



**Northridge Hospital
Medical Center.**

A Dignity Health Member



Northridge Hospital Medical Center

Community Benefit Report 2012

Community Benefit Implementation Plan 2013

A message from Saliba H. Salo, Chief Executive Officer, Northridge Hospital Medical Center and Community Board Chair Salvador Esparza

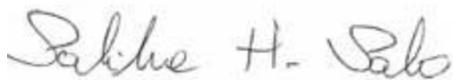
At Northridge Hospital Medical Center we share a commitment to optimize the health of the community we are privileged to serve. Vital to this effort is the collaboration we enjoy with our community partners. How we contribute to the quality of life and the environment in our communities has always been a key measure of our success and it will continue to be so as we move forward.

In January 2012 Dignity Health, formerly Catholic Healthcare West, announced changes in our governance structure and name that will better position the system to welcome new partners in a changing healthcare landscape. The new name, Dignity Health, was chosen because dignity has been one of our core values since our founding. It is deeply embedded in our culture and clearly describes who we are and what we stand for. Our new governance structure more accurately reflects our current composition of both religiously sponsored and community sponsored hospitals.

During fiscal year 2012 we, like the nation, were impacted by the continuing economic downturn and experienced both successes and challenges. Despite declining revenue from government sponsored patients, we provided \$58,275,386 million in charity care, community benefits and unreimbursed patient care at Northridge Hospital.

At Northridge Hospital, we strive to manage our resources and advance our healing ministry in a manner that benefits the common good now and in the future. Despite today's challenges we see this as a time of great hope and opportunity for the future of health care. We want to acknowledge and thank the women and men who have worked together in a spirit of collaboration to address the health priorities of our community through health and wellness programs and services.

In accordance with policy the Northridge Hospital Community Board of Directors has reviewed and approved the annual Community Benefit Report and Implementation Plan at their October, 2012 meeting.



Saliba H. Salo
President/CEO



Salvador Esparza
Chairman, Board of Directors

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EXECUTIVE SUMMARY

Northridge Hospital Medical Center (NHMC), celebrating its 57th anniversary, proudly serves the 2.1 million residents of the Greater San Fernando Valley. Northridge is a 411-bed, nonprofit facility affiliated with and sharing the values of Dignity Health, formerly Catholic Healthcare West (CHW), of Dignity, Collaboration, Excellence, Justice and Stewardship. The hospital with over 2,100 employees, 800 affiliated physicians in 55 specialties and over 500 volunteers has forged ahead as the leader in the San Fernando Valley by offering uncompromisingly high quality care, extensive outreach services and state of the art comprehensive technology.

Major programs and services include: CardioVascular Center, Leavey Cancer Center, Adult and Pediatric Trauma Center, Emergency Services, Center for Rehabilitation Medicine, Behavioral Health, Babies First Maternity Services, Carole Pump Women's Center, Orthopedic Services, a Stroke Center and an incredible array of technology including: da Vinci Robotic Surgery, Gamma Knife, Trilogy Linear Accelerator and the 64-slice CT Scanner.

In response to identified unmet health-related needs in the community needs assessment, Northridge Hospital has focused on increasing access to health care for the broader and underserved populations. Of particular focus has been responding to the epidemic of childhood obesity in our area, as well as sexual and domestic violence and alcohol and chemical dependency and mental health problems.

The Center for Assault Treatment Services (CATS) provides treatment to victims of sexual assault and abuse and provides child abuse education to professionals who work with children, and to children in the public school system and their parents.

The School-based Obesity & Diabetes Initiative (SODI) is a partnership with the Los Angeles Unified School District (LAUSD) Local District 1 to reduce the epidemic rate of obesity and diabetes by targeting elementary, middle and high school students, parents and staff in 36 high need schools. Assessments, nutrition and physical fitness programs are provided throughout the year.

The Valley CARES Family Justice Center (FJC) provides service delivery for victims of domestic and sexual violence and child and elder abuse in an underserved population. Important collaborators, located in FJC include: Los Angeles Police Department, District and City Attorneys, Valley Trauma Center, Neighborhood Legal Services and the Department of Children and Family Services, among others.

The Hospital Emergency Department Initiative (EDI) is a collaboration between the Northridge Hospital Emergency Department and Tarzana Treatment Centers to achieve a 5% decrease in readmissions of patients who are frequent users of ED services. The focus is on alcohol and chemical dependency and mental health diagnoses.

The Family Practice Center and Family Medicine Residency Program provides both inpatient and outpatient care to the underserved in the community. Resident physicians provide care ranging from prenatal to pediatric and from adult to geriatric medicine. Ongoing health outreach, prevention and education with community partners are also an integral part of the safety net program.

Congestive Heart Failure Initiative (CHFI) provides a bridge for patients with congestive heart failure, who have a history of repeated utilization of healthcare services, to appropriate care. The collaboration with Tarzana Treatment Centers manages patient referral for primary care and does tracking and follow-up to improve the quality of life by increasing their self-efficacy and avoiding admissions.

The final Community Benefit Report documents our commitment to the health and improved quality of life in our community and reports a net community benefit of \$58,275,386.



DIGNITY HEALTH Mission, Vision & Values

Mission Statement of Northridge Hospital Medical Center (Dignity Health Mission Statement)

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

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

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

- Dignity – Respecting the inherent value and worth of each person.
- Collaboration – Working together with people who support common values and vision to achieve goals.
- Justice – Advocating for social change and acting in ways that promote respect for all persons and demonstrate compassion for our sisters and brothers who are powerless.
- Stewardship – Cultivating the resources entrusted to us to promote healing and wholeness.
- Excellence – Exceeding expectations through teamwork and innovation.

The Mission Statement was reviewed and affirmed in October 2012 by the NHMC Community Board of Directors and the NHMC Senior Leadership Team (SLT).

ORGANIZATIONAL COMMITMENT

We have a significant presence in our community with best practice community benefit programs such as CATS and SODI. Northridge Hospital's organizational commitment to a wide range of community benefit and outreach program ensures that adequate resources are allocated to respond to the unmet health needs as identified in the community needs assessment. The Community Board of Directors, Foundation Board of Directors, Senior Leadership Team and key departments are at the forefront of meeting our commitment to improve the health status of the local community and address contributing factors to poor health.

The President/CEO and Senior Leadership Team are involved in the community benefit process as the strategic plan is developed. Community Benefit is a major pillar of the hospital's 2012 strategic plans:

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

As part of orientation for new managers and directors, a presentation is given on community benefits. This helps maintain the understanding and support of departments throughout the hospital who are vital in contributing resources and reports to the hospital's community benefit programs. The Community Board operates as a committee of the whole for community benefit purposes. Presentations and discussions are on the Board agenda throughout the year to seek their input and update them on the progress made toward identified goals.

The hospital's active grant program involves the community board, who makes the grant presentations annually at their January Board meeting.

This year we were proud to award six grants - totaling **\$165,918**. In total for the last eleven years of the Community Grants Program, Northridge Hospital has awarded over **\$1.27 million** in community grants to **70** non-profit groups. This year's grantees were:

- **National Alliance on Mental Illness (NAMI) San Fernando Valley** - \$6,000 - NAMI will bring additional mental health classes and support groups to Northridge Hospital.
- **Neighborhood Legal Services** - \$20,000 - Will provide additional legal services for Valley CARES Family Justice Center and develop a sustainable volunteer attorney model to support the center.
- **El Nido Family Centers** - \$25,000 - The grant supports children and families affected by child abuse, neglect and domestic violence.
- **Haven Hills** - \$30,000 - Program provides shelter, crisis intervention, counseling and advocacy to women and children who are victims of domestic violence.
- **Mid and West Valley Family YMCA's** - \$40,000 - The YMCA will implement PLAY – Physical Learning Activities for Youth - in elementary schools participating in the NHMC's School-based Obesity and Diabetes Initiative.
- **Tarzana Treatment Centers** - \$44,918 - "Decreasing Emergency Department Use through Education and Assessment" connects NHMC ER patients in need to primary care, substance abuse and mental health treatment.

The NHMC Community Board of Directors approved the 2012 Community Benefit Report/2013 Community Benefit Plan in October 2012.

The Community Board is representative of our service area and its cultural diversity. The Board composition is: 62% male and 38% female with 7% Asian, 21.5% Caucasian, 21.5% Hispanic, 14% African American and 36% other.

Non-quantifiable Community Benefits

Collaboration with community partners in local capacity building and community building is significant. Our key measurable community benefit initiatives – CATS, SODI and the Family Justice Center revolve around strong partnerships with area organizations, most notably:

- Los Angeles Unified School District
 - Student Health and Human Services
 - District One School Nurses
 - Student Medical Services and Obesity Clinic
 - Coordinated School Health Facilitator
 - Primary Intervention Counselor Program
- Los Angeles Police Department
- Los Angeles City Attorney
- Valley Trauma Center
- Neighborhood Legal Services
- Haven Hills
- California State University, Northridge
- Domestic Abuse Center
- Tarzana Treatment Center
- Valley Care Community Consortium
- San Fernando Valley Child Abuse Council
- International Association of Forensic Nurses
- National Family Justice Center Alliance
- Domestic Abuse Center

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

In addition to the key measurable initiatives profiled in this report, there are hospital-wide contributions and collaborations that reach out to our community's vulnerable populations. These are outlined in more detail on page 14 under other programs.

Briefly, they include free mammograms and colonoscopies conducted by the Leavey Cancer Center, free screening fairs held monthly on women's health issues and men's issues such as prostate examinations. We have a crisis team available 24/7 in our Behavioral Health Department for individuals at risk of self harm.

COMMUNITY

DEFINITION OF COMMUNITY

Northridge Hospital Medical Center is located in Service Planning Area 2 (SPA 2) of the County of Los Angeles, California and serves the residents of SPA 2. The hospital's primary service area is based on a percentage of hospital discharges and is also used in various other departments of the system and hospital, including strategy and planning.

DESCRIPTION OF THE COMMUNITY

Northridge Hospital serves SPA 2, a 999.24 square miles area consisting of thirty-six cities and sixty-five zip codes. The two million residents are diverse with no racial group currently representing a majority (40.11% white, 41.47% Latino, 10.48% Asian and 3.61% African American). In SPA 2 in 2009, the majority of births were to Hispanic mothers between the ages of 20-29; an estimated 13.5% of adults were diagnosed with depression; prevalence of cardiac disease was shown at 26.87%; cancer cases represented 2.80% (52,893) of the population; *Diabetes Mellitus* was the seventh leading cause of death; and 38.8% of adults and 20.4% of our youth were overweight, 17% of adults were obese and 7% were diagnosed with diabetes.

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

- ❖ Population: 1.1 million residents evenly distributed among the male and female
- ❖ Diversity: 30.7% Caucasian, 3.8% African American, 51.9% Latino, 11.1% Asian & Pacific Islander and 2.4% other
- ❖ Average household income between \$50,000-60,000 with 22% earning less than \$25,000 annually;
- ❖ No H.S. Diploma: 25.2%
- ❖ Uninsured: 19.20%
- ❖ Unemployed: 5.9%
- ❖ Renters: 41.1%
- ❖ Medi-cal Patients: 15.81%
- ❖ 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.

As per the Community Needs 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.

According to the 2010 Assessing the Community's Needs: A Triennial report on San Fernando and Santa Clarita Valleys, two of the key needs that are not addressed by Northridge Hospital are affordable housing and access to affordable dental health services. Housing is a major concern due to the lack of permanent supportive housing, Section 8 vouchers and emergency beds. Dental health services that are affordable and accessible are the fifth key priority needs for the uninsured and underinsured residents in our service area. Northridge Hospital does not have the resources to address these two issues. The hospital does make referrals, however we do not have programs that specifically target these two key needs.

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

COMMUNITY BENEFIT PLANNING PROCESS

DEVELOPING THE HOSPITAL'S COMMUNITY BENEFIT REPORT AND PLAN

2010 SPA 2 Triennial Community Needs Assessment

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

CHW Community Needs Index

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

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

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

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

Factors taken into consideration

In developing the hospital's community benefit plan, 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. The social and contextual barriers to accessing healthcare place people in poverty at a disadvantage with respect to preventing disease, managing illness and survival.

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

Culture Barriers

UCLA's School of Public Health and the California Public Health Department's California Health Interview Survey Research found that cultural barriers lead to a number of health disparities ranging from increased prevalence of disease to a greater inability to sign up for government health insurance programs. Recent federal research by the National Academies' Institute of Medicine has concluded that minorities receive lower-quality care than that given to whites, even when adjusting for insurance status, and that this pattern contributes to higher death rates and shorter life spans. Sixty-nine percent of residents in NHMC's primary service area are minorities.

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). Twenty-six percent of residents in NHMC's primary service center age 16 and above have not graduated from high school.

Insurance Barriers

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

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). Forty-one percent of residents in the hospital's primary service area live in rental units.

Addressing identified health issues

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

New or existing services

Existing services include:

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

Factors considered in selecting interventions

The following factors are taken into consideration in selecting interventions:

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

Services specifically addressing a vulnerable population

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

Services specifically aimed at improving the health status of the community

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

Programs serve to contain the growth of community health care costs

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

PLANNING FOR THE UNINSURED/UNDERINSURED PATIENT POPULATION

Financial Assistance/Charity Care Policy

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

Process to ensure internal implementation of policy

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

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

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

PLAN REPORT AND UPDATE INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

SUMMARY OF KEY PROGRAMS AND INITIATIVES

Center for Healthier Communities (CHC)

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

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

Dedicated to the treatment of children and adults who are victims of sexual abuse/assault or domestic violence, CATS, is the only program in the San Fernando and Santa Clarita Valleys that provides forensic interviews, forensic evidence collection and counseling 24 hours-a-day, seven days-a-week. The CATS team of experts provides these services free of charge in a supportive environment. CATS' collaborative partners include the local rape crisis center, law enforcement, District Attorney's Office, and the Los Angeles County Department of Children and Family Services among others. In fiscal year 2012, CATS provided medical evidentiary examinations in a compassionate and caring environment for 885 victims of all ages. CATS' outreach component provided more than 1,067 professionals, who are mandated child abuse reporters, with the tools necessary to identify and report any reasonable suspicion of child abuse. The CATS net community benefit for both its clinical and outreach components for FY2012 was \$1,444,471.

- **Valley CARES Family Justice Center**

Family Justice Centers are now considered a "best practice" in service delivery models for victims of interpersonal violence, including domestic violence, sexual assault, child abuse and elder abuse. The concept is to place necessary services for victims in one location and thereby reduce the number of places a victim has to go to receive services. The documented and published outcomes include a reduction in domestic violence homicides, increased safety, and improved cooperation with the prosecutor's office, thereby reducing recantation and increasing the prosecution of interpersonal violence cases. Northridge Hospital, in collaboration with the Los Angeles Police Department, District Attorney's Office, City Attorney's Office, Valley Trauma Center, Haven Hills, Domestic Abuse Center, Neighborhood Legal Services and Department of Children and Family Services, opened the first Family Justice Center in the County of Los Angeles in 2010. The Valley CARES net community benefit for FY2012 was \$428,366.

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

The School-based Obesity and Diabetes Initiative is a program designed to reduce the rate of obesity and diabetes locally by targeting primarily elementary school students, their parents and school staff in the Los Angeles Unified School District (LAUSD) schools located in the San Fernando Valley. The program recruits local, regional and national agencies to provide on-site nutrition and fitness programs, and evaluates the effectiveness of these programs. CHC's collaborative partners include: Northridge Hospital's Cardiology and Cancer Departments LAUSD Local District 1, School-based Health Clinics, Parent Center Directors and Parent Facilitators, the Alzheimer's Association, American Cancer Society, American Diabetes Association, American Heart Association, California State University, Northridge—Department of Dietetic Internship and Department of Kinesiology, Dairy Council of California, Enrichment Works, Health Net, Healthy Food School Coalition, Health Care Partners, Mid-Valley YMCA, Network for a Healthy California—LAUSD and Latino Campaign, Northeast Valley Health Corporation, Partners in Care Foundation, Providence Holy Cross, Sustainable Economic Enterprises of Los Angeles, University of California Cooperation Extension Los Angeles County Valley Care Community Consortium, and local elected officials. During FY2012, the initiative focused on 33 schools and reached a total of 24,300 students, parents, teachers and staff. In addition the federally funded project, PEP 4 Kids, provided four public schools with a physical education and nutrition program for elementary school students. The total net community benefit was \$764,346.
- Promoting Alternatives for Teen Health through Artes Teatro (PATH-AT)**

PATH-AT is a local Adolescent Family Life Demonstration Project conducted in the north and northeast San Fernando Valley in the City of Los Angeles by Northridge Hospital Medical Center's (NHMC) Center for Healthier Communities. The goal of the PATH-AT Program is to engage middle school students (ages 12 to 15) and their families in learning and understanding the benefits of abstaining from premarital sex, through the use of Peer Educators and theater arts. PATH-AT targets Latino middle school students in high need communities who are at high risk for early sexual experimentation and out-of-wedlock pregnancy, as well as other risky activities such as the use of drugs and alcohol. Targeted students primarily come from first and second-generation Mexican-American families. Over the course of 3 years (2007-2010) 1620 participants enrolled in the program. During its final year, PATH – AT staff and evaluation team submitted an article to the *Journal of Health Care for the Poor and Underserved*. The article, entitled "Using Theater Arts to Engage Latino Families in Dialogue about Adolescent Sexual Health: The PATH-AT Program", was published in February 2012. The total net community benefit was \$10,245.

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 FY2012 was \$67,710.

Congestive Heart Failure Initiative

The Congestive Heart Failure Initiative (CHFI) is a collaboration between Northridge Hospital Medical Center (NHMC) and Tarzana Treatment Centers (TTC) to demonstrate a decrease in readmissions within six months of a prior Emergency Department visit for pre-identified participants in the hospital's Congestive Heart Failure preventive health intervention long term improvement plan. As part of this project, hospital personnel providing discharge services refer eligible patients to an on-site TTC case manager who manages patients requiring case management services. This includes intake and assessment, individualized case planning, case conferencing, coordinating with other coordinators of client care or services, referral to ambulatory care, distribution of transportation vouchers and follow-up. Patients are also encouraged to enroll in the CHAMP program. The total net community benefit for FY2012 was \$17,805.

The Northridge Family Practice Center and Family Medicine Residency Program

The Northridge Family Medicine Residency Program, in conjunction with the faculty group, provides both inpatient and outpatient care to many of the underserved in the community. They are an integral part of providing care in the San Fernando Valley. The total net community benefit is \$9,152,854.

- **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 \$341,630. The majority of the activities conducted by the Cancer Center are underwritten by grant funds.

- Free Mammograms are provided to low-income, uninsured or underinsured women through funding from the Harold Pump Foundation and includes education, screening guidelines and cancer awareness. This program is coordinated by the Leavey Cancer Center's Navigator Program.
 - During the fiscal year, 1,009 women were provided with free mammograms to screen them for breast cancer. There were two positive breast cancer diagnoses which were referred for treatment.
- **Free Colonoscopies** are provided to low-income, uninsured or underinsured men and women through funding from the Harold Pump Foundation. This program is coordinated by the Leavey Cancer Center's Navigator Program.
 - 82 colonoscopies were performed. These individuals were identified as needing the procedure based on the self reported answers they provided on a screening tool used. The colon cancer outreach is provided at a variety of education and screenings offered throughout the year. None have tested positive for colon cancer
- **Harold Pump Foundation Sponsored Screening Fairs**, through the Leavey Cancer Center's *Reaching Out* program (formerly known as *La Fiesta para Su Salud*), are one-day events where those who are uninsured or underinsured can receive cancer screening procedures and other health screenings in a single day in a single location. In partnership with Vallarta Supermarkets, Park Parthenia Apartments and many community centers and churches, flyers were distributed throughout the community reaching out to people without health insurance. All the abnormal tests are followed up with assistance from Northridge Family Practice Clinic. The following number of screenings were performed at each fair:
 - **September 2011:** 115 cervical, 121 breast, 43 prostate
 - **December 2011:** 88 breast, 11 prostate

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

- **January 2012:** 57 breast
- **February 2012:** 83 breast
- **March 2012:** 94 breast
- **April 2012:** 89 breast

- **May 2012:** 109 breast, 20 prostate
- **June 2012:** 75 breast

- **Navigator Program Community Outreach** - The program educates the community about cancer awareness, cancer screening guidelines, and how to decrease risk factors for cancer. The program also signs up people who are uninsured or underinsured for free mammograms with additional funding received from the Harold Pump Memorial Foundation.
 - 6,134 individuals in 78 community groups have been educated about breast and/or colon cancer awareness and screening guidelines and informed about our free mammogram programs. Guardian Angel Church members, Vaughn School based Clinic clients and M.E.N.D community center were among the groups educated.
 - The Navigator Program has formed a relationship with the School-based Obesity and Diabetes Initiative (SODI) that is part of Northridge Hospital's Center for Healthier Communities. The Navigator program teaches the parents how to decrease their risks for cancer and what the cancer screening guidelines are. The participants are members of parent groups at the LAUSD schools and 246 individuals were reached.
 - To further augment our services, we obtained grant funding to provide massage therapy to Cancer patients. We provided services to 1539 individuals over the last year.
 - The Navigator Program also offers support groups that serve the needs of specialized groups within the community. Such groups include the Brain Tumor Support Group, who serves an average of 15 patients per session, Trigeminal Neuralgia Support Group, and the 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 Radiation Oncology and the Surgical Oncology services. As a resource for each patient's unique needs during their care at the Cancer Center, patients can rely on their Navigator for compassionate support, encouragement and education.
 - The RN Navigator provides pre-and-post operative surgery education, helps patients and their families connect with psychosocial support such as the NHMC's partnerships with the American Cancer Society and WeSpark to offer support groups, classes and programs.
 - Patients are familiarized with the Hospital through our comprehensive Patient Orientation Program, *Navigating Through Your Cancer Journey*.

- **Oncology Welcome Packages** are given to each patient at their initial consult, before treatment. Each package includes various samples such as Biotene for dry mouth, chapstick, gentle hair and body wash, lotion, toothpaste, toothbrush, fiber one, thermometer, a book of laughs and many other things. These packages help ease the anxiety of possible symptoms the patient may experience during treatment.
- **Patient Home Aid** sponsored by Harold Pump Foundation's Family Money Fund has provided 680 total hours of service to 11 patients during the fiscal year for home aid so they could be discharged from the hospital to live out the end of their lives in the comfort of their own homes.
- **Transportation** sponsored by Harold Pump Foundation's Family Money Fund has provided 311 trips to 52 patients for their medical appointments at the cancer center.
- **Helping Hands Holiday Jam** - For the past eight years, NHMC, the NHMC Foundation and the Cancer Center have partnered with the Harold Pump Foundation to provide a Christmas wonderland for over 304 disadvantaged children each year. Hospital departments, staff and volunteers participate in this charitable event which provides games, activities, lunch, a visit with Santa and Christmas gifts for children from local Title 1 schools. In some cases the gifts they receive may be the only gifts they will get for the holidays. Many staff members, who volunteer at this event, have stated how personally rewarding it is for them as well.

Crisis Services Program

NHMC'S Behavioral Health Department Crisis Services Program provides crisis intervention for the urgent Mental Health care needs of individuals at risk of self-harm, at risk of danger to others, or who are gravely disabled and unable to care for themselves. The Crisis/Intake line assesses and evaluates all calls for appropriate referral resources or follow-up services. During fiscal year 2012, the Crisis Services Program served 6,165 individuals. Collaborative partners include Valley Community Mental Health, West Valley Mental Health, Adult Protective Services and the LAPD Smart Team. NHMC'S Emergency Department and the emergency departments of nine area hospitals-Providence Saint Joseph Medical Center, Providence Holy Cross Medical Center, Valley Presbyterian Hospital, Sherman Oaks Hospital, Huntington Memorial Hospital, Henry Mayo Hospital, West Hills Hospital, Kaiser and Providence Tarzana Hospital refer psychiatric cases to NHMC'S Crisis Services Program Crisis Team for evaluation and intervention. The total net community benefit was \$1,816,744.

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 44,451 patients during fiscal year 2012. Of this amount 26,302 were indigent or low-income patients who were not able to afford to pay for services or did not have health insurance. The total net community benefit was \$7,487,000.

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 1,015 persons in FY2012; of this amount 518 were low-income and could not afford to pay for services or did not have health insurance. The total net community benefit was \$774,000.

Richie Pediatric Trauma Center

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

The PTC provided care for 240 persons in FY2012; of this amount 158 were low-income and could not afford to pay for services or did not have health insurance. The total cost of care for these patients was supported by a grant from the “Richie Fund” in the amount of \$1,740,000.

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

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

DESCRIPTION of KEY PROGRAMS and INITIATIVES (Program Digests)

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

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

Center for Assault Treatment Services (CATS)	
Hospital CB Priority Areas	<p>X Increase access to appropriate health care services for the poor and underserved</p> <p>X Promote collaboration and reduction of duplicative health services</p> <p>Address the obesity and diabetes epidemic</p> <p>Reduce rate of births to adolescents</p> <p>X Increase services to victims of trauma and violence</p>
Program Emphasis	<p>X Disproportionate Unmet Health-Related Needs</p> <p>X Primary Prevention</p> <p>X Seamless Continuum of Care</p> <p>X Build Community Capacity</p> <p>X Collaborative Governance</p>
Link to Community Needs Assessment, Vulnerable Population	<p>Programs are needed that focus on personal development and mental health of adolescents and better education on programs and services available in the community.</p>
Program Description	<p>CATS' expert team of forensic nurses, under the direction of the Clinical Manager and Medical Director, provides medical evidentiary examinations and forensic interviews for adult and child victims of sexual assault, sexual abuse and domestic violence in a safe, comforting and private environment that preserves the dignity of the victim. CATS also provides child abuse prevention education to professionals in the San Fernando Valley who work with children and are therefore mandated by law to report any reasonable suspicion of child abuse. CATS collaborates with the local rape crisis center, Valley Trauma Center, to provide case management and counseling for victims; law enforcement and the District Attorney's Office in prosecution; child protective services; local school districts and community based organizations to deliver these services.</p>
FY 2012	
Goal FY 2012	<p>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.</p>

2012 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • By June 30, 2012, provide medical evidentiary examinations, case management and counseling to 850 victims of sexual abuse and assault of all ages. • By June 30, 2012 provide prevention education to a minimum of 1,200 mandated child abuse reporters and the general public. • By June 30, 2012 develop strategic plan for expansion efforts. • By June 30, 2012 raise funds to support program components.
Baseline	Sexual assault victims need immediate post-abuse treatment. Few victims disclose and even fewer mandated reporters report incidence of abuse.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Conduct medical evidentiary exams of victims of sexual abuse/assault and DV of all ages. • Conduct forensic interviews. • Work closely with child protective services, law enforcement and the District Attorney's office to assist in the investigation process. • Work closely with the Valley Trauma Center to provide post-trauma case management and counseling to victims. • Outreach to public and private schools, hospitals, clinics and other community-based organizations. • Develop training materials and conduct trainings. • Evaluate results.
Result FY 2012	<ul style="list-style-type: none"> • CATS provided medical evidentiary exams and forensic interviews to 885 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 1,116 mandated child abuse reporters. • CATS raised \$315,000 in funds from private and corporate foundations, its annual walk/run event, retail campaigns, social and business clubs and individual donors.
NHMC Contribution/Program Expense	\$1,444,471
FY 2013	
Goal 2012	Provide clinical forensic services to victims of sexual abuse, sexual assault and domestic violence; and provide child abuse prevention education to professionals who work with children throughout the San Fernando and Santa Clarita Valleys.
2013 Objective measure/Indicator of Success	<ul style="list-style-type: none"> • By June 30, 2013 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, 2013, provide medical evidentiary examinations, case management and counseling to 900 victims of sexual

	<p>abuse and assault of all ages.</p> <ul style="list-style-type: none"> • By June 30, 2013 provide prevention education to 1,000 mandated child abuse reporters and the general public. • By June 30, 2013 raise funds to support program components.
Baseline	Same as above
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Work closely with law enforcement and the District Attorney's Office. • Conduct roll call trainings at local law enforcement precincts/divisions. • Conduct medical evidentiary examinations and forensic interviews. • Review and update materials for mandated reporters. • Review and update CATS website. • Publish annual newsletter. • Outreach to public schools and community-based organizations. • Conduct trainings on-site at local agencies and schools for mandated child abuse reporters. • Write grants to support CATS components. • Conduct CATS Victory for Victims Walk/Run and the LA Marathon Team to promote awareness of child abuse and raise funds.

Family Practice Center and Family Medicine Residency Program	
Hospital CB Priority Areas	<p>X Increase access to appropriate health care services for the poor and underserved</p> <p>X Promote collaboration and reduction of duplicative health services</p> <p>X Address the obesity and diabetes epidemic</p> <p>X Reduce rate of births to adolescents</p> <p>Increase services to victims of trauma and violence</p>
Program Emphasis	<p>X Disproportionate Unmet Health-Related Needs</p> <p>X Primary Prevention</p> <p>X Seamless Continuum of Care</p> <p>X Build Community Capacity</p> <p>X Collaborative Governance</p>
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 2012	
Goal FY 2012	To provide a safety net for patients in our community both in the hospital and in the ambulatory setting, with emphasis on becoming an integral part of the local neighborhood and continue outreach prevention education efforts.
2012 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Number of indigent patients seen on the inpatient hospital service. • Number of patients seen through Medi-Cal or HMO Medi-Cal. • Number of patients seen through all state-funded service programs for low-income patients, such as CHDP, CCS, PACT. • Number of indigent patients seen in the Family Practice Center, including specialty clinics and the Diabetes Indigent Program. • Continuation of partnerships and outreach prevention education efforts with local schools, senior centers and community agencies.
Baseline	There is insufficient access to primary medical services across population groups. Chronic diseases account for many of the acute care

	inpatient admissions across age groups. The large number of Latino residents results in a disproportionate incidence of diabetes in the San Fernando Valley. Therefore, special attention needs to be given to the diagnosis, treatment, prevention and education of diabetes.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Continue Family Medicine coverage of admissions through the hospital emergency department including involvement with the obstetrical and surgical panel coverage. • Continue and expand hospital inpatient service at Northridge Hospital Medical Center. • Contract with Medi-Cal HMO's as the State of California continues to move additional patients into managed Medi-Cal. • Maintain "Diabetes Indigent Program." • Maintain community partnerships and outreach prevention education efforts, including health education for the youth, high school sports coverage, obesity and diabetes prevention in children and adults, general health screenings, and senior center screenings.
Result FY 2012	<ul style="list-style-type: none"> • 17,266 total visits in the hospital over a one year period, a decrease 4.36% from last year's total of 19,000. <ul style="list-style-type: none"> ○ 65% of visits are for indigent/underserved care, including uninsured, Medi-Cal, and HMO Medi-Cal patients. • 20,956 total patient visits in the Family Practice Center, including specialty clinics and the Diabetes Indigent Program. <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 including pap-o-ramas.
Hospital's Contribution / Program Expense	\$9,152,854
FY 2013	
Goal 2013	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.

2013 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. • Continuation and expansion of partnerships and outreach prevention education efforts with local schools, senior centers, and community agencies. • Partnerships include: <ul style="list-style-type: none"> ○ CSUN (California State Northridge University) Family Focus Resource Center will work with residents and families at the FPC to help parents with special needs children better access school-based services. ○ Northeast Valley Health Corporation clinics - Residents on our expanded community medicine rotation will rotate through various services at this Federally Qualified Clinic providing medical care to underserved populations in the San Fernando Valley. ○ Collaboration with Northridge Hospital's SODI Program (School-Based Obesity & Diabetes Initiative). ○ Increased collaboration and coordination with hospital based services including rotations with the expanded palliative care program and with the hospital chaplains.
Baseline	Same as above.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Continue Family Medicine coverage of admissions through the hospital emergency department including involvement with the obstetrical and surgical panel coverage. • Continue and expand hospital inpatient service at Northridge Hospital Medical Center including increased faculty hours for supervision of inpatient care. • Contract with Medi-Cal HMO's as the State of California continues to move additional patients into managed Medi-Cal. • Maintain community partnerships and outreach prevention education efforts, including health education for the youth, high school sports coverage, obesity and diabetes prevention in children and adults, general health screenings and senior center screenings. • Continuation of on-site psychological services to assist patients with psychiatric diagnoses and those dealing with the stress of managing chronic diseases.

Emergency Department Initiatives (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 Reduce rate of births to adolescents Increase services to victims of trauma and violence
Program Emphasis	<ul style="list-style-type: none"> X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Link to Community Needs Assessment	EDI 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 2012	
Goal FY 2012	<p>The LTIP Emergency Department Initiative (EDI) is a collaboration between Northridge Hospital Medical Center (NHMC) and Tarzana Treatment Center (TTC). The Northridge Hospital ED and TTC collaborate on reducing recidivism in the ED by at least 5% from base line. The objective of the collaboration is to reduce health disparities among populations with disproportionate unmet health-related needs, specifically individuals with alcohol and/or chemical dependency and mental health conditions. Additionally, the focus is on those patients who are uninsured or underinsured. Referrals are made to the TTC Case Manager by an MD. The TTC Case Manager provides an assessment, individualized plan of care and assistance in establishing follow-up services.</p> <p>The target population for this program is any patient who has 3 or more visits to the Emergency Department and a diagnosis related to drug/alcohol addiction and/or underlying psychiatric disturbances.</p>
2012 Objective	<ul style="list-style-type: none"> • Numbers of ED patients receiving TTC intervention.

Measure/Indicator of Success	<ul style="list-style-type: none"> • 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. • Percentage reduction of recidivism.
Baseline	<u>Number of visits to ED six months prior to TTC intervention.</u>
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Educate ED staff regarding appropriate referrals. • TTC to provide case management for referred patients. • NHMC and TTC maintain database. • TTC follows up with patients. • TTC Independent Evaluator reviews and analyzes data. • NHMC reviews and analyzes data.
Result FY 2012	<p>From June 2011 to May 2012,</p> <ul style="list-style-type: none"> • Total number of patients receiving intervention for year = 308. • Number of patients with 3 or more visits receiving intervention= 60. • Number with no return visits after intervention = 31. • Percentage with no return visits after intervention = 52%. • 60 patients have been referred to the TTC case manager who met the criteria of 3 or more visits prior to intervention. The number of visits before intervention equals 353. As of May 31, 2012, the number of visits after intervention equals 112, for a reduction of 68%. Of the 60 patients, 52% of them have had no return visits, for a total of 31 patients. • Number of patients with less than 3 visits receiving intervention = 248. • Number with no return visits after intervention = 185. • Percentage with no return visits after intervention = 75%. • The number of visits before intervention was 324. The number of visits after intervention was 118 for a reduction of 66%.
Hospital's Contribution / Program Expense	\$67,710
FY 2013	
Goal 2013	<p>The LTIP Emergency Department Initiative (EDI) is a collaboration between Northridge Hospital Medical Center (NHMC) and Tarzana Treatment Center (TTC). The Northridge Hospital ED and TTC collaborate on reducing recidivism in the ED by at least 5% from base line. The objective of the collaboration is to reduce health disparities among populations with disproportionate unmet health-related needs, specifically individuals with alcohol and/or chemical dependency and mental health conditions. Additionally, the focus is on those patients who are uninsured or underinsured. Referrals are made to the TTC Case Manager by an MD. The TTC Case Manager provides an assessment, individualized plan of care and assistance in establishing follow-up services.</p>

	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.
2013 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Numbers of ED patients receiving TTC intervention. • Number of ED visits and/or hospital admissions six months prior to TTC intervention. • Number of ED visits and/or hospital admissions six months post TTC intervention.
Baseline	Same as above.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • ED committee to hold bi-monthly meetings to implement enhancements. • TTC to provide case management for referred patients. • TTC to follow up with patients. • NHMC and TTC to maintain databases on patients referred. • Review and analyze data. • Evaluate effectiveness of program

School-based Obesity & Diabetes Initiative (SODI)	
Hospital CB Priority Areas	<ul style="list-style-type: none"> X Increase access to appropriate health care services for the poor and underserved X Promote collaboration and reduction of duplicative health services X Address the obesity and diabetes epidemic Reduce rate of births to adolescents Increase services to victims of trauma and violence
Program Emphasis	<ul style="list-style-type: none"> X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Link to Community Needs Assessment	The School-based Obesity and Diabetes Initiative will address the need to reduce the rate of childhood obesity and related diseases in the San Fernando Valley of Los Angeles County.
Program Description	The School-based Obesity and Diabetes Initiative (SODI) was launched in partnership Los Angeles School District (LAUSD) Local District 1 to reduce the rate of obesity and diabetes locally by targeting primarily elementary school students, parents and staff in schools located in underserved San Fernando Valley communities. SODI assisted participating LAUSD schools in implementing wellness programs with a focus on nutrition and physical fitness. SODI's collaborative partners included: Northridge Hospital's Cardiology and Cancer Departments, LAUSD Local District 1, Coordinated School Health, K-12 Physical Education, School-based Health Clinics, Parent Center Directors and Parent Facilitators; the Alzheimer's Association, American Cancer Society, American Diabetes Association, American Heart Association, California Action for Healthy Kids, California Project LEAN, California State University, Northridge–Department of Dietetic Internship and Department of Kinesiology, Enrichment Works, Gelson's Supermarkets, General Mills Foundation–Champions for Healthy Kids, Health Net, Mid-Valley YMCA, Network for a Healthy California–LAUSD and Champions for Change-Los Angeles Region, Nike, Northeast Valley Health Corporation, Partners in Care Foundation, Sustainable Economic Enterprises of Los Angeles, Valley Care Community Consortium (VCCC); Los Angeles City Councilman Tony Cardenas, Los Angeles County Supervisor Zev Yaroslavsky, California State Senator Alex Padilla, and U. S. Congressman, Howard Berman.
FY 2012	
Goal 2012	<ul style="list-style-type: none"> • Increase physical activity and improve nutrition with the ultimate goal of decreasing childhood obesity rates.
2012 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • By June 2012 conduct wellness campaigns in 32 schools. • By June 2012 increase the number of students who engage in physical activity in PEP 4 Kids schools. • By June 2012 the increase students knowledge of good nutrition. • By June 2012 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>
Intervention 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 2012	<ul style="list-style-type: none"> • SODI continued collaboration with schools; expanded PEP 4 Kids program to 4 schools. • New community partners recruited. • Coordinated programs at participating schools. <p>Parent Classes Programs:</p> <ul style="list-style-type: none"> • <i>Alzheimer's Awareness</i> class offered at Sepulveda MS. • Breast and colon cancer presentation provided at Burton, Stagg, and Fulbright ES. • <i>Carbohydrate Counting</i> conducted at Nevada ES. • <i>Chronic Disease Self Management Program</i> conducted at Rosa Parks Learning Center. • <i>Cooking demonstration</i> provided at Liggett ES. • <i>Diabetes Awareness and Prevention</i> class conducted at Canoga Park and Fulbright ES. • <i>Fit Families for Life 3-week series</i> completed at Kennedy HS, Andasol, Enadia Way, Nevada, and Stagg ES. • <i>Fitness demonstration</i> conducted at Nevada ES. • <i>Go Red Por Tu Corazon</i> workshop conducted at Mulholland MS and Noble Elementary School. • <i>Good Cooking (a one-time workshop)</i> completed at Cohasset, Stagg, Burton, Noble, Danube, and Limerick ES. • <i>Good Cooking 4-week series</i> (physical activity and nutrition) completed at: Fulbright, Ranchito, Winnetka, and Sepulveda MS. • <i>Health screenings</i>– HUD Grant provided at Cohasset and Anatola ES. • <i>Healthy Eating</i> class provided at Hart and Tarzana ES. • <i>Healthy Eating and Healthy Lives</i> offered at Panorama City ES. • <i>Healthy Cooking for Families</i> workshop series (CSUN) provided at Langdon ES. • <i>Healthy Women</i> workshop series conducted at Noble ES. • <i>Parent walking groups through VCCC</i> provided at Noble, Fulbright,

Limerick, and Stagg ES.

- *Plan, Save, and Shop* workshop series conducted at Langdon and Limerick ES.
- *School Nutrition Policies* class provided at Emelita, Gledhill, Tarzana Es, Northridge and Sepulveda MS.
- *Stress management* class provided at Canoga Park, Cantara, Chase, Danube ES, and Mulholland MS.
- Zumba demonstrations through YMCA offered at Chase, Danube, Haskell, and Noble ES.

Student Classes and Programs:

- *Food For Thought & Food For Thought 2* Nutrition and physical activity educational theatrical plays presented at 5 schools: Sunny Brae, Emelita, Lemay, Langdon, Mayall, Panorama City, Ranchito, Panorama City, and Liggett ES.
- *Marathon Kids* program provided at Rosa Parks Learning Center.
- Playground Markings Enhancement: Alta California, Burton, Mayall, and Winnetka.

Special School Events for Students and Parents:

- Noble Elementary School's *Family FitnessFun*.
- *Los Angeles County Community Advisory Committee (Health Net)* at Mulholland MS.
- *Parent Volunteer Recognition luncheon* at Langdon Elementary School.
- Parents and students participated at the *Marathon for Kids* hosted at UCLA.
- Tri-YMCA Healthy Kids Day at Lake Balboa Park.
- Families participated in Tony Cardenas Health Fair at Japanese Gardens.
- Provided nutritional information for families at Iglesia Poder de Dios Health Fair.
- Spin the Wheel game and nutrition information at Stagg's Health Fair.
- Parents from Gault ES and Mulholland MS participated in the American Heart Association Luncheon at the JW Marriott in Downtown LA.

Teachers/School Staff

- Provided CATCH Curriculum & Training for Langdon, Nevada, Winnetka, Alta California, Burton, Noble, Fulbright, Sunny Brae, Limerick, and Mayall.
- My Plate Staff Development at Panorama City and Anatola ES.

PEP 4 Kids (Carol M. White Grant) at Panorama City Elementary School (PCES), Langdon ES, Liggett Elementary School & Rosa Parks Learning Center (RPLC)

- Continued programming at Liggett ES, PCES, & RPLC.
- Hired and placed 1 additional Physical Education (PE) Teacher at

	<p>Langdon ES.</p> <ul style="list-style-type: none"> • 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 fields at Liggett and Langdon ES. • Contracted with Registered Dietician to conduct classroom presentations and one-on-one counseling sessions with students. • <i>Family Fitness Summer challenge</i> at Rosa Parks ES. • <i>Fit Families</i> conducted at Langdon and Liggett ES by VCCC for overweight kids and their families. • <i>Active Kids Active Families</i> provided by Mid-Valley YMCA. • <i>MyPlate</i> presentation for 5th grade students at Rosa Parks ES conducted by CSUN Health Education students. • Health Presentations at Panorama City ES by NHMC Family residency program. <p>Outcomes:</p> <p>Parents</p> <ul style="list-style-type: none"> • Participant pre/post surveys for nutrition and cooking classes indicate strong parent support for class and positive changes made in relation to exercise and diet. • Walking groups pre/post screens indicate increased cardiovascular health for most participants. • Cholesterol screening results indicate decreases in cholesterol levels for significant number of participants. <p>Students</p> <ul style="list-style-type: none"> • PEP 4 Kids evaluation data indicated a 13.6% increase from baseline in the percentage of students who meet 60 minutes of daily Physical Activity. • PEP 4 Kids evaluation data indicated a 16% increase from baseline of students who achieved age-appropriate cardiovascular fitness levels. • PEP 4 Kids evaluation data indicated a 8.8% increase from baseline in the percentage of students who consumed fruit and vegetable two or more times per day <p>PEP 4 Kids evaluation data indicated a 18% decrease in BMI scores of 25 and above.</p>
Hospital's Contribution / Program Expense	\$764,346
FY 2013	
2013 Objective Measure/Indicator of	<p>Students</p> <ul style="list-style-type: none"> • By June 30, 2013 improve Fitnessgram scores among grade 5

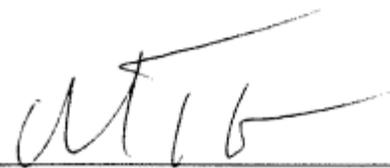
<p>Success</p>	<p>students.</p> <ul style="list-style-type: none"> • By June 30, 2013 increase amount of daily physical activity among elementary school students. <p>Parents</p> <ul style="list-style-type: none"> • By June 30, 2013, improve nutrition and fitness levels. <p>Teachers and School Staff</p> <ul style="list-style-type: none"> • By June 30, 2013, train teachers and school staff in evidence-based PE curriculum (CATCH).
<p>Baseline</p>	<p>Same as above</p>
<p>Intervention Strategy for Achieving Goal</p>	<p>Continue to work closely with participating SODI School Administrators and staff to effectively encourage increased physical fitness and health for the entire school communities by using the following strategies:</p> <ul style="list-style-type: none"> • Coordinate fitness and nutrition at 33 schools. • Provide PE instruction for students and teachers at 4 school. • Facilitate PE instruction for 4th and 5th grade students at 3 additional schools. • Disseminate health education materials regarding nutrition and exercise to parents via school mailings, newsletters, and school parent meetings. • Utilize bi-lingual registered dietician to conduct nutrition counseling sessions for students with BMI >25 at 4 schools. • 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 10 elementary schools. • Continue collaboration with existing partners. • Establish collaborations with new partners.

Valley CARES Family Justice Center	
Hospital CB Priority Areas	<ul style="list-style-type: none"> X Increase access to appropriate health care services for the poor and underserved X Promote collaboration and reduction of duplicative health services Address the obesity and diabetes epidemic Reduce rate of births to adolescents X Increase services to victims of trauma and violence
Program Emphasis	<ul style="list-style-type: none"> X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Link to Community Needs Assessment	The Family Justice Center (FJC) is a one-stop shop designed to provide comprehensive services link for victims of interpersonal violence.
Program Description	Family Justice Centers are now considered a “best practice” in service delivery models for victims of interpersonal violence, including domestic violence, sexual assault, child abuse and elder abuse. The concept is to place necessary services for victims in one location and thereby reduce the number of places a victim has to go to receive services. The documented and published outcomes include a reduction in domestic violence homicides, increased safety and improved cooperation with the prosecutor’s office, thereby reducing recantation and increasing prosecution of interpersonal violence cases. Northridge Hospital and collaborators, the Los Angeles Police Department, District Attorney’s Office, City Attorney’s Office, Valley Trauma Center, Haven Hills, Domestic Abuse Center, Neighborhood Legal Services and the Department of Children and Family Services, are launching the first family justice center in the County of Los Angeles.
FY 2012	
Goal FY 2012	To become fully operational as a Family Justice Center.
2012 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • To develop new protocols as needed. • To facilitate the co-location of additional partners. • To tailor software program to meet the needs of co-located agencies. • To serve victims of interpersonal violence. • To host the grand opening of the Family Justice Center. • To raise funds to sustain the initiative. • To share lessons learned with emerging family justice centers.
Baseline	Same as above.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Update Operations Manual. • Review protocols and develop new ones. • Provide comprehensive services to victims of interpersonal by on-site and off-site partners. • Collect and evaluate data. • Write grants.

	<ul style="list-style-type: none"> • Develop multiple revenue sources. • Expand the Governance Committee.
Result FY 2012	<ul style="list-style-type: none"> • Policies and protocols reviewed and revised as needed to adapt to client needs and service delivery flow. • Successful Open House for FJC well attended by politicians and community. • Additional on site partner added – County Victim Assistance; Los Angeles City Attorney. • Services broadened to include sexual assault victims receiving civil legal services, victim assistance and counseling on site. • Forensic Interview Room equipped with recording equipment. • ETO software customized for our FJC and in full use and collecting data from all partners. • Attended National FJC California Initiative Learning Exchange Team Conference in San Diego – presentation made. • Hosted a Strangulation Training for multidisciplinary professionals. • Participant in research evaluation of FJCs for the National JFC Alliance. • Valley CARES is a national model for forensic medical unit- Networked with FJCs across the country on starting a forensic medical unit within FJC. • CSUN Sociology dept performing evaluation of outcomes for FJC • Funds raised from Verizon, Los Angeles County Supervisor Zev Yaroslavsky, California Family Justice Initiative and OVW grant.
Hospital's Contribution / Program Expense	\$428,366
FY 2013	
Goal 2013	To transition the FJC to a new location and new lead agency.
2013 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Relocate FJC without interruption in service. • Increase the number of on-site services for victims. • Smoothly transition the FJC to new lead agency. • Raise funds to sustain initiative.
Baseline	Interpersonal violence is a seriously underreported crime. Many victims who do report are unable to access the services they need to begin the recovery process. There is no one place in the San Fernando Valley where victims can access all the services they need under one roof.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Hold regular meetings to facilitate the relocation. • Finalize space plan and develop matrix for move. • Set up communications system to inform service providers and community of relocation. • Revise the Operations Manual to reflect new location and client flow • Convene meetings to facilitate the smooth transfer of the FJC to new lead agency. • Identify funds for initiative. • Meet with new potential on site service providers.

Northridge Hospital Medical Center
 Classified Summary of Quantifiable Benefits
 For period from 7/1/2011 through 6/30/2012
 Classified as to Poor and Broader Community
 Updated: September 21st, 2012

	<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	11,648	9,539,299	0	9,539,299	2.8%	2.5%
Medicaid	28,688	94,672,857	85,836,416	8,836,441	2.6%	2.3%
Community Services:						
Community Benefit Operations	0	671,569	0	671,569	0.2%	0.2%
Community Health Improvement Services	58,788	2,780,788	3,000	2,777,788	0.8%	0.7%
Financial and In-Kind Contributions	44	1,913,078	0	1,913,078	0.6%	0.5%
Subsidized Health Services	48,405	9,152,854	0	9,152,854	2.7%	2.4%
Totals for Community Services	107,237	14,518,289	3,000	14,515,289	4.2%	3.7%
Totals for Living in Poverty	147,573	118,730,445	85,839,416	32,891,029	9.6%	8.5%
Benefits for Broader Community						
Unpaid Costs of Medicare	21,635	100,567,433	77,919,606	22,647,827	6.6%	5.8%
Community Services:						
Community Building Activities	807	327,843	178	327,665	0.1%	0.1%
Community Health Improvement Services	14,483	1,132,204	500	1,131,704	0.3%	0.3%
Financial and In-Kind Contributions	375	82,530	0	82,530	0.0%	0.0%
Health Professions Education	4,894	1,086,109	0	1,086,109	0.3%	0.3%
Research	156	102,179	0	102,179	0.0%	0.0%
Subsidized Health Services	100	6,343	0	6,343	0.0%	0.0%
Totals for Community Services	20,815	2,737,208	678	2,736,530	0.8%	0.7%
Totals for Broader Community	42,450	103,304,641	77,920,284	25,384,357	7.4%	6.5%
Grand Total including unpaid cost of Medicare:	190,023	222,035,086	163,759,700	58,275,386	16.9%	15.0%
Grand Total excluding unpaid cost of Medicare:	168,388	121,467,653	85,840,094	35,627,559	10.3%	9.2%



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


NON-QUANTIFIABLE BENEFIT

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

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

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

TELLING THE STORY

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

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

ATTACHMENTS

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

Executive Summary of Financial Assistance/Charity Care Policy

CNI, Map of the Community and Zip Codes

**NORTHRIDGE HOSPITAL MEDICAL CENTER
COMMUNITY BOARD
July 2012**

Hildy Aguinaldo, JD, MPH
Attorney
Lewis Brisbois Bisgaard & Smith, LLP

Thomas Nowlin
Principal
B.T. Nowlin & Associates

Magued Beshay, MD
Gastroenterologist
Facey Medical Group

Celeste Ortiz
VP, Human Resources
Medtronic Diabetes

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

Ube Pump
Community Leader

Zouheir Elias, MD
President, Medical Staff
Northridge Hospital Medical Center

Saliba Salo
President/CEO
Northridge Hospital Medical Center

Sal Esparza, DHA
Assistant Professor
California State University, Northridge
Chair, Community Board

Hooshang Semnani, MD
Pediatrician
General Director, PICU Services
Northridge Hospital Medical Center

Patrick Hawthorne
President
Northridge Lumber
Chair, Northridge Hospital Foundation

Rosanne Silberling, PhD
Dean of Nursing
West Coast University

Lamya Jarjour, MD
OB/GYN
Chair, Bioethics Committee
Northridge Hospital Medical Center

William Watkins, PhD
VP, Student Affairs,
California State University, Northridge

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

Policy Overview:

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

Eligibility for Patient Payment Assistance:

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

Determination of Financial Need:

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

- Dignity Health’s values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of payment assistance. Requests for payment assistance shall be processed promptly, and the Dignity Health facility shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

Patient Payment Assistance Guidelines:

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

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

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

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

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

Budgeting and Reporting:

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

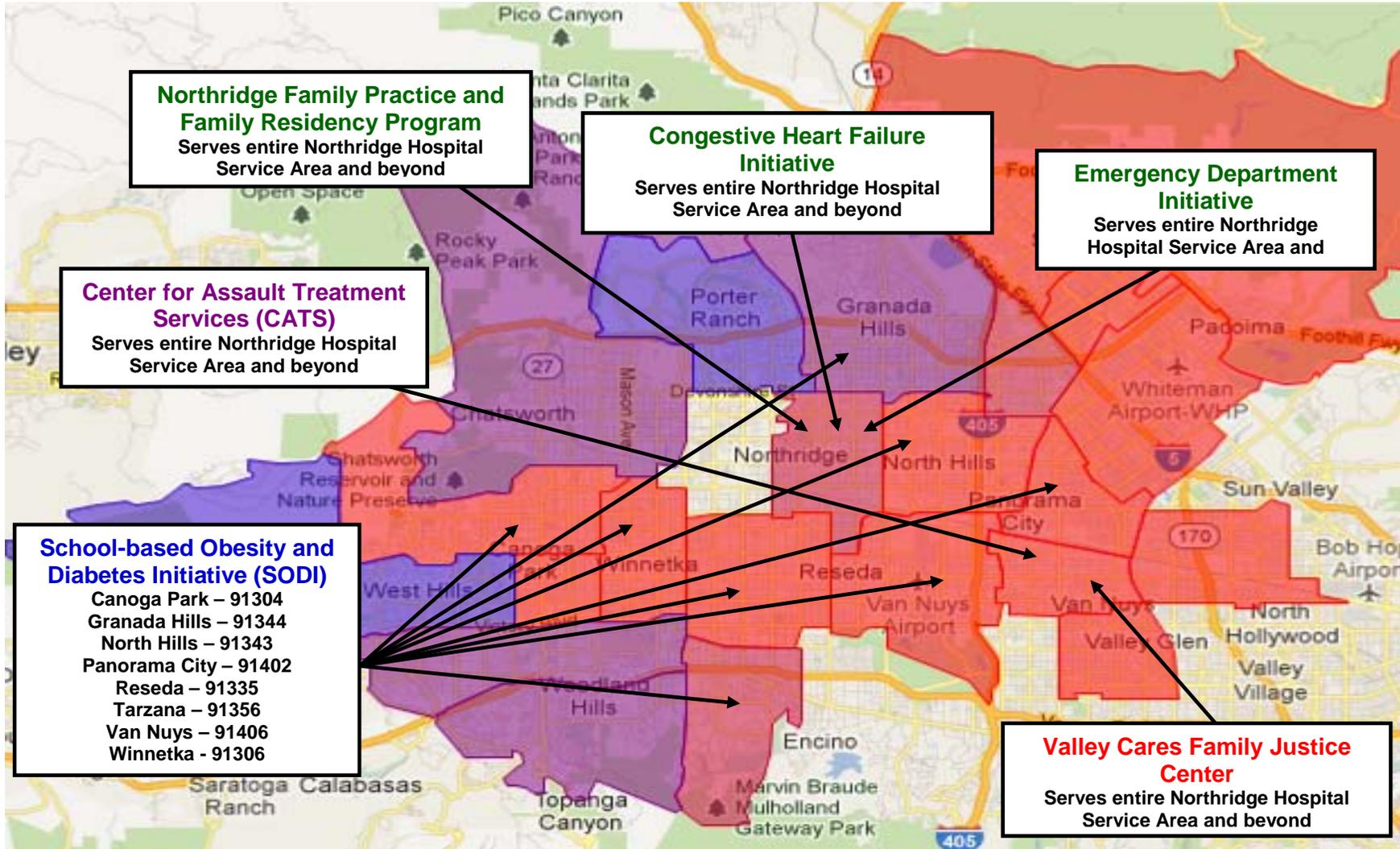
Relationship to Collection Policies:

- Dignity Health system management shall develop policies and procedures for internal and external collection practices by Dignity Health facilities that take into account the extent to which the patient qualifies for payment assistance, a patient's good faith effort to apply for a governmental program or for payment assistance from Dignity Health, and a patient's good faith effort to comply with his or her payment agreements with the Dignity Health facility.
- For patients who qualify for payment assistance and who are cooperating in good faith to resolve their hospital bills, Dignity Health facilities may offer interest-free extended payment plans to eligible patients, will not impose wage garnishments or liens on primary residences and will not send unpaid bills to outside collection agencies.

Regulatory Requirements:

IN IMPLEMENTING THIS POLICY, DIGNITY HEALTH MANAGEMENT AND DIGNITY HEALTH FACILITIES SHALL COMPLY WITH ALL FEDERAL, STATE AND LOCAL LAWS, RULES AND REGULATIONS THAT MAY APPLY TO ACTIVITIES CONDUCTED PURSUANT TO THIS POLICY.

2012 Northridge Hospital Community Needs Index (CNI) Map – San Fernando Valley Community Benefit Initiatives



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

CNI Score Median: 4.2 (CNI Zip Codes follow on next page)

2012 Northridge Hospital Community Needs Index (CNI) Zip Codes

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

	<u>Zip Code</u>	<u>CNI Score</u>	<u>Population</u>	<u>City</u>	<u>County</u>	<u>State</u>
■	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
■	91325	3.6	33,859	Northridge	Los Angeles	California
■	91326	1.8	31,870	Northridge/Porter Ranch	Los Angeles	California
■	91331	4.6	100,588	Arleta	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
■	91405	4.8	55,579	Van Nuys	Los Angeles	California
■	91406	4.6	55,026	Van Nuys	Los Angeles	California
■	91605	5	61,676	North Hollywood	Los Angeles	California

CNI Score Median: 4.2