



## **Northridge Hospital Medical Center**

### **Community Benefit Report 2013 Community Benefit Implementation Plan 2014**



A message from Saliba H. Salo, President/CEO, and Rosanne Silberling, PhD, Board Chair, Northridge Hospital Medical Center

When we talk about health care today, the words *budget*, *cut*, and *restraint* get used a lot. It is impersonal and it is a way to look at health care by the numbers rather than by the patient. One word that has somehow lost its meaning is also the word we believe in most of all – the word *care*. At Northridge Hospital Medical Center we strive to reintroduce humankindness to an industry focused on finance.

The Affordable Care Act created the National Prevention Council and called for the development of a National Prevention Strategy to realize the benefits of prevention for the health of all Americans. The overarching goals of the plan are to empower people, ensure healthy and safe community environments, promote clinical and community preventive services, and eliminate health disparities.

The Dignity Health system goals reflect those of health reform, namely expanding access, redesigning the delivery system, and utilizing limited resources in better, more coordinated ways so that quality can be continuously improved and patients and communities are healthier. These goals will be achieved through thoughtful *care*, whether it is demonstrated in the hospital or through the programs and services we offer in the community.

At Northridge Hospital we share a commitment to optimize the health of our community. In fiscal year 2013 Northridge Hospital provided \$61,109,500 in financial assistance, community benefit and unreimbursed patient care. Because we care, how we contribute to the quality of life and the environment in our communities has always been and will continue to be a key measure of our success.

In accordance with policy, the Northridge Hospital Community Board has reviewed and approved the annual Community Benefit Report and Implementation Plan at their October 8, 2013 meeting.

A handwritten signature in black ink that reads "Saliba H. Salo".

Saliba H. Salo  
President/CEO

A handwritten signature in black ink that reads "Rosanne Silberling".

Rosanne Silberling, RN, EdD  
Community Board Chair

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## EXECUTIVE SUMMARY

Throughout its 58 year history, Northridge Hospital Medical Center has continued its solemn responsibility, accountability and obligation to work with and for the 1.2 million residents in its service area. Northridge Hospital, a Dignity Health member, is a 411 bed non-profit facility, located in the San Fernando Valley, which is equal to the sixth largest city in the United States. The Hospital has approximately 2,000 employees, 700 affiliated physicians in 59 specialties and over 450 volunteers.

Major programs and services include: the CardioVascular Center, Leavey Cancer Center, Adult and Pediatric Trauma Center, Emergency Services, Center for Rehabilitation Medicine, Behavioral Health, Women and Children (OB, NICU, PICU & Pediatrics), the Carole Pump Women's Center, Orthopedic Services, a Stroke Center and an incredible array of technology including: the newly acquired Siemens Hybrid Bi-plane Surgical Suite, the first on the West Coast, designed for cardiac, vascular and cardiothoracic patients; the da Vinci Robotic Surgery; Gamma Knife; and Trilogy Linear Accelerator.

The Community Board, Administration and Hospital leadership work to continuously improve quality and service which is verified by the numerous accreditations, certifications, honors and recognitions including:

- Ranked Among the Top 5% in the Nation for Clinical Excellence by Healthgrades 2 Years in a Row.
- Named One of America's 100 Best Hospitals for Cardiac Surgery and Critical Care by Healthgrades in 2013.
- Healthgrades Maternity Care Excellence Award for 2013, 7 years in a row.
- Gold Seal of Approval™ from The Joint Commission.
- One of the first designated STEMI (Heart Attack) Receiving Centers in Los Angeles County.
- The Leavey Cancer Center has earned two high accreditations from the Association of Community Cancer Centers and the American College of Surgeons (ACOS).
- The Center for Rehabilitation Medicine has received accreditation from CARF (Commission on Accreditation of Rehabilitation Facilities).
- The Joint Commission has certified Northridge Hospital as an Advanced Primary Stroke Center—the first one in the central San Fernando Valley.
- Our Pediatric Intensive Care Unit and Pediatric Unit are certified by the rigorous standards of California Children's Services.
- The *Los Angeles Daily News* Readers have named us the Best Hospital for Pediatric Care, 3 years in a row.
- **Designated a Blue Distinction Center for Hip and Knee Replacement** by *Anthem Blue Cross*.

The Triennial Community Health Needs Assessment was conducted this year by Northridge Hospital in collaboration with Valley Care Community Consortium (VCCC), an organization of over 120 community service agencies, schools, hospitals and others. Our Community Benefit Plan is based on this solid foundation utilizing both the Triennial Assessment and the Community Needs Index (CNI) developed by Dignity Health. Our measurable Community Health Initiatives outlined in this report are focused on the at-risk and underserved populations identified in the assessment. These neighborhoods have the most significant barriers to healthcare services. The programs, that have proved sustainable over the years, include:

- The Center for Assault Treatment Services (CATS)
- The School-based Obesity and Diabetes Initiative (SODI)/School Wellness Initiative
- The Family Practice Center Clinic and Family Medicine Residency Program
- The Behavioral Health ED Emergency Department Initiative (EDI)
- The Valley CARES Family Justice Center
- PEP 4 Kids - A Cardiovascular Fitness Program

The net Community Benefit for FY2013 totals \$61,109,500.



## **MISSION STATEMENT**

### **I. Hospital's Mission**

#### **A. Mission Statement (Dignity Health Mission Statement)**

We are committed to furthering the healing mission 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.

We share and demonstrate the following five core values of Dignity Healthy:

- Dignity – Respecting the inherent value and worth of each person.
- Collaboration – Working together with people who support common values and vision to achieve 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.

The Mission Statement was reviewed and affirmed in October 2013 by the NHMC Community Board of Directors and the NHMC Senior Leadership Team (SLT).

## ORGANIZATIONAL COMMITMENT

### I. Hospital's organizational commitment

#### A. Organizational commitment to the Community Benefit process

1. Summary of how governing body, CEO and SLT are involved in CHNA process and the Community Benefit planning process

The Community Board and Hospital Leadership team is committed to assuring that our medical center is at the forefront of improving the community's health status and access to healthcare and addressing the issues that are primary health concerns.

Northridge Hospital's organizational commitment is to a wide range of community benefit and outreach programs. Adequate resources need to be allocated from throughout the hospital to respond to these unmet health needs. Some of the active department participants include: The Emergency Department, The Leavey Cancer Center, the Carole Pump Women's Center, the Cardiovascular Center, the Behavioral Health Department, the Marketing Communications Department, and The Northridge Hospital Foundation. The hospital's Center for Healthier Communities is the champion for addressing health needs and the health status of the community and supervises the Childhood Wellness Programs/Schools Obesity and Diabetes Initiative, the PEP 4 Kids Program and CATS (Center for Assault Treatment Services).

This year we were proud to award eight grants - totaling **\$190,794**. The Community Board made the grant presentations to the organizations at their January 2013 Board meeting. For the last twelve years of the Community Grants Program, we have awarded more than **\$2.7 million** in community grants to **78** non-profit groups.

- **San Fernando Valley Rescue Mission** - \$10,000 – "Rescue SOS" provides outreach services to meet the needs of the chronically homeless in the San Fernando Valley.
- **Los Angeles Unified School District, ESC North** - \$15,000 – To support the "School-based Obesity & Diabetes Initiative", a Health Navigator will work with the district school health clinics to provide diabetes and obesity health education and case management to students.
- **El Nido Family Centers** - \$ 15,000 – The "Child Abuse Prevention and Treatment Program" supports children and families affected by child abuse, neglect and domestic violence.
- **Enrichment Works** - \$15,300 - "Food for Thought: My Plate" will be performed in eight of the NHMC School-based Diabetes & Obesity Initiative schools.
- **Asian Pacific Women's Center** - \$20,494 – "Community Education and Empowerment" is a program for domestic violence outreach in the Asian Pacific communities.
- **Los Angeles Police Foundation** - \$35,000 – "Lethality Risk Reduction Project" will help reduce the lethal risk to victims of domestic violence and sexual assault through a coordinated response.
- **Tarzana Treatment Centers** - \$40,000 - "Decreasing Emergency Department Use through Education and Assessment" connects NHMC ER patients in need to primary care, substance abuse and mental health treatment.
- **California State University, Northridge** - \$40,000 – "Let's Cook and Move" will provide physical activity and nutrition education programs to students and parents in NHMC School-based Diabetes & Obesity Initiative schools.

## 2. Summary of Community Board's role and responsibilities

The role of the Community Board is to participate in the process of establishing priorities, plans and programs for the Healthy Communities Initiatives, based on an assessment of community needs and assets. They also approve the community benefit plan for the hospital and monitor progress toward identified goals. The community benefit plan is developed in accordance with standards and procedures of Dignity Health.

Our Community Board is very representative of the culturally diverse community we serve and provides perspective and support in achieving the mission and vision. The Board composition is: 64% male and 36% female with 21% Caucasian, 28% Hispanic, 14% African American and 37% other.

The respected and knowledgeable members of the Board are also charged with assisting the hospital in developing the strategic direction and monitoring the hospital's implementation of its goals and strategic initiatives. (See Appendix A, Board of Directors). The NHMC Community Board of Directors approved the 2013 Community Benefit Report/2014 Community Benefit Plan in October 2013.

### **B. Non-Quantifiable Community Benefits**

Collaboration with community partners in local capacity building and community building is significant and revolve around strong partnerships with area organizations, most notably:

- American Heart Association
- California State University, Northridge
- Enrichment Works
- Healthcare Partners
- Los Angeles Unified School District Educational Service Center North
- Los Angeles Police Department
- Los Angeles City Attorney
- Los Angeles County District Attorney
- Neighborhood Legal Services
- Network for a Healthy California
- Tarzana Treatment Center
- Tri-Valley YMCA
- Valley Care Community Consortium
- Valley Trauma Center

Our affiliation with area political leaders is also significant. We work closely with Los Angeles City Council Members Nury Martinez, Richard Alarcon, and Mitch Englander, U.S. Congressmen Tony Cardenas and Brad Sherman, LA County Supervisor Zev Yaroslavsky, California State Senator Alex Padilla and, Los Angeles Chief of Police, Charlie Beck.

Our environmental initiatives are significant with Ecology goals for solid waste and medical waste that are met or exceeded each year; awards including Practice Greenhealth Partner in Change for waste reduction, mercury elimination and other successful pollution prevention programs. Antimicrobial Faucet laminar Devices installed throughout the hospital have restricted water flow from 4-6 gallons per minute to 1.5 gallons per minute.

# COMMUNITY

## II. Community

### A. Definition of Community

#### 1. Key Factors

The key factors considered in defining the community are the hospital's service area, geographic boundaries, demographics, and the barriers to accessing care including the poverty rates, insurance, transportation, culture and education.

#### 2. Description of the Community

Northridge Hospital Medical Center's service area includes 1.2 million individuals residing in 27 zip codes in the San Fernando and Santa Clarita Valleys of Los Angeles County and a portion of the city of Simi Valley in Ventura County. This highly urbanized area is interspersed with mountain ranges and public open space. The region has pockets of extreme poverty. Fifteen of the 27 zip codes have approximately 821,000 residents who fall into the highest needs category using Dignity Health's Community Need Index (CNI) which identified the five prominent barriers to health care access (income, culture, education, insurance and housing). The recovery has been slow following the Great Recession, and poverty remains a significant barrier for families in many communities. Racial and ethnic diversity has increased due to immigration.

#### 3. Demographics

The demographics of NHMC's service area, as defined above, include:

- ❖ Population: 1.2 million residents evenly distributed among males and females
- ❖ Diversity: 49.57% Latino, 33.45% Caucasian, 10.81% Asian & Pacific Islander, 3.57% African American, and 2.59% other
- ❖ Average household income between \$50,000-60,000 with 20% earning less than \$25,000 annually;
- ❖ No H.S. Diploma: 15.10%
- ❖ Uninsured: 19.01%
- ❖ Unemployed: 7.6%
- ❖ Renters: 41.8%
- ❖ Medi-cal Patients: 15.83%
- ❖ Other area hospitals include Mission Community Hospital; Providence Holy Cross, St. Joseph's & Tarzana; West Hills; Valley Presbyterian; Kaiser Permanente; and Olive View County Hospital.

#### 4. Disproportionate Unmet Health Needs Communities

As per the Community Need Index, the specific neighborhoods with Disproportionate Unmet Health-related Needs (DUHN) in NHMC's primary 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.

One of the key needs identified in Northridge Hospital's 2013 Community Health Needs Assessment: A Triennial Report, not being addressed by Northridge Hospital is access to affordable dental health services. Northridge Hospital does not have the resources to address this health issue. The hospital does make referrals, however we do not have a program that specifically targets dental care.

# COMMUNITY BENEFIT PLANNING PROCESS

## III. Planning process

### A. Community Health Needs Assessment Process

Northridge Hospital Medical Center, in collaboration with the Valley Care Community Consortium (VCCC), developed Northridge Hospital's 2013 Community Health Needs Assessment, A Triennial Report, in compliance with the new federal requirements. VCCC is the health planning collaborative for the San Fernando and Santa Clarita Valleys in Los Angeles County. The first step was a review of the 2010 needs assessment conducted by VCCC in collaboration with NHMC and several other area hospitals. This information was updated with more recent statistics from city, county, state and national sources. Data was summarized from secondary data sources to describe 17 health issues. Tables of diseases by zip code focusing on the hospital's primary service area, using 2012 Thomson Reuters Databook, were compared with available county, state and national data (California Department of Public Health, Los Angeles Department of Public Health, the Centers for Disease Control, Healthy People 2020) were analyzed.

Based on this analysis, discussion topics were developed to gather primary data through local focus groups, community forums, paper surveys, an online survey and interviews with key informants that reached across the hospital's catchment area with a focus on persons and areas impacted by health disparities. Dignity Health's Community Need Index, which provides five indicators related to health disparity and hospital readmissions, revealed that two-thirds of residents live in 15 zip codes that have the highest need score. The ten most immediate community health needs identified, listed from highest need to lowest, included:

1. Access and consistent source of primary care
2. Dental care access (adult and youth)
3. Mental health and substance abuse
4. Diabetes management
5. Poverty rates
6. Healthy eating
7. Uninsured population
8. Heart disease
9. Obesity/overweight
10. Prevention and wellness

The Hospital Community Board voted to accept the 2013 Community Health Needs Assessment and address all of the 10 immediate community needs except dental care.

The 12 most pressing intermediary community health needs included aging, asthma, cancer, caregiver support, care coordination, child abuse & domestic violence, education, hypertension, lack of physical activity, language barriers, teen births and smoking.

NHMC's 2013 Community Needs Assessment Report was disseminated to the community via mailings, posting on the hospital's website, and distribution at community forums. 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.

## **B. Assets Assessment**

The assessment identified a number of strong community assets including a broad range of health care (clinics, hospitals, cancer and heart disease resources, HIV and STD services), mental health care (crisis resources, suicide prevention services, mental health services for children and adults), oral health, health and human services (housing, youth development, violence prevention, child abuse services), and parks and recreation resources tailored to the unique needs of the diverse communities in the hospital's service area. The assets were inventoried to better understand the existing landscape so that new partnerships may be forged and gaps warranting attention could be identified in order to address unmet community need.

## **C. Developing the Implementation Plan**

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

- **Saliba Salo**, President & Chief Executive Officer
- **Barb Payne, RN**, Interim Chief Nurse Executive
- **Ron Rozanski**, Senior Vice President, Operations
- **Noachim Marco, MD**, Vice President, Medical Affairs
- **Michael Taylor**, Chief Financial Officer
- **Teddi Grant**, Vice President, Marketing, Community Benefits and Mission Integration
- **Nana Deeb**, Vice President, Clinical Services
- **Susan Paulsen**, Director, Human Resources
- **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)

2. Factors taken into consideration

In developing the hospital's community benefit plan, data on the hospital's primary service area was considered including household income distribution, race and ethnicity, educational level, insurance and housing:

Income Barriers: Twenty percent of households in NHMC's primary service center (PSA) made less than \$25,000 and six percent were unemployed. Health outcomes have been linked to living in impoverished neighborhoods. An estimated that individuals living in areas with the greatest income inequalities 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's California Health Interview Survey Research 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

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: Thirty-five percent of residents in the hospital's primary service area are uninsured or on Medi-Cal.

Housing Barriers: The 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).

### 3. 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.

Existing services include:

- The Center for Assault Treatment Services (CATS)
- The Family Practice Center
- School-based Obesity and Diabetes Initiative (SODI)
- PEP 4 Kids, a Cardiovascular Fitness Program
- 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

The following factors are taken into consideration in selecting interventions:

- The community needs identified in Northridge Hospital's 2013 Community Health Needs Assessment: A Triennial Report
- The under-served communities identified in Dignity Health'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

### 4. 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 residing in the 15 zip codes identified in Dignity Health's Community Need Index as high need communities.

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.

### 5. 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.

#### **D. Planning for the Uninsured/Underinsured Patient Population**

1. Financial Assistance/Charity Care Policy

Northridge Hospital Medical Center's Financial Assistance and Charity Care Policy are directed by its parent company Dignity Health. A copy of the Dignity Health Financial Assistance Policy summation is included in the Appendix.

2. 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.

3. Process to inform 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](http://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 January 2013.

## PLAN REPORT AND UPDATE

### IV. Plan Report and Update Including Measurable Objectives and Timeframes

#### A. 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 2013, CATS provided medical evidentiary examinations in a compassionate and caring environment for almost 1,000 victims of all ages. CATS' outreach component provided more than 1,000 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 FY2013 was \$1,072,879.

- **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 center has transitioned to the Valley Trauma Center which has assumed the leadership role. The Valley CARES net community benefit for FY2013 was \$159,602.

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

The School Wellness 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 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: Northridge Hospital's Cardiology and Cancer Departments 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 State University, Northridge–Department of Dietetic Internship and Department of Kinesiology, Dairy Council of California, Enrichment Works, Health Net, Healthy Food School Coalition, Health Care Partners, Mid-Valley YMCA, Network for a Healthy California–LAUSD and Latino Campaign, Northeast Valley Health Corporation, Partners in Care Foundation, Providence Holy Cross, Sustainable Economic Enterprises of Los Angeles, University of California Cooperation Extension Los Angeles County Valley Care Community Consortium, and local elected officials. During FY2013, the initiative focused on 33 schools and reached a total of 34,131 students, parents, teachers and staff. The total net community benefit was \$274,180.

- **PEP 4 Kids, a Cardiovascular Fitness Program**

The federally funded project, PEP 4 Kids, provided four public schools with a full-time credentialed Physical Education teacher. Classroom teachers in four LAUSD elementary schools were trained by credentialed PE teachers to implement the evidence-based CATCH fitness and nutrition curriculum with the goal of improving students' cardiovascular fitness. The total net community benefit was \$500,000.

### **Emergency Department Initiative**

The LTIP Emergency Department Initiative (EDI) is a collaboration between Northridge Hospital Medical Center (NHMC) and Tarzana Treatment Center (TTC). The objective of the collaboration is to reduce health disparities among populations with disproportionate unmet health-related needs, specifically individuals with alcohol and/or chemical dependency and mental health conditions by at least 5% from base line. Additionally, the focus is on those patients who are uninsured or underinsured. Referrals are made to the TTC Case Manager by an MD. The TTC Case Manager provides an assessment, individualized plan of care and assistance in establishing follow-up services. 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 FY2013 was \$11,999.

### **Congestive Heart Failure Initiative**

The Congestive Heart Failure Initiative (CHFI) is a collaboration between Northridge Hospital Medical Center (NHMC) and Tarzana Treatment Centers (TTC) to demonstrate a decrease in readmissions within six months of a prior Emergency Department visit for pre-identified participants in the hospital's Congestive Heart Failure preventive health intervention long term improvement plan. As part of 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, coordinating with other coordinators of client care or services, referral to ambulatory care, distribution of transportation vouchers and follow-up. Patients are also

encouraged to enroll in the Congestive Heart Active Management Program. The total net community benefit for FY2013 was \$1,517.

### **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 \$9,262,466.

- **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. Twelve full-time faculty, additional part-time faculty, 23 resident physicians and over 100 community physicians are involved in the teaching programs each year. The Program also collaborates with Federally Qualified Community Clinics 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.

### **Other Programs:**

- **Leavey Cancer Center**

The total net community benefit for the Cancer Center was \$522,059. 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, 1,068 women were provided with free mammograms to screen them for breast cancer. There were 33 positive breast cancer diagnoses which were referred for treatment.

- **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.

A thorough needs assessment identified a change in the amount of the disenfranchised population in the community. Therefore, toward the end of 2011, the Cancer Center increased the frequency of its free cancer health screenings fair to monthly. Screening fairs are now being offered on a monthly basis for mammograms and prostate screening on a quarterly basis, in order to be able to reach out to more people. The program is now geared toward mammograms and prostate screenings-since these are the predominant cancers within our community.

- **July 2012:** 97 breast
  - **August 2012:** 74 breast
  - **September 2012:** 103 breast
  - **October 2012:** 96 breast
  - **November 2012:** 114 breast
  - **December 2012:** 78 breast
  - **January 2013:** 45 breast
  - **February 2013:** 77 breast
  - **March 2013:** 92 breast
  - **April 2013:** 103 breast
  - **May 2013:** 98 breast, 20 prostate
  - **June 2013:** 91 breast
- **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 mammograms with additional funding received from the Harold Pump Memorial Foundation.
    - 5,212 individuals in 76 community groups have been educated about breast and/or colon cancer awareness and screening guidelines and informed about our free mammogram 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 187 individuals were reached.
    - To further augment our services, we obtained grant funding to provide massage therapy to Cancer patients. We provided services to 1,696 individuals over the last year.
    - 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, Trigeminal Neuralgia Support Group, Breast Cancer Support Group, and a Survivorship Support Group.
  - **Patient Advocate**
    - A part-time bilingual Patient Advocate, who holds a Bachelor's Degree in Health Administration, was hired to assist the Outreach Navigator with both outreach

and inpatient needs, including assistance with transportation and home health issues. Moreover, the Patient Advocate assumes the role of librarian to provide education and information to all patients and families at the Cancer Center library.

- **The RN Navigator**

- The RN Navigator is the patient's point-of-contact concierge for any issues or questions and helps to coordinate patient appointments with other specialties to ensure a smooth transition among hospital services. She meets with patients one-on-one to better acquaint them with all of our services including our Oncology Unit, Thomas & Dorothy Leavey Cancer Center, Carole Pump Women's Center, Harold Pump Department of Radiation Oncology and the Surgical Oncology services. As a resource for each patient's unique needs during their care at the Cancer Center, patients can rely on their Navigator for compassionate support, encouragement and education.
- The RN Navigator provides pre-and-post operative surgery education, helps patients and their families connect with psychosocial support such as the NHMC's partnerships with the American Cancer Society and WeSpark to offer support groups, classes and programs.
- Patients are familiarized with the Hospital through our comprehensive Patient Orientation Program, *Navigating Through Your Cancer Journey*.

- **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. 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 1,726 total hours of service to 17 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.
- **Transportation** sponsored by Harold Pump Foundation's Family Money Fund has provided 740 trips to 65 patients for their medical appointments at the cancer center.
- **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 294 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.

### **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 43,751 patients during fiscal year 2013. Of this amount

28,279 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 \$7,540,000.

### **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 1,096 persons in FY2013; of this amount 521 were low-income and could not afford to pay for services or did not have health insurance. The total net community benefit was \$527,000.

### **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 provided care for 205 persons in FY2013; of this amount 166 were low-income and could not afford to pay for services or did not have health insurance. The total cost of care for these patients was supported by a grant from the "Richie Fund" in the amount of \$1,740,000.

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.

**B. Description of Key Programs and Initiatives**

The Community Benefit programs that are a major focus include the following:

- **Center for Assault Treatment Services**
- **Family Practice Center**
- **Emergency Department Initiative**
- **School-based Obesity & Diabetes Initiative**
- **PEP 4 Kids, a Cardiovascular Fitness Program**

<b>Center for Assault Treatment Services (CATS)</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>X Increase access to appropriate health care services for the poor and underserved</li> <li>X Promote collaboration and reduction of duplicative health services</li> <li>Address the obesity and diabetes epidemic</li> <li>Address heart disease</li> <li>Provide access to mental health and substance abuse services</li> <li>X Increase services to victims of trauma and violence</li> </ul>
<b>Program Emphasis</b>	<ul style="list-style-type: none"> <li>X Disproportionate Unmet Health-Related Needs</li> <li>X Primary Prevention</li> <li>X Seamless Continuum of Care</li> <li>X Build Community Capacity</li> <li>X Collaborative Governance</li> </ul>
<b>Link to Community Needs Assessment, Vulnerable Population</b>	Programs are needed that focus on personal development and mental health of adolescents and better education on programs and services available in the community.
<b>Program Description</b>	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.
<b>FY 2013</b>	
<b>Goal FY 2013</b>	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.
<b>2013 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• By June 30, 2013, provide medical evidentiary examinations, case management and counseling to 850 victims of sexual abuse and assault of all ages.</li> </ul>

	<ul style="list-style-type: none"> <li>• By June 30, 2013 provide prevention education to a minimum of 1,200 mandated child abuse reporters and the general public.</li> <li>• By June 30, 2013 develop strategic plan for expansion efforts.</li> <li>• By June 30, 2013 raise funds to support program components.</li> </ul>
<b>Baseline</b>	Sexual assault victims need immediate post-abuse treatment. Few victims disclose and even fewer mandated reporters report incidence of abuse.
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Conduct medical evidentiary exams of victims of sexual abuse/ assault and DV of all ages.</li> <li>• Conduct forensic interviews.</li> <li>• Work closely with child protective services, law enforcement and the District Attorney's office to assist in the investigation process.</li> <li>• Work closely with the Valley Trauma Center to provide post-trauma case management and counseling to victims.</li> <li>• Outreach to public and private schools, hospitals, clinics and other community-based organizations.</li> <li>• Develop training materials and conduct trainings.</li> <li>• Evaluate results.</li> </ul>
<b>Result FY2013</b>	<ul style="list-style-type: none"> <li>• CATS provided medical evidentiary exams and forensic interviews to almost 1,000 victims of sexual abuse and assault. Law enforcement was billed at the rate of \$730 per case for the medical evidentiary exams.</li> <li>• Case management was provided to all victims and they were offered free counseling.</li> <li>• CATS Outreach Staff provided Child Abuse Education to 1,004 mandated child abuse reporters.</li> <li>• CATS raised \$324,000 in funds from private and corporate foundations, its annual walk/run event, retail campaigns, social and business clubs and individual donors.</li> </ul>
<b>NHMC Contribution/ Program Expense</b>	\$1,274,182
<b>FY 2014</b>	
<b>Goal 2014</b>	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.
<b>2014 Objective measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• By June 30, 2014 relocate to a new satellite office with partner agencies resulting in a best practice one stop shop for victims of sexual assault and abuse.</li> <li>• By June 30, 2014, provide medical evidentiary examinations, case management and counseling to 900 victims of sexual abuse and assault of all ages.</li> <li>• By June 30, 2014 provide prevention education to 1,000 mandated child abuse reporters and the general public.</li> <li>• By June 30, 2014 raise funds to support program components.</li> </ul>
<b>Baseline</b>	Same as above

<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Work closely with law enforcement and the District Attorney's Office.</li> <li>• Conduct roll call trainings at local law enforcement precincts/divisions.</li> <li>• Conduct medical evidentiary examinations and forensic interviews.</li> <li>• Review and update materials for mandated reporters.</li> <li>• Review and update CATS website.</li> <li>• Publish annual newsletter.</li> <li>• Outreach to public schools and community-based organizations.</li> <li>• Conduct trainings on-site at local agencies and schools for mandated child abuse reporters.</li> <li>• Write grants to support CATS components.</li> <li>• Conduct CATS Victory for Victims Walk/Run and the LA Marathon Team to promote awareness of child abuse and raise funds.</li> </ul>
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<b>Family Practice Center and Family Medicine Residency Program</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>X Increase access to appropriate health care services for the poor and underserved</li> <li>X Promote collaboration and reduction of duplicative health services</li> <li>X Address the obesity and diabetes epidemic</li> <li>Address heart disease</li> <li>Provide access to mental health and substance abuse services</li> <li>Increase services to victims of trauma and violence</li> </ul>
<b>Program Emphasis</b>	<ul style="list-style-type: none"> <li>X Disproportionate Unmet Health-Related Needs</li> <li>X Primary Prevention</li> <li>X Seamless Continuum of Care</li> <li>X Build Community Capacity</li> <li>X Collaborative Governance</li> </ul>
<b>Link to Community Needs Assessment</b>	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.
<b>Program Description</b>	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. 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.
<b>FY 2013</b>	
<b>Goal FY 2013</b>	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.
<b>2013 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• Number of indigent patients seen on the inpatient hospital service.</li> <li>• Number of patients seen through Medi-Cal or HMO Medi-Cal.</li> <li>• Number of patients seen through all state-funded service programs for low-income patients, such as CHDP, CCS, PACT.</li> <li>• Number of indigent patients seen in the Family Practice Center, including specialty clinics and the Diabetes Indigent Program.</li> <li>• Continuation of partnerships and outreach prevention education efforts with local schools, senior centers and community agencies.</li> </ul>
<b>Baseline</b>	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.
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Continue Family Medicine coverage of admissions through the hospital emergency department including involvement with the obstetrical and surgical panel coverage.</li> <li>• Continue and expand hospital inpatient service at Northridge Hospital Medical Center.</li> <li>• Contract with Medi-Cal HMO's as the State of California continues to move additional patients into managed Medi-Cal.</li> <li>• Maintain "Diabetes Indigent Program."</li> <li>• 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.</li> </ul>
<b>Result FY 2013</b>	<ul style="list-style-type: none"> <li>• 19,156 total visits in the hospital over a one year period, an increase .09% from last year's total of 17/266. <ul style="list-style-type: none"> <li>○ 65% of visits are for indigent/underserved care, including uninsured, Medi-Cal, and HMO Medi-Cal patients.</li> </ul> </li> <li>• 21,869 total patient visits in the Family Practice Center, including specialty clinics and the Diabetes Indigent Program. <ul style="list-style-type: none"> <li>○ 65% of visits are for indigent/underserved care, including uninsured, Medi-Cal, and HMO Medi-Cal.</li> </ul> </li> <li>• Implementation of a hospitalist fellowship program to address increased inpatient care volume of indigent patients.</li> <li>• Ongoing community partnerships and outreach programs: <ul style="list-style-type: none"> <li>○ Sutter Middle School Health Education Program reaching near 400 students annually.</li> <li>○ 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.</li> <li>○ High school football games coverage for Monroe High School, as their Team Physician.</li> <li>○ Partnership with Partners in Care's Disease Prevention and Health Promotion Program at local senior centers.</li> </ul> </li> <li>• Local Screening Health Fairs and community presentations.</li> </ul>
<b>Hospital's Contribution / Program Expense</b>	\$9,262,466
<b>FY 2014</b>	
<b>Goal 2014</b>	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.
<b>2014 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• Number of indigent patients seen on the inpatient hospital service.</li> <li>• Number of patients seen through Medi-Cal or HMO Medi-Cal.</li> <li>• Number of patients seen through all state-funded service programs for low-income patients, such as CHDP, CCS, PACT.</li> </ul>

	<ul style="list-style-type: none"> <li>• Number of indigent patients seen in the Family Practice Center including Specialty Clinics.</li> <li>• Continuation and expansion of partnerships and outreach prevention education efforts with local schools, senior centers, and community agencies.</li> <li>• Partnerships include: <ul style="list-style-type: none"> <li>○ 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.</li> <li>○ 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.</li> <li>○ Collaboration with Northridge Hospital's SODI Program (School-Based Obesity &amp; Diabetes Initiative).</li> <li>○ Increased collaboration and coordination with hospital based services including rotations with the expanded palliative care program and with the hospital chaplains.</li> </ul> </li> </ul>
<b>Baseline</b>	Same as above.
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Continue Family Medicine coverage of admissions through the hospital emergency department including involvement with the obstetrical and surgical panel coverage.</li> <li>• Continue and expand hospital inpatient service at Northridge Hospital Medical Center including increased faculty hours for supervision of inpatient care.</li> <li>• Contract with Medi-Cal HMO's as the State of California continues to move additional patients into managed Medi-Cal.</li> <li>• 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.</li> <li>• Continuation of on-site psychological services to assist patients with psychiatric diagnoses and those dealing with the stress of managing chronic diseases.</li> </ul>

<b>Emergency Department Initiative (EDI)</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>X Increase access to appropriate health care services for the poor and underserved</li> <li>X Promote collaboration and reduction of duplicative health services</li> <li>Address the obesity and diabetes epidemic</li> <li>Address heart disease</li> <li>X Provide access to mental health and substance abuse services</li> <li>Increase services to victims of trauma and violence</li> </ul>
<b>Program Emphasis</b>	<ul style="list-style-type: none"> <li>X Disproportionate Unmet Health-Related Needs</li> <li>X Primary Prevention</li> <li>X Seamless Continuum of Care</li> <li>X Build Community Capacity</li> <li>X Collaborative Governance</li> </ul>
<b>Link to Community Needs Assessment</b>	EDI 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 and other health-related issues.
<b>Program Description</b>	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.
<b>FY 2013</b>	
<b>Goal FY 2013</b>	<p>The Emergency Department Initiative (EDI) is a collaboration between Northridge Hospital Medical Center (NHMC) and Tarzana Treatment Center (TTC). The Northridge Hospital ED and TTC collaborate on reducing recidivism in the ED by at least 5% from base line. The objective of the collaboration is to reduce health disparities among populations with disproportionate unmet health-related needs, specifically individuals with alcohol and/or chemical dependency and mental health conditions. Additionally, the focus is on those patients who are uninsured or underinsured. Referrals are made to the TTC Case Manager by an MD. The TTC Case Manager provides an assessment, individualized plan of care and assistance in establishing follow-up services.</p> <p>The target population for this program is any patient who has 3 or more visits to the Emergency Department and a diagnosis related to drug/alcohol addiction and/or underlying psychiatric disturbances.</p>
<b>2013 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• Numbers of ED patients receiving TTC intervention.</li> <li>• Number of ED visits and/or hospital admissions six months prior to TTC intervention.</li> <li>• Number of ED visits and/or hospital admissions six months post TTC</li> </ul>

	<p>intervention.</p> <ul style="list-style-type: none"> <li>Percentage reduction of recidivism.</li> </ul>
<b>Baseline</b>	<u>Number of visits to ED six months prior to TTC intervention.</u>
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>Educate ED staff regarding appropriate referrals.</li> <li>TTC to provide case management for referred patients.</li> <li>NHMC and TTC maintain database.</li> <li>TTC follows up with patients.</li> <li>TTC Independent Evaluator reviews and analyzes data.</li> <li>NHMC reviews and analyzes data.</li> </ul>
<b>Result FY 2013</b>	<p>From June 2012 to June 2013,</p> <ul style="list-style-type: none"> <li>Total number of patients receiving intervention for year = 285.</li> <li>Number of patients with 3 or more visits receiving intervention= 74.</li> <li>Number with no return visits after intervention = 35.</li> <li>Percentage with no return visits after intervention = 47%.</li> <li>74 patients have been referred to the TTC case manager who met the criteria of 3 or more visits prior to intervention. The number of visits before intervention equals 623. As of May 31, 2013, the number of visits after intervention equals 228, for a reduction of 63%. Of the 74 patients, 47% of them have had no return visits, for a total of 35 patients.</li> <li>Number of patients with less than 3 visits receiving intervention = 211.</li> <li>Number with no return visits after intervention = 156.</li> <li>Percentage with no return visits after intervention = 74%.</li> <li>The number of visits before intervention was 260. The number of visits after intervention was 105 for a reduction of 60%.</li> </ul>
<b>Hospital's Contribution / Program Expense</b>	\$11,999
<b>FY 2014</b>	
<b>Goal 2014</b>	<p>The Emergency Department Initiative (EDI) is a collaboration between Northridge Hospital Medical Center (NHMC) and Tarzana Treatment Center (TTC). The Northridge Hospital ED and TTC collaborate on reducing recidivism in the ED by at least 5% from base line. The objective of the collaboration is to reduce health disparities among populations with disproportionate unmet health-related needs, specifically individuals with alcohol and/or chemical dependency and mental health conditions. Additionally, the focus is on those patients who are uninsured or underinsured. Referrals are made to the TTC Case Manager by an MD. The TTC Case Manager provides an assessment, individualized plan of care and assistance in establishing follow-up services. The target population for this program is any patient who has 3 or more visits to the Emergency Department and a diagnosis related to drug/alcohol addiction and/or underlying psychiatric disturbances.</p>
<b>2014 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>Numbers of ED patients receiving TTC intervention.</li> <li>Number of ED visits and/or hospital admissions three months prior to TTC intervention.</li> <li>Number of ED visits and/or hospital admissions three months post</li> </ul>

	TTC intervention.
<b>Baseline</b>	Same as above.
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• ED committee to hold bi-monthly meetings to implement enhancements.</li> <li>• TTC to provide case management for referred patients.</li> <li>• TTC to follow up with patients.</li> <li>• NHMC and TTC to maintain databases on patients referred.</li> <li>• Review and analyze data.</li> <li>• Evaluate effectiveness of program</li> </ul>

<b>School-based Obesity &amp; Diabetes Initiative (SODI)</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>X Increase access to appropriate health care services for the poor and underserved</li> <li>X Promote collaboration and reduction of duplicative health services</li> <li>X Address the obesity and diabetes epidemic</li> <li>X Address heart disease</li> <li>Provide access to mental health and substance abuse services</li> <li>Increase services to victims of trauma and violence</li> </ul>
<b>Program Emphasis</b>	<ul style="list-style-type: none"> <li>X Disproportionate Unmet Health-Related Needs</li> <li>X Primary Prevention</li> <li>X Seamless Continuum of Care</li> <li>X Build Community Capacity</li> <li>X Collaborative Governance</li> </ul>
<b>Link to Community Needs Assessment</b>	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.
<b>Program Description</b>	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 State University, Northridge—Department of Dietetic Internship and Department of Kinesiology, Enrichment Works, 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.
<b>FY 2013</b>	
<b>Goal 2013</b>	<ul style="list-style-type: none"> <li>• Increase physical activity and improve nutrition with the ultimate goal of decreasing childhood obesity rates.</li> </ul>
<b>2013 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• By June 2013 conduct wellness campaigns in 32 schools.</li> <li>• By June 2013 increase the number of students who engage in physical activity.</li> <li>• By June 2013 the increase students knowledge of good nutrition.</li> <li>• By June 2013 continue to recruit new partners.</li> <li>• Evaluate results.</li> </ul>
<b>Baseline</b>	Obesity and its related diseases, in particular diabetes, have reached

	<p>epidemic proportions in the San Fernando Valley of Los Angeles County. Thirty nine percent of adults in SPA 2 are overweight and twenty eight percent of youth in the East San Fernando Valley are overweight. Panorama City (19.38%), Van Nuys (17.80%) and North Hills (17.22 %) have the highest percent change in the total estimated cases of diabetes. If this trend continues, one third of children born in the year 2000 will develop Type II diabetes.</p>
<p><b>Intervention Strategy for Achieving Goal</b></p>	<ul style="list-style-type: none"> <li>• Offer program and assistance to principals at each school.</li> <li>• Identify partners to work with each school.</li> <li>• Coordinate partner's roles in addressing schools' needs.</li> <li>• Develop and implement programs for schools.</li> <li>• Monitor progress.</li> <li>• Evaluate results.</li> </ul>
<p><b>Result FY 2013</b></p>	<ul style="list-style-type: none"> <li>• SODI continued collaboration with schools; New community partners recruited.</li> <li>• Coordinated programs at participating schools.</li> </ul> <p>Parent Classes Programs:</p> <ul style="list-style-type: none"> <li>• <i>A Taste of Good Health</i> (CSUN) nutrition classes provided at Alta California, Cantara, Hart, Haskell, and Napa ES.</li> <li>• <i>Alzheimer's Awareness</i> class offered at Andasol, Canoga Park, Nevada, Plummer, Ranchito, Chase ES, Mulholland, and Sepulveda MS</li> <li>• <i>Carbohydrate Counting</i> conducted at Haskell ES.</li> <li>• <i>Cooking demonstration</i> offered at Ranchito ES.</li> <li>• <i>Diabetes Awareness and Prevention</i> class conducted at Ranchito ES.</li> <li>• <i>Diabetes Self Management Program</i> provided at Hart ES.</li> <li>• <i>Fit Families for Life 3-week series</i> completed at Burton, Canoga Park, Limerick and Stagg, Tarzana, and Winnetka ES.</li> <li>• <i>Fitness demonstration</i> conducted at Nevada ES.</li> <li>• <i>Go Red Por Tu Corazon</i> workshop conducted at Gault ES.</li> <li>• <i>Health screenings conducted</i> Cohasset, Anatola, Gault, Hart, and Ranchito ES.</li> <li>• <i>Healthy Women</i> workshop series conducted at Alta California and Sunny Brae ES.</li> <li>• <i>Nutrition educations classes (HUD)</i> provided at Cohasset, Gault, and Anatola ES.</li> <li>• <i>Parent walking groups through VCCC</i> provided at Noble, Fulbright, Limerick, and Stagg ES.</li> <li>• <i>Re-Think Your Drink</i> presentation completed at Andasol, Canoga Park, Fullbright, Gledhill, Hart, Nevada, Noble, Ranchito, and Tarzana ES.</li> <li>• <i>School Nutrition Policies</i> class provided at Nevada ES.</li> <li>• <i>Stress management</i> class provided at Danube ES.</li> <li>• <i>Physical activity</i> through YMCA offered at Ranchito ES</li> </ul> <p><b>Student Classes and Programs:</b></p> <p><i>Food for Thought: MyPlate</i> Nutrition and physical activity educational theatrical plays presented at 8 schools: Burton Cantara, Ranchito,</p>

	<p>Liggett, Langdon, Panorama City, Mayall, &amp; Winnetka ES</p> <ul style="list-style-type: none"> <li>• <i>Jump Rope for Heart</i> event: conducted at Liggett ES.</li> <li>• Playground Markings Enhancement: Langdon ES</li> </ul> <p><b>Special School Events for Students and Parents:</b></p> <ul style="list-style-type: none"> <li>• <i>Los Angeles County Community Advisory Committee (Health Net)</i> at Mulholland MS.</li> <li>• Provided nutritional information for families at Iglesia Poder de Dios Health Fair.</li> <li>• Spin the Wheel game and nutrition information at Stagg's Health Fair.</li> <li>• School Wellness Kick Off at Northridge Hospital Medical Center's Penthouse.</li> </ul>
<b>Hospital's Contribution / Program Expense</b>	\$264,346
<b>FY 2014</b>	
<b>2014 Objective Measure/Indicator of Success</b>	<p><b>Students</b></p> <ul style="list-style-type: none"> <li>• By June 30, 2014: students will: <ul style="list-style-type: none"> <li>○ Improve Fitnessgram scores among (5 grade students).</li> <li>○ receive 40 minutes/week of physical education instruction; CATCH curriculum</li> <li>○ Increase daily physical activity (elementary school students)</li> <li>○ Improve nutrition habits</li> <li>○ Participate in the fit families program; at risk families</li> </ul> </li> </ul> <p><b>Parents</b></p> <ul style="list-style-type: none"> <li>• By June 30, 2014: <ul style="list-style-type: none"> <li>○ 200 students will participate in Parent Institute for Quality Education (PIQE)</li> <li>○ 120 parents will participate in the 6-week Chronic Disease Self Management <i>Healthy Living</i> program</li> <li>○ Increase knowledge about good nutrition and fitness</li> </ul> </li> </ul> <p><b>Teachers and School Staff</b></p> <ul style="list-style-type: none"> <li>• By June 30, 2014, 320 teachers and school staff will be trained the evidence-based PE curriculum (CATCH).</li> </ul>
<b>Baseline</b>	Same as above
<b>Intervention Strategy for Achieving Goal</b>	<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"> <li>• Coordinate fitness and nutrition at 33 schools.</li> <li>• Provide PE instruction for students and teachers at 4 schools.</li> <li>• Facilitate PE instruction for 4<sup>th</sup> and 5<sup>th</sup> grade students at 4 schools.</li> <li>• Disseminate health education materials regarding nutrition and exercise to parents via school mailings, newsletters, and school parent meetings.</li> <li>• Utilize bi-lingual health navigator to conduct case management</li> <li>• Promote and facilitate VCCC parent walking clubs.</li> <li>• Provide teachers with technical assistance in utilizing the CATCH curriculum.</li> </ul>

	<ul style="list-style-type: none"><li>• Conduct skill building workshops for Parent Center Directors.</li><li>• Facilitate cholesterol, glucose, weight, and BMI screenings for parents.</li><li>• Promote and facilitate fitness and nutrition plays at 8 elementary schools.</li><li>• Continue collaboration with existing partners.</li><li>• Establish collaborations with new partners.</li></ul>
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<b>Physical Education Program 4 Kids (PEP4Kids)</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>X Increase access to appropriate health care services for the poor and underserved</li> <li>X Promote collaboration and reduction of duplicative health services</li> <li>X Address the obesity and diabetes epidemic</li> <li>X Address heart disease</li> <li>Provide access to mental health and substance abuse services</li> <li>Increase services to victims of trauma and violence</li> </ul>
<b>Program Emphasis</b>	<ul style="list-style-type: none"> <li>X Disproportionate Unmet Health-Related Needs</li> <li>X Primary Prevention</li> <li>X Seamless Continuum of Care</li> <li>X Build Community Capacity</li> <li>X Collaborative Governance</li> </ul>
<b>Link to Community Needs Assessment</b>	The PEP 4 Kids program addresses the need to increase cardiovascular fitness levels in elementary school students in the San Fernando Valley of Los Angeles County.
<b>Program Description</b>	The Physical Education Program 4 Kids (PEP4Kids) was launched in partnership with Los Angeles School District Educational Service Center North (LAUSD-ESCN) to increase cardiovascular fitness and nutrition in K-5 students in four elementary schools located in the underserved communities of Panorama City and North Hills of the San Fernando Valley. PEP 4Kids collaborative partners included: LAUSD Physical Education Advisor, Parent Center Directors and Parent Facilitators; the Alzheimer's Association, American Diabetes Association, American Heart Association, California Action for Healthy Kids, California State University, Northridge–Department of Dietetic Internship and Department of Kinesiology, Enrichment Works, Health Net, Mid-Valley YMCA, Network for a Healthy California–LAUSD and Champions for Change-Los Angeles Region, Sustainable Economic Enterprises of Los Angeles, and Valley Care Community Consortium (VCCC).
<b>FY 2013</b>	
<b>Goal 2013</b>	<ul style="list-style-type: none"> <li>• Increase physical activity and improve nutrition with the ultimate goal of improving cardiovascular fitness and decreasing childhood obesity rates.</li> </ul>
<b>2013 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• By June 2013: <ul style="list-style-type: none"> <li>• Nearly 2,900 students will achieve 60 minutes of Physical Activity daily as measured by accelerometers</li> <li>• Nearly 2,900 students will improve cardiovascular fitness</li> <li>• Fitnessgram scores for 5<sup>th</sup> graders will increase</li> <li>• Approximately 120 Classroom teachers will be trained to implement the evidence-based CATCH PE and nutrition curriculum</li> <li>• Students will improve healthy nutrition behaviors regarding fruit and vegetable consumption</li> <li>• Parents will improve health and fitness knowledge and behaviors</li> </ul> </li> </ul>
<b>Baseline</b>	Lack of physical activity and sedentary lifestyles has contributed to the increased rate of cardiovascular related diseases. Low-income

	<p>communities lack parks, recreational facilities, opportunities for walking and bicycling. Furthermore, due to gang violence, children are seldom allowed to play outdoors. Finally, the local elementary schools lack formal physical education programs due to their increased focus on academic achievement.</p>
<p><b>Intervention Strategy for Achieving Goal</b></p>	<ul style="list-style-type: none"> <li>• Offer program and assistance to principals at each school.</li> <li>• Identify partners to work with each school.</li> <li>• Coordinate partner's roles in addressing schools' needs.</li> <li>• Develop and implement programs for schools.</li> <li>• Monitor progress.</li> <li>• Evaluate results.</li> </ul>
<p><b>Result FY 2013</b></p>	<p><b>PEP 4 Kids (Carol M. White Grant) at Panorama City, Langdon, Liggett Elementary School &amp; Rosa Parks Learning Center (RPLC)</b></p> <ul style="list-style-type: none"> <li>• Continued Physical Education Instruction to K-5 students by PE teachers.</li> <li>• Conducted ongoing capacity building (Professional Development) for classroom teachers.</li> <li>• Collected 4 follow-up measurements: BMI, Cardiovascular Assessment, Physical Activity assessment via Pedometers and recall data entry, and Fruit and Vegetable Intake recall.</li> <li>• PE Teachers conducted Fitnessgram assessment for 5<sup>th</sup> graders.</li> <li>• Peaceful Playground Markings were placed on PE field at Langdon ES.</li> <li>• Registered Dietician continued to conduct one-on-one counseling sessions with students and their parents.</li> <li>• <i>PE teacher collaborated with LAs BEST Summer</i> program at PCES.</li> <li>• <i>Fit Families</i> conducted at PCES by VCCC for at-risk kids and their families.</li> <li>• <i>Nutrition information</i> boards presented at all four schools</li> <li>• <i>Food for Thought: MyPlate</i> Nutrition and physical activity educational theatrical plays presented at: Liggett, Langdon, and Panorama City</li> <li>• <i>Jump Rope for Heart event:</i> conducted at Liggett ES.</li> <li>• Playground Markings Enhancement: Langdon ES</li> <li>• <b>New community partners recruited</b></li> </ul> <p><b>Parents</b></p> <ul style="list-style-type: none"> <li>• <i>Chronic Disease Self Management Program</i> conducted at Liggett ES.</li> <li>• <i>Re-think your drink</i> presentation provided at Langdon ES and Rosa Parks Learning Center.</li> <li>• <i>Cooking demonstration</i> provided at Rosa Parks Learning Center.</li> <li>• <i>Cholesterol and glucose</i> screenings provided at Langdon and Liggett ES.</li> <li>• <i>Weight of the Nation</i> presentation and physical activity conducted Langdon ES and Rosa Parks Learning Center.</li> <li>• <i>Expanded Food and Nutrition Education Program</i> conducted at Rosa Parks Learning Center.</li> <li>• <i>Healthy Hearts, Healthy Families</i> 10-week program provided at Langdon ES and Panorama City.</li> </ul>

	<p><b>Outcomes:</b></p> <p><b>Students</b></p> <ul style="list-style-type: none"> <li>• PEP 4 Kids evaluation data indicated a <ul style="list-style-type: none"> <li>• 21% increase in daily physical activity levels (60 minutes) (baseline of 16% to 37%),</li> <li>• 25% increase in cardiovascular fitness (baseline of 34% to 59%),</li> <li>• 25% decrease in BMI scores of 25 and above (baseline of 40% to 15%), and</li> <li>• 8% decrease in fruit and vegetable consumption (baseline of 18.2% to 10%) was observed.</li> </ul> </li> </ul>
<b>Hospital's Contribution / Program Expense</b>	\$500,000
<b>FY 2014</b>	
<b>2014 Objective Measure/Indicator of Success</b>	<p><b>Students</b></p> <ul style="list-style-type: none"> <li>• By June 30, 2014: <ul style="list-style-type: none"> <li>• Nearly 2,900 students will achieve 60 minutes of Physical Activity daily as measured by accelerometers</li> <li>• Nearly 2,900 students will improve cardiovascular fitness</li> <li>• Improve Fitnessgram scores (5 grade students).</li> <li>• Students will improve healthy nutrition behaviors regarding fruit and vegetable consumption</li> </ul> </li> </ul> <p><b>Parents</b></p> <ul style="list-style-type: none"> <li>• By June 30, 2014: <ul style="list-style-type: none"> <li>• Parents will increase fitness and nutrition knowledge</li> </ul> </li> </ul> <p><b>Teachers and School Staff</b></p> <ul style="list-style-type: none"> <li>• By June 30, 2014, 120 teachers and school staff will be fully trained in the evidence-based PE curriculum (CATCH).</li> </ul>
<b>Baseline</b>	Same as above
<b>Intervention Strategy for Achieving Goal</b>	<p>Continue to work closely with participating PEP4Kids 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"> <li>• Coordinate fitness and nutrition.</li> <li>• Provide PE instruction for students and teachers at 4 schools.</li> <li>• Facilitate PE instruction for K – 5 grade students at 4 schools.</li> <li>• Disseminate health education materials regarding nutrition and exercise to parents via school mailings, newsletters, and school parent meetings.</li> <li>• Provide teachers with technical assistance in utilizing the CATCH curriculum.</li> <li>• Conduct skill building workshops for Parent Center Directors.</li> <li>• Promote and facilitate fitness and nutrition plays.</li> <li>• Continue collaboration with existing partners.</li> </ul>

## VI. Community Benefit and Economic Value

### A. Classified Summary of Un-sponsored Community Benefit Expense

Northridge Hospital Medical Center  
 Classified Summary of Quantifiable Benefits  
 For period from 7/1/2012 through 6/30/2013  
 Classified as to Poor and Broader Community  
 Updated: July 30th, 2013

	<u>Persons</u>	<u>Total Expense</u>	<u>Offsetting Revenue</u>	<u>Net Benefit</u>	<u>% of Organization</u>	
					<u>Expenses</u>	<u>Revenues</u>
<b><u>Benefits for Living in Poverty</u></b>						
Financial Assistance	14,291	11,170,784	0	11,170,784	3.2%	3.0%
Medicaid	28,281	91,786,170	76,874,728	14,911,442	4.3%	4.0%
<b>Community Services:</b>						
Community Benefit Operations	1	702,779	0	702,779	0.2%	0.2%
Community Health Improvement Services	53,926	2,923,850	7,500	2,916,350	0.8%	0.8%
Financial and In-Kind Contributions	31	1,642,481	0	1,642,481	0.5%	0.4%
Subsidized Health Services	35,131	9,262,466	0	9,262,466	2.7%	2.5%
<b>Totals for Community Services</b>	<b>89,089</b>	<b>14,531,576</b>	<b>7,500</b>	<b>14,524,076</b>	<b>4.2%</b>	<b>3.9%</b>
<b>Totals for Living in Poverty</b>	<b>131,661</b>	<b>117,488,530</b>	<b>76,882,228</b>	<b>40,606,302</b>	<b>11.7%</b>	<b>10.9%</b>
<b><u>Benefits for Broader Community</u></b>						
Unpaid Costs of Medicare	19,763	93,803,941	76,567,402	17,236,539	5.0%	4.6%
<b>Community Services:</b>						
Community Building Activities	794	335,142	0	335,142	0.1%	0.1%
Community Health Improvement Services	13,140	1,138,847	1,000	1,137,847	0.3%	0.3%
Financial and In-Kind Contributions	383	89,138	0	89,138	0.0%	0.0%
Health Professions Education	5,026	1,704,532	0	1,704,532	0.5%	0.5%
<b>Totals for Community Services</b>	<b>19,343</b>	<b>3,267,659</b>	<b>1,000</b>	<b>3,266,659</b>	<b>0.9%</b>	<b>0.9%</b>
<b>Totals for Broader Community</b>	<b>39,106</b>	<b>97,071,600</b>	<b>76,568,402</b>	<b>20,503,198</b>	<b>5.9%</b>	<b>5.5%</b>
<b>Grand Total including unpaid cost of Medicare:</b>	<b>170,767</b>	<b>214,560,130</b>	<b>153,450,630</b>	<b>61,109,500</b>	<b>17.6%</b>	<b>16.4%</b>
<b>Grand Total excluding unpaid cost of Medicare:</b>	<b>151,004</b>	<b>120,756,189</b>	<b>76,883,228</b>	<b>43,872,961</b>	<b>12.6%</b>	<b>11.8%</b>

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

## **B. How costs were estimated**

Utilizing the decision support clinical cost accounting system, the standardized content categories established by the Catholic Health Association, and calculation guidelines provided by Dignity Health Corporate Financial Reporting, facility finance staff prepare reimbursement-based Community Benefit information on a quarterly basis including the uncompensated costs of providing services through charity care, Medicaid, Medicare and other programs for indigent persons.

## **C. Telling the Story**

Northridge Hospital makes the annual Community Benefit Report available to a wide range of community individuals and organizations, including:

- Senior Leadership Team and Department Leadership presentations and information
- Posting the entire plan, as well as the current Community Needs Health Assessment on the hospital's website at [www.northridgehospital.org](http://www.northridgehospital.org).
- Mailing the plan to our large group of collaborators in the community including, California State University, Northridge, Valley Care Community Consortium (VCCC), Tarzana Treatment Centers, etc.
- Producing a summary of key initiatives for distribution to over 200 Valley Care Community Consortium member organizations and agencies.
- Distributing the plan to local, county and state government officials.
- Distributing the plan to local non-profit organizations which have participated in the Community Grants Programs over the years.
- Publicizing the key points in the hospital's community magazine, *HealthSpeak* which is mailed to approximately 200,000 community residents.
- Plan will be posted to the Dignity Health website at [http://www.dignityhealth.org/Who\\_We\\_Are/Community\\_Health/235026](http://www.dignityhealth.org/Who_We_Are/Community_Health/235026).

## **ATTACHMENTS**

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

**Executive Summary of Financial Assistance/Charity Care Policy**

**CNI, Map of the Community and Zip Codes**

**NORTHRIDGE HOSPITAL MEDICAL CENTER  
COMMUNITY BOARD  
July, 2013**

Hildy Aguinaldo, JD,MPH  
Lewis Brisbois Bisgaard & Smith

Thomas Nowlin  
Principal  
B.T. Nowlin & Associates

Magued Beshay, M.D.  
Gastroenterologist  
Facey Medical Group

Celeste Ortiz  
V.P. Human Resources  
Medtronic Diabetes

Donald Crane, JD  
President/CEO  
California Association of Physician Groups

Ube Pump  
Community Advocate

Zouheir Elias, M.D.  
President, Medical Staff  
Northridge Hospital Medical Center

Saliba Salo  
President/CEO  
Northridge Hospital Medical Center

Sal Esparza, DHA  
Assistant Professor  
California State University, Northridge

Hooshang Semnani, M.D  
Pediatrician  
General Director, PICU Services  
Northridge Hospital Medical Center

Pat Hawthorne  
President  
Northridge Lumber  
*Chair, Northridge Hospital Foundation*

Rosanne Silberling, Ph.D.  
Dean of Nursing  
West Coast University

Lamya Jarjour, M.D.  
OB/GYN  
Chair, Bioethics Committee  
Northridge Hospital Medical Center

William Watkins, PhD  
V.P. Student Affairs  
California State University, Northridge

DIGNITY HEALTH  
SUMMARY OF PATIENT PAYMENT ASSISTANCE POLICY  
(June 2012)

Policy Overview:

Dignity Health is committed to providing payment 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, Dignity Health strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Payment assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with Dignity Health's procedures for obtaining payment 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 Payment Assistance:

- Eligibility for payment 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 payment 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 Dignity Health 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 payment assistance and a determination of financial need occur prior to rendering of services. The need for payment 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 payment assistance becomes known.
- Dignity Health's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of payment assistance. Requests for payment assistance

shall be processed promptly, and the Dignity Health facility shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

#### Patient Payment 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 termination 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 Dignity Health 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 Dignity Health 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 Dignity Health facility.

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

#### Communication of the Payment Assistance Program to Patients and the Public:

- Information about patient payment assistance available from Dignity Health, including a contact number, shall be disseminated by the Dignity Health 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 Dignity Health facility may elect. Such information shall be provided in the primary languages spoken by the populations served by the Dignity Health facility.
- Any member of the Dignity Health facility staff or medical staff may make referral of patients for payment assistance. The patient or a family member, a close friend or associate of the patient may also make a request for payment assistance.

#### Budgeting and Reporting:

- Specific dollar amounts and annual plans for patient payment assistance will be included within the Social Accountability Budget of the Dignity Health facility. Dignity Health facilities will report patient payment assistance calculated at cost in the annual Social Accountability Report and may voluntarily report such information as deemed appropriate.
- Patient payment 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.

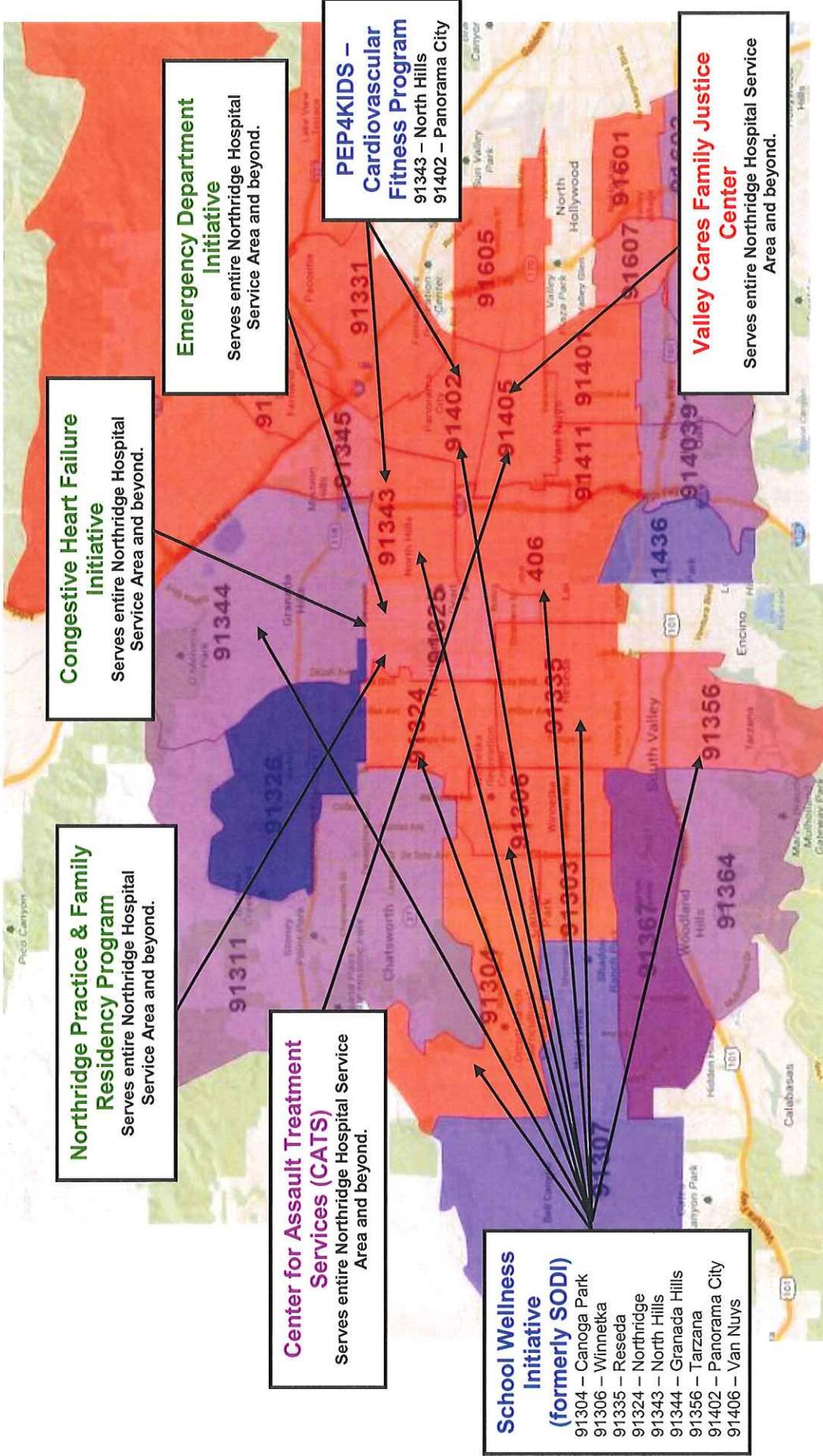
Relationship to Collection Policies:

- Dignity Health system management shall develop policies and procedures for internal and external collection practices by Dignity Health facilities that take into account the extent to which the patient qualifies for payment assistance, a patient's good faith effort to apply for a governmental program or for payment assistance from Dignity Health, and a patient's good faith effort to comply with his or her payment agreements with the Dignity Health facility.
- For patients who qualify for payment assistance and who are cooperating in good faith to resolve their hospital bills, Dignity Health 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, DIGNITY HEALTH MANAGEMENT AND DIGNITY HEALTH FACILITIES SHALL COMPLY WITH ALL FEDERAL, STATE AND LOCAL LAWS, RULES AND REGULATIONS THAT MAY APPLY TO ACTIVITIES CONDUCTED PURSUANT TO THIS POLICY.

# 2013 Northridge Hospital Community Needs Index (CNI) Map San Fernando Valley Community Benefit Initiatives



**Congestive Heart Failure Initiative**  
Serves entire Northridge Hospital Service Area and beyond.

**Emergency Department Initiative**  
Serves entire Northridge Hospital Service Area and beyond.

**PEP4KIDS - Cardiovascular Fitness Program**  
91343 - North Hills  
91402 - Panorama City

**Valley Cares Family Justice Center**  
Serves entire Northridge Hospital Service Area and beyond.

**Northridge Practice & Family Residency Program**  
Serves entire Northridge Hospital Service Area and beyond.

**Center for Assault Treatment Services (CATS)**  
Serves entire Northridge Hospital Service Area and beyond.

**School Wellness Initiative (formerly SODI)**  
91304 - Canoga Park  
91306 - Winnetka  
91335 - Reseda  
91324 - Northridge  
91343 - North Hills  
91344 - Granada Hills  
91356 - Tarzana  
91402 - Panorama City  
91406 - Van Nuys

**Highest Need**  
4.2 - 5 Highest

**3.4 - 4.1 2nd Highest**

**2.6 - 3.3 Mid**

**1.8 - 2.5 2nd Lowest**

**1 - 1.7 Lowest**

**CNI Score Median: 3.8 (CNI Zip Codes and Population follow on next page)**

Lowest Need ■ 1 - 1.7 Lowest ■ 1.8 - 2.5 2nd Lowest ■ 2.6 - 3.3 Mid ■ 3.4 - 4.1 2nd Highest ■ 4.2 - 5 Highest

Zip Code	CNI Score	Population	City	County	State
91303	4.8	26,068	Canoga Park	Los Angeles	California
91304	4.2	51,633	Canoga Park	Los Angeles	California
91306	4.2	47,789	Winnetka	Los Angeles	California
91307	1.8	25,038	West Hills	Los Angeles	California
91311	2.6	36,517	Chatsworth	Los Angeles	California
91324	4.2	26,766	Northridge	Los Angeles	California
91325	3.6	33,859	Northridge	Los Angeles	California
91326	1.8	31,870	Porter Ranch	Los Angeles	California
91331	4.6	100,588	Pacoima	Los Angeles	California
91335	4.2	72,404	Reseda	Los Angeles	California
91340	4.6	35,814	San Fernando	Los Angeles	California
91342	4.2	89,950	Sylmar	Los Angeles	California
91343	4.8	60,918	North Hills	Los Angeles	California
91344	2.8	51,097	Granada Hills	Los Angeles	California
91345	3.8	18,285	Mission Hills	Los Angeles	California
91356	3.4	30,352	Tarzana	Los Angeles	California
91364	2.6	25,217	Woodland Hills	Los Angeles	California
91367	3	39,422	Woodland Hills	Los Angeles	California
91401	4.8	42,605	Van Nuys	Los Angeles	California
91402	4.8	72,717	Panorama City	Los Angeles	California
91403	3.2	22,663	Sherman Oaks	Los Angeles	California
91405	4.8	55,579	Van Nuys	Los Angeles	California
91406	4.6	55,026	Van Nuys	Los Angeles	California
91411	4.6	26,287	Sherman Oaks	Los Angeles	California
91423	3	28,369	Sherman Oaks	Los Angeles	California
91436	1.8	14,165	Encino	Los Angeles	California
91601	4.8	40,413	North Hollywood	Los Angeles	California
91602	3	16,315	North Hollywood	Los Angeles	California
91604	2.8	26,782	Studio City	Los Angeles	California
91605	5	61,676	North Hollywood	Los Angeles	California
91607	3.6	29,379	Valley Village	Los Angeles	California