to afford medically necessary care, a range of prevention and health improvement programs conducted by the hospital and with community partners, and investing in efforts that address social determinants of health.

Northridge Hospital shares a commitment with others to improve the health of our community, and delivers programs and services to help achieve that goal. The Community Benefit 2018 Report and 2019 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 2018 (FY18), Northridge Hospital provided $36,754,476 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, and other community benefits. The hospital also incurred $21,541,397 in unreimbursed costs of caring for patients covered by Medicare.

Northridge Hospital's Community Board reviewed, approved and adopted the Community Benefit 2018 Report and 2019 Plan at its November 13, 2018 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.

Julie Sprengel

Interim President/CEO

Carol Stern

Chairperson, Board of Directors

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# At-a-Glance Summary

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|---|---|
| **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 1.6 million residents of multiple cultures and ethnic backgrounds. |
| **Economic Value of Community Benefit** | $36,754,476 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits<br><br>$21,541,397 in unreimbursed costs of caring for patients covered by Medicare |
| **Significant Community Health Needs Being Addressed** | The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Those needs are:<br><br>• 1 Diabetes<br>• 2 Obesity/Overweight<br>• 3 Mental Health<br>• 4 Heart Disease and Stroke<br>• 5 Housing/Homeless<br>• 6 Cancer (all types)<br>• 7 Hypertension/High Blood Pressure<br>• 8 Dental Health<br>• 9 Violence (domestic, sexual, child)<br>• 10 Substance Abuse (drug and alcohol) |
| **FY18 Actions to Address Needs** | Diabetes Wellness RX Program – Evidence-based Diabetes Self-Management Program provided at no cost to community residents in English and Spanish.<br><br>Center for Assault Treatment Services – Forensic interviews and medical exams for child and adult victims of sexual abuse/assault, domestic violence, child maltreatment, human trafficking, and dating abuse. Outreach prevention education and mandated reporter training.<br><br>Family Practice Residency Program – In conjunction with the faculty group provided education and training to residents who then provide both inpatient and outpatient care to many of the underserved in the community.<br><br>Community and School Wellness Initiative – Partnership with Los Angeles Unified School District to implement physical activity, nutrition education, parent education in community on site at each school.<br><br>Activate your Heart – Evidence-based program in partnership with Mid Valley YMCA to provide 8 week cardiovascular prevention education, physical activity, and stress management to reduce the incidence of cardiovascular disease in low income communities.<br><br>Safe Dates – Evidence-based program provided to West Valley Boys and Girls Club sites (2 middle schools and 4 high schools) is an evidence-based adolescent dating abuse prevention curriculum designed to raise students' awareness of what constitutes healthy and abusive dating relationships. |

| | |
|---|---|
| **Planned Actions for FY19** | Diabetes Wellness– Continuation of Diabetes Self-Management programs at no cost to low-income underserved population with pre-diabetes and type 2 diabetes diagnosis. Additionally, begin the process toward National Diabetes Prevention Program trainings and accreditation. Four 8-week sessions will be provided each over a three-year time frame.<br><br>Center for Assault Treatment Services – Forensic interviews and medical exams for child and adult victims of sexual abuse/assault, domestic violence, child maltreatment, human trafficking, and dating abuse. Outreach prevention education and mandated reporter training. A new lease has been approved by City of Los Angeles for space at the Family Justice Center for 10 years.<br><br>Family Medicine Residency Program – In conjunction with the UCLA faculty group provide education and training to residents who then provide both inpatient and outpatient care to many of the underserved in the community. Each year over the next three years a new cohort of residence will begin their training.<br><br>Community and School Wellness Initiative – Partnership with Los Angeles Unified School District to implement physical activity, nutrition education, parent education in community on site at each school.<br><br>Activate your Heart has been renamed and in 2019 will be the Healthier Living Chronic Disease Self-Management – Evidence-based program to provide 8 week hypertension self-management, cardiovascular prevention education, physical activity, and stress management to reduce the incidence of chronic disease in low income communities. Sessions will be provided at multiple community based sites and on site.<br><br>Safe Dates and Escape Now– Evidence-based programs provided to West Valley Boys and Girls Club sites (2 middle schools and 4 high schools) is an adolescent dating abuse prevention curriculum designed to raise students' awareness of what constitutes healthy and abusive dating relationships. Escape Now violence prevention program for adults with developmental disabilities at New Horizons.<br><br>Alzheimer's Disease and Related Dementia (ADRD) Program – A collaborative effort to improve the quality of respite and home-based services and case management to Alzheimer's Disease and Related Dementia individuals including community-based education, outreach, and support to caregivers and workers caring for ADRD individuals. |

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 upon request 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

Northridge Hospital Medical Center is a part of Dignity Health, a non-profit health care system made up of more than 60,000 caregivers and staff who deliver excellent care to diverse communities in 21 states. Headquartered in San Francisco, Dignity Health is the fifth largest health system in the nation.

At Dignity Health, we unleash the healing power of humanity through the work we do every day, in hospitals, in other care sites and the community.

## 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.

# OUR HOSPITAL AND THE COMMUNITY SERVED

## About Northridge Hospital Medical Center (NHMC)

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 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. NHMC has over 1,850 employees, 800 affiliated physicians, and over 400 volunteers. 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, Pediatric Trauma Center, Stroke Center, and Neonatal ICU.

## Description of the Community Served

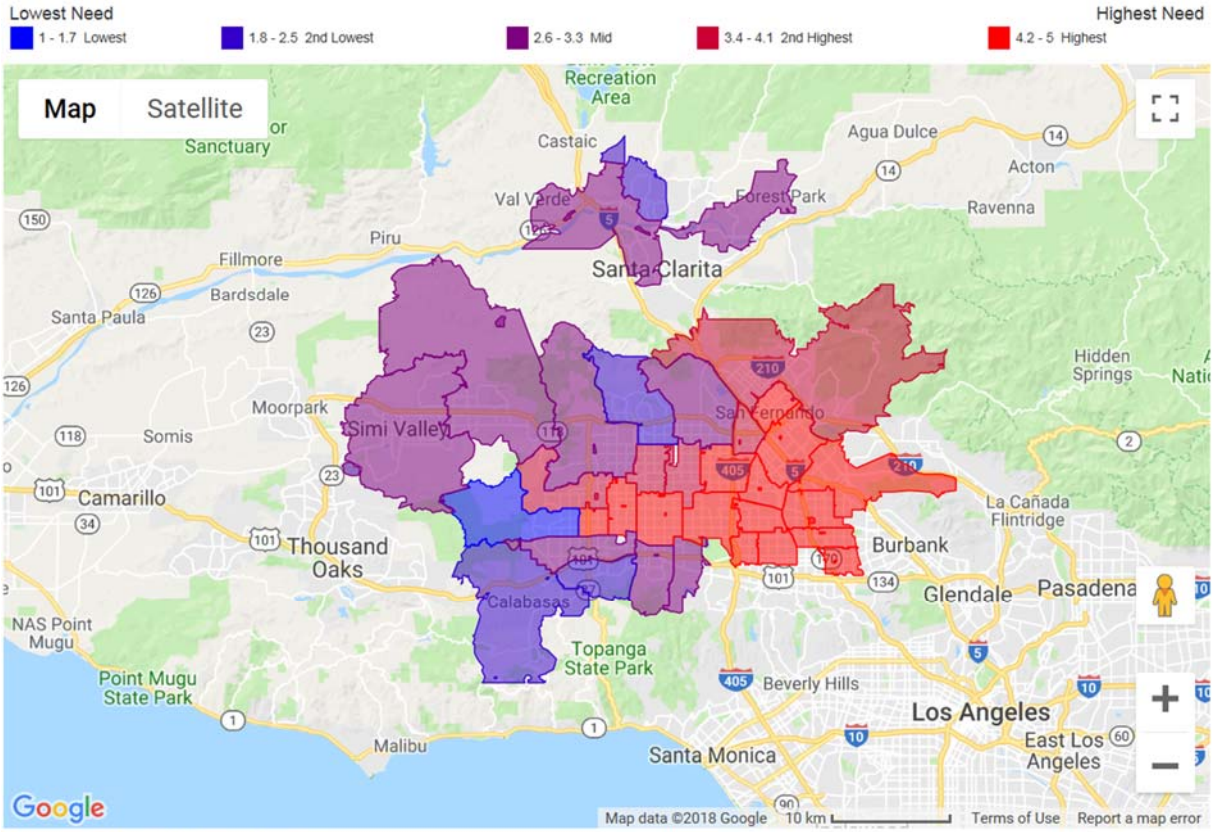
Northridge Hospital Medical Center's (NHMC) service region spans cities, communities, and unincorporated areas in the San Fernando Valley and Santa Clarita Valley in Los Angeles County and Simi Valley in Ventura County. The geographic area is comprised of 24 cities with 34 ZIP codes which represent 83% of the total patients served at Northridge Hospital Medical Center in fiscal year 2018.

| | |
|---|---|
| **Total Population** | 1,581,789 |
| **Race** | |
| White - Non-Hispanic | 33.5% |
| Black/African American - Non-Hispanic | 3.6% |
| Hispanic or Latino | 48.6% |
| Asian/Pacific Islander | 11.4% |
| All Others | 2.9% |
| **Total Hispanic & Race** | 100.0% |
| **Median Income** | $73,611 |
| **Unemployment** | 4.9% |
| **No High School Diploma** | 20.5% |
| **Medicaid *** | 27.6% |
| **Uninsured** | 6.9% |

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

Source: © 2018 The Claritas Company, © Copyright IBM Corporation 2018

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. The Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores.




Mean(zipcode): 3.6 / Mean(person): 3.8 CNI Score Median: 3.9 CNI Score Mode: 4.4

| Zip Code | CNI Score | Population | City | County | State |
|---|---|---|---|---|---|
| 91302 | 2.2 | 27825 | Calabasas | Los Angeles | California |
| 91303 | 4.4 | 28834 | Canoga Park | Los Angeles | California |
| 91304 | 4 | 52067 | Canoga Park | Los Angeles | California |
| 91306 | 4.2 | 46662 | Winnetka | Los Angeles | California |
| 91307 | 1.6 | 25078 | West Hills | Los Angeles | California |
| 91311 | 3 | 38345 | Chatsworth | Los Angeles | California |
| 91316 | 3.2 | 27930 | Encino | Los Angeles | California |
| 91324 | 3.8 | 28905 | Northridge | Los Angeles | California |
| 91325 | 3.6 | 36458 | Northridge | Los Angeles | California |
| 91326 | 2.4 | 37119 | Porter Ranch | Los Angeles | California |
| 91331 | 4.4 | 108616 | Pacoima | Los Angeles | California |
| 91335 | 4.4 | 77548 | Reseda | Los Angeles | California |
| 91340 | 4.2 | 36126 | San Fernando | Los Angeles | California |
| 91342 | 4 | 97400 | Sylmar | Los Angeles | California |
| 91343 | 4.4 | 63655 | North Hills | Los Angeles | California |
| 91344 | 2.8 | 53062 | Granada Hills | Los Angeles | California |
| 91345 | 3.8 | 18876 | Mission Hills | Los Angeles | California |
| 91351 | 3.2 | 34209 | Canyon Country | Los Angeles | California |
| 91352 | 4.4 | 49267 | Sun Valley | Los Angeles | California |
| 91354 | 2.4 | 32017 | Valencia | Los Angeles | California |
| 91355 | 2.8 | 38453 | Valencia | Los Angeles | California |
| 91356 | 3.2 | 30284 | Tarzana | Los Angeles | California |
| 91364 | 2.4 | 26163 | Woodland Hills | Los Angeles | California |
| 91367 | 2.6 | 43003 | Woodland Hills | Los Angeles | California |
| 91401 | 4.4 | 39964 | Van Nuys | Los Angeles | California |
| 91402 | 4.6 | 73682 | Panorama City | Los Angeles | California |
| 91405 | 4.6 | 53031 | Van Nuys | Los Angeles | California |
| 91406 | 4.4 | 56247 | Van Nuys | Los Angeles | California |
| 91411 | 4.4 | 24545 | Van Nuys | Los Angeles | California |
| 91601 | 4.4 | 40756 | North Hollywood | Los Angeles | California |
| 91605 | 4.6 | 57903 | North Hollywood | Los Angeles | California |
| 91606 | 4.6 | 46291 | North Hollywood | Los Angeles | California |
| 93063 | 2.6 | 56653 | Simi Valley | Ventura | California |
| 93065 | 2.8 | 74815 | Simi Valley | Ventura | California |

# COMMUNITY ASSESSMENT AND 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 impact; and engaging the Community Board Members and other stakeholders in the development of an annual community benefit plan and triennial Implementation Strategy.

## Community Health Needs Assessment

The significant needs that form the basis of the hospital's community health programs were identified in the most recent Community Health Needs Assessment (CHNA), which was adopted in May of 2016.

The hospital conducts a CHNA at least every three years to inform its community heath strategy and program planning. The CHNA report contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods, including: the data used; how the hospital solicited and took into account input from a public health department, members or representatives of medically underserved, low-income and minority populations; and the process and criteria used in identifying significant health needs and prioritizing them;
- Presentation of data, information and assessment findings, including a prioritized list of identified significant community health needs;
- Community resources (e.g., organizations, facilities and programs) potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

## CHNA Significant Health Needs

The community health needs assessment identified the following significant community health needs:

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. This need is being addressed through our Diabetes Wellness and Health Homes program
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. Nutrition and physical activity programs are being offered at Los Angeles Unified School District Title 1 schools.

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. Staff have been trained and certified in the Mental Health First Aid for Youth curriculum to support local area youth.

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. The Activate Your Health program utilizing the American Health Association Empowered to Serve Curriculum will be continued to address this need.

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). The 2017 count showed another 4% increase totaling 7,627 homeless with only 1,775 of those sheltered. A community benefit grant was provided to Los Angeles Family Housing to help address this issue.

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. The Cancer Center host bi monthly health fairs offering free mammograms to community residents.

7. Hypertension/High Blood Pressure – Death rates due to stroke continues to be in the top five leading causes of death. A newly implanted program to address this issue will be continued in 2019 and consist 8 week classes, daily self-monitoring and home visit to reduce hypertension among the Medicaid and uninsured population.

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. Grant support was provided to LA Trust for Children to address this need since it is outside the services of the hospital.

9. Child/Domestic Abuse (Including Sexual Assault) in fiscal year 2017 the Center for Assault Treatment Services treated 1,106 victims of sexual and domestic violence over 53% of those victims were children. Additional evidence-based prevention programs and intervention programs including Safe Dates (Adolescent Dating Abuse Prevention Program), Escape Now (Victim Prevention), Beyond Trauma (Domestic Violence Peer Support Curriculum), and Bringing in the Bystander Curriculum will be offered in 2019.

10. Substance Abuse (Drugs & Alcohol) In SPA 2, drug overdose is the third cause of premature death in people before the age of 75. Currently other than providing inpatient medical treatment for those needing detoxification and overdose care we rely on our community partners to help address this growing need in our community.

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at https://www.dignityhealth.org/northridgehospital/who-we-are/serving-the-community/community-needs-assessment or upon request at the hospital's Community Health office.

## Creating the Community Benefit Plan

Rooted in Dignity Health's mission, vision and values, Northridge Hospital Medical Center is dedicated to improving community health and delivering community benefit with the engagement of its management team, Community Board and Community Benefit Grants Committee. The board is composed of community members who provide stewardship and direction for the hospital as a community resource (see Appendix A). The committee is composed of a mix of community members and staff members from our Care Coordination, Mission, and Center for Healthier Communities departments. These parties review community benefit plans and program updates prepared by the hospital's community health director and other staff. Additionally, the committee members assist with the review and selection process of non-profit agency grant submissions.

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
- Emphasize Prevention
- Contribute to a Seamless Continuum of Care
- Build Community Capacity
- Demonstrate Collaboration

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. The Community Benefit Grants Committee was established to review the needs and participate in the reading and scoring of local non-profit grant requests, to assure that those selected for funding were working in collaboration and partnering with the hospital to meet the highest need areas. Many of the projects in place to address needs were in their second 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.

Programs to address chronic disease self-management, cardiovascular health, and dating abuse prevention will be carried into 2019 because of the evidence of success and impact it is having in our community. Staff training has occurred to increase the number of evidence-based programs to expand our ability to continue to address immediate needs and increase our capacity to provide prevention and early intervention to reduce health disparities and focus on upstream measures to address the social determinants of health.

# 2018 REPORT AND 2019 PLAN

This section presents strategies and program activities the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It summarizes actions taken in FY18 and planned activities for FY19, with statements on anticipated impacts, planned collaboration, and patient financial assistance for medically necessary care. Program Digests provide detail on select programs' goals, measurable objectives, expenses and other information.

This report specifies planned activities consistent with the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in community assets and resources directed to those needs may merit refocusing the hospital's limited resources to best serve the community.

## Report and Plan Summary

| **Health Need**: **Diabetes** | | | |
|---|---|---|---|
| **Strategy or Activity** | **Summary Description** | **Active FY18** | **Planned FY19** |
| Diabetes Wellness | 1. Implement one of two evidence based programs Stanford Model Diabetes Self-Management (target audience low-income Latino population)<br>2. Components include support group discussions, physical activity, grocery store tours, food demonstrations, bi-lingual speakers specializing in diabetes care, and clinical measurements for evaluation | ☒ | ☒ |
| Healthy Homes Chronic Disease Self-Management | 1. In partnership with California Department of Public Health work to encourage daily glucose monitoring in Medi-Cal and uninsured population<br>2. Start process toward National Diabetes Prevention Program training required by the CDC<br>3. Built partnership with Vision y Compromiso to provide community based programs | ☒ | ☒ |
| **Anticipated Impact**: Anticipated results include increased knowledge in diabetes self-management with reductions in glucose levels, cholesterol, and A1C levels; reduced rates of morbidities due to uncontrolled diabetes and increased rates of annual foot and eye screenings. Increased use of community health promotoras. | | | |

| **Health Need**: **Obesity/Overweight (Children and Adults)** | | | |
|---|---|---|---|
| **Strategy or Activity** | **Summary Description** | **Active FY18** | **Planned FY19** |
| School Wellness Initiative | 1. Elementary school class room nutrition classes<br>2. Healthy messaging bulletin boards<br>3. Monthly Healthy Facts Newsletter | ☒ | ☒ |
| One Generation | 1. Long term case management services | ☒ | ☐ |

| | | | |
|---|---|---|---|
| | 2. Quarterly health screenings, nutrition and disease management education and socialization events,<br>3. Access and transportation coordination<br>4. ONEgeneration Senior Enrichment Center | | |
| **Anticipated Impact**: Increased consumption/purchase of healthy food; creation of policy model for building interdisciplinary collaborations to create healthier environments; increased awareness in health prevention achieving benefits of whole person health (mind, body, spirit, and social) | | | |

| **Health Need**: **Mental Health** | | | |
|---|---|---|---|
| **Strategy or Activity** | **Summary Description** | **Active FY18** | **Planned FY19** |
| Mental Health First Aid USA | 1. Staff trained and certified to provide initial health to young people experiencing problems such as depression, anxiety disorders, psychosis, and substance abuse disorders<br>2. Referrals and linkages to behavioral health and community service as need for identified youth participating in our youth-based programs | ☒ | ☒ |
| **Anticipated Impact**: Increased knowledge of community resources and linkages to mental health services, substance abuse services and housing for individuals with behavioral health needs. The ability to help identify and get into services those youth at risk for suicide, violence prevention, and depression. | | | |

| **Health Need**: **Heart Disease** | | | |
|---|---|---|---|
| **Strategy or Activity** | **Summary Description** | **Active FY18** | **Planned FY19** |
| Activate your Heart | 1. Conduct 10 eight-week 2 hour- sessions of evidence based heart disease prevention classes including 20 minutes of stress management and 40 minutes exercise program with grocery market tours, food demos, and nutrition education<br>2. Provide base line and follow up screenings of, BMI, glucose, cholesterol, and blood pressure | ☒ | ☒ |
| **Anticipated Impact**: Increased knowledge of what leads to cardio vascular disease and how to prevent and manage existing heart disease. Reduce the risk of new on-set cardio vascular disease. Increased screening rates. Additionally, increases awareness of risk factors for stroke and diabetic disease. | | | |

| **Health Need**: **Affordable Housing/Homelessness** | | | |
|---|---|---|---|
| **Strategy or Activity** | **Summary Description** | **Active FY18** | **Planned FY19** |
| Homeless Coalition | 1. Continue to attend monthly meetings to address homelessness and affordable housing issues | ☒ | ☒ |
| **Anticipated Impact**: Provide wrap around services to homeless population on the path to improved health, permanent housing, and long-term stability. Reduce the cost of health care services to those that are uninsured/underinsured. | | | |

| **Health Need**: **Cancer** | | | |
|---|---|---|---|
| **Strategy or Activity** | **Summary Description** | **Active FY18** | **Planned FY19** |
| Patient Navigator Program and Support Group | 1. Free mammogram screenings<br>2. Free four-week smoking cessation workshops<br>3. Social and emotional support one-to-one and in support group settings for community members<br>4. Outreach and education at community and hospital based health fairs | ☒ | ☒ |
| **Anticipated Impact**: To lower the occurrence rate of multiple types of cancers and promote awareness and early detection. To provide help, support, and encouragement to breast cancer patients and care givers. | | | |

| **Health Need**: **Hypertension/High Blood Pressure** | | | |
|---|---|---|---|
| **Strategy or Activity** | **Summary Description** | **Active FY18** | **Planned FY19** |
| Family Medicine Center & Residency | 1. Provides inpatient and outpatient clinical care to the underserved in the community<br>2. Care provided ranges from prenatal to pediatric to adult to geriatric medicine and chronic disease | ☒ | ☒ |
| Hypertension Self-Management Project | 1. Provide hypertension prevention education<br>2. Provide monitors and daily tracking logs to encourage daily self-monitoring of blood pressure<br>3. Home visits and completion of individual care plans | ☒ | ☒ |
| **Anticipated Impact**: To provide a safety net for patients in the community that are uninsured or underinsured. Being an integral part of the local neighborhood and continue to provide ongoing outreach prevention and education. Increased capacity of community members to monitor their blood pressure. | | | |
| Health Homes Program | 1. Evidence-based health education classes.<br>2. Patient education on daily self-monitoring of blood pressure and blood sugar.<br>3. Home visits for complex patients.<br>4. Grocery Market Tours which provide real-world nutrition education. | ☒ | ☒ |
| **Anticipated Impact**: The Health Homes Program provides local assistance to targeted priority populations in Los Angeles County using evidence-based strategies to build support for lifestyle change and to increase engagement of Community Health Workers to promote linkages between health systems and community resources for adults with high blood pressure and adults with prediabetes and/or who are at risk for type 2 diabetes. | | | |

| **Health Need**: **Dental/Oral Health** | | | |
|---|---|---|---|
| **Strategy or Activity** | **Summary Description** | **Active FY18** | **Planned FY19** |
| LA Trust for Children Oral Health Initiative | 1. Develop dental hubs at 10 elementary schools<br>2. Provide oral health education and screenings linking to dental homes<br>3. Improve compliance with the kindergarten oral health mandate | ☒ | ☐ |

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|---|
| **Anticipated Impact**: Improve kindergarten oral health assessment compliance rate from baseline of 30% to 90% in 10 schools with dental health hubs. Connect minimum of 50% of students screened in need or oral health treatment into a dental home. |

| **Health Need**: **Child/Adult Domestic/Sexual Abuse & Assault** | | | |
|---|---|---|---|
| **Strategy or Activity** | **Summary Description** | **Active FY18** | **Planned FY19** |
| Center for Assault Treatment Services (CATS) | 1. Provide compassionate, comprehensive medical examinations and forensic interviews<br>2. Community outreach and education about prevention of abuse, identifying abuse, consequences of abuse and how to report<br>3. Provide expert witness testimony in court | ☒ | ☒ |
| Coalition to Abolish Slavery and Trafficking (CAST) | 1. Conduct trainings annually for providers<br>2. Technical consultations and linkages for victims<br>3. Development of Train-the-Trainer materials | ☒ | ☒ |
| Journey Out | 1. Case management and crisis response<br>2. Peer mentorship<br>3. Wrap around services (including housing, mental health, substance abuse) | ☒ | ☐ |
| Safe Dates | 1. Conduct six ten week sessions to middle school aged children and parents to reduce dating violence<br>2. Change attitudes and behavior regarding healthy relationships and provide education on how to help other victims<br>1. Multi-disciplinary team of forensic nurse examiner, social worker, and health educators will conduct program to reduce the rate of middle school aged children that are victims of dating violence (physical, emotional, sexual, and verbal). | ☒ | ☒ |
| Escape Now | 1. Conduct sixteen cohorts of six-week training which will be conducted twice a week at New Horizons in North Hills, CA.<br>1. Provide individuals with developmental disabilities with a wide range of abuse situations. The curriculum consists of 12 instructional lessons with three broad units being (1) Knowledge of Abuse and Self-Empowerment, (2) Decision Making Strategy Training, and (3) Support Group Sessions. | ☒ | ☒ |
| **Anticipated Impact**: Increased capacity to serve victims of sexual and domestic abuse and assault, child maltreatment, and human trafficking victims. Deliver coordinated community response and enhance awareness and expertise of service providers and community groups working with victims of trafficking. 7% of trafficking victims placed in safe housing, 30% of trafficking victims will transition out of "the life"; Both Safe Dates and Escape Now have proven abilities to help participants teenagers recognize the difference between caring, supportive relationships, and controlling, manipulative, or abusive dating relationships. Each program reduces violence and victimization. | | | |

| Health Need: Substance Abuse (Drugs & Alcohol) | | | |
|---|---|---|---|
| **Strategy or Activity** | **Summary Description** | **Active FY18** | **Planned FY19** |
| Center for Living and Learning Healthy Connections | 1. Case management and navigation services<br>2. Training on harm reduction and overdose prevention strategies<br>3. Care coordination for those transitioning from homelessness, drug treatment, and incarceration | ☒ | ☐ |
| **Anticipated Impact**: Improved coordination of care and increased knowledge about how to access and navigate the health care system; Reduce inappropriate emergency room use by directing to the proper substance abuse, mental health care provider, and primary medical home. | | | |

## Community Grants Program

One important way the hospital helps to address community health needs is by awarding financial grants to non-profit organizations working together to improve health status and quality of life in the communities we serve. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations.

In FY18, the hospital awarded five grants totaling $183,512. Below is a complete listing of FY18 grant projects; some projects may be described elsewhere in this report.

| Grant Recipient | Project Name | Amount |
|---|---|---|
| LA Family Housing | Healthy Homes | $50,000 |
| Journey Out | Rapid Response, Assessment & Crisis Management Victims of Sex Trafficking | $62,012 |
| Triumph Foundation | Triumph's Return to Community Program | $21,500 |
| LA Trust for Children's Health | Oral Health Initiative (Kindergarten Mandate) | $25,000 |
| ONEgeneration | Community Based Health Promotion Program | $25,000 |

## Anticipated Impact

The anticipated impacts of the hospital's activities on significant health needs are summarized above, and for select program initiatives 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 needed and beneficial care; and help create conditions that support good health. The hospital is committed to measuring and evaluating key initiatives. The hospital creates and makes public an annual Community Benefit Report and Plan, and evaluates impact and sets priorities for its community health program in triennial Community Health Needs Assessments.

## 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 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:

| | |
|---|---|
| Alzheimer's Association | American Diabetes and Heart Associations |
| California Department of Public Health | California State University, Northridge |
| Coalition to Abolish Slavery and Trafficking | Department of Child and Family Services |
| Department of Parks and Recreation | Journey Out |
| Los Angeles County Department of Mental Health | LA Family Housing |
| Los Angeles City and District Attorney | Los Angeles Police Department |
| Los Angeles Unified School District | Los Angeles County Department of Public Health |
| Meet Each Need with Dignity | Mid Valley YMCA |
| Neighborhood Legal Services | One Generation |
| Pacoima Beautiful | Network for a Healthy California |
| Tarzana Treatment Center | Triumph |
| Strength United | Valley Care Community Consortium |

Community-wide collaboration is prevalent with various staff members participating in community wide collaborations including: LAUSD Nutrition Task Force, Los Angeles Regional Human Trafficking Task Force, San Fernando and Santa Clarita Homeless Coalition, and participating as board members.

## Financial Assistance for Medically Necessary Care

Northridge Hospital Medical Center delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services. A plain language summary of the hospital's Financial Assistance Policy is in Appendix C. The amount of financial assistance provided in FY18 is listed in the Economic Value of Community Benefit section of this report.

The hospital notifies and informs patients and members of the community about the Financial Assistance Policy in ways reasonably calculated to reach people who are most likely to require patient financial assistance. These include:

- providing a paper copy of the plain language summary of the Policy to patients as part of the intake or discharge process;
- providing patients a conspicuous written notice about the Policy at the time of billing;
- posting notices and providing brochures about the financial assistance program in hospital locations visible to the public, including the emergency department and urgent care areas, admissions office and patient financial services office;
- making the Financial Assistance Policy, Financial Assistance Application, and plain language summary of the Policy widely available on the hospital's web site;
- making paper copies of these documents available upon request and without charge, both by mail and in public locations of the hospital; and
- providing these written and online materials in appropriate languages.

Staff meets with each patient to share financial assistance information. Additionally, Cyracom translation phone and video relaying equipment is available to provide access to 24 different languages including American Sign Language for our multi-cultural catchment area and those that are deaf or hard of hearing. Community partner agencies including recuperative care and FQHC partners are made aware of the financial assistance programs when planning coordination of care.

### 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<br>☐ Mental Health ☐Heart Disease and Stroke<br>❑ Affordable Housing Homelessness ☐Cancer<br>☒Hypertension/High Blood Pressure ☐Dental Health<br>❑ Child/Domestic Abuse/ Sexual Assault ☐Substance Abuse |
| **Core Principals Addressed** | ×Focus on Disproportionate Unmet Health-Related Needs<br>☒ Emphasize Prevention<br>☒ Contribute to a Seamless Continuum of Care<br>❑ Build Community Capacity<br>☒ 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 4 community based sites to reduce diabetes. Program consist of free 6 week program that will include education, exercise, discounted YMCA membership, healthy food demonstrations, grocery store tours and follow up. |
| **Community Benefit Category** | Community Health Improvement Services |
| **FY 2018 Report** | |
| **Program Goal / Anticipated Impact** | Expand access to diabetes self-management health education to Latino adults with Type 2 diabetes |
| **Measurable Objective(s) with Indicator(s)** | 60% of Diabetic Type 2 will Decrease glucose levels by 10%<br>80% of participants will increase knowledge of diabetes management, nutrition, and fitness |
| **Intervention Actions for Achieving Goal** | 10 six-week Evidence based diabetes education sessions were conducted at FQHC Clinics and other community based sites |
| **Planned Collaboration** | This project was a collaborative effort with the funder Medtronic, YMCA and hospital Cardiology team conducting baseline and follow up measurements. Additional partnerships included local Federally Qualified Healthcare Centers (FQHC). |
| **Program Performance / Outcome** | To date, the Northridge Hospital Foundation's Diabetes Wellness Rx program has made a difference in the lives of 329 in FY 2018 specifically, its more than 100 participants with Type 2 diabetes including increasing their knowledge of |

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| | diabetes management, nutrition and fitness and improving indicators of wellness – BMI, fasting glucose and cholesterol. |
| **Hospital's Contribution / Program Expense** | Program expenses were $88,743 less off setting grant funding of $27,600 in FY 2018 with hospital contribution of $61,143 |
| **FY 2019 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. Become DPP certified. |
| **Measurable Objective(s) with Indicator(s)** | At the end of 3 months 80% 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, Federally Qualified Healthcare Centers (FQHC) Vision y Compromiso, and Valley Care Community Consortium |
| **Center for Assault Treatment Services (CATS)** | |
| **Significant Health Needs Addressed** | ☐ Diabetes ☐Obesity/Overweight<br>☐Mental Health ☐Heart Disease and Stroke<br>❑ Affordable Housing Homelessness ☐Cancer<br>❑ Hypertension/High Blood Pressure ☐Dental Health<br>☒Child/Domestic Abuse/ Sexual Assault ☐Substance Abuse |
| **Program Emphasis** | ☒ Focus on Disproportionate Unmet Health-Related Needs<br>☒ Emphasize Prevention<br>☒ Contribute to a Seamless Continuum of Care<br>☒ Build Community Capacity<br>☒ Demonstrate Collaboration |
| **Program Description** | CATS expert team of forensic examiners, under the direction of the Program 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. Northridge Hospital supports CATS by providing staffing and funding. |
| **Community Benefit Category** | Community Health Improvement |
| **FY 2018Report** | |
| **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, 2018 provided 1106 medical evidentiary examinations and forensic interviews for child and adult victims of sexual, human trafficking, and domestic violence. In addition provided follow up and post –abuse care and participated as expert witness at court.<br>• 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. |

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| **Intervention Actions for Achieving Goal** | • Conducted medical evidentiary exams for victims of sexual/domestic assault/abuse of all ages<br>• Conducted forensic interviews<br>• Work closely with child protective services, law enforcement and the District Attorney's office to assist in the investigation process<br>• Work closely with partner agencies at Family Justice Center<br>• Outreach to public and private organizations including schools, hospitals, clinics, and other community based organizations<br>• Develop training materials and conduct trainings |
| **Planned Collaboration** | Strength United, Coalition to Abolish Slavery and Trafficking (CAST), Jewish Family Service Family Violence Project, Journey Out, 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 1106 victims of sexual abuse and assault.<br>• CATS staff provided outreach to 1,528 mandated reporters and an additional 1,339 at the Victory for Victims Walk/Run and approximately 2,000 individuals and 7 community based health fairs<br>• In partnership with Strength United case management/counseling was provided to all victims at no cost<br>• Reputation for program excellence is leading law enforcement from inside and outside the area to increase usage of the CATS facility.<br>• 2018 Victory for Victims Walk Run helped to raise funds in the amount of $161,601 to offset the cost of the program. |
| **Hospital's Contribution / Program Expense** | In FY 2018, we served 1,106 victims and unreimbursed expenses totaled $900,629 which the hospital contributed. |
| **FY 2019 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)** | By June 30, 2019 include high quality clinical forensic services to more than 1100 victims of sexual and domestic violence.<br>By June 30, 2019 provide community outreach education on how to identify and report child/elder abuse to 1,500 mandated reporters and an additional 3,000 community individuals at the Victory for Victims Walk/Run and community based health fairs and events to help Break the Silence and Stop the Abuse.<br>By June 30, 2019 provide at least 6 eight week sessions of Safe Dates to middle school aged children<br>Continue to be a member of the Sexual Assault Response Team and Domestic Assault Response Team, and Human Trafficking Task Force.<br>By June 30, 2019 provide at least 10 12 week sessions of Escape Now to adults with developmental disabilities |
| **Intervention Actions for Achieving Goal** | • Support and purchase additional equipment to keep current technology<br>• Provide continuing education through webinars, classes, and conferences to keep staff current in the field to maintain status as expert witnesses in court<br>• Continue to work with all partners at the Family Justice Center |

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| | • Work closely with law enforcement and the District Attorney's Office<br>• Conduct roll call trainings at local law enforcement precincts/divisions<br>• Conduct medical evidentiary examinations and forensic interviews.<br>• Review and update training materials for community outreach<br>• 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<br>• Increase staff to keep up with volume to help prevent burn out<br>• 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, Journey Out and Strength United. |
| **Family Practice Residency Program** | |
| **Significant Health Needs Addressed** | ☒ Diabetes ☒Obesity/Overweight<br>☐Mental Health ☒Heart Disease and Stroke<br>❑ Affordable Housing Homelessness ☐Cancer<br>☒Hypertension/High Blood Pressure ☐Dental Health<br>☐Child/Domestic Abuse/ Sexual Assault ☐Substance Abuse |
| **Program Emphasis** | ☒ Focus on Disproportionate Unmet Health-Related Needs<br>☒ Emphasize Prevention<br>☒ Contribute to a Seamless Continuum of Care<br>☒ Build Community Capacity<br>❑ Demonstrate Collaboration |
| **Program Description** | The Northridge Hospital Family Medicine Residency Program, in conjunction with UCLA faculty group, provides physician training to residents who then provide both inpatient and outpatient care to many of the underserved in the community. 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. 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 2018 Report** | |
| **Program Goal / Anticipated Impact** | To provide training to future physicians who during the residency program are providing 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. |
| **Measurable Objective(s) with Indicator(s)** | Physicians will complete residency programs and become community-based physicians. |
| **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.<br>• Provided outpatient services.<br>• Ongoing community partnerships and outreach prevention education efforts, including health education for the youth, high school sports coverage, |

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| | 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** | • Ongoing community partnerships and outreach programs:<br>o Sutter Middle School Health Education Program<br>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.<br>o High school football games coverage for Monroe High School, as their Team Physician.<br>o Partnership with Partners in Care's Disease Prevention and Health Promotion Program at local senior centers.<br>Local Screening Health Fairs and community presentations. |
| **Hospital's Contribution / Program Expense** | Program expenses totaled $3,458,039 with offsetting revenue of $995,505 with the hospital contribution of $2,462,534. |
| **FY 2019 Plan** | |
| **Program Goal / Anticipated Impact** | Continue to provide site for physicians to receive high quality training and site for residency program. Residents will 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<br>• Measure number of patients seen through Medi-Cal and managed Medi-Cal<br>• Measure number of patients seen through all state-funded service programs for low-income patients such as CHDP, CCS, PACT<br>• Measure number of indigent patients seen in Family Practice Center including Specialty Clinics<br>• 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.<br>• Continue and expand hospital inpatient service at Northridge Hospital Medical Center.<br>• Contract with Medi-Cal HMO's as the State of California continues to move additional patients into managed Medi-Cal.<br><br>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 Initiative | |
|---|---|
| **Significant Health Needs Addressed** | ☐ Diabetes ☒Obesity/Overweight<br>☐Mental Health ☒Heart Disease and Stroke<br>❑ Affordable Housing Homelessness ☐Cancer<br>☒Hypertension/High Blood Pressure ☐Dental Health<br>☐Child/Domestic Abuse/ Sexual Assault ☐Substance Abuse |
| **Program Emphasis** | ☒ Focus on Disproportionate Unmet Health-Related Needs<br>☒ Emphasize Prevention<br>❑ Contribute to a Seamless Continuum of Care<br>❑ Build Community Capacity<br>❑ 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. In FY 18 the Community and School Wellness Imitative consists of three programs that are supported by the hospital and with offsetting grant revenues. Programs included are My Plate, Activate your Heart and School Wellness Healthier Living Programs. The Great Kindness Challenge is an anti-bullying program. |
| **Community Benefit Category** | Community Health Improvement and Community Building |
| **FY 2018 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 18 there were 772 adults impacted by the school-based prevention programs and 35 local elementary, middle and high schools engaging over 30,000 children received anti bullying, nutritional health education and or physical activity instruction. |
| **Measurable Objective(s) with Indicator(s)** | NHMC staff conducted informative sessions and a community based walking group at CDI Learning Center.<br>80% of youth are familiar with my plate and the choose water curriculum<br>Youth completed 319 kindness acts at 35 school sites |
| **Intervention Actions for Achieving Goal** | • Offer program and assistance to principals at each school.<br>• Identify partners to work with each school.<br>• Coordinate partner's involvement in addressing schools' needs.<br>• Conduct cooking demonstrations and grocery store tours<br>• Implement grant-funded programs at schools.<br>• Monitor progress.<br>• 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 |

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| | Internship and Department of Kinesiology, Enrichment Works, Health Net, Mid-Valley YMCA, Valley Care Community Consortium (VCCC) . |
| **Program Performance / Outcome** | **Activate your Heart** provided ten sessions at community based sites: The program has been pivotal in providing CV health education, stress management, physical fitness, grocery store tours, cooking demonstrations and clinical screenings to residents in low-income Latino communities and school sites that do not have the resources available to be able to educate their families about CVD.<br>Grocery market tours, which are scheduled after the "Reading Nutrition Labels" session, have been crucial in providing participants with a hands-on activity from the lessons learned in class.<br>***Measurement Results***<br>Both clinical and behavioral baseline and follow-up data for the participants in the eight-week sessions have been collected, and positive progress was demonstrated.<br>• Reach: 182 / Track: 101<br>• Clinical: The program was effective at improving health metrics other than directly reducing weight/BMI. Cholesterol: 100% of participants with elevated cholesterol (>200) in Week 1 had at least a 10% reduction in their reading in Week 10, far surpassing the goal of 75%. Blood Pressure: 72.7% of participants with high blood pressures (SBP>120) lowered it, surpassing the goal of 70%. Glucose: 75.0% of participants with elevated glucose (>100 for fasting or >140 for non-fasting) had a lower reading in Week 10, surpassing the goal of 70%. BMI and WEIGHT: Only 16.1% and 17.3% of participants with high BMI or weight met the goal of reducing BMI by at least 1 point or losing 5 pounds, respectively, significantly underperforming on these metrics.<br>• Behavioral: Physical Activity: 100% of participants increased their physical activity to at least 30 minutes per day, twice per week, far surpassing the goal of 75%. Nutrition Knowledge: 66.7% of participants improved their nutrition knowledge scores over the program cycle, underperforming for the goal of 90%. CVD Knowledge: 56.8% of participants improved their CVD risk knowledge scores over the program cycle, underperforming for the goal of 90%.<br><br>Walking Groups: School-based walking groups designed to improve cardiovascular health and prevent and/or manage chronic conditions. Walking groups took place at seven school sites around the community. |
| **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 18 program expenses were $714,922 with $399,121 in offsetting grant revenues the hospital contributed $315,801 |
| **FY 2019 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 |

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| | 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 June 2019 conduct wellness campaigns in 34 schools.<br>• By June 2019 increase students' knowledge of good nutrition pre/post test.<br>• By June 2019 continue to recruit new partners.(3 new partners)<br>• By June 2019 provide 10 grocery store tours and food demonstrations<br>• By June 2019 conduct four 10 week Activate your Heart Sessions<br>• By June 2019 help facilitate one train-the-trainer session<br>• By June 2019 conduct 3 community based walking groups |
| **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** | Los Angeles Unified School District (34 schools in the San Fernando Valley), Vallarta, Super King, Los Angeles County Department of Public Health, FQHC's, School-based Health Clinics, Parent Center Directors and Parent Facilitators; California State University, Northridge–Department of Dietetic Internship and Department of Kinesiology, Pacoima Beautiful, Mid-Valley YMCA, Valley Care Community Consortium (VCCC) . |

# ECONOMIC VALUE OF COMMUNITY BENEFIT

The economic value of community benefit for patient financial assistance is calculated using a cost-to-charge ratio, and for Medicaid and other categories of community benefit using a cost accounting methodology.

**Northridge Hospital Medical Center**
**Complete Summary - Classified Including Non Community Benefit (Medicare)**
**For period from 7/1/2017 through 6/30/2018**

| | Persons | Net Benefit | % of Org. Expenses |
|---|---|---|---|
| **Benefits for Living in Poverty** | | | |
| **Financial Assistance** | **2,163** | **3,581,509** | **0.8** |
| **Medicaid *** | **41,476** | **26,298,679** | **6.1** |
| **Community Services** | | | |
| A - Community Health Improvement Services | 7,172 | 1,132,839 | 0.3 |
| E - Cash and In-Kind Contributions | 5 | 1,038,325 | 0.2 |
| G - Community Benefit Operations | 23 | 780,230 | 0.2 |
| **Totals for Community Services** | **7,200** | **2,951,394** | **0.7** |
| **Totals for Living in Poverty** | **50,839** | **32,831,582** | **7.6** |
| **Benefits for Broader Community** | | | |
| **Community Services** | | | |
| A - Community Health Improvement Services | 14,181 | 263,051 | 0.1 |
| B - Health Professions Education | 2,682 | 3,613,597 | 0.8 |
| E - Cash and In-Kind Contributions | 492 | 46,246 | 0.0 |
| **Totals for Community Services** | **17,355** | **3,922,894** | **0.9** |
| **Totals for Broader Community** | **17,355** | **3,922,894** | **0.9** |
| **Totals - Community Benefit** | **68,194** | **36,754,476** | **8.5** |
| **Medicare** | **25,613** | **21,541,397** | **5.0** |
| **Totals with Medicare** | **93,807** | **58,295,873** | **13.5** |

Net Benefit equals costs minus any revenue from patient services, grants or other sources.

* The hospital was required to record some Medicaid Provider Fee revenue in FY18 that was attributable to FY17 services. If all FY17 Medicaid Provider Fee revenue had been recorded in FY17, the hospital's FY18 net benefit for Medicaid would have been $34,340,806.

# APPENDIX A: COMMUNITY BOARD ROSTER

**NORTHRIDGE HOSPITAL MEDICAL CENTER**

**COMMUNITY BOARD**
**July, 2018**

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|---|---|
| Justin Ako<br>Chair, Dept. of Health Administration<br>West Coast University | Maritza Artan<br>Community Resident<br>Granada Hills, CA 91344 |
| Azmi Atiya, M.D.<br>18350 Roscoe Blvd., #201<br>Northridge, CA 91325 | Art Jacinto<br>Community Resident<br>West Hills, CA 91304 |
| Felice L. Klein<br>Community Resident<br>Northridge, CA 91325 | Moufid Nemeh, M.D.<br>18250 Roscoe Blvd., #235<br>Northridge, CA 91324 |
| Barbra Miner<br>Barbara Miner Consulting<br>Porter Ranch, CA 91326 | Daren Schlecter<br>Law Office of Daren Schlecter<br>Los Angeles, CA 90067 |
| Julie Sprengel<br>Interim President/Sr. V.P. Operations So Ca<br>Dignity Health<br>251 South Lake Avenue, 8th floor<br>Pasadena, CA 91101 | Carol Stern<br>CEO, Pro Pharma Pharmaceutical Consultants<br>Northridge, CA 91328-0130 |
| Steve Valentine<br>Vice President/Advisory Consulting Services<br>Premier Inc.<br>Bell Canyon, CA 91307 | Anil Wadhwani, M.D.<br>18300 Roscoe Blvd.<br>Northridge, CA 91328 |
| William Watkins<br>V.P. Student Affairs<br>CSUN<br>Northridge, CA 91330 | |

# 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. T**he 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.
- **Beyond Trauma** – Peer support group curriculum for domestic violence victims being led by social worker at local domestic violence shelter.
- **Helping Hands Holiday Jam** - We are preparing for the 12th annual event, the Northridge Hospital Foundation has provided a Christmas wonderland for disadvantaged children from eight Title 1 LAUSD school children
- **Great Kindness Challenge –** We just completed our third year of participation in this anti-bullying campaign. Thirty-three schools participated in the GKC campaign, engaging approximately 27,319 students who were exposed to the message of "Kindness Matters."
- **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. Increases capacity to offer free prevention education in our most vulnerable communities.
- **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.

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 that continues to support loans approved in 2016 and are current in 2018.

**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.

**Abode Communities (Abode)**

A partner of Dignity Health since 2010, Abode is considered a thought leader in the affordable housing industry and since 2012, has placed in service 500 affordable housing units within the County of Los Angeles, with another 900 affordable units currently under construction and expected to be placed in service over the next several years. With Dignity Health's support, Abode has built affordable housing in Long Beach, Hollywood, South and Central Los Angeles. In 2014 Dignity Health approved a 7-year $2,000,000 line of credit to fund acquisition and predevelopment costs related to new development projects.

These investments in community both address one of the top five concerns of affordable housing/homelessness, which has continued to grow in our hospital service area.

# 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 for your hospital. 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.