



Northridge Hospital Medical Center

A member of CHW



Northridge Hospital Medical Center

**Community Benefit Report 2011
Community Benefit Plan 2012**

TABLE OF CONTENTS

Executive Summary	3
Mission Statement	5
CHW Mission Statement	
Organizational Commitment	6
Community	8
Definition of Community	8
Community Needs and Assets Assessment Process	8
Community Benefit Planning Process	9
Developing the Hospital's Community Benefit Report and Plan	9
Planning for the Uninsured/Underinsured Patient Population	12
Plan Report, Update, Measurable Objectives and Timeframes	13
Summary of Key Programs and Initiatives	13
Description of Key Programs and Initiatives (Program Digests)	19
Community Benefit and Economic Value	
Report – Classified Summary of Un-sponsored Community Benefits	35
Non-quantifiable Benefit	36
Telling the Story	38
Attachments:	
Northridge Hospital Medical Center Community Board Membership Roster	40
Executive Summary of Financial Assistance/Charity Care Policy	41
Community Benefit Graphs	44
CNI, Map of the Community and Zip Codes	47

EXECUTIVE SUMMARY

The Community Benefit Services offered by Northridge Hospital Medical Center (NHMC) show a significant increase in net community benefit Services for the Poor of 75.56%. The 2011 amount was \$16,908,292 versus the prior year of \$9,630,988. NHMC's net community benefit services shows a 271% total increase from \$16,490,661 in FY 2003 to this year's total of \$61,133,371. There was, however, a 9% decrease in overall net community benefit of \$61,133,371 compared to FY2010's total of \$67,185,703. The focus and diligence in instituting and measuring community benefit education and outreach activities resoundingly illustrates the increased demand from the uninsured and underinsured populations and the commitment of the team at NHMC.

It is interesting to note that the combined populations of both the San Fernando Valley and sections of the Santa Clarita Valley served by NHMC are equal to the sixth largest city in the United States and consist of nearly half of the residents in the City of Los Angeles, CA. Northridge Hospital is a 411-bed non-profit facility. The Hospital, with approximately 2,200 employees, 750 affiliated physicians in 59 specialties and over 435 volunteers, has forged ahead as the leader in the Valley by offering uncompromisingly high quality care, extensive educational outreach services and state-of-the art comprehensive health care programs.

For 56 years, Northridge has continued its solemn obligation to work with and for the residents of this large community. We are affiliated with Catholic Healthcare West (CHW) and share their values of Dignity, Collaboration, Excellence, Justice, and Stewardship.

Northridge's report documents the overall community benefit economic value and provision of much needed services to the Disproportionate Unmet Health Needs (DUHN) population. In addition to thousands of documented outreach activities, we also maintain and enhance ongoing and measurable Community Health Initiatives outlined in the report. They include:

- Received full accreditation from The Joint Commission this year
- The Center for Assault Treatment Services (CATS)
- The School-based Obesity and Diabetes Initiative (SODI)
- The Family Practice Clinic and Residency Program
- The Valley CARES Family Justice Center (FJC)
- Emergency Department Initiative (EDI)
- Congestive Heart Failure Initiative

Northridge Hospital has earned numerous esteemed accreditations, licenses and certifications, which are not just awards; they are our commitment to superior care. Some of the honors include:

- Emergency Department Approved for Pediatrics (EDAP) designation and accreditation from California Children's Services (CCS).
- The Leavey Cancer Center has garnered two accreditations including the Association of Community Cancer Centers and the American College of Surgeons (ACOS) as a comprehensive care center. Only 25% of hospitals nationwide have received the prestigious ACOS accreditation.
- We are one of the first designated STEMI (Heart Attack) Receiving Centers in Los Angeles County.

- The CardioVascular Center also received the Blue Distinction for Cardiac Care Designation from Blue Cross/Blue Shield for demonstrating exceptional cardiac care and achieving better overall outcomes for patients.
- The Center for Rehabilitation Medicine again received accreditation from CARF (Commission on Accreditation or Rehabilitation Facilities).
- Our Level II Trauma Center was certified by the American College of Surgeons, which recognizes the highest levels of clinical quality for injured patients. The Trauma Services also celebrates their 25th Anniversary and is one of only two Level II Trauma Centers in the community.

The Community Benefit Plan of NHMC is based on a solid foundation utilizing both the Triennial Community Needs Assessment conducted for Service Planning Area (SPA 2) and the Community Needs Index (CNI) developed by CHW in partnership with Solucient LLC. These documents serve as a chronology and index of health needs and issues prevalent among our population groups and a tool for improving community health.

MISSION STATEMENT

Catholic Healthcare West and our Sponsoring Congregations 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 Values

Catholic Healthcare West is committed to providing high-quality, affordable health care 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 and demonstrate compassion for our sisters and brothers who are powerless.

Stewardship

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

Excellence

Exceeding expectations through teamwork and innovation.

This CHW/Northridge Hospital Medical Center mission statement and core values appear on staff name badges, in external and internal brochures and literature and throughout the facilities' collateral materials and signage. New Employee Orientation and New Leadership Orientation offer an educational curriculum on the topic. Community Benefit continues to be an integral component of the NHMC Strategic Operating Plan and budget process.

ORGANIZATIONAL COMMITMENT

Northridge Hospital's organizational commitment to community benefit process ensures that the key vice presidents and senior managers are involved and adequate resources are allocated to respond to the unmet health needs of the community as identified in the community needs assessment. The leadership team is committed to assuring that our medical center is at the forefront of improving the health status of the local community and addressing the societal issues that are contributing factors to poor health.

The President/CEO and the Senior Leadership Team (SLT) are involved in the Community Benefit process each year as the strategic plan is developed. Coordination of community benefit is under the jurisdiction and direction of the Vice President of Marketing, Community Services and Mission Integration. The Director of the Center for Healthier Communities is an integral part of administering and leading many of the strategic initiatives in the plan. The Senior Leadership Team (Executive Management Team) of Northridge Hospital Medical Center maintains oversight for community benefit.

Community Benefit is a major pillar of the hospital's 2011-2012 strategic plans. Our six strategic pillars are:

- Quality/Patient Experience
- Human Capital
- Financial
- Growth
- **Community Benefit**
- Image

All new managers and directors are given a presentation on community benefits. As a direct result, understanding and support has steadily increased, departments continue to remain enthusiastically involved and are contributing resources to the hospital's existing community benefit programs. The Community Board operates as a committee of the whole for community benefit purposes. Presentations are made by staff to the Community Board throughout the year to update them on the progress made toward identified goals and to seek their input.

The NHMC Board of Directors approved the 2011 Community Benefit Report/2012 Community Benefit Plan in October 2011.

Six grants were awarded to local organizations. 29 requests totaling \$906,000 were received and we awarded the maximum of \$151,760 to the following non-profit organizations:

- ❖ **Valley Family Center**, \$15,760 - The "Domestic Violence Program" offers counseling, support groups and case management for the victims and those witnessing domestic violence.
- ❖ **Sustainable Economic Enterprises of Los Angeles**, \$20,000 - The "Good Cooking" programs will continue providing needed nutrition education to parents of students in the LAUSD District 1 schools through our SODI Initiative.
- ❖ **Valley Trauma Center**, \$ 20,000 - The grant supports and enhances the Valley CARES Family Justice Center

- ❖ **Enrichment Works**, \$23,000 - “Food for Thought 2: The Message Comes Home” uses theater to inspire learning and target childhood obesity and diabetes in our LAUSD, District 1 School-based Obesity & Diabetes Initiative schools.
- ❖ **Los Angeles Police Foundation**, \$23,000 - The grant will expand the role of the LAPD officers based at the Valley CARES Family Justice Center.
- ❖ **Tarzana Treatment Centers**, \$50,000 - “Decreasing Emergency Department Use through Education and Assessment” will connect those in need of primary care, substance abuse and mental health treatment.

The Community Board is representative of our service area and its cultural diversity. **The Community Board is made up of 29.4% Caucasian, 35.3% Latino, 11.8% African American and 23.5% other. The Board is 59% male and 41% female.**

COMMUNITY

DEFINITION OF COMMUNITY

SPA 2 consists of thirty-six cities and sixty-five zip codes. In excess of two million people live in the San Fernando and Santa Clarita Valleys (SPA 2). The racial and ethnic composition of SPA 2 remains diverse, especially in the San Fernando Valley where many cultures have converged in one area, and no racial group currently represents a majority (40.11% white, 41.47% Latino, 10.48% Asian and 3.61% African American). Service Planning Area 2 (SPA 2) encompasses 999.24 square miles and is the largest of Los Angeles County's eight service planning areas. The hospital's Community Health Initiatives identified on page 3 were formed in response to the geographic and demographic data which includes:

- ❖ 27,960 total births in SPA 2. The majority of births were to Hispanic mothers between the ages of 20-29 and 58.32% (14,352).
- ❖ An estimated 13.5% of adults were diagnosed with depression in 2009.
- ❖ SPA 2 prevalence of cardiac disease in 2009 is shown at 26.87% (508,051).
- ❖ Cancer Cases in 2009 represent 2.80% (52,893) of the population. Breast Cancer represents 0.80% (15,149 cases), prostate cancer accounts for 0.58% (10,912). *Diabetes Mellitus* was the seventh leading cause of death in SPA 2 with 405 deaths, which calculates to 3.34% of SPA 2 deaths.
- ❖ 38.8% of adults in SPA 2 were *overweight*, 17% were obese and 7% were diagnosed with diabetes. The percentage of youth in SPA 2 who were overweight was 20.4% which makes this a critical community initiative for the hospital.
- ❖ The total estimated cases of asthma are 7.56% (142,951) of the population.
- ❖ 12% of households had incomes under \$15,000 and 21% earned less than \$35,000.

COMMUNITY NEEDS AND ASSET ASSESSMENT PROCESS

Two tools were used to assess the needs: CHW's CNI and the 2010 Assessing the Community's Needs: A Triennial Report on San Fernando Valley and Santa Clarita Valley.

Community Needs Index (CNI)

The CHW Community Needs Index aggregates five socio-economic indicators known to contribute to health disparity – income, culture/language, education, housing status and insurance coverage. Data was combined from Census 2000 data and Solucient (Thomson-Reuters) proprietary information including data on admission rates per 1,000 population for each targeted zip code. The CNI was updated in 2011.

As per the CNI, the specific neighborhoods with Disproportionate Unmet Health-related Needs (DUHN) in NHMC's service area are Canoga Park, North Hills, North Hollywood, Pacoima, Panorama City, San Fernando and Van Nuys. DUHN neighborhoods are characterized as having the most significant barriers to health care access.

The targeted communities are primarily Latino and low-income. Key needs of the targeted communities include access to primary care, transportation and health care insurance coverage; programs that address the high rate of obesity, asthma and teen births; mental health services; wellness programs; better education on available programs and affordable medications.

COMMUNITY BENEFIT PLANNING PROCESS

DEVELOPING THE HOSPITAL'S COMMUNITY BENEFIT REPORT AND PLAN

2010 SPA 2 Triennial Community Needs Assessment

A strong foundation of data is utilized to develop Northridge Hospital's community benefit plan. The majority of the statistics are obtained from the 2010 SPA 2 Triennial Community Needs Assessment Report, a collaborative process involving meetings, research, interviews, forums and a written survey to prioritize community needs. NHMC analyzed and integrated additional data, specifically, information that was obtained from the CHW Community Needs Index and the Zip Code Databook. The County of Los Angeles, Department of Health Services – Public Health also published a report on the Key Indicators of Public Health by Service Planning Area (SPA), which was analyzed.

CHW Community Needs Index

The CHW Community Needs Index by local zip codes was also integrated into prioritizing community benefit initiatives so that the most-needy areas where the disproportionate uninsured healthcare needs population (DUHN) were the major focus.

Use of existing resources included institutional services and expertise, staff and volunteer resources, financial resources and community partner alliances. Once completed, NHMC matches its resources and capability against the identified community needs to determine which ones NHMC could most positively impact in a quality and cost-effective manner.

The NHMC Senior Leadership Team (SLT) involved in setting priorities includes:

- **Michael L. Wall**, President & Chief Executive Officer
- **Saliba Salo**, Chief Operating Officer
- **Ann Dechairo-Marino PhD, RN**, Senior Vice President, Patient Care Services, CNE
- **Ron Rozanski**, Senior Vice President, Operations
- **Noachim Marco, MD**, Vice President, Medical Affairs
- **Teddi Grant**, Vice President, Marketing, Community Benefits and Mission Integration
- **George Leisher**, Vice President, Human Resources
- **Nana Deeb**, Vice President, Clinical Services
- **Megan Micaletti**, Assistant Vice President
- **Adrienne Crone**, Manager, Administration Support
- **Brian Hammel**, President, Northridge Hospital Foundation
- **Bonnie Bailer**, Director, Center for Healthier Communities (Ad Hoc)

Factors taken into consideration

In developing the hospital's community benefit plan the following factors from CHW's Community Needs Index were taken into consideration:

Income Barriers

Decades of research on how social class links to health outcomes, living in impoverished neighborhoods, and social and contextual barriers to accessing healthcare place people in poverty at a disadvantage with respect to preventing disease, managing illness and survival.

Additional research has suggested that, when personal characteristics and household income were controlled, individuals living in areas with the greatest inequalities in income were 30% more likely to report their health as fair or poor than individuals living in areas with the smallest inequalities in income.

Culture Barriers

UCLA's School of Public Health and the California Public Health Department have taken a leadership position in highlighting the importance of race and ethnicity to address health disparities. Through their California Health Interview Survey Research, they found that cultural barriers lead to a number of health disparities ranging from increased prevalence of disease to a greater inability to sign up for government health insurance programs. Moreover, recent federal research by the National Academies' Institute of Medicine has concluded that minorities receive lower-quality care than that given to whites, even when adjusting for insurance status, and that this pattern contributes to higher death rates and shorter life spans.

Education Barriers

Lack of education has also been cited as a major reason for poor health in numerous research articles. Specifically, limited education has been linked to poor decision-making where health issues are concerned and a greater likelihood to engage in high-risk behaviors (such as unprotected sex in cases of sexually transmitted disease or poor eating habits in the case of diabetes and heart disease).

Insurance Barriers

CHW has long advocated for universal access to health care for all Americans. While much has recently been published on the financial impacts of the more than 43 Million uninsured in the health care delivery system, the health outcomes studies are equally striking.

Housing Barriers

CHW's internal working group concluded that use of rental housing might mean that members of a community are: more transient and have a less stable home and family because they are more likely to move; and are more likely to suffer from poor housing conditions which can lead to health issues because the landlord may not upkeep a rental property (e.g., lead paint, adequate ventilation systems, safe neighborhoods). Other indicators include homelessness and domestic violence.

Addressing identified health issues

Identified health issues were addressed by the hospital through the implementation and expansion of programs and services that benefit the community and are responsive to community needs.

New or existing services

Existing services include:

- The Center for Assault Treatment Services (CATS)
- The Family Practice Center

- School-based Obesity and Diabetes Initiative (SODI)
- Emergency Department Initiative
- The Leavey Cancer Center outreach activities
- Community education classes and a broad range of support groups
- Valley CARES Family Justice Center to serve victims of domestic violence
- Congestive Heart Failure Initiative in the Emergency Department

Factors considered in selecting interventions

The following factors are taken into consideration in selecting interventions:

- The community needs identified in the Assessing the Community's Needs: A Triennial Report on San Fernando and Santa Clarita Valleys
- The under-served communities identified in CHW's Community Needs Index
- The barriers to accessing care
- The impact of the existing programs
- The resources available to expand existing programs
- The hospital's ability to build coalitions among local community based organizations to address health disparities

Services specifically addressing a vulnerable population

Northridge Hospital's community benefit programs and services profiled in this report are all designed to address vulnerable populations.

Services specifically aimed at improving the health status of the community

The community benefit services and programs aimed at improving the health status of the community include the Family Practice Center, the School-based Obesity and Diabetes Initiative and the Emergency Department Initiatives.

Programs serve to contain the growth of community health care costs

The Center for Assault Treatment Services, Family Practice Center, the School-based Obesity and Diabetes Initiative and the Cancer Center's outreach programs aim to contain the growth of health care needs by providing prevention education and community outreach.

PLANNING FOR THE UNINSURED/UNDERINSURED PATIENT POPULATION

Financial Assistance/Charity Care Policy

Northridge Hospital Medical Center's Financial Assistance and Charity Care Policy are directed by its parent company, Catholic Healthcare West.

Process to ensure internal implementation of policy

To ensure hospital staff's implementation of this policy, it has been publicized by the Marketing Department through bi-lingual English/Spanish posters displayed throughout the hospital in public areas. The policy also appears in the Admitting Packet, the Patient Room Guide, and on the Hospital's Website. Furthermore, department managers review this policy with their staff at staff meetings, when appropriate.

Process for informing the public of the hospital's Financial Assistance/Charity Care policy

Bi-lingual signage throughout the hospital contains information and instructions on how to access financial assistance. The Northridge Hospital website, www.northridgehospital.org, contains comprehensive information on the hospital's policies and how to access services and assistance. Bi-lingual signage, literature and pamphlets are posted and distributed throughout the hospital to inform the public regarding Northridge Hospital's financial assistance and charity care policy. Bi-lingual information is printed in the new Admitting Guide and the Patient Room Guide which was updated in 2011.

PLAN REPORT AND UPDATE INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

SUMMARY OF KEY PROGRAMS AND INITIATIVES

Center for Healthier Communities (CHC)

The Center for Healthier Communities' (CHC) mission is to identify and provide innovative solutions to the community's unmet health needs with a focus on collaboration and coalition building. Through high quality prevention education and treatment services, CHC strives to promote healthy behaviors and improve the quality of life for residents of the San Fernando and Santa Clarita Valleys. CHC programs include:

- **Center for Assault Treatment Services (CATS)**

Dedicated to the treatment of children and adults who are victims of sexual abuse/assault or domestic violence, CATS, is the only program in the San Fernando and Santa Clarita Valleys that provides forensic interviews, forensic evidence collection and counseling 24 hours-a-day, seven days-a-week. The CATS team of experts provides these services free of charge in a supportive environment. CATS' collaborative partners include the local rape crisis center, law enforcement, District Attorney's Office, and the Los Angeles County Department of Children and Family Services among others. In fiscal year 2011, CATS provided medical evidentiary examinations in a compassionate and caring environment for 945 victims of all ages. CATS' outreach component provided more than 1,067 professionals, who are mandated child abuse reporters, with the tools necessary to identify and report any reasonable suspicion of child abuse. The CATS net community benefit for both its clinical and outreach components for FY2011 was \$1,531,631.

- **Valley CARES Family Justice Center**

Family Justice Centers are now considered a "best practice" in service delivery models for victims of interpersonal violence, including domestic violence, sexual assault, child abuse and elder abuse. The concept is to place necessary services for victims in one location and thereby reduce the number of places a victim has to go to receive services. The documented and published outcomes include a reduction in domestic violence homicides, increased safety, and improved cooperation with the prosecutor's office, thereby reducing recantation and increasing the prosecution of interpersonal violence cases. Northridge Hospital, in collaboration with the Los Angeles Police Department, District Attorney's Office, City Attorney's Office, Valley Trauma Center, Haven Hills, Domestic Abuse Center, Neighborhood Legal Services and Department of Children and Family Services, opened the first Family Justice Center in the County of Los Angeles in 2010. The Valley CARES net community benefit for FY2011 was \$521,102.

- **School-based Obesity and Diabetes Initiative (SODI)**

The School-based Obesity and Diabetes Initiative is a program designed to reduce the rate of obesity and diabetes locally by targeting primarily elementary school students, their parents and school staff in the Los Angeles Unified School District (LAUSD) schools located in the San Fernando Valley. The program assists public schools in implementing their wellness plans, recruits local, regional and national agencies to provide on-site nutrition and fitness programs, and evaluates the effectiveness of these programs. CHC's collaborative partners include: LAUSD Local District 1, School-based Health Clinics, Parent Center Directors and Parent Facilitators, the Alzheimer's Association, American Cancer Society, American Diabetes Association, American Heart Association, California Action for Healthy Kids, California Project LEAN, California State University, Northridge–Department of Dietetic Internship and Department of Kinesiology, Enrichment Works, Health Net, Mid-Valley YMCA, Network for a Healthy California–Champions for Change Los Angeles Region, Northeast Valley Health Corporation, Partners in Care Foundation, Sustainable Economic Enterprises of Los Angeles, Valley Care Community Consortium, and local elected officials. During FY2011, six new schools were added, expanding the initiative from 30 to 36 schools and reaching a total of 25,459 students, parents, teachers and staff. In addition a new federally funded project was launched. Titled PEP 4 Kids, it provides three public schools with a physical education and nutrition program for elementary school students. The total net community benefit was \$457,703.

- **Promoting Alternatives for Teen Health through Artes Teatro (PATH-AT)**

PATH-AT is a local Adolescent Family Life Demonstration Project conducted in the north and northeast San Fernando Valley in the City of Los Angeles by Northridge Hospital Medical Center's (NHMC) Center for Healthier Communities. The goal of the PATH-AT Program is to engage middle school students (ages 12 to 15) and their families in learning and understanding the benefits of abstaining from premarital sex, through the use of Peer Educators and theater arts. PATH-AT targets Latino middle school students in high need communities who are at high risk for early sexual experimentation and out-of-wedlock pregnancy, as well as other risky activities such as the use of drugs and alcohol. Targeted students primarily come from first and second-generation Mexican-American families. Over the course of 3 years (2007-2010) 1620 participants enrolled in the program. During its final year, PATH –AT staff and evaluation team submitted an article to the *Journal of Health Care for the Poor and Underserved*. The article, entitled "Using Theater Arts to Engage Latino Families in Dialogue about Adolescent Sexual Health: The PATH-AT Program", will be published in February 2012. The total net community benefit was \$270,052.

Emergency Department and Congestive Heart Failure Initiative

Northridge Hospital's Emergency Department Initiative is a collaboration between NHMC and Tarzana Treatment Center (TTC) with a focus on congestive heart failure, drug/alcohol addiction and/or underlying psychiatric disturbances. Under this project, hospital personnel providing discharge services refer eligible patients to an on-site TTC case manager who manages patients requiring case

management services. This includes intake and assessment, individualized case planning, case conferencing, collaborating with other coordinators of client care or services, referrals to ambulatory care, mental health care, substance abuse treatment, housing, vocational services, distribution of transportation vouchers and follow-up. Data collection and tracking also take place. TTC meets regularly with NHMC staff to review data and evaluate results. The total net community benefit for FY2011 was \$96,698.

The Northridge Family Practice Center and Family Medicine Residency Program

The Northridge Family Medicine Residency Program, in conjunction with the faculty group, provides both inpatient and outpatient care to many of the underserved in the community. They are an integral part of providing care in the San Fernando Valley. The total net community benefit is \$10,971,607.

- **The Family Medicine Residency Program**

The first residency program to be established in a community hospital in the San Fernando Valley, the Northridge Family Medicine Residency Program is affiliated with UCLA's David Geffen School of Medicine. The three-year program is fully accredited by the Accreditation Council on Graduate Medical Education. Nine full-time faculty, additional part-time faculty, 22 resident physicians and over 100 community physicians are involved in the teaching programs each year. The Program also collaborates with a Federally Qualified Community Clinic for supplementary training of resident physicians on an outpatient basis and to care for an additional under-served patient population.

- **The Family Medicine Inpatient Service**

Resident physicians, under the supervision of attending physicians, provide hospital care to many of the patients admitted through the emergency department. A significant number of the patients needing admission who present to the hospital emergency department are uninsured or underinsured. The residency program serves as one of the main admitting panel groups for these underserved patients. Inpatient management includes acute life-threatening conditions, chronic illnesses, general medical evaluations, obstetrical care, surgical problems and pediatrics.

- **The Family Practice Center**

The outpatient Family Practice Center (FPC) provides comprehensive health care to individuals and families of all age groups and all cultural backgrounds. Care provided ranges from prenatal to pediatric to adult and geriatric medicine. Over the years, through private and state funded programs, in partnership with various organizations, the FPC has worked to extend its various services including comprehensive diabetes management, breast and cervical cancer screenings, family planning, psychological counseling and patient education to the uninsured and underinsured in the community. Additionally, specialty clinics in sports medicine, dermatology, podiatry and nutrition are made available through the FPC. Ongoing health outreach, prevention and education efforts with community partners are also an integral component of the FPC's efforts to engage and serve its community.

Other Programs:

- **Leavey Cancer Center**

The total net community benefit for the Cancer Center was \$178,322. The majority of the activities conducted by the Cancer Center are underwritten by grant funds.

- Free Mammograms are provided to low-income, uninsured or underinsured women through funding from the Harold Pump Foundation and includes education, screening guidelines and cancer awareness. This program is coordinated by the Leavey Cancer Center's Navigator Program.
 - During the fiscal year, 1,480 women were provided with free mammograms to screen them for breast cancer. There were two positive breast cancer diagnoses which were referred for treatment.
- **Free Colonoscopies** are provided to low-income, uninsured or underinsured men and women through funding from the Harold Pump Foundation. This program is coordinated by the Leavey Cancer Center's Navigator Program.
 - 172 colonoscopies were performed. These individuals were identified as needing the procedure based on the self reported answers they provided on a screening tool used. The colon cancer outreach is provided at a variety of education and screenings offered throughout the year. None have tested positive for colon cancer
- **Harold Pump Foundation Sponsored Screening Fairs**, through the Leavey Cancer Center's *Reaching Out* program (formerly known as *La Fiesta para Su Salud*), are one-day events where those who are uninsured or underinsured can receive cancer screening procedures and other health screenings in a single day in a single location. In partnership with Vallarta Supermarkets, Park Parthenia Apartments and many community centers and churches, flyers were distributed throughout the community reaching out to people without health insurance. All the abnormal tests are followed up with assistance from Northridge Family Practice Clinic. The following number of screenings were performed at each fair:
 - **September 2010:** 114 cervical, 109 breast, 35 prostate
 - **December 2010:** 122 cervical, 126 breast, 49 prostate
 - **February 2011:** 107 cervical, 114 breast, 59 prostate
 - **May 2011:** 85 cervical, 91 breast, 9 prostate
- **Navigator Program Community Outreach** - The program educates the community about cancer awareness, cancer screening guidelines, and how to decrease risk factors for cancer. The program also signs up people who are uninsured or underinsured for free colonoscopies and free mammograms with additional funding received from the Harold Pump Memorial Foundation.
 - 5,414 individuals in 44 community groups have been educated about breast and/or colon cancer awareness and screening guidelines and informed about our free mammogram and free colonoscopy programs. Guardian Angel Church members, Vaughn School based Clinic clients and M.E.N.D community center were among the groups educated.
 - The Navigator Program has formed a relationship with the School-based Obesity and Diabetes Initiative (SODI) that is part of Northridge Hospital's Center for Healthier Communities. The Navigator program teaches the parents how to decrease their risks for

- cancer and what the cancer screening guidelines are. The participants are members of parent groups at the LAUSD schools and 211 individuals were reached.
- This year we were fortunate to be able to bring music therapy to 458 of our patients. The research indicates that music therapy can decrease a patient's anxiety, depression, confusion and even pain.
 - To further augment our services, we obtained grant funding to provide massage therapy to Cancer patients. We provided services to 948 individuals over the last year.
 - In an effort to meet the diverse needs of our community we initiated a Spanish language cancer support group in 2009 and continue to offer this service.
 - The Navigator Program also offers support groups that serve the needs of specialized groups within the community. Such groups include the Brain Tumor Support Group, who serves an average of 15 patients per session, Trigeminal Neuralgia Support Group, and the Breast Cancer Support Group.
- **Oncology Welcome Packages** are given to each patient at their initial consult, before treatment. Each package includes various samples such as Biotene for dry mouth, chapstick, gentle hair and body wash, lotion, toothpaste, toothbrush, fiber one, thermometer, a book of laughs and many other things. We also include the latest issue of Whole Living Magazine. These packages help ease the anxiety of possible symptoms the patient may experience during treatment.
 - **Patient Home Aid** sponsored by Harold Pump Foundation's Family Money Fund has provided 5,967 total hours of service to 32 patients during the fiscal year for home aid so they could be discharged from the hospital to live out the end of their lives in the comfort of their own homes.
 - **Annual "Life is Precious" Fashion Show** was held by the NHMC Leavey Cancer Center in October 2010, to celebrate the dramatic stories of cancer survivors and raise cancer awareness in collaboration with the American Cancer Society, We Spark and other community partners.
 - **Helping Hands Holiday Jam** - For the past eight years, NHMC, the NHMC Foundation and the Cancer Center have partnered with the Harold Pump Foundation to provide a Christmas wonderland for over 280 disadvantaged children each year. Hospital departments, staff and volunteers participate in this charitable event which provides games, activities, lunch, a visit with Santa and Christmas gifts for children from local Title 1 schools. In some cases the gifts they receive may be the only gifts they will get for the holidays. Many staff members, who volunteer at this event, have stated how personally rewarding it is for them as well.

Crisis Services Program

NHMC'S Behavioral Health Department Crisis Services Program provides crisis intervention for the urgent Mental Health care needs of individuals at risk of self-harm, at risk of danger to others, or who are gravely disabled and unable to care for themselves. The Crisis/Intake line assesses and evaluates all calls for appropriate referral resources or follow-up services. During fiscal year 2011, the Crisis Services Program served **5,735** individuals. Collaborative partners include Valley Community Mental Health, West Valley Mental Health, Adult Protective Services and the LAPD Smart Team. NHMC'S Emergency Department and the emergency departments of nine area hospitals-Providence Saint Joseph Medical Center, Providence Holy Cross Medical Center, Valley Presbyterian Hospital, Sherman Oaks

Hospital, Huntington Memorial Hospital, Henry Mayo Hospital, West Hills Hospital, Kaiser and Providence Tarzana Hospital refer psychiatric cases to NHMC'S Crisis Services Program Crisis Team for evaluation and intervention. The total net community benefit was \$2,371,178.

Emergency Services

Northridge Hospital Medical Center's Emergency Department provides 24-hour, seven-day-a-week state-of-the-art emergency medical services to all patients regardless of their ability to pay. The Emergency Department served 42,893 patients during fiscal year 2011. Of this amount 22,773 were indigent or low-income patients who were not able to afford to pay for services or did not have health insurance. The total net community benefit was \$6,947,000.

Trauma Center

NHMC's Level II Trauma Center (one of only two in the San Fernando Valley) provides trauma care to all trauma victims throughout the region regardless of their ability to pay. Collaborative partners include Los Angeles County Medical Services, Los Angeles Police Department and Los Angeles City and County Fire Departments. The Trauma Services Program provided trauma care for 1,150 persons in FY2011; of this amount 584 were low-income and could not afford to pay for services or did not have health insurance. The total net community benefit was \$195,000.

Richie Pediatric Trauma Center

Northridge Hospital has the first and only Pediatric Trauma Center (PTC) in the San Fernando Valley. The Level II Richie Pediatric Trauma Center opened In October 2010 as the only facility in the San Fernando Valley that provides immediate, urgent medical care to infants, children and adolescents with life-threatening traumatic injuries 24-hours-a-day. When a child is injured our Pediatric Trauma Team is immediately assembled to await the patient's arrival. The aim is to provide medical treatment within the Platinum 30 Minutes – known as the first half hour that increases the chance of survival (called the Golden Hour, 60 minutes, for adults but reduced for fragile children).

The PTC is staffed physicians with expertise in more than 20 subspecialties, which include Emergency Medicine, Anesthesia, Orthopedics and Neurosurgery and uses equipment and medications (packaged in accurate unit doses) just for pediatric use. The PTC's multifaceted care is supported by the Pediatric Intensive Care Unit (PICU) and Pediatrics Unit, which are staffed by 24/7 by many specialists and physicians. Also, equipped with a helipad, we expedite care to traumatically injured children 24-hours-a-day.

The PTC is named after Richie Alarcon – the infant son of Los Angeles District 7 Council-member Richard Alarcon – who was traumatically injured in a vehicle accident. Richie's transport out of the Valley extended beyond the Platinum 30 Minutes, and he died the next day. Shortly after, Alarcon (who was then a State Senator) introduced legislation to establish funding for Northridge Hospital's Pediatric Trauma Center. He received help to get the bill passed from Senator Alex Padilla, 20th District, the L.A. County Board of Supervisors and L.A. County Supervisor Zev Yaroslavsky, 3rd District.

DESCRIPTION of KEY PROGRAMS and INITIATIVES (Program Digests)

The Community Benefit programs that are a major focus for fiscal years 2010-2011 include the following:

- **Center for Assault Treatment Services**
- **Family Practice Center**
- **Emergency Department and Congestive Heart Failure Initiatives**
- **School-based Obesity & Diabetes Initiative**
- **Valley CARES Family Justice Center**

Center for Assault Treatment Services (CATS)	
Hospital CB Priority Areas	<ul style="list-style-type: none"> X Increase access to appropriate health care services for the poor and underserved X Promote collaboration and reduction of duplicative health services Address the obesity and diabetes epidemic Reduce rate of births to adolescents X Increase services to victims of trauma and violence
Program Emphasis	<ul style="list-style-type: none"> X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Link to Community Needs Assessment, Vulnerable Population	Programs are needed that focus on personal development and mental health of adolescents and better education on programs and services available in the community.
Program Description	CATS' expert team of forensic nurses, under the direction of the Clinical Manager and Medical Director, provides medical evidentiary examinations and forensic interviews for adult and child victims of sexual assault, sexual abuse and domestic violence in a safe, comforting and private environment that preserves the dignity of the victim. CATS also provides child abuse prevention education to professionals in the San Fernando Valley who work with children and are therefore mandated by law to report any reasonable suspicion of child abuse. CATS collaborates with the local rape crisis center, Valley Trauma Center, to provide case management and counseling for victims; law enforcement and the District Attorney's Office in prosecution; child protective services; local school districts and community based organizations to deliver these services.
FY 2011	
Goal FY 2011	Provide clinical forensic services to victims of sexual assault, sexual abuse and domestic violence; child abuse prevention education to professionals who work with children as well as to children in the public school system and their parents.
2011 Objective Measure/Indicator of	<ul style="list-style-type: none"> • By June 30, 2011, provide medical evidentiary examinations, case management and counseling to 850 victims of sexual abuse and

Success	<p>assault of all ages.</p> <ul style="list-style-type: none"> • By June 30, 2011 provide prevention education to a minimum of 1,200 mandated child abuse reporters and the general public. • By June 30, 2011 develop strategic plan for expansion efforts. • By June 30, 2011 raise funds to support program components.
Baseline	Sexual assault victims need immediate post-abuse treatment. Few victims disclose and even fewer mandated reporters report incidence of abuse.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Conduct medical evidentiary exams of victims of sexual abuse/ assault and DV of all ages • Conduct forensic interviews • Work closely with child protective services, law enforcement and the District Attorney's office to assist in the investigation process • Work closely with the Valley Trauma Center to provide post-trauma case management and counseling to victims • Outreach to public and private schools, hospitals, clinics and other community-based organizations • Develop training materials and conduct trainings • Evaluate results
Result FY 2011	<ul style="list-style-type: none"> • CATS provided medical evidentiary exams and forensic interviews to victims of sexual abuse and assault. Case management was provided to all victims and they were offered free counseling. • CATS Outreach Staff provided Child Abuse Education to 1,095 mandated child abuse reporters meeting the target by 91% • CATS developed a strategic plan for expansion into a Family Justice Center model. • CATS raised \$200,000 in funds from private and corporate foundations, its annual walk/run event, retail campaigns, social and business clubs and individual donors.
NHMC Contribution/ Program Expense	\$1,531,631
FY 2012	
Goal 2012	Provide clinical forensic services to victims of sexual abuse, sexual assault and domestic violence; and provide child abuse prevention education to professionals who work with children throughout the San Fernando and Santa Clarita Valleys.
2012 Objective measure/Indicator of Success	<ul style="list-style-type: none"> • By June 30, 2012, provide medical evidentiary examinations, case management and counseling to 1,000 victims of sexual abuse and assault of all ages. • By June 30, 2012 provide prevention education to a minimum of 1,200 mandated child abuse reporters and the general public. • By June 30, 2012 expand CATS medical unit to treat victims of domestic violence. • By June 30, 2012 raise funds to support program components

Baseline	Same as above
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Work closely with law enforcement and the District Attorney’s Office • Conduct roll call trainings at local law enforcement precincts/divisions • Conduct medical evidentiary examinations and forensic interviews • Review and update materials for mandated reporters • Review and update CATS website • Publish annual newsletter • Outreach to public schools and community-based organizations • Conduct trainings on-site at local agencies and schools for mandated child abuse reporters • Write grants to support CATS components • Conduct CATS Victory for Victims Walk/Run and the LA Marathon Team to promote awareness of child abuse and raise funds

Family Practice Center and Family Medicine Residency Program	
Hospital CB Priority Areas	<ul style="list-style-type: none"> X Increase access to appropriate health care services for the poor and underserved X Promote collaboration and reduction of duplicative health services X Address the obesity and diabetes epidemic X Reduce rate of births to adolescents Increase services to victims of trauma and violence
Program Emphasis	<ul style="list-style-type: none"> X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Link to Community Needs Assessment	The Family Practice Center (FPC) programs and services link to the community's need for affordable primary and specialty medical services, for more preventive care and wellness programs for children and adults and the need for programs to combat obesity and diabetes.
Program Description	The Northridge Family Medicine Residency Program, in conjunction with the faculty group, provides both inpatient and outpatient care to many of the underserved in the community. The outpatient Family Practice Center (FPC) provides comprehensive health care to individuals and families of all age groups and all cultural backgrounds. The care provided ranges from prenatal to pediatric to adult and geriatric medicine. Over the years, through private and state-funded programs, in partnership with various organizations, the FPC has worked to extend its various services, such as comprehensive diabetes management, breast and cervical cancer screenings, family planning, psychological counseling and patient education for the uninsured and under-insured in the community. Additionally, specialty clinics in sports medicine, dermatology, podiatry and nutrition are made available through the FPC. Ongoing health outreach, prevention and education efforts with community partners are also an integral component of the FPC's efforts to engage and serve its community.
FY 2011	
Goal FY 2011	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.
2011 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Number of indigent patients seen on the inpatient hospital service. • Number of patients seen through Medi-Cal or HMO Medi-Cal. • Number of patients seen through all state-funded service programs for low-income patients, such as CHDP, CCS, PACT. • Number of indigent patients seen in the Family Practice Center, including specialty clinics and the Diabetes Indigent Program. • Continuation of partnerships and outreach prevention education efforts with local schools, senior centers and community agencies.

Baseline	There is insufficient access to primary medical services across population groups. Chronic diseases account for many of the acute care inpatient admissions across age groups. The large number of Latino residents results in a disproportionate incidence of diabetes in the San Fernando Valley. Therefore, special attention needs to be given to the diagnosis, treatment, prevention and education of diabetes.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Continue Family Medicine coverage of admissions through the hospital emergency department including involvement with the obstetrical and surgical panel coverage. • Continue and expand hospital inpatient service at Northridge Hospital Medical Center • Contract with Medi-Cal HMO's as the State of California continues to move additional patients into managed Medi-Cal. • Maintain "Diabetes Indigent Program" • Maintain community partnerships and outreach prevention education efforts, including health education for the youth, high school sports coverage, obesity and diabetes prevention in children and adults, general health screenings, and senior center screenings.
Result FY 2011	<ul style="list-style-type: none"> • 18,054 total visits in the hospital over a one year period, a decrease 4.98% from last year's total of 19,000. <ul style="list-style-type: none"> ○ 40% of visits are for indigent/underserved care, including uninsured, Medi-Cal, and HMO Medi-Cal patients • 20,566 total patient visits in the Family Practice Center, including specialty clinics and the Diabetes Indigent Program <ul style="list-style-type: none"> ○ 40% of visits are for indigent/underserved care, including uninsured, Medi-Cal, and HMO Medi-Cal • Implementation of a hospitalist fellowship program to address increased inpatient care volume of indigent patients • Ongoing community partnerships and outreach programs <ul style="list-style-type: none"> ○ Sutter Middle School Health Education Program reaching near 400 students annually ○ Obesity and Diabetes Prevention Elementary School Outreach Program reaching near 400 students annually ○ Northridge Middle School "Food for Thought" project engaged eighth grade students, parents, teachers and residents in using photo diaries to increase awareness of food choices. ○ High school football games coverage for Monroe High School, as their Team Physician ○ Partnership with Partners in Care's Disease Prevention and Health Promotion Program at local senior centers • Local Screening Health Fairs and community presentations including pap-o-ramas.
Hospital's Contribution / Program Expense	\$10,971,607

FY 2012	
Goal 2012	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.
2012 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Number of indigent patients seen on the inpatient hospital service. • Number of patients seen through Medi-Cal or HMO Medi-Cal. • Number of patients seen through all state-funded service programs for low-income patients, such as CHDP, CCS, PACT. • Number of indigent patients seen in the Family Practice Center • Continuation and expansion of partnerships and outreach prevention education efforts with local schools, senior centers, and community agencies. • Partnerships include: <ul style="list-style-type: none"> ○ CSUN (California State Northridge University) Family Focus Resource Center will work with residents and families at the FPC to help parents with special needs children better access school-based services. ○ Northeast Valley Health Corporation clinics - Residents on our expanded community medicine rotation will rotate through various services at this Federally Qualified Clinic providing medical care to underserved populations in the San Fernando Valley. ○ Collaboration with Northridge Hospital's SODI Program (School-Based Obesity & Diabetes Initiative) ○ Increased collaboration and coordination with hospital based services including rotations with the expanded palliative care program and with the hospital chaplains.
Baseline	Same as above.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Continue Family Medicine coverage of admissions through the hospital emergency department including involvement with the obstetrical and surgical panel coverage. • Continue and expand hospital inpatient service at Northridge Hospital Medical Center including increased faculty hours for supervision of inpatient care. • Contract with Medi-Cal HMO's as the State of California continues to move additional patients into managed Medi-Cal. • 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. • Continuation of on-site psychological services to assist patients with psychiatric diagnoses and those dealing with the stress of managing chronic diseases.

Emergency Department and Congestive Heart Failure Initiatives (EDI/CHF)	
Hospital CB Priority Areas	<ul style="list-style-type: none"> X Increase access to appropriate health care services for the poor and underserved X Promote collaboration and reduction of duplicative health services Address the obesity and diabetes epidemic Reduce rate of births to adolescents Increase services to victims of trauma and violence
Program Emphasis	<ul style="list-style-type: none"> X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Link to Community Needs Assessment	EDI/CHF addresses the need to reduce emergency department visits and hospital readmissions among primarily low-income patients who are better served at clinics and need a medical home, addressing mental health, substance abuse, congestive heart failure, and other health-related issues.
Program Description	These initiatives are a partnership between Northridge Hospital Medical Center (NHMC) and Tarzana Treatment Center (TTC). Under these projects, hospital personnel providing discharge services refer eligible patients to an on-site TTC case manager who works with patients requiring case management services. This includes intake and assessment, individualized case planning, case conferencing, coordinating with other coordinators of client care or services, referral to ambulatory care, mental health care, substance abuse treatment, housing, vocational services, distribution of transportation vouchers and follow-up. Data collection and tracking also take place. TTC meets regularly with NHMC staff to review data and evaluate results.
FY 2011	
Goal FY 2011	To avoid hospital or emergency department admissions among 50% of participants in the hospital's intervention program(s) for the top two chronic conditions identified in the community needs assessment and utilization data.
2011 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • By June 30, 2011, ED to refer 150 patients to onsite Tarzana Treatment Center Case Manager • By June 30, 2010, TTC to provide case management services to 50% of patients referred to TTC. • By June 30, 2011, provide community referrals to 100% of patients provided case management services by Tarzana Treatment Center's Case Manager.
Baseline	Number of visits to ED six months prior to TTC intervention
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Educate ED staff regarding appropriate referrals • TTC to provide case management for referred patients • NHMC and TTC maintain database • TTC follows up with patients

	<ul style="list-style-type: none"> • TTC Independent Evaluator reviews and analyze data • NHMC reviews and analyzes data
Result FY 2011	<ul style="list-style-type: none"> • 38% of patients with alcohol/drug or psychiatric disturbances had no return visits after TTC's intervention • 79% reduction in recidivism among patients with alcohol/drug or psychiatric disturbances compared to number of visits prior to intervention. • 18 patient visits with CHF discharge diagnosis of CHF. One of them was referred to TTC. • 100% reduction in recidivism due to the fact that the one CHF patient who received the TTC intervention has not returned to the hospital.
Hospital's Contribution / Program Expense	\$96,698
FY 2012	
Goal 2012	To avoid hospital or emergency department admissions among 50% of participants in the hospital's intervention program(s) for the top two chronic conditions identified in the community needs assessment and utilization data.
2012 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Numbers of ED patients receiving TTC intervention • Number of ED visits and/or hospital admissions six months prior to TTC intervention • Number of ED visits and/or hospital admissions six months post TTC intervention
Baseline	Same as above.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • ED committee to hold bi-monthly meetings to implement enhancements • TTC to provide case management for referred patients • TTC to follow up with patients • Expansion of CHF to include referral of patients into the CHAMP program • NHMC, CHAMP and TTC to maintain databases on patients referred • Review and analyze data • Evaluation effectiveness of program

School-based Obesity & Diabetes Initiative (SODI)	
Hospital CB Priority Areas	<ul style="list-style-type: none"> X Increase access to appropriate health care services for the poor and underserved X Promote collaboration and reduction of duplicative health services X Address the obesity and diabetes epidemic Reduce rate of births to adolescents Increase services to victims of trauma and violence
Program Emphasis	<ul style="list-style-type: none"> X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Link to Community Needs Assessment	The School-based Obesity and Diabetes Initiative will address the need to reduce the rate of childhood obesity and related diseases in the San Fernando Valley of Los Angeles County.
Program Description	The School-based Obesity and Diabetes Initiative (SODI) was launched in partnership Los Angeles School District (LAUSD) Local District 1 to reduce the rate of obesity and diabetes locally by targeting primarily elementary school students, parents and staff in schools located in underserved San Fernando Valley communities. SODI assisted participating LAUSD schools in implementing wellness programs with a focus on nutrition and physical fitness. SODI's collaborative partners included: Northridge Hospital's Cardiology and Cancer Departments, LAUSD Local District 1, Coordinated School Health, K-12 Physical Education, School-based Health Clinics, Parent Center Directors and Parent Facilitators; the Alzheimer's Association, American Cancer Society, American Diabetes Association, American Heart Association, California Action for Healthy Kids, California Project LEAN, California State University, Northridge–Department of Dietetic Internship and Department of Kinesiology, Enrichment Works, Gelson's Supermarkets, General Mills Foundation–Champions for Healthy Kids, Health Net, Mid-Valley YMCA, Network for a Healthy California–LAUSD and Champions for Change-Los Angeles Region, Nike, Northeast Valley Health Corporation, Partners in Care Foundation, Sustainable Economic Enterprises of Los Angeles, Valley Care Community Consortium (VCCC); Los Angeles City Councilman Tony Cardenas, Los Angeles County Supervisor Zev Yaroslavsky, California State Senator Alex Padilla, and U. S. Congressman, Howard Berman.
FY 2011	
Goal 2011	<ul style="list-style-type: none"> • Increase physical activity and improve nutrition with the ultimate goal of decreasing childhood obesity rates
2011 Objective Measure/Indicator of	<ul style="list-style-type: none"> • By June 2011 recruit six additional schools bringing the total to 36 schools participating in the initiative.

Success	<ul style="list-style-type: none"> • By June 2011 complete needs assessment for each new school. • By June 2011 establish roles of partners in addressing schools' needs • By June 2011 continue to recruit new partners • Evaluate results
Baseline	<p>Obesity and its related diseases, in particular diabetes, have reached epidemic proportions in the San Fernando Valley of Los Angeles County. Twenty-five percent of boys and eighteen percent of girls attending public schools in grades 5, 7 and 9 are overweight. If this trend continues, one third of children born in the year 2000 will develop Type II diabetes.</p>
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Offer program and assistance to principals at each school • Assist with needs assessment and school health improvement plans • Identify partners to work with each school • Coordinate partners roles in addressing schools' needs • Develop and implement programs for schools • Monitor progress • Evaluate results
Result FY 2011	<ul style="list-style-type: none"> • SODI added six new schools, expanding from 30 to 36 schools • New community partners recruited: LA Care, Blue Shield, Healthy Food School Coalition, Healthcare Partners, and University of California Cooperative Extension (UCCE). • Established expectations for each community partner (see list above) and coordinated programs at participating schools <p>Parent Classes Programs:</p> <ul style="list-style-type: none"> • <i>Alzheimer's Awareness classes</i> provided at 11 schools: Sunny Brae, Noble, Emelita, Nevada, Danube, Langdon, Gledhill Elementary Schools, Rosa Parks Learning Center, Northridge and Columbus MS, and Kennedy HS. • <i>Children's Health – Nutrition, Fitness and Weight</i> conducted at Andasol Elementary School. • <i>Diabetes Awareness and Prevention</i> completed at 9 schools: Stagg, Chase, Tarzana, Hart, Canoga Park, Mayall, Ranchito, Danube, and Nevada Elementary Schools. • <i>Fit Families for Life 3-week series</i> completed at 11 schools: Columbus MS., Gledhill, Stagg, Fulbright, Panorama City, Danube, Plummer, Liggett, Cantara, Mayall Elementary Schools and Rosa Parks Learning Center. • <i>Getting a Healthy Life</i> provided at Nevada Elementary School. • <i>Go Red Por Tu Corazon</i> workshop conducted at Mulholland MS and Burton Elementary School. • <i>Good Cooking 4-week series</i> (physical activity and nutrition) completed at 3 schools: Valley Regional #6, Langdon and Canoga Park Elementary School. • <i>Good Cooking (a one-time workshop)</i> completed at Cohasset Elementary School. • <i>Healthy Cooking for Families</i> provided at 7 schools: Panorama City,

	<p>Stagg, Emelita, Limerick, Nevada Elementary Schools, Mulholland MS, and Kennedy HS.</p> <ul style="list-style-type: none"> • <i>Healthy Lifestyles & Cooking CSUN Mini grant</i> provided at 5 schools: Haskell, Noble, Tarzana Elementary School, Sepulveda and Northridge MS. • <i>Managing Stress 4-week series</i> completed at Noble Elementary School. • <i>Salad and Dance presentation</i> – HUD Grant provided at Cohasset Elementary School. • <i>School Nutrition Policies class</i> provided at Panorama City Elementary School. • <i>Stress Management and Physical Activity class</i> conducted at 13 schools: Nevada, Emelita, Noble, Stagg, Ranchito, Panorama City, Mayall, Plummer, Liggett, Danube Elementary Schools, Rosa Parks Learning Center, Mulholland and Northridge MS. • <i>Parent walking groups through VCCC</i> provided at 17 schools: Burton, Canoga Park, Danube, Fulbright, Gledhill, Hart, Haskell, Langdon, Napa, Noble, Stagg, Sunny Brae Elementary Schools, Rosa Parks Learning Center, Mulholland and Columbus MS, • <i>Medical Weight Scales</i> provided to parent centers (to be used in conjunction with parent wellness programs) at 5 new schools: Valley Regional #6, Lorne, Emelita, Stagg and Winnetka Elementary Schools – the total number of schools with medical scales is 31. • <i>Tools for a Healthy Life</i>, train-the trainer held at the LAUSD, LD 1 monthly parent center directors’ meeting. • <i>PEP 4 Kids Parent-in-service</i> (morning and evening) at Panorama City, Rosa Parks Learning Center, and Liggett Elementary School. <p>Student Classes and Programs:</p> <ul style="list-style-type: none"> • <i>Food For Thought 2</i> Nutrition and physical activity educational theatrical play presented at 8 schools: Mayall, Emelita, Ranchito, Plummer, Panorama City, Liggett, and Lorne Elementary Schools, and Rosa Parks Learning Center • <i>Food & Fun For Kids</i> –CSUN after-school classes conducted at Ranchito Elementary School. • <i>Students Taking Charge</i> provided at Kennedy HS. • <i>Marathon Kids</i> program provided at Hart and Noble Elementary Schools. • <i>SODI presentation</i> at Canoga Park HS. <p>PEP 4 Kids (Carol M. White Grant) at Panorama City Elementary School (PCES), Liggett Elementary School & Rosa Parks Learning Center (RPLC)</p> <ul style="list-style-type: none"> • Hired and placed 3 Physical Education (PE) Teachers at Liggett ES, PCES, & RPLC • Physical Education Instruction to K-5 students by PE teachers • Conducted ongoing hands on training (Professional Development) for
--	---

	<p>classroom teachers</p> <ul style="list-style-type: none"> • Collected baseline data and 4 follow-up measurements: BMI, Cardiovascular Assessment, Physical Activity assessment via Pedometers and recall data entry, and Fruit and Vegetable Intake recall • PE Teachers conducted Fitnessgram assessment for 5th graders • Peaceful Playground Markings were placed on PE fields at PCES and RPLC • Purchased & distributed new PE equipment and evidence-based curriculum (CATCH) <p>Special School Events for Students and Parents:</p> <ul style="list-style-type: none"> • Valley Care Community Consortium’s <i>Turkey Run Family Festival</i> at Lake Balboa. • Canoga Park Elementary School’s <i>Health Fair</i>. • Ranchito’s <i>Nutrition Fair</i> (March) and <i>Jr. Olympics</i> (June). • <i>School Nutrition Fair</i> at Stagg Elementary School. • <i>Community Health Fair where?</i> • Parents from Noble, Mulholland and Langdon participated in the <i>Go RED Por Tu Corazon</i> luncheon at JW Marriot. • <i>Los Angeles County Community Advisory Committee (Health Net)</i> at Rosa Parks Learning Center. • <i>Parent Volunteer Recognition luncheon</i> at Langdon Elementary School. • Chase Elementary School’s <i>Health Fair and Walk-a-thon</i>. • Parents and students participated at the <i>Marathon for Kids</i> hosted at UCLA. • <i>Health Fair</i> at the Community Family Center at Park Parthenia Apartments- (100 Parents from Napa E.S., Parthenia E.S. and Northridge M.S.). • <i>Health fair/screenings</i> in Van Nuys sponsored by the American Diabetes Association. • Latino Health Awareness Month “<i>Healthy Change is Within Your Reach</i>” event for students, parents and children at Noble. • Chase Elementary School’ <i>Walk to School Health Fair</i>. • Presentation on <i>Healthy Eating for the Holidays</i> for the parents at Leichman Special Education Center. • Tulsa El’s <i>Bring Your Parent to School health fair</i>. <p>Teachers/School Staff and Parents</p> <ul style="list-style-type: none"> • Provided CATCH Curriculum Training at PCES for <i>PEP 4 Kids</i> schools • Provided a laptop computer, Fitnessgram software and Fitnessgram software training (one per school) for 12 teachers to use in Fitnessgram testing
--	---

	<p>Outcomes:</p> <p>Parents</p> <ul style="list-style-type: none"> • Participant pre/post surveys for nutrition and cooking classes indicate strong parent support for class and positive changes made in relation to exercise and diet • Walking groups pre/post screens indicate increased cardiovascular health for most participants • Cholesterol screening results indicate dramatic decreases in cholesterol levels for significant number of participants <p>Students</p> <ul style="list-style-type: none"> • PEP 4 Kids evaluation data indicated a 6% increase from baseline in the percentage of students who meet 60 minutes of daily Physical Activity • PEP 4 Kids evaluation data indicated a 4% increase from baseline of students who achieved age-appropriate cardiovascular fitness levels. • PEP 4 Kids evaluation data indicated a 6.2% increase from baseline in the percentage of students who consumed fruit and vegetable two or more times per day • Fitness/Nutrition education play surveys indicate positive changes in students' attitudes towards choosing healthy snacks over junk food and incorporating exercise into their lives
Hospital's Contribution / Program Expense	\$457,703
FY 2012	
2012 Objective Measure/Indicator of Success	<p>Students, Parents and Teachers and School Staff</p> <p>Students</p> <ul style="list-style-type: none"> • Improve Fitnessgram scores among grade 5 students • Increase amount of daily physical activity among elementary school students <p>Parents</p> <ul style="list-style-type: none"> • Improve nutrition and fitness levels <p>Teachers and School Staff</p> <ul style="list-style-type: none"> • Train teachers and school staff in evidence based PE curriculum (CATCH)
Baseline	Same as above
Intervention Strategy for Achieving Goal	<p>Continue to work closely with participating SODI School Administrators and staff to effectively encourage increased physical fitness and health for the entire school communities by using the following strategies:</p> <ul style="list-style-type: none"> • Coordinate fitness, nutrition, and cooking programs at 15 schools • Provide PE instruction for students and teachers at 4 schools • Disseminate health education materials regarding nutrition and exercise to parents via school mailings, newsletters, phone systems and/or school parent meetings • Facilitate <i>Active for Life</i> campaigns in schools to increase

	<p>opportunities for physical fitness for school staff</p> <ul style="list-style-type: none"> • Utilize existing bi-lingual case manager to assist the obesity clinic physician and dietician in providing on-going services and support to clients in addressing their eating/weight problems • Promote and facilitate VCCC parent walking clubs • Provide teachers with technical assistance in utilizing the Fitnessgram software • Conduct Parent Center Director Trainings for new class facilitators and refresher classes for current facilitators • Facilitate cholesterol, glucose, weight, BMI screenings for parents • Promote and facilitate fitness and nutrition plays at 10 elementary schools • Continue collaboration with existing partners • Establish collaborations with new partners
--	--

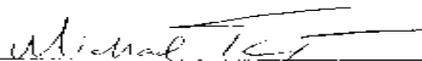
Valley CARES Family Justice Center	
Hospital CB Priority Areas	<ul style="list-style-type: none"> X Increase access to appropriate health care services for the poor and underserved X Promote collaboration and reduction of duplicative health services Address the obesity and diabetes epidemic Reduce rate of births to adolescents X Increase services to victims of trauma and violence
Program Emphasis	<ul style="list-style-type: none"> X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Link to Community Needs Assessment	The Family Justice Center (FJC) is a one-stop shop designed to provide comprehensive services link for victims of interpersonal violence.
Program Description	Family Justice Centers are now considered a “best practice” in service delivery models for victims of interpersonal violence, including domestic violence, sexual assault, child abuse and elder abuse. The concept is to place necessary services for victims in one location and thereby reduce the number of places a victim has to go to receive services. The documented and published outcomes include a reduction in domestic violence homicides, increased safety and improved cooperation with the prosecutor’s office, thereby reducing recantation and increasing prosecution of interpersonal violence cases. Northridge Hospital and collaborators, the Los Angeles Police Department, District Attorney’s Office, City Attorney’s Office, Valley Trauma Center, Haven Hills, Domestic Abuse Center, Neighborhood Legal Services and the Department of Children and Family Services, are launching the first family justice center in the County of Los Angeles.
FY 2011	
Goal FY 2011	To launch the Family Justice Center in Van Nuys
2011 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • To put in place the processes necessary to open the doors • To facilitate the co-location of the various partners • To host the grand opening of the Family Justice Center
Baseline	Interpersonal violence is a seriously underreported crime. Many victims who do report are unable to access the services they need to begin the recovery process. There is no one place in the San Fernando Valley where victims can access all the services they need under one roof.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Prepare the Operations Manual • Hold regular meetings of the Steering Committee and larger group • Research and install security system • Finalize renovations and furnish facility • Set up communications system • Co-locate initial partners • Identify funds for initiative

Result FY 2011	<ul style="list-style-type: none"> • Operations Manual developed • Protocols developed • Security system installed • Renovations completed and facility fully furnished • Los Angeles Police Department Major Assault Crimes unit co-located • The Valley Trauma Center co-located • Neighborhood Legal Services co-located • Reception/In-take coordinator hired • Governance Committee established • Funds raised from Verizon, Los Angeles County Supervisor Zev Yaroslavsky, California Family Justice Initiative and Reese Witherspoon • Funding from US Department of Housing and Urban Development covered cost of renovation • Doors to Valley CARES officially opened
Hospital's Contribution / Program Expense	\$521,102
FY 2012	
Goal 2012	To become fully operational as a Family Justice Center
2011 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • To develop new protocols as needed • To facilitate the co-location of additional partners • To tailor software program to meet the needs of co-located agencies • To serve victims of interpersonal violence • To host the grand opening of the Family Justice Center • To raise funds to sustain the initiative • To share lessons learned with emerging family justice centers
Baseline	Same as above.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Update Operations Manual • Review protocols and develop new ones • Provide comprehensive services to victims of interpersonal by on-site and off-site partners • Collect and evaluate data • Write grants • Develop multiple revenue sources • Expand the Governance Committee

341 Northridge Hospital Medical Center
 Complete Summary - Classified Including Non Community Benefit
 For period from 7/1/2010 through 6/30/2011

NHMC uses the cost accounting methodology.

	<u>Persons</u>	<u>Total Expense</u>	<u>Offsetting Revenue</u>	<u>Net Benefit</u>	<u>% of Organization Expenses Revenue</u>	
<u>Benefits for Living in Poverty</u>						
Traditional Charity Care	10,686	8,220,142	0	8,220,142	2.2	1.9
Unpaid Cost of Medicaid	28,223	97,742,613	92,076,473	5,666,140	1.5	1.3
Community Services						
Cash and In-Kind Contributions	30,006	2,593,198	0	2,593,198	0.7	0.6
Community Building Activities	32	1,852	0	1,852	0.0	0.0
Community Health Improvement Services	21,453	2,889,999	4,000	2,885,999	0.8	0.7
Health Professions Education	21,600	10,971,607	0	10,971,607	3.0	2.5
Subsidized Health Services	12	455,636	0	455,636	0.1	0.1
Totals for Community Services	73,103	16,912,292	4,000	16,908,292	4.6	3.9
Totals for Living in Poverty	112,012	122,875,047	92,080,473	30,794,574	8.4	7.1
<u>Benefits for Broader Community</u>						
Community Services						
Cash and In-Kind Contributions	8,308	290,649	0	290,649	0.1	0.1
Community Benefit Operations	8	354,504	0	354,504	0.1	0.1
Community Building Activities	1,376	239,922	2,291	237,631	0.1	0.1
Community Health Improvement Services	47,636	3,797,506	931	3,796,575	1.0	0.9
Health Professions Education	4,923	3,386,108	0	3,386,108	0.9	0.8
Research	156	66,522	0	66,522	0.0	0.0
Subsidized Health Services	11,319	455,158	0	455,158	0.1	0.1
Totals for Community Services	73,726	8,590,369	3,222	8,587,147	2.3	2.0
Totals for Broader Community	73,726	8,590,369	3,222	8,587,147	2.3	2.0
Totals - Community Benefit	185,738	131,465,416	92,083,695	39,381,721	10.7	9.1
Unpaid Cost of Medicare	20,374	101,149,474	79,397,824	21,751,650	5.9	5.0
Totals with Medicare	206,112	232,614,890	171,481,519	61,133,371	16.7	14.2
Totals Including Medicare	206,112	232,614,890	171,481,519	61,133,371	16.7	14.2


 Michael Taylor
 Vice President and Chief Financial Officer
 Northridge Hospital Medical Center

NON-QUANTIFIABLE BENEFIT

Northridge Hospital Medical Center works collaboratively with community partners in local capacity building, and in community-wide health planning. Some of the hospital's involvement includes:

- Board President, Valley Care Community Consortium
- Committee Member, Triennial San Fernando Valley SPA 2 Community Needs Assessment Collaborative
- Board Member, San Fernando Valley Economic Alliance
- Board Member, San Fernando Valley Child Abuse Council
- Valley Industry Community Association (VICA)
- Committee Chairman, LA City Councilman Greig Smith's Northridge 100 Centennial
- President, Northwest Nursing Leadership Council, HASC (Hospital Association of Southern California)
- President, Board of Directors, WYNGS (Rebuilding Lives after Spinal Cord Injury)
- International Association of Forensic Nurses
- California Sexual Assault Investigators Association
- Member, National Family Justice Center Alliance
- Los Angeles Police Department
- Los Angeles City Attorney
- Valley Trauma Center
- Neighborhood Legal Services
- Haven Hills
- Committee Member, Los Angeles Unified School District 1 & 2 Councils
- California State University Northridge – Dept. of Kinesiology
- Enrichment Works
- Partners in Care Foundation
- WeSpark
- Parkinson's Association
- Valley Community Clinic
- Domestic Abuse Center
- Northeast Valley Health Corporation
- Tarzana Treatment Centers
- WISE & Healthy Aging
- Providence Holy Cross- Latino Health Promoter Program
- Sustainable Economic Enterprises of Los Angeles
- Alzheimer's Association
- Executive Women International
- Assistance League of Southern California
- Collaborative Partner, American Diabetes Association

- National Children’s Alliance, Associate Member
- American Professional Society for Abused Children
- Member, American Heart Association
- Network for a Healthy California
- Member, California Diabetes Program
- Los Angeles Unified School District:
 - Local District One Organization Facilitator
 - Coordinated School Health Facilitator
 - Student Health and Human Services
 - Primary Intervention Counselor Program
 - District One School Nurses, District Nursing Services
 - Student Medical Services and Obesity Clinic

TELLING THE STORY

Each year, Northridge Hospital Medical Center publicizes the Community Report by:

- Presenting the report internally to the Senior Leadership Team, Hospital Leadership Team, and through internal publications for all staff members and physicians
- Putting the plan on the hospital's website at www.NorthridgeHospital.org
- Distributing the plan to local, county and state government officials
- Producing summary of key initiatives for distribution to Valley Care Community Consortium member organizations and agencies
- Summarizing key points in the hospital's community *HealthSpeak* publication mailed to approximately 200,000 residents of the community
- Publishing a summary of key points for distribution at community-based meetings

ATTACHMENTS

**Northridge Hospital Medical Center
Community Board Membership Roster**

Executive Summary of Financial Assistance/Charity Care Policy

Community Benefit Graphs

CNI, Map of the Community and Zip Codes

**NORTHRIDGE HOSPITAL MEDICAL CENTER
COMMUNITY BOARD
July, 2010**

Hildy Aguinaldo
Lewis Brisbois Bisgaard & Smith

Donald Gloisten
GBS Financial Corporation

Kevin Ariani, MD
Physician

Lamya Jarjour, MD
Physician

Hilary Baker
California State University, Northridge

Thomas Nowlin
Healthcare Management

Magued Beshay, MD
Facey Medical Group

Celeste Ortiz
Medtronic

Wayne Bradshaw
Broadway Federal Bank

Ube Pump
Community Advocate

Don Crane
CAPG -California Association
Of Physician Groups

Tere Napal-Saad, MD
Physician

Rosanne Curtis, PhD
Mount St. Mary's College

Hooshang Semnani, MD
Physician

Sal Esparza
California State University, Northridge

Tony Torres
Black & White Towing

Michael Wall, President
Northridge Hospital Medical Center

CATHOLIC HEALTHCARE WEST
SUMMARY OF PATIENT FINANCIAL ASSISTANCE POLICY
(June 2008)

Policy Overview:

Catholic Healthcare West (CHW) is committed to providing financial assistance to persons who have health care needs and are uninsured or under-insured, ineligible for a government program, and otherwise unable to pay for medically necessary care based on their individual financial situations. Consistent with its mission to deliver compassionate, high quality, affordable health care services, and to advocate for those who are poor and disenfranchised, CHW strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Financial assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with CHW's procedures for obtaining financial assistance, and to contribute to the cost of their care based on individual ability to pay. Individuals with financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services.

Eligibility for Patient Financial Assistance:

- Eligibility for financial assistance will be considered for those individuals who are uninsured, ineligible for any government health care benefit program, and unable to pay for their care, based upon a determination of financial need in accordance with the policy.
- The granting of financial assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, or immigration status, sexual orientation or religious affiliation.

Determination of Financial Need:

- Financial need will be determined through an individual assessment that may include:
 - a. An application process in which the patient or the patient's guarantor is required to cooperate and supply all documentation necessary to make the determination of financial need;
 - b. The use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay;
 - c. a reasonable effort by the CHW facility to explore and assist patients in applying for appropriate alternative sources of payment and coverage from public and private payment programs; and will take into account the patient's assets and other financial resources.
- It is preferred but not required that a request for financial assistance and a determination of financial need occur prior to rendering of services. The need for financial assistance may be re-evaluated at each subsequent rendering of services, or at any time additional information relevant to the eligibility of the patient for financial assistance becomes known.
- CHW's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of financial assistance. Requests for financial assistance shall be processed promptly, and the CHW facility shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

Patient Financial Assistance Guidelines:

Services eligible under the policy will be made available to the patient on a sliding fee scale, in accordance with financial need as determined by the Federal Poverty Level (FPL) in effect at the time of the determination as follows:

- Patients whose income is at or below 200% of the FPL are eligible to receive free care;
- Patients whose income is above 200% but not more than 350% of the FPL are eligible to receive services at the average rates of payment the CHW facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater in amount for the same services;
- Patients whose income is above 350% but not more than 500% of the FPL are eligible to receive services at 135% of the average rates the CHW facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater for the same services;
- Patients whose income exceeds 500% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of the CHW facility.

CHW's administrative policy for Eligibility and Application for Payment Assistance shall define what qualifies as *income* for these purposes.

Communication of the Financial Assistance Program to Patients and the Public:

- Information about patient financial assistance available from CHW, including a contact number, shall be disseminated by the CHW facility by various means, including the publication of notices in patient bills and by posting notices in the Emergency and Admitting Departments, and at other public places as the CHW facility may elect. Such information shall be provided in the primary languages spoken by the populations served by the CHW facility.
- Any member of the CHW facility staff or medical staff may make referral of patients for financial assistance. The patient or a family member, a close friend or associate of the patient may also make a request for financial assistance.

Budgeting and Reporting:

- Specific dollar amounts and annual plans for patient financial assistance will be included within the Social Accountability Budget of the CHW facility. CHW facilities will report patient financial assistance calculated at cost in the annual Social Accountability Report and may voluntarily report such information as deemed appropriate.
- Patient financial assistance statistics shall be disclosed in annual financial statements but shall not include amounts that are properly considered to be bad debt or contractual discounts.

Relationship to Collection Policies:

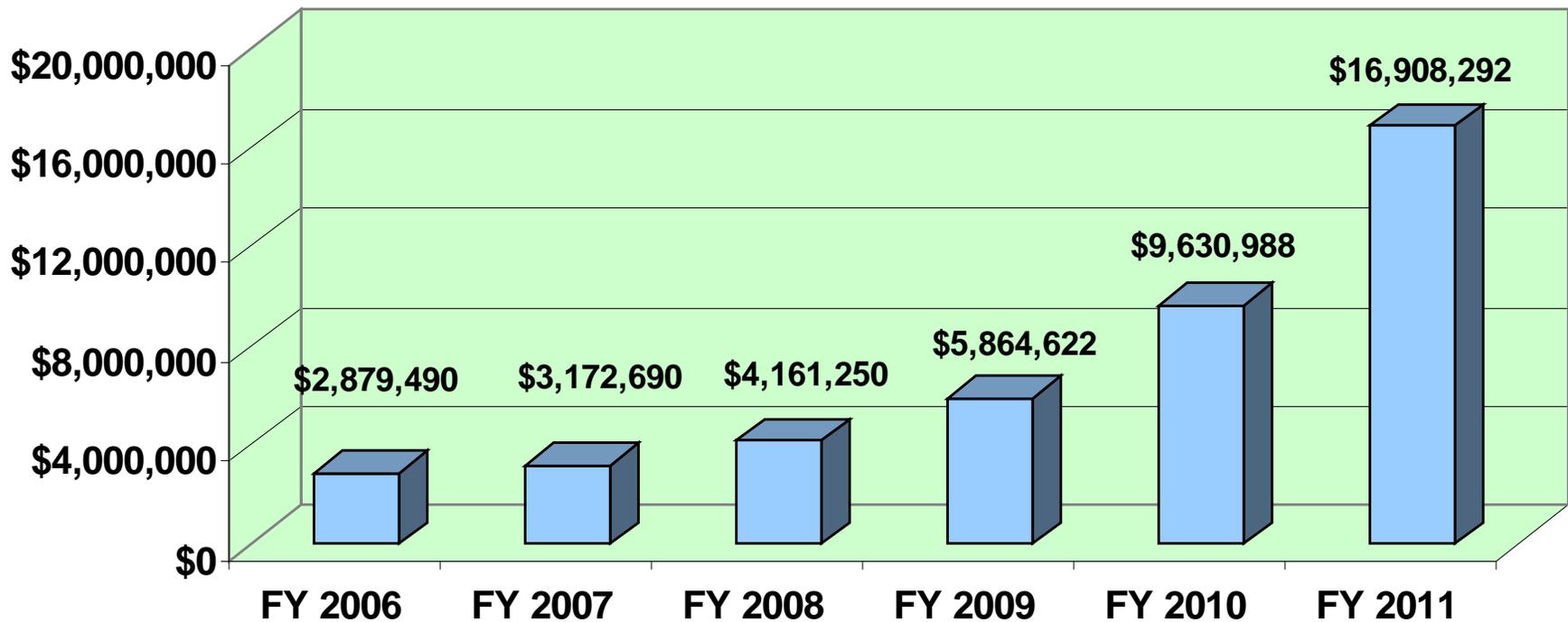
- CHW system management shall develop policies and procedures for internal and external collection practices by CHW facilities that take into account the extent to which the patient qualifies for financial assistance, a patient's good faith effort to apply for a governmental program or for financial assistance from CHW, and a patient's good faith effort to comply with his or her payment agreements with the CHW facility.
- For patients who qualify for financial assistance and who are cooperating in good faith to resolve their

hospital bills, CHW facilities may offer interest-free extended payment plans to eligible patients, will not impose wage garnishments or liens on primary residences and will not send unpaid bills to outside collection agencies.

Regulatory Requirements:

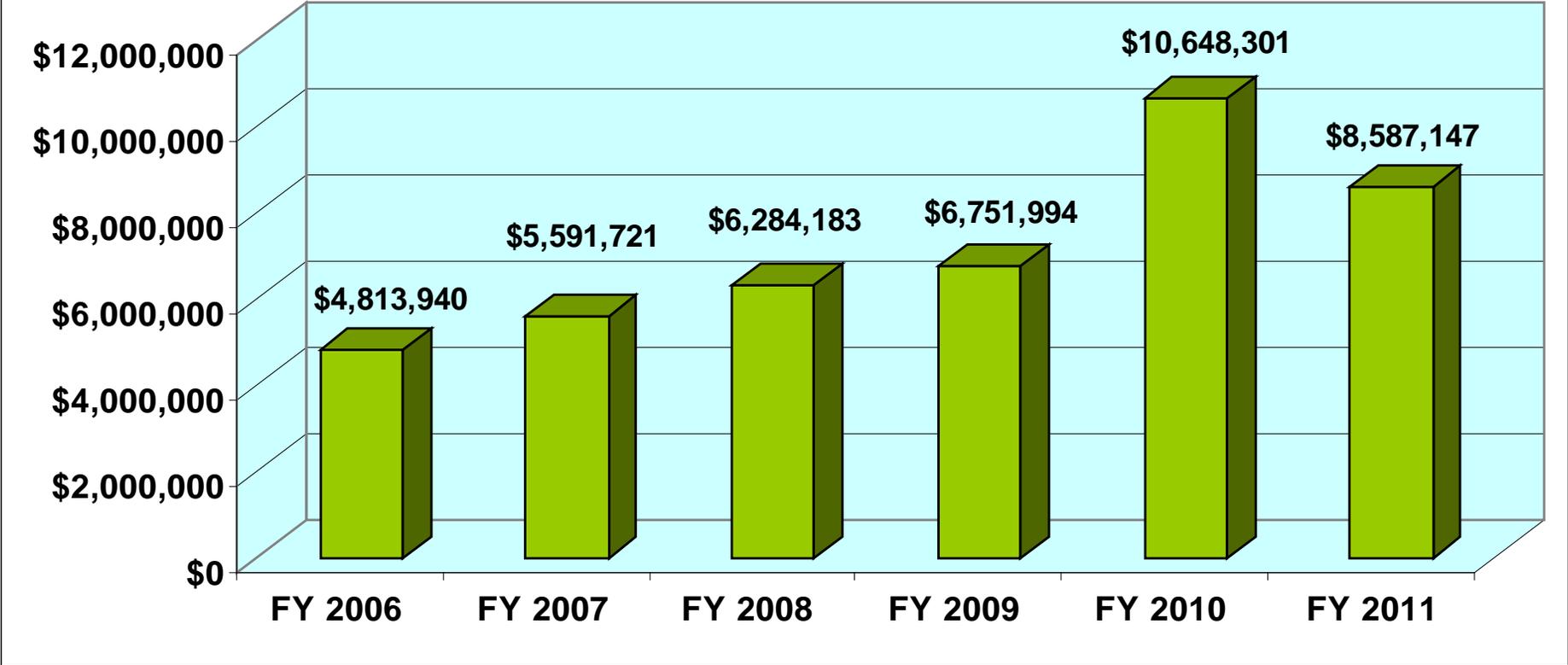
In implementing this policy, CHW management and CHW facilities shall comply with all federal state and local laws, rules and regulations that may apply to activities conducted pursuant to this policy.

Northridge Hospital Medical Center Net Community Benefit Services for the Poor (does not include the unpaid cost of Medicaid)

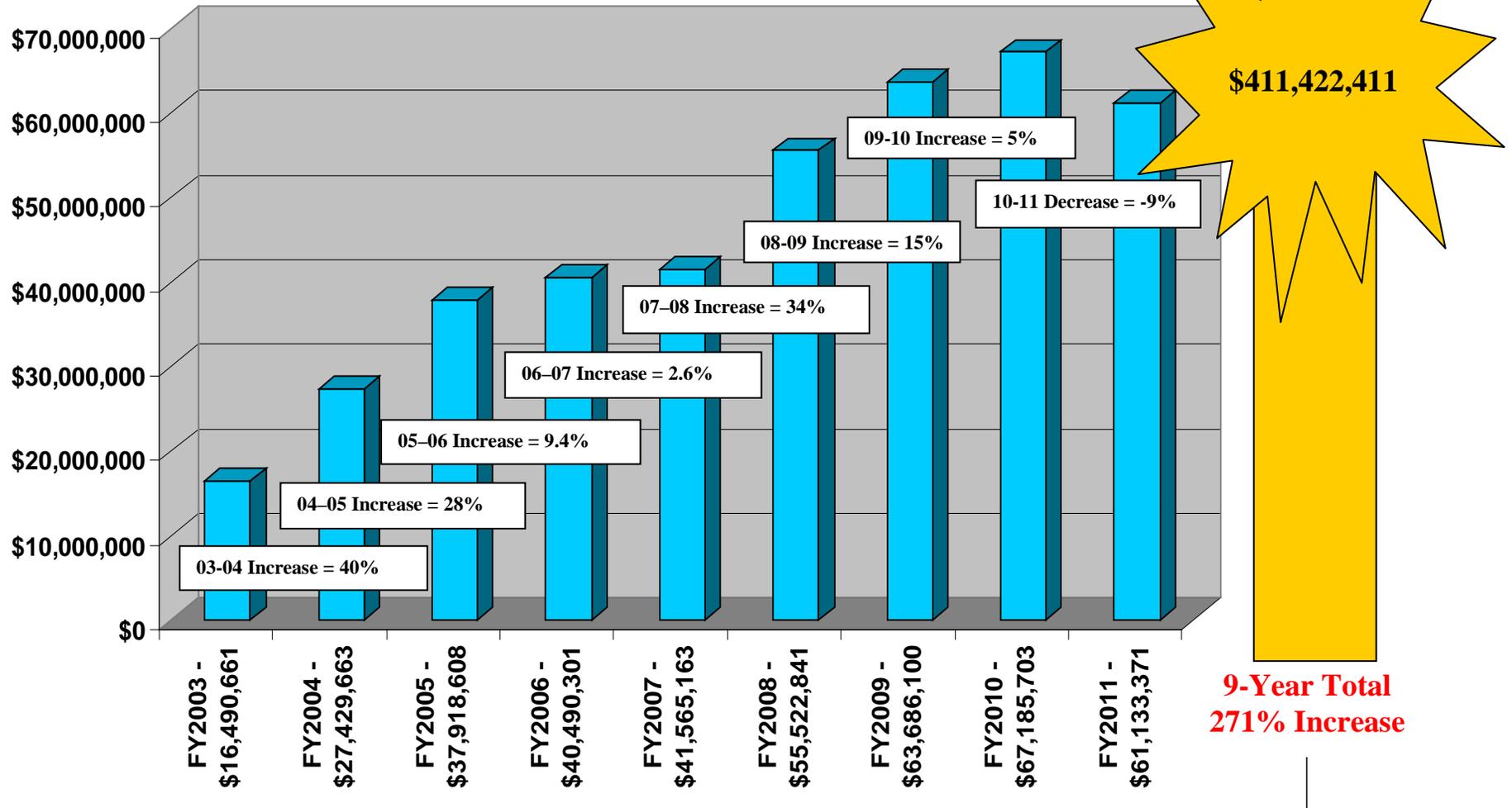


Northridge Hospital Medical Center Net Community Benefit Services for the Broader Community

(Does not include the unpaid cost of Medicare)



Northridge Hospital Net Community Benefit



Northridge Hospital Medical Center Community Needs Index by Zip Code

Community Benefit Initiatives

