



Northridge Hospital Medical Center

Community Benefit Report 2014 Community Benefit Implementation Plan 2015

A message from Saliba H. Salo, President and CEO of Northridge Hospital Medical Center, and Rosanne Silberling, Chair of the Dignity Health Northridge Hospital Community Board.

The **Hello humankindness** campaign launched by Dignity Health is a movement ignited and based on the proven idea that human connection, be it physical, verbal, or otherwise, leads to better health. At Dignity Health the comprehensive approach to community health improvement recognizes the multi-pronged effort needed to meet immediate and pressing needs, to partner with and support others in the community, and to invest in efforts that address the social determinants of health.

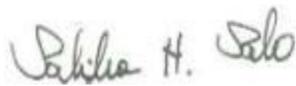
At Northridge Hospital we share a commitment to improve the health of our community and have offered programs and services to achieve that goal. The 2014 Annual Report and 2015 Plan for Community Benefit fulfills section 501 (r) of the Patient Protection and Affordable Care Act, where each hospital must complete a community health needs assessment every three years and develop a community health implementation plan to document how it will address the significant health needs of the community. We are proud to provide this report as a continuation of the work we have done over the past 59 years to better the health of the communities we serve.

In addition, California State Senate Bill 697 requires not-for-profit hospitals to annually report its community benefit efforts and measurable objectives as well as its plans for the coming year. Encouraged and mandated by its governing body, Dignity Health hospitals comply with both mandates at each of its facilities, including those in Nevada and Arizona, and is proud of the outstanding programs and services that have been offered to improve the health of the communities we serve.

In fiscal year 2014, Northridge Hospital provided \$50,539,880 in financial assistance, community benefit, and unreimbursed patient care. Including the unreimbursed cost of caring for patients covered by Medicare, the total expense was \$70,725,555.

Dignity Health's Northridge Hospital Board of Directors has reviewed and approved the annual Community Benefit Report and Implementation Plan at their September 2014 meeting.

Thank you for taking the time to review our report and plan. If you have any questions, please contact us at 818-885-5339.



Saliba H. Salo
President/CEO



Rosanne Silberling, RN, EdD
Chairperson, Board of Directors

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EXECUTIVE SUMMARY

Northridge Hospital Medical Center (NHMC) is celebrating its 59th anniversary proudly serving the 2.1 million residents of the Greater San Fernando Valley. Northridge Hospital, a Dignity Health member, is a 409 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 1,800 employees, 700 affiliated physicians in 59 specialties and over 400 volunteers. The hospital has forged ahead as the leader in the Valley by offering uncompromisingly high quality care, extensive outreach services and state-of-the-art comprehensive health care services.

This year, the hospital had its rigorous accreditation survey from The Joint Commission resulting in a Gold Seal of Approval™ from The Joint Commission (TJC).

In January, we were very proud to be designated as a **Pediatric Medical Center (PMC)** by Los Angeles County as the only PMC in the San Fernando Valley. Our PMC designation supports Los Angeles County's goal to transport 9-1-1 patients to the right place the first time. The hospital's helipad was also enhanced to receive larger emergency helicopters.

Complementing this status is our **Richie Pediatric Trauma Center**. This team responds immediately to treat children within the Platinum 30 Minutes, the first half hour after injury that increases a child's chance of survival.

The hospital was named one of **America's Best 100 Specialty Care Hospitals** by Healthgrades for Critical Care 3 years in a row, the **Top 5% in the nation for Clinical Excellence** 4 years in a row and **Maternity Care Excellence**, 7 years in a row.

In all, Northridge Hospital has received a total of 14 nationally recognized honors from Healthgrades attesting to the award winning quality care. Others include: five-stars for: Hip Fracture Treatment, Heart Attack Treatment, Chronic Obstructive Pulmonary Disease, Sepsis Treatment, Colorectal Surgeries, Respiratory Failure, and Pneumonia Treatment.

Other major awards include: The Leavey Cancer Center's two high accreditations from the Association of Community Cancer Centers and the American College of Surgeons (ACOS) and The Center for Rehabilitation Medicine's accreditation from Commission on Accreditation of Rehabilitation Facilities (CARF).

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, used for cardiac, vascular and cardiothoracic patients; **da Vinci Robotic Surgery SI**; **Gamma Knife**; and **Trilogy Linear Accelerator**.

The Triennial Community Health Needs Assessment was conducted in 2013 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 to be effective and 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)
- PEP 4 Kids - A Cardiovascular Fitness Program

MISSION STATEMENT

Mission Statement (Dignity Health Mission Statement)

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

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

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 September 2014 by the NHMC Community Board of Directors and the NHMC Senior Leadership Team (SLT).

ORGANIZATIONAL COMMITMENT

Hospital's organizational commitment

Organizational commitment to the Community Benefit process

Summary of how governing body, CEO and Senior Leadership Team (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. They review data on safety, quality, patient satisfaction, physician credentials and financial reports.

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/School-based Obesity and Diabetes Initiative, the PEP 4 Kids Program and CATS (Center for Assault Treatment Services).

Each year, Northridge Hospital participates in the Dignity Health Community Grant Program, which focuses on supporting nonprofit community organizations whose mission is to provide access to healthcare services for underserved populations. This year we were proud to award six grants - totaling **\$185,835**. For the last 13 years of the Community Grants Program, we are proud to say that we have awarded more than **\$1.65 million** in community grants to **84** non-profit groups. The 2013 grant winners were recognized at the January 2014 Community Board of Directors meeting:

- **Hope of the Valley Rescue Mission** - \$10,835 – This grant provides funding for Genesis House to meet the needs of homeless single-mother families in the San Fernando Valley.
- **Sustainable Economic Enterprises of L.A.** - \$20,000 - This will provide Good Cooking/Buena Cocina nutrition classes in our School Wellness Initiative schools.
- **Mary Magdalene Project** - \$ 30,000 - The grant supports comprehensive services to female victims to help break the cycle of domestic trafficking and prostitution.
- **Valley CARES Family Justice Center** - \$30,000 – The grant will aid in the development of cultural and age-sensitive curriculum for interactions with traumatized children during forensic medical interviews and follow-up.
- **American Heart Association** - \$45,000 – Along with partner agencies Valley Care Community Consortium and the Mid-Valley Family YMCA, Shape-Up Your Heart, will improve the heart health of students and their families in local schools.
- **Tarzana Treatment Centers** - \$50,000 – The grant continues the successful “Decreasing Emergency Department Use through Education and Assessment” initiative to connect those in need to primary care, substance abuse and mental health treatment.

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: 42% Caucasian, 17% Hispanic/Latino, 4% African American and 33% other. 58% are male and 42% are female.

The respected and knowledgeable members of the Board are also charged with assisting the hospital in 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 2014 Community Benefit Report/2015 Community Benefit Plan in September 2014.

Non-Quantifiable Community Benefits

Collaboration with community partners in local capacity building and community building is significant and revolves 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
- Parent Institute for Quality Education
- Tarzana Treatment Center
- Tri-Valley YMCA
- Valley Care Community Consortium
- Strength United (formerly Valley Trauma Center)

Our affiliation with area political leaders is also significant. We work closely with Los Angeles City Council Members Nury Martinez 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

Definition of Community

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.

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.

Demographics

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

- ❖ Population: 1.2 million residents evenly distributed among males and females
- ❖ Diversity: 49.62% Latino, 33.42% Caucasian, 10.80% 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%
- ❖ CNI Score
- ❖ 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

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.

Assets Assessment

The assessment identified a number of strong community assets including a broad range of health care resources (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.

Developing the Implementation Plan

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

- **Saliba Salo**, President & Chief Executive Officer
- **Mary Jane Jones, RN**, 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

Teddi Grant, Vice President, Marketing, Community Benefits and Mission Integration, and **Bonnie Bailer**, Director of the Center for Healthier Communities, were the principal authors of the Community Health Needs Assessment and the Community Benefit Report/Plan.

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. It is 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.

Language/Culture Barriers: Access to culturally and linguistically competent care is a necessary component in improving health status. Language and culture barriers can contribute to an increased prevalence of disease and lower recruitment into government health programs. Research has shown that patients whose primary language is not English may be compromised in their understanding of their medical situation, be confused about

instructions following hospital discharge, and may not be able to read their prescription labels or understand self-care instruction for chronic conditions.

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).

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 Wellness/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

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

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.

Programs serve to contain the growth of community health care costs

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

Planning for the Uninsured/Underinsured Patient Population

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, 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 Hospital's Admitting Guide and the Patient Room Guide which were updated in April 2014.

PLAN REPORT AND UPDATE

Plan Report and Update Including Measurable Objectives and Timeframes

Summary of Key Programs and Initiatives

Center for Healthier Communities (CHC)

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

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

Dedicated to the treatment of children and adults who are victims of sexual abuse/assault or domestic violence, CATS, is the only program in the San Fernando and Santa Clarita Valleys that provides forensic interviews and forensic evidence collection as well as access to an advocate 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, the City Attorney's Office and the Los Angeles County Department of Children and Family Services, among others. In fiscal year 2014, 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 1,100 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 FY2014 was \$667,809

- **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 Educational Service Center North, 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 FY2014, the initiative focused on 34 schools and reached more than 34,000 students, parents, teachers and staff. The total net community benefit was \$103,355.

- **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 for FY2014 was \$15,000.

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 FY2014 was \$10,790.

The Northridge Family Practice Center and Family Medicine Residency Program

The Northridge Family Medicine Residency Program, in conjunction with the faculty group, provides both inpatient and outpatient care to many of the underserved in the community. They are an integral part of providing care in the San Fernando Valley. The total net community benefit is \$10,034,662.

- **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 \$524,336. 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, 911 women were provided with free mammograms to screen them for breast cancer. There were 3 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*) one-day events are hosted where those who are uninsured can receive cancer screening procedures and other health screenings in a single day in a single location. In partnership with the El Salvador Foundation, local LAUSD Title 1 schools, charter schools and many community centers and churches, flyers are 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 screenings on a semi-annual 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 2013:** 78 mammograms
- **August 2013:** 67 mammograms
- **September 2013:** 103 mammograms
- **October 2013:** 103 mammograms & 22 Prostate Exams
- **November 2013:** 88 mammograms
- **December 2013:** 90 mammograms
- **January 2014:** 53 mammograms
- **February 2014:** 80 mammograms
- **March 2014:** 75 mammograms
- **April 2014:** 68 mammograms
- **May 2014:** 54 mammograms
- **June 2014:** 52 mammograms
- **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.

- 7,656 individuals in 77 community groups have been educated about breast and/or colon cancer awareness and screening guidelines and informed about our free mammogram program. St. Finbar Church community members, Cesar Chavez Commemoration Day Resource Fair attendees and Tierra Del Sol Foundation staff 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 230 individuals were reached.
- To further augment our services, we obtained grant funding to provide massage therapy to Cancer patients. We provided services to 1,704 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 Trigeminal Neuralgia Support Group and Breast Cancer 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 a Radiation Oncology and the Surgical Oncology services. As 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.
- **Patient Home Aid** sponsored by Harold Pump Foundation's Family Fund the program has provided 836 total hours of service to 19 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 Fund the program has provided 1,256 trips to 93 patients for their medical appointments at the cancer center.
- **Helping Hands Holiday Jam** - For the past nine years, NHMC, the NHMC Foundation and the Cancer Center have partnered with the Harold Pump Foundation to provide a Christmas wonderland for over 290 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 47,566 patients during fiscal year 2014. Of this amount 30,647 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 \$10,589,000.

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 1,049 persons in FY2014; of this amount 492 were low-income and could not afford to pay for services or did not have health insurance. The total net community benefit was \$2,863,000.

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. 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 207 persons in FY2014; of this amount 134 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 \$1,475,000.

The PTC is staffed by 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 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 former Los Angeles District 7 Council-member Richard Alarcon – who was traumatically injured in a vehicle accident. Richie's

transport out of the Valley extended beyond the Platinum 30 Minutes, and he died the next day. Shortly after, Alarcon (who was then a State Senator) introduced legislation to establish funding for Northridge Hospital's Pediatric Trauma Center. He received help to get the bill passed from Senator Alex Padilla, 20th District, the L.A. County Board of Supervisors and L.A. County Supervisor Zev Yaroslavsky, 3rd District.

Description of Key Programs and Initiatives

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

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

Center for Assault Treatment Services (CATS)	
Hospital CB Priority Areas	<ul style="list-style-type: none"> X Increase access to appropriate health care services for the poor and underserved X Promote collaboration and reduction of duplicative health services Address the obesity and diabetes epidemic Address heart disease Provide access to mental health and substance abuse services X Increase services to victims of trauma and violence
Program Emphasis	<ul style="list-style-type: none"> X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Link to Community Needs Assessment, Vulnerable Population	Programs are needed that focus on personal development and mental health of adolescents and better education on programs and services available in the community.
Program Description	CATS' expert team of forensic nurses, under the direction of the Clinical Director 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, Strength United (aka Valley Trauma Center), to provide case management and counseling for victims, law enforcement, the District Attorney's Office, child protective services; local school districts and community based organizations to deliver these services.
FY 2014	
Goal FY 2014	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.
2014 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • By June 30, 2014, provide medical evidentiary examinations and forensic interviews, as well as access to case management and counseling to 850 victims of sexual abuse and assault of all ages.
	<ul style="list-style-type: none"> • By June 30, 2014 provide prevention education to a minimum of 1,100 mandated child abuse reporters and the general public.

	<ul style="list-style-type: none"> By June 30, 2014 raise funds to support program components.
Baseline	Sexual assault victims need immediate post-abuse treatment. Few victims disclose and even fewer mandated reporters report incidence of abuse.
Implementation Strategy for Achieving Goal	<ul style="list-style-type: none"> Conduct medical evidentiary exams of victims of sexual abuse/assault and DV of all ages. Conduct forensic interviews. Work closely with child protective services, law enforcement and the District Attorney's office to assist in the investigation process. Work closely with Strength United (aka the Valley Trauma Center) to provide post-trauma case management and counseling to victims. Outreach to public and private schools, hospitals, clinics and other community-based organizations. Develop training materials and conduct trainings. Evaluate results.
Result FY2014	<ul style="list-style-type: none"> 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. Case management was provided to all victims and they were offered free counseling. CATS Outreach Staff provided Child Abuse Education to 1,004 mandated child abuse reporters. CATS raised \$320,000 in funds from private and corporate foundations, its annual walk/run event, retail campaigns, social and business clubs and individual donors.
NHMC Contribution/ Program Expense	\$667,809
FY 2015	
Goal 2015	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.
2015 Objective measure/Indicator of Success	<ul style="list-style-type: none"> By June 30, 2015 relocate to a new satellite office with partner agencies resulting in a best practice one stop shop for victims of sexual assault and abuse. By June 30, 2015, provide medical evidentiary examinations, case management and counseling to 900 victims of sexual abuse and assault of all ages. By June 30, 2015 provide prevention education to 1,100 mandated child abuse reporters and the general public. By June 30, 2015 raise funds to support program components.
Baseline	Same as above
Implementation Strategy for Achieving Goal	<ul style="list-style-type: none"> Work closely with law enforcement and the District Attorney's Office. Conduct roll call trainings at local law enforcement precincts/divisions.

	<ul style="list-style-type: none"> • Conduct medical evidentiary examinations and forensic interviews. • Review and update materials for mandated reporters. • Review and update CATS website. • Publish annual newsletter. • Outreach to public schools and community-based organizations. • Conduct trainings on-site at local agencies and schools for mandated child abuse reporters. • Write grants to support CATS components. • Conduct CATS Victory for Victims Walk/Run and the LA Marathon Team to promote awareness of child abuse and raise funds.
Community Benefit Category	<p>CATS Clinical: A2-e Community-based Clinical Services-Ancillary/Other Clinical Services</p> <p>CATS Outreach: A1-b Community Health Education - Public Dissemination of Materials and Information</p>

Family Practice Center and Family Medicine Residency Program	
Hospital CB Priority Areas	<ul style="list-style-type: none"> X Increase access to appropriate health care services for the poor and underserved X Promote collaboration and reduction of duplicative health services X Address the obesity and diabetes epidemic Address heart disease Provide access to mental health and substance abuse services Increase services to victims of trauma and violence
Program Emphasis	<ul style="list-style-type: none"> X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Link to Community Needs Assessment	The Family Practice Center (FPC) programs and services link to the community's need for affordable primary and specialty medical services, for more preventive care and wellness programs for children and adults and the need for programs to combat obesity and diabetes.
Program Description	The Northridge Family Medicine Residency Program, in conjunction with the faculty group, provides both inpatient and outpatient care to many of the underserved in the community. The outpatient Family Practice Center (FPC) provides comprehensive health care to individuals and families of all age groups and all cultural backgrounds. The care provided ranges from prenatal to pediatric to adult and geriatric medicine. Over the years, through private and state-funded programs, in partnership with various organizations, the FPC has worked to extend its various services, such as comprehensive diabetes management, breast and cervical cancer screenings, family planning, psychological counseling and patient education for the uninsured and under-insured in the community. Ongoing health outreach, prevention and education efforts with community partners are also an integral component of the FPC's efforts to engage and serve its community.
FY 2014	
Goal FY 2014	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.
2014 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Number of indigent patients seen on the inpatient hospital service. • Number of patients seen through Medi-Cal or HMO Medi-Cal. • Number of patients seen through all state-funded service programs for low-income patients, such as CHDP, CCS, PACT. • Number of indigent patients seen in the Family Practice Center, including specialty clinics and the Diabetes Indigent Program. • Continuation of partnerships and outreach prevention education efforts with local schools, senior centers and community agencies.
Baseline	There is insufficient access to primary medical services across population groups. Chronic diseases account for many of the acute care inpatient admissions across age groups. The large number of Latino residents results in a disproportionate incidence of diabetes in the San Fernando Valley. Therefore, special attention needs to be

	given to the diagnosis, treatment, prevention and education of diabetes.
Implementation Strategy for Achieving Goal	<ul style="list-style-type: none"> • Continue Family Medicine coverage of admissions through the hospital emergency department including involvement with the obstetrical and surgical panel coverage. • Continue and expand hospital inpatient service at Northridge Hospital Medical Center. • Contract with Medi-Cal HMO's as the State of California continues to move additional patients into managed Medi-Cal. • Maintain "Diabetes Indigent Program." • Maintain community partnerships and outreach prevention education efforts, including health education for the youth, high school sports coverage, obesity and diabetes prevention in children and adults, general health screenings, and senior center screenings.
Result FY 2014	<ul style="list-style-type: none"> • 19,708 total visits in the hospital over a one year period, an increase .09% over FY2013's total of 19,156. <ul style="list-style-type: none"> ○ 65% of visits are for indigent/underserved care, including uninsured, Medi-Cal, and HMO Medi-Cal patients. • 22,099 total patient visits in the Family Practice Center, including specialty clinics and the Diabetes Indigent Program, an increase of .98 over FY2013's total of 21,869. <ul style="list-style-type: none"> ○ 65% of visits are for indigent/underserved care, including uninsured, Medi-Cal, and HMO Medi-Cal. • Implementation of a hospitalist fellowship program to address increased inpatient care volume of indigent patients. • Ongoing community partnerships and outreach programs: <ul style="list-style-type: none"> ○ Sutter Middle School Health Education Program reaching near 400 students annually. ○ 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. ○ High school football games coverage for Monroe High School, as their Team Physician. ○ Partnership with Partners in Care's Disease Prevention and Health Promotion Program at local senior centers. • Local Screening Health Fairs and community presentations.
Hospital's Contribution / Program Expense	\$10,034,662
FY 2015	
Goal 2015	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.
2015 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Number of indigent patients seen on the inpatient hospital service. • Number of patients seen through Medi-Cal or HMO Medi-Cal. • Number of patients seen through all state-funded service programs for low-income patients, such as CHDP, CCS, PACT.

	<ul style="list-style-type: none"> • Number of indigent patients seen in the Family Practice Center including Specialty Clinics. • Continuation and expansion of partnerships and outreach prevention education efforts with local schools, senior centers, and community agencies. • Partnerships include: <ul style="list-style-type: none"> ○ CSUN (California State Northridge University) Family Focus Resource Center will work with residents and families at the FPC to help parents with special needs children better access school-based services. ○ Northeast Valley Health Corporation clinics - Residents on our expanded community medicine rotation will rotate through various services at this Federally Qualified Clinic providing medical care to underserved populations in the San Fernando Valley. ○ Collaboration with Northridge Hospital's SODI Program (School-Based Obesity & Diabetes Initiative). ○ Increased collaboration and coordination with hospital based services including rotations with the expanded palliative care program and with the hospital chaplains.
Baseline	Same as above.
Implementation Strategy for Achieving Goal	<ul style="list-style-type: none"> • Continue Family Medicine coverage of admissions through the hospital emergency department including involvement with the obstetrical and surgical panel coverage. • Continue and expand hospital inpatient service at Northridge Hospital Medical Center including increased faculty hours for supervision of inpatient care. • Contract with Medi-Cal HMO's as the State of California continues to move additional patients into managed Medi-Cal. • Maintain community partnerships and outreach prevention education efforts, including health education for the youth, high school sports coverage, obesity and diabetes prevention in children and adults, general health screenings and senior center screenings. • Continuation of on-site psychological services to assist patients with psychiatric diagnoses and those dealing with the stress of managing chronic diseases.
Community Benefit Category	C-3 Hospital Outpatient Services

Emergency Department Initiative (EDI)	
Hospital CB Priority Areas	<ul style="list-style-type: none"> X Increase access to appropriate health care services for the poor and underserved X Promote collaboration and reduction of duplicative health services Address the obesity and diabetes epidemic Address heart disease X Provide access to mental health and substance abuse services Increase services to victims of trauma and violence
Program Emphasis	<ul style="list-style-type: none"> X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Link to Community Needs Assessment	EDI 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.
Program Description	These initiatives are a partnership between Northridge Hospital Medical Center (NHMC) and Tarzana Treatment Center (TTC). Under these projects, hospital personnel providing discharge services refer eligible patients to an on-site TTC case manager who works with patients requiring case management services. This includes intake and assessment, individualized case planning, case conferencing, coordinating with other coordinators of client care or services, referral to ambulatory care, mental health care, substance abuse treatment, housing, vocational services, distribution of transportation vouchers and follow-up. Data collection and tracking also take place. TTC meets regularly with NHMC staff to review data and evaluate results.
FY 2014	
Goal FY 2014	<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. 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>
2014 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Numbers of ED patients receiving TTC intervention. • Number of ED visits and/or hospital admissions six months prior to TTC intervention. • Number of ED visits and/or hospital admissions six months post TTC intervention.

	<ul style="list-style-type: none"> Percentage reduction of recidivism.
Baseline	<u>Number of visits to ED six months prior to TTC intervention.</u>
Implementation Strategy for Achieving Goal	<ul style="list-style-type: none"> Educate ED staff regarding appropriate referrals. TTC to provide case management for referred patients. NHMC and TTC maintain database. TTC follows up with patients. TTC Independent Evaluator reviews and analyzes data. NHMC reviews and analyzes data.
Result FY 2014	<p>During the 2013 calendar year,</p> <ul style="list-style-type: none"> Total number of patients with more than 3 visits prior to receiving Tarzana Treatment Center intervention, who were seen by the on-site case manager = 646. Number of patients with 3 or more visits after receiving the TTC intervention= 332 Percentage of patients who were admitted to the ED or hospital within three months after receiving the intervention = 51.4%.
Hospital's Contribution / Program Expense	\$10,790
FY 2015	
Goal 2015	<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. 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>
2015 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> Number of ED patients receiving TTC intervention. Number of ED visits and/or hospital admissions three months prior to TTC intervention. Number of ED visits and/or hospital admissions three months post TTC intervention.
Baseline	Same as above.
Implementation Strategy for Achieving Goal	<ul style="list-style-type: none"> ED committee to hold bi-monthly meetings to implement enhancements. TTC to provide case management for referred patients. TTC to follow up with patients. NHMC and TTC to maintain databases on patients referred. Review and analyze data. Evaluate effectiveness of program

Community Benefit Category	A3-e Healthcare Support Services Information and Referral
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School Wellness/School-based Obesity & Diabetes Initiative (SODI)	
Hospital CB Priority Areas	<ul style="list-style-type: none"> X Increase access to appropriate health care services for the poor and underserved X Promote collaboration and reduction of duplicative health services X Address the obesity and diabetes epidemic X Address heart disease Provide access to mental health and substance abuse services Increase services to victims of trauma and violence
Program Emphasis	<ul style="list-style-type: none"> X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Link to Community Needs Assessment	The School Wellness Initiative (aka School-based Obesity and Diabetes Initiative) will address the need to reduce the rate of childhood obesity and related diseases in the San Fernando Valley of Los Angeles County.
Program Description	The School Wellness Initiative 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. School Wellness Initiative assisted participating LAUSD schools in implementing wellness programs with a focus on nutrition and physical fitness. This program'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.
FY 2014	
Goal 2014	Increase physical activity and improve nutrition with the ultimate goal of decreasing childhood obesity rates.
2014 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • By June 2014 conduct wellness campaigns in 34 schools. • By June 2014 increase the number of students who engage in physical activity. • By June 2014 increase the number of parent/child academic engagement. • By June 2014 improve access to healthcare services for children. • By June 2014 increase students' knowledge of good nutrition. • By June 2014 continue to recruit new partners.

	<ul style="list-style-type: none"> Evaluate results.
Baseline	<p>Obesity and its related diseases, in particular diabetes, have reached epidemic proportions in the San Fernando Valley of Los Angeles County. 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>
Implementation Strategy for Achieving Goal	<ul style="list-style-type: none"> Offer program and assistance to principals at each school. Identify partners to work with each school. Coordinate partner's involvement in addressing schools' needs. Raise funds to develop programs at the schools Implement grant-funded programs at schools. Monitor progress. Evaluate results.
Result FY 2014	<ul style="list-style-type: none"> The School Wellness Initiative continued collaboration with schools and recruited new community partners. Coordinated programs at participating schools. <p>Parent Classes Programs:</p> <ul style="list-style-type: none"> <i>A Taste of Good Health workshop at Gault and Cantara ES.</i> <i>Alzheimer's 4-week series at Alta Ca, Langdon, Noble, Plummer, Stagg, Sunny Brea, Liggett ES, Panorama City, and Haskell ES.</i> <i>Cooking demonstrations at Stagg, Canoga Park ES, and Columbus MS.</i> <i>Chronic Disease Self Management Program (English) at Tarzana ES.</i> <i>Diabetes Awareness and Prevention class at Harding ES.</i> <i>Fit Families for Life 3-week series at Rosa Parks Learning Center and Mulholland MS.</i> <i>Fitness demonstration at Haskell ES.</i> <i>Go Red Por Tu Corazon workshop at Gault ES.</i> <i>Health screenings at Panorama City, Canoga Park, Hart ES, Columbus MS and Canoga Park HS</i> <i>Healthy Parenting 3 week series at Fulbright and Liggett ES.</i> <i>VCCC Parent walking groups at Noble, Fulbright, Limerick, and Stagg ES.</i> <i>Plan, Save and Shop 8-week series at Nevada ES.</i> <i>Picky Eaters presentation at Ranchito ES.</i> <i>School Nutrition Policies class at Nevada, Stagg and Noble ES.</i> <i>Shape-up your Heart program at Noble ES.</i> <i>Stress management 3-week series at Nevada ES.</i> <i>Parent Engagement Education Program (CPHIZI) at Columbus MS and Canoga Park HS.</i> <i>Chronic Disease Self-Management Program (CPHIZI) at Canoga Park ES, Hart ES, Columbus MS, and Canoga Park HS.</i> <i>Diabetes Self-Management Program (CPHIZI) at Canoga Park ES, and Columbus MS.</i> <i>Glucose and Cholesterol screenings at Canoga Park ES, Hart ES,</i>

	<p><i>Columbus MS, and Canoga Park HS.</i></p> <p>Student Classes and Programs:</p> <p><i>Food for Thought: MyPlate</i> Nutrition and physical activity educational theatrical plays at 8 schools: Plummer, Stagg, Fullbright, Mayall, Alta California, Canoga Park, Gault, and Noble ES.</p> <p>Fit Families, an after-school program targeting students with a high Body Mass Index and their families at Burton, Noble, Ranchito and Mayall ES.</p> <p><i>Evidence-based Coordinated Approach to Child Health (CATCH):</i></p> <ul style="list-style-type: none"> Physical Education program for students in grades 1-5 at 6 elementary schools: Hart, Canoga Park, Panorama City, Langdon, Liggett, and Rosa Parks Physical Education and Nutrition program for 4th and 5th grade students at 8 elementary schools: Mayall, Noble, Plummer, Alta California, Burton, Chase, Ranchito and Stagg. <p><i>Case Management and student referrals</i> at Canoga Park ES, Hart ES, Columbus MS, and Canoga Park HS.</p> <p><i>Columbus School Based Clinic:</i> In-kind medical services by LAUSD Nurse Practitioners, School Physician, and Registered Dietician at the Columbus Middle School Clinic including individual nutrition and fitness counseling, immunization, physical exams, sports physicals, diagnosis and treatment of minor illnesses, assistance with asthma, other chronic illnesses, routine lab tests, screenings, vision and audiometric testing.</p> <p>Special School Events for Students and Parents:</p> <ul style="list-style-type: none"> <i>Los Angeles County Community Advisory Committee (Health Net)</i> at Mulholland MS; Nutritional information for families at Iglesia Poder de Dios and Stagg ES Health Fairs; Healthy Parenting presentation at Proyecto del Barrio; Incentives for Ranchito's Jr. Olympics; and Northridge Hospital Community Health Fair (Canoga Park Health Improvement Zone Initiative) at Columbus MS.
Hospital's Contribution / Program Expense	\$103,355
FY 2015	
Goal 2015	To improve the overall health of families with students in the local public school system in the San Fernando Valley of Los Angeles through the implementation of best practice and evidence-based nutrition and fitness programs, school-wide campaigns and effective collaborations with outside partners.
2015 Objective Measure/Indicator of Success	<p>Students</p> <ul style="list-style-type: none"> By June 30, 2015: students will: <ul style="list-style-type: none"> Improve Fitnessgram scores among (5 grade students). Receive 40 minutes/week of physical education instruction;

	<p>CATCH curriculum</p> <ul style="list-style-type: none"> ○ Increase daily physical activity (elementary school students) ○ Improve nutrition habits ○ Participate in the fit families program; at risk families <p>Parents</p> <ul style="list-style-type: none"> ● By June 30, 2015: <ul style="list-style-type: none"> ○ 200 parents will participate in Parent Institute for Quality Education (PIQE) ○ 120 parents will participate in the 6-week Chronic Disease Self Management <i>Healthy Living</i> program ○ Increase knowledge about good nutrition and fitness ○ Will participate in Choose Health LA Kids activities: <ul style="list-style-type: none"> ▪ Grocery Store Tours and food demonstrations ▪ 6-week parent education classes ▪ 30 parents will participate in the Parent Collaborative <p>Teachers and School Staff</p> <ul style="list-style-type: none"> ● By June 30, 2015, 549 teachers and school staff will be trained the evidence-based PE curriculum (CATCH).
Baseline	Same as above
Implementation Strategy for Achieving Goal	<p>Continue to work closely with participating School Administrators and staff to effectively encourage increased physical fitness and health for the entire school communities by using the following strategies:</p> <ul style="list-style-type: none"> ● Coordinate fitness and nutrition at 34 schools. ● Provide PE instruction for students and teachers at 8 schools. ● Disseminate health education materials regarding nutrition and exercise to parents via school mailings, newsletters, and school parent meetings. ● Utilize bi-lingual health navigator to conduct case management ● Promote and facilitate VCCC parent walking clubs. ● Provide teachers with technical assistance in utilizing the CATCH curriculum. ● Conduct skill building workshops for Parent Center Directors. ● Facilitate cholesterol, glucose, weight, and BMI screenings for parents. ● Promote and facilitate fitness and nutrition plays at 8 elementary schools. ● Conduct grocery store tours and food demonstrations ● Develop Parent Collaborative ● Conduct community outreach to local restaurants ● Maintain Community Resource Guide up to date ● Continue collaboration with existing partners. ● Establish collaborations with new partners.
Community Benefit Category	A1-a Community Health Education Lectures/Workshops

Physical Education Program 4 Kids (PEP4Kids)	
Hospital CB Priority Areas	<ul style="list-style-type: none"> X Increase access to appropriate health care services for the poor and underserved X Promote collaboration and reduction of duplicative health services X Address the obesity and diabetes epidemic X Address heart disease Provide access to mental health and substance abuse services Increase services to victims of trauma and violence
Program Emphasis	<ul style="list-style-type: none"> X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Link to Community Needs Assessment	The 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.
Program Description	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).
FY 2014	
Goal 2014	Increase physical activity and improve nutrition with the ultimate goal of improving cardiovascular fitness and decreasing childhood obesity rates.
2014 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • By June 2013: <ul style="list-style-type: none"> • Nearly 2,900 students will achieve 60 minutes of Physical Activity daily as measured by accelerometers • Nearly 2,900 students will improve cardiovascular fitness • Fitnessgram scores for 5th graders will increase • Approximately 120 Classroom teachers will be trained to implement the evidence-based CATCH PE and nutrition curriculum • Students will improve healthy nutrition behaviors regarding fruit and vegetable consumption • Parents will improve health and fitness knowledge and behaviors
Baseline	Lack of physical activity and sedentary lifestyles has contributed to the increased rate of cardiovascular related diseases. Low-income communities lack parks, recreational facilities, opportunities for walking and bicycling. Furthermore, due to gang violence, children are seldom

	<p>allowed to play outdoors. Finally, the local elementary schools lack formal physical education programs due to their increased focus on academic achievement.</p>
Implementation Strategy for Achieving Goal	<ul style="list-style-type: none"> • Offer program and assistance to principals at each school. • Identify partners to work with each school. • Coordinate partner's roles in addressing schools' needs. • Develop and implement programs for schools. • Monitor progress. • Evaluate results.
Result FY 2014	<p>PEP 4 Kids (Carol M. White Grant) at Panorama City, Langdon, Liggett Elementary Schools & Rosa Parks Learning Center (RPLC)</p> <ul style="list-style-type: none"> • Continued Physical Education Instruction to K-5 students by PE teachers. • Conducted ongoing capacity building (Professional Development) for classroom teachers. • Collected 4 follow-up measurements: BMI, Cardiovascular Assessment, Physical Activity assessment via Pedometers and recall data entry, and Fruit and Vegetable Intake recall. • PE Teachers conducted Fitnessgram assessment for 5th graders. • Peaceful Playground Markings were placed on PE field at Langdon ES. • Registered Dietician continued to conduct one-on-one counseling sessions with students and their parents. • <i>PE teacher collaborated with LAs BEST Summer</i> program at PCES. • <i>Fit Families</i> conducted at PCES by VCCC for at-risk kids and their families. • <i>Nutrition information</i> boards presented at all four schools • <i>Food for Thought: MyPlate</i> Nutrition and physical activity educational theatrical plays presented at: Liggett, Langdon, and Panorama City • <i>Jump Rope for Heart event:</i> conducted at Liggett ES. • Playground Markings Enhancement: Langdon ES • New community partners recruited <p>Parents</p> <ul style="list-style-type: none"> • <i>Chronic Disease Self Management Program</i> conducted at Liggett ES. • <i>Re-think your drink</i> presentation provided at Langdon ES and Rosa Parks Learning Center. • <i>Cooking demonstration</i> provided at Rosa Parks Learning Center. • <i>Cholesterol and glucose</i> screenings provided at Langdon and Liggett ES. • <i>Weight of the Nation</i> presentation and physical activity conducted Langdon ES and Rosa Parks Learning Center. • <i>Expanded Food and Nutrition Education Program</i> conducted at Rosa Parks Learning Center. • <i>Healthy Hearts, Healthy Families</i> 10-week program provided at Langdon ES and Panorama City. <p>Outcomes: Students</p>

	<ul style="list-style-type: none"> • PEP 4 Kids evaluation data indicated a <ul style="list-style-type: none"> • 21% increase in daily physical activity levels (60 minutes) (baseline of 16% to 37%), • 25% increase in cardiovascular fitness (baseline of 34% to 59%), • 25% decrease in BMI scores of 25 and above (baseline of 40% to 15%), and • 8% decrease in fruit and vegetable consumption (baseline of 18.2% to 10%) was observed.
Hospital's Contribution / Program Expense	\$15,000
FY 2015	
2015 Objective Measure/Indicator of Success	The PEP4Kids program ended on June 30, 2014. Due to lack of funding, this program has been discontinued. However, the participating schools will still receive parent nutrition and fitness classes conducted by our partner agencies.
Community Benefit Category	A1-a Community Health Education Lectures/Workshops

The implementation strategies in the above descriptions of key initiatives and programs specify community health needs that the Hospital has determined to meet in whole or in part and that are consistent with its mission. The Hospital reserves the right to amend these implementation strategies as circumstances warrant. For example, certain needs may be more pronounced and require enhancements to the described strategic initiatives. During the three years ending December 31, 2015, other organizations in the community may decide to address certain needs, indicating that the Hospital then should refocus its limited resources to best serve the community.

Community Benefit and Economic Value Classified Summary of Un-sponsored Community Benefit Expense

Northridge Hospital Medical Center
Classified Summary of Quantifiable Benefits
For period from 7/1/2013 through 6/30/2014
Classified as to Poor and Broader Community
Updated: September 11st, 2014

	<u>Persons</u>	<u>Total Expense</u>	<u>Offsetting Revenue</u>	<u>Net Benefit</u>	<u>% of Organization Expenses Revenues</u>	
Benefits for Living in Poverty						
Financial Assistance	13,874	8,574,831	0	8,574,831	2.6%	2.5%
Medicaid	30,004	83,817,251	57,631,149	26,186,102	8.0%	7.7%
Community Services:						
Community Benefit Operations	0	861,627	249,158	612,469	0.2%	0.2%
Community Health Improvement Services	72,670	3,551,863	2,062,252	1,489,611	0.5%	0.4%
Financial and In-Kind Contributions	31	767,303	0	767,303	0.2%	0.2%
Subsidized Health Services	36,122	10,093,065	58,403	10,034,662	3.1%	2.9%
Totals for Community Services	108,823	15,273,858	2,369,813	12,904,045	3.9%	3.8%
Totals for Living in Poverty	152,701	107,665,940	60,000,962	47,664,978	14.6%	14.0%
Benefits for Broader Community						
Unpaid Costs of Medicare	17,817	91,923,465	71,737,790	20,185,675	6.2%	5.9%
Community Services:						
Community Building Activities	849	365,530	0	365,530	0.1%	0.1%
Community Health Improvement Services	14,361	956,457	118,860	837,597	0.3%	0.2%
Financial and In-Kind Contributions	456	83,385	0	83,385	0.0%	0.0%
Health Professions Education	4,939	1,588,390	0	1,588,390	0.5%	0.5%
Totals for Community Services	20,605	2,993,762	118,860	2,874,902	0.9%	0.8%
Totals for Broader Community	38,422	94,917,227	71,856,650	23,060,577	7.1%	6.7%
Grand Total including unpaid cost of Medicare:	191,123	202,583,167	131,857,612	70,725,555	21.6%	20.7%
Grand Total excluding unpaid cost of Medicare:	173,306	110,659,702	60,119,822	50,539,880	15.4%	14.8%



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

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 means-tested programs.

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.
- 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.

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, 2014**

Justin Ako
Chair, Dept. of Health Administration
West Coast University

Barbra Miner
Independent Consultant
Strategic Development

Azmi Atiya, M.D.
Cardiothoracic Surgery
NHMC Medical Staff President

Celeste Ortiz
V.P. Human Resources
Medtronic Diabetes

Magued Beshay, M.D.
Gastroenterologist
Facey Medical Group

Saliba Salo
President
Northridge Hospital Medical Center

Jacob Bustos
Market Manager
Panera Bread

Hooshang Semnani, M.D
PICU
Northridge Hospital Medical Center

Donald Crane, JD
President/CEO
CAPG

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

Lamya Jarjour, M.D.
Women's Center
Northridge Hospital Medical Center

Carol Stern
CEO, Pro Pharma Pharmaceutical
Consultants

Valerie Kohler
Retired Insurance Broker

William Watkins, PhD
V.P. Student Affairs
CSUN

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.

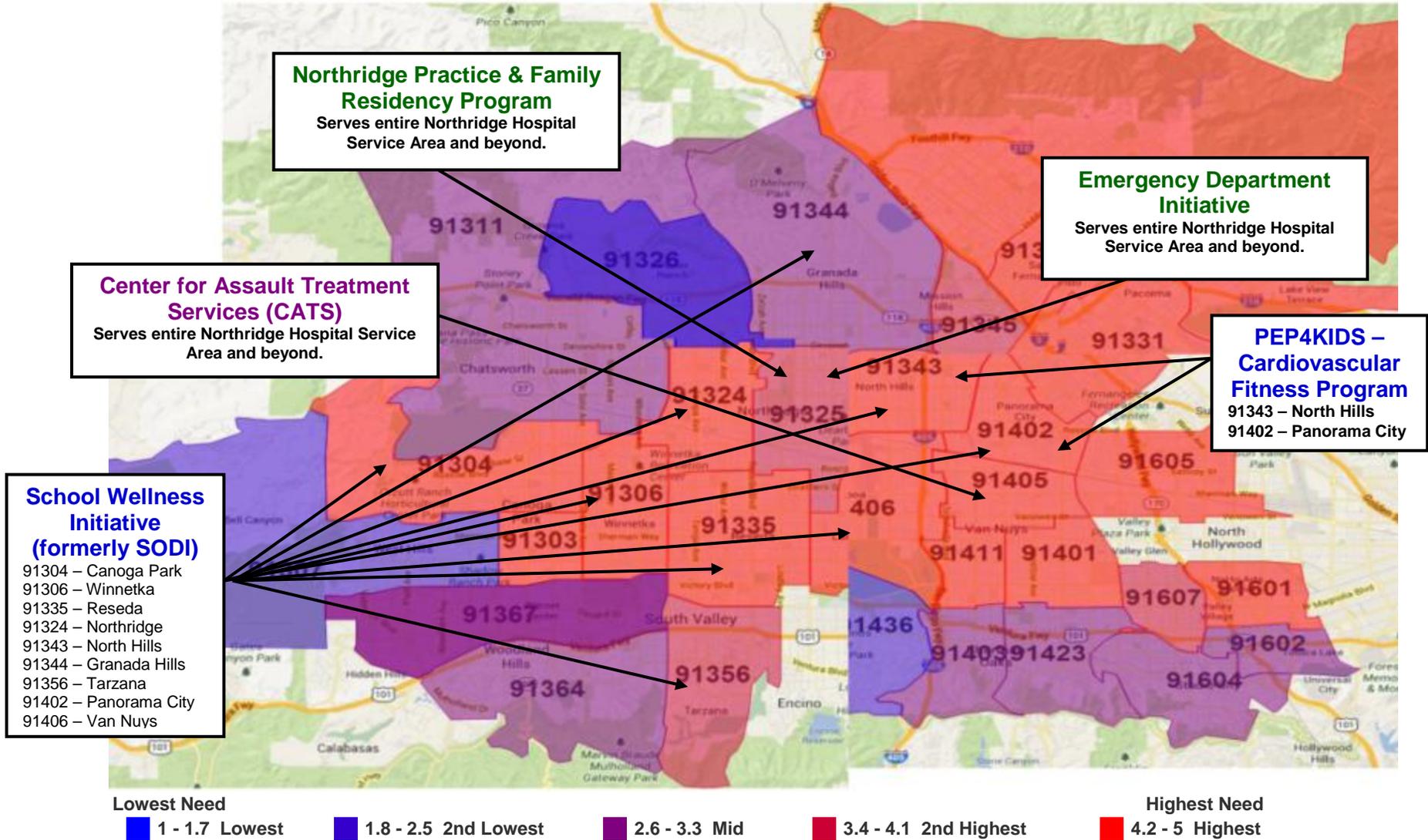
Relationship to Collection Policies:

- 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.

2014 Northridge Hospital Community Needs Index (CNI) Map San Fernando Valley Community Benefit Initiatives



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

Highest Need

 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