one step at a time
UNABLE TO WALK OR TALK
AFTER BEING STRUCK BY
A CAR, GRANT VIRGIN
JOURNEYS BACK TO HEALTH

100 years of giving
CELEBRATING THE ASSOCIATES
AND AFFILIATES, CHLA’S
STEADFAST FUNDRAISING
FORCE, FOR A CENTURY
OF GENEROSITY

growing hope
THE PROMISING SCIENCE OF
REGENERATIVE MEDICINE

three of a kind
A TRIO OF DOCTORS
JOIN FORCES TO BREAK
NEW GROUND IN FETAL
HEART SURGERY
our mission
We create hope and build healthier futures.

our history
Founded in 1901, Children’s Hospital Los Angeles is one of the nation’s leading children’s hospitals and is acknowledged worldwide for its leadership in pediatric and adolescent health. CHLA is one of only 10 children’s hospitals in the nation—and the only one on the West Coast—to be named to the prestigious U.S. News & World Report Honor Roll for 2013-14.

The Saban Research Institute of Children’s Hospital Los Angeles is one of the few freestanding research centers in the U.S. where scientific inquiry is combined with clinical care and is devoted exclusively to children. The Institute’s investigators hold faculty appointments at the Keck School of Medicine of the University of Southern California (USC), and the center is an academic member of the Los Angeles Basin Clinical and Translational Science Institute, an academic-clinical-community consortium.

Children’s Hospital Los Angeles is a premier teaching hospital and has been affiliated with the Keck School of Medicine of USC since 1932.
Seizing Opportunity in a Time of Change

Every hospital in the nation is undergoing a significant transformation. While the full impact of the Affordable Care Act is unclear, Children’s Hospital Los Angeles is making adjustments to align with the government’s goal of providing better care for more citizens at a lower cost to taxpayers, while remaining true to our mission of creating hope and building healthier futures for infants, children and young adults.

We are ready for the changes the Affordable Care Act will bring. We are watching for trends that spell opportunity, looking for strategic partnerships that will ensure our future, adjusting our cost structure and revising care models to help patients recover and maintain their health more efficiently. We owe it to the patients and families in our care to remain a fiscally healthy institution, so that we can serve them far into the future.

We are taking steps now to provide care to more kids than ever before. Access is key to that effort. In 2013, we opened outpatient centers in the South Bay and Santa Monica, adding to our existing satellite locations in Arcadia and Valencia—bringing our services closer to more Angelenos. Southern Californians have never had more access to the expertise of our top physicians and caregivers.

As you review this year’s Imagine annual report, you’ll see what access to the latest medical and technological breakthroughs can mean—whether it’s treating iron overload in cancer patients, exploring the future of regenerative medicine or taking research into neurodevelopmental disorders to the next level. Plus, you’ll read about how we are working to build stronger and healthier families through our L.A. Fathers program. You’ll also learn that access to care is our legacy, as our very first supporters, the Associates and Affiliates, are celebrating a century of support for our institution. They are woven into the very fabric of our organization.

Thank you for helping us make our mission a reality.

Sincerely,

Richard Cordova, FACHE
President and Chief Executive Officer
Children’s Hospital Los Angeles
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The 27th annual Nautica Malibu Triathlon, presented by Equinox, featured 5,400 participants who swam, biked and ran side by side along the shores of Malibu, raising more than $1.08 million for the Children’s Hospital Los Angeles Pediatric Cancer Research Program.

Thomas Coates, MD, section head of Hematology in the Division of Hematology, Oncology and Blood and Marrow Transplantation at Children’s Hospital Los Angeles and principal investigator at The Saban Research Institute, and four other co-principal investigators received a five-year, $9.5 million grant from the National Institutes of Health.

For the fifth year in a row, U.S. News & World Report named Children’s Hospital Los Angeles to its elite Honor Roll of the nation’s “best” children’s hospitals. It is one of only 10 children’s hospitals in the country and the only one on the West Coast to make the list.

In a special dedication ceremony, Children’s Hospital Los Angeles honored Cheryl Saban, PhD (right), and Marion Anderson (left), who, along with their spouses, Haim Saban (center) and the late John E. Anderson, jointly funded the $10 million construction of a pedestrian bridge over Sunset Boulevard.

These Children’s Hospital Los Angeles nurses were chosen as fellows of the prestigious American Academy of Nursing: (from left) Nancy Blake, PhD, RN, NEA-BC, CCRN, patient care services director in Critical Care Services; Nancy Pike, PhD, RN, CPNP-AC, FNP-BC, FAHA, of Cardiothoracic Surgery; and Rita Secola, PhD, RN, CPON, patient care services director in Hematology, Oncology and Blood and Marrow Transplantation.

Mary Dee Hacker, MBA, RN, NEA-BC, FAAN, chief nursing officer and vice president of Patient Care Services at Children’s Hospital Los Angeles, was named as a representative to the Commission on the Magnet Recognition Program. She is the first commissioner from a pediatric hospital.

“American Idol” finalists (from left) Candice Glover, Amber Holcomb, Angie Miller and Kree Harrison paid a visit to Children’s Hospital, inspiring dozens of young patients with an intimate private concert, bedside visits and participation in a variety of activities.

Henri Ford, MD, MHA, FACS, FAAP, Children’s Hospital Los Angeles surgeon in chief, traveled to his native country of Haiti to oversee the distribution of more than $326,000 in reusable pediatric medical equipment, supplies and hospital room furniture donated by Children’s Hospital.
Balance Sheet
As of June 30, 2013 and 2012

(in thousands)

<table>
<thead>
<tr>
<th>ASSETS</th>
<th>2013</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>$26,676</td>
<td>$9,368</td>
</tr>
<tr>
<td>Accounts receivable, net</td>
<td>98,828</td>
<td>80,790</td>
</tr>
<tr>
<td>Other current assets</td>
<td>126,920</td>
<td>169,406</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>252,424</td>
<td>259,564</td>
</tr>
<tr>
<td>Assets limited as to use, net of current portion</td>
<td>509,171</td>
<td>455,530</td>
</tr>
<tr>
<td>Pledges receivable, net of current portion</td>
<td>48,565</td>
<td>48,414</td>
</tr>
<tr>
<td>Other assets</td>
<td>23,868</td>
<td>30,310</td>
</tr>
<tr>
<td>Property, plant and equipment, net</td>
<td>911,088</td>
<td>906,925</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>$1,745,116</td>
<td>$1,700,743</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LIABILITIES AND NET ASSETS</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable and accrued expenses</td>
<td>$42,460</td>
<td>$48,096</td>
</tr>
<tr>
<td>Other current liabilities</td>
<td>52,632</td>
<td>79,105</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>95,092</td>
<td>127,201</td>
</tr>
<tr>
<td>Long-term debt, net of current portion</td>
<td>487,314</td>
<td>482,907</td>
</tr>
<tr>
<td>Other noncurrent liabilities</td>
<td>39,073</td>
<td>41,792</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td>621,479</td>
<td>651,900</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NET ASSETS</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unrestricted</td>
<td>834,044</td>
<td>773,682</td>
</tr>
<tr>
<td>Restricted</td>
<td>289,593</td>
<td>275,161</td>
</tr>
<tr>
<td><strong>Total Net Assets</strong></td>
<td>1,123,637</td>
<td>1,048,843</td>
</tr>
</tbody>
</table>

**Total Liabilities and Net Assets** | $1,745,116 | $1,700,743 |
## Statements of Activities
For the years ended June 30, 2013 and 2012

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVENUES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net patient service revenue</td>
<td>$645,231</td>
<td>$615,804</td>
</tr>
<tr>
<td>Other revenue</td>
<td>220,890</td>
<td>211,333</td>
</tr>
<tr>
<td><strong>Total Revenues</strong></td>
<td><strong>866,121</strong></td>
<td><strong>827,137</strong></td>
</tr>
<tr>
<td><strong>EXPENSES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries, wages and employee benefits</td>
<td>412,620</td>
<td>385,188</td>
</tr>
<tr>
<td>Professional fees and purchased services</td>
<td>145,586</td>
<td>138,686</td>
</tr>
<tr>
<td>Supplies</td>
<td>113,099</td>
<td>99,549</td>
</tr>
<tr>
<td>Utilities</td>
<td>13,044</td>
<td>11,613</td>
</tr>
<tr>
<td>Other expenses</td>
<td>70,718</td>
<td>80,840</td>
</tr>
<tr>
<td><strong>Total Operating Expenses</strong></td>
<td><strong>755,067</strong></td>
<td><strong>715,876</strong></td>
</tr>
<tr>
<td>Earnings before interest, depreciation and amortization</td>
<td>111,054</td>
<td>111,261</td>
</tr>
<tr>
<td><strong>DEPRECIATION, AMORTIZATION AND INTEREST</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>48,070</td>
<td>35,308</td>
</tr>
<tr>
<td>Interest</td>
<td>24,117</td>
<td>25,400</td>
</tr>
<tr>
<td><strong>Total Depreciation, Amortization and Interest</strong></td>
<td><strong>72,187</strong></td>
<td><strong>60,708</strong></td>
</tr>
<tr>
<td><strong>EXCESS (DEFICIENCY) OF REVENUES OVER EXPENSES</strong></td>
<td>$38,867</td>
<td>$50,553</td>
</tr>
<tr>
<td><strong>OTHER (LOSSES) GAINS</strong></td>
<td>22,237</td>
<td>(25,940)</td>
</tr>
<tr>
<td><strong>EXCESS OF REVENUES OVER EXPENSES AND OTHER (LOSSES) GAINS</strong></td>
<td>$61,104</td>
<td>$24,613</td>
</tr>
</tbody>
</table>
For the fiscal year ended June 30, 2013

**KEY STATISTICS**

<table>
<thead>
<tr>
<th>Statistic</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of licensed beds</td>
<td>568</td>
</tr>
<tr>
<td>Discharges</td>
<td>13,834</td>
</tr>
<tr>
<td>Patient days</td>
<td>102,788</td>
</tr>
<tr>
<td>Average length of stay (days)</td>
<td>7.4</td>
</tr>
<tr>
<td>Outpatient visits¹</td>
<td>318,966</td>
</tr>
<tr>
<td>Emergency Department visits</td>
<td>70,455</td>
</tr>
<tr>
<td>Traumas treated</td>
<td>489</td>
</tr>
<tr>
<td>Medical transports</td>
<td>2,240</td>
</tr>
<tr>
<td>Surgeries</td>
<td>16,010</td>
</tr>
<tr>
<td>Active medical staff</td>
<td>595</td>
</tr>
<tr>
<td>Employees</td>
<td>5,201</td>
</tr>
<tr>
<td>Total National Institutes of Health funding</td>
<td>$20.6 million</td>
</tr>
<tr>
<td>Total research funding</td>
<td>$65.5 million</td>
</tr>
<tr>
<td>Total number of active patents</td>
<td>162</td>
</tr>
</tbody>
</table>

**CHARITY CARE AND OTHER COMMUNITY BENEFITS**

<table>
<thead>
<tr>
<th>Type of Benefit</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charity care²</td>
<td>$2.7 million</td>
</tr>
<tr>
<td>Unreimbursed costs of medical services for government-sponsored programs³</td>
<td>$153.5 million</td>
</tr>
<tr>
<td>Research activities</td>
<td>$31.3 million</td>
</tr>
<tr>
<td>Health professions education</td>
<td>$20.7 million</td>
</tr>
<tr>
<td>Subsidized health services</td>
<td>$4.3 million</td>
</tr>
<tr>
<td>Community health improvement services and other community benefits</td>
<td>$8.9 million</td>
</tr>
</tbody>
</table>

**TOTAL COMMUNITY BENEFIT⁴**  
$221.4 MILLION

---

¹ Includes outpatient and lab visits.
² Includes cost of care provided to those with no health insurance.
³ The Medi-Cal program partially offsets these losses through the Disproportionate Share Hospital Program, designed to support "safety net" hospitals such as Children’s Hospital Los Angeles. The hospital received $41.8 million in Disproportionate Share Hospital funding in fiscal year 2013.
⁴ In January 2010, the state of California enacted legislation that provides for supplemental payments to certain hospitals funded by a quality assurance fee paid by participating hospitals as well as matching federal funds (the “Hospital Fee Program”). Supplemental payments and fees related to the Hospital Fee Program produced a net benefit of $134.5 million to Children’s Hospital Los Angeles in the fiscal year ended June 30, 2013.
One of California’s most generous philanthropic couples, Joyce and Stanley Black, made a $15 million unrestricted gift to fund research and clinical care programs at Children’s Hospital Los Angeles. Shortly after the gift was announced, Joyce passed away following a lengthy battle with cancer. In honor of one of the largest individual contributions in the history of Children’s Hospital, the Gateway Building has been renamed the Joyce and Stanley Black Family Building.
that can lead to hearing loss. Though today the condition is easily treated with antibiotics, Joyce underwent a double mastoidectomy, a procedure that removes an infected part of the bone behind the ear. Without the superior quality of care provided by Children’s Hospital, Joyce may have faced permanent hearing loss.

Joyce and Stanley have been longtime fundraisers and supporters of many wonderful organizations in addition to Children’s Hospital Los Angeles, including City of Hope, Vista del Mar, Cedars-Sinai Medical Center, the Jewish Federation, Jewish Big Brothers, the National Conference of Christians and Jews, Jewish Vocational Services, the Boy Scouts of America and Los Angeles ORT College. Stanley also serves as a member of the World Business Council and Chief Executives Organization and is a former member of the Young Presidents Organization.

Active in political circles and an avid art and sculpture collector, Stanley also collects proverbs and inspirational words. He compiled many of them into a self-published book, “Thoughts to Live By,” which he distributed to family, friends and associates. Illustrating his fervor for life and charity, the compilation of sayings includes “Sometimes, it is better to be 80 years young than 40 years old” and “Give and it will be given to you.” The book was inspired by his father, Jack, who worked in the garment industry.

Stanley lives in Los Angeles and has a son, Jack, and two daughters, Janis Black Warner and Jill Black Zalben, who both work at Black Equities and serve as directors of the Stanley and Joyce Black Family Foundation. Jill’s son, Zachary Zalben, also works for the company and is one of six grandchildren.
Pat Levitt’s research into the origins of childhood brain disorders promises to transform CHLA’s Institute for the Developing Mind.

“Well, I count, right?” Pat Levitt, PhD, asks.

He raises his hand as if announcing his presence—or swearing himself in. Having just been told his explanation that 1 in 5 U.S. children has a brain disorder sounds too high, he offers himself up as evidence.

“I grew up with a developmental disability—I stuttered,” says Levitt, director of the Developmental Neurogenetics program and the Simms/Mann Chair in Developmental Neurogenetics within the Institute for the Developing Mind at Children’s Hospital Los Angeles.

“I had no fluent speech at all. Zero. One of my brothers stuttered. My father stuttered. I had an uncle who stuttered—a great-uncle, actually.”

Levitt says his family history demonstrates how early intervention can mitigate neurological impairments. He began seeing a speech language pathologist when he was 9 or 10; his brother received therapy as a teenager; his father, not at all.

“My father stuttered, severely, even as an adult. My brother is much improved, but still has more hesitant speech than I do. I give talks to 10,000 people and typically have no hesitation at all. I received intervention relatively early and my brain architecture changed.”

Levitt says brain architecture often. Why the brain does what it does and what can happen to compromise its development has galvanized his 40 years of research. He came to Children’s Hospital last July from the University of Southern California, where he oversees the Neuroscience Graduate Program, for his best opportunity yet at a fuller understanding of how the mix of genetic and environmental factors produces brain disorders.

“We want to take the research findings and work with clinicians here to identify those children who are at greatest risk,” he says, “and then get them into programs that will change their developmental trajectory.”

Numerous genetic sources of brain disorders have already been identified, some in Levitt’s own lab, including the discovery of a gene that increases risk for autism. He cites several prenatal environmental influences that also increase risk for neurodevelopmental disorders: first-trimester viral infections, malnutrition, prematurity and drug use.

Levitt is now trying to determine how genes and the environment weigh upon each other. He mentions studies by Heather Volk, PhD, principal investigator at The Saban Research Institute of Children’s Hospital Los Angeles, testing the combination of a genetic variation and high exposure to air pollution, each of which carries an independent risk for autism. “When you put the two together, we see that the risk goes up,” he says. “That’s a good example of what our program is striving for.”

It would be too simple—and wrong—to presume that Levitt’s own neurological issues naturally led him to seek answers on brain disorders.
“In high school, I couldn’t stand science,” he says. “I was thinking about law. But I still stuttered back then. A stuttering lawyer? How was that going to work?”

An undergraduate class in developmental biology spun him around. “I was blown away by the idea that you could start out with a few cells and create us. How do you start simple and make something so complex? How does that work?”

After a professor invited him to join a research project, he grew enthralled with scientific discovery—and nothing in 40 years has diminished that. “There’s something really exciting and romantic about it,” he says.

In one profound six-year period, Levitt’s research identified a gene that increases risk for autism spectrum disorder (2006); showed that the gene is more common in children who have both autism and gastrointestinal issues (2009); and discovered the prevalence of high levels of oxidative stress in those same kids who have autism and GI problems (2012).

He loves that discovery often happens by accident. The finding of a genetic connection between autism spectrum disorder and gastrointestinal disturbances—“a game changer,” Levitt says—was set in motion during a coffee break at an autism grant review session, when a parent approached Levitt and mentioned reading that 40 percent of autistic children have GI problems. He had been sent that same article, but set it aside. “I thought, ‘Oh, that’s nice. I don’t study the gastrointestinal system.’”

The conversation prompted an aha moment—the jingling of an idea. Back in the lab, Levitt confirmed that the genetic variant exists more commonly in children who have both autism and GI issues than it does in those with only autism. “Sometimes it’s serendipity,” he says. “Stuff just comes together; you can’t explain it.”

He acknowledges that not all aha moments pan out, recalling one that ended in an oh-no moment after progressing from inspiration to experimentation. “I had a roommate in college who put tuna fish on top of spaghetti with red sauce. It was his aha moment, and it was awful. He’s now a famous chemist.”

Levitt would applaud him for trying, though. “There has to be a willingness to take a chance. That’s the environment I want to create for our program.”

“About 80 percent of that space is occupied by DNA that is regulatory,” he says, “meaning it controls when and where the genes are turned on and off. That’s where genetic variation is. If we can figure out how that regulation occurs, and the influence of environment, we can figure out what goes wrong in brain development, and then how to fix it. That’s the holy grail, and that’s what we’re going after.”
I cannot believe this.

It was all an exasperated Ramen Chmait, MD, could think. His patient, 28-year-old Sandra Barraza, lay on an operating table at CHA Hollywood Presbyterian Medical Center in her sixth month of pregnancy, fastened in for a surgery intended to open up her baby’s critically narrow aortic valve. It had taken a consummate amount of diligence, trust, coordination and expertise to lead her there. This would be the first time the procedure, called a fetal aortic valvuloplasty, was performed by doctors from the Institute for Maternal-Fetal Health (IMFH), a partnership of physicians across Children’s Hospital Los Angeles and the University of Southern California. In fact, this would be the first time the procedure was done anywhere in Southern California.

Barely a year earlier, the trio of doctors who would work to pass a needle through Barraza’s womb into a fetal heart the size of a walnut would not have been available to her. Frank Ing, MD, an interventional cardiologist whose job it would be to widen the impaired valve with a balloon, only came to Children’s Hospital in September 2012. The director of the hospital’s Cardiac Catheterization Laboratory, he had done the procedure multiple times, but not here.
Chmait, an obstetrician who specializes in fetal surgeries, had also participated in the procedure, but again, never at Children’s Hospital—and never with Ing.

The third player was pediatric cardiologist Jay Pruetz, MD, an expert in the use of ultrasound imagery to identify fetal heart disease. Today his images would guide Chmait’s needle into the uterus, through the fetal chest wall and toward the left ventricle. Ing would then run a wire through the needle, ride a balloon along the wire until it reached the aortic valve, and inflate it.

Painstaking run-throughs had made it so that places, positions and responsibilities were so familiar, the threat of any glitch was virtually removed.

And then this happened.

Barraza’s baby had been sedated, but right after the sedation was administered, the fetus turned onto its stomach. Now Chmait had no access to the heart, with a fetus rendered still by the anesthetic. Just minutes earlier it had been on its back, in perfect position.

“I remember thinking,” Chmait says, “I cannot believe this.”

Risk vs. reward

Pruetz had already waited more than five years for this day, and now he would have to wait a little longer. Unlike Ing and Chmait, Pruetz, who came on staff at Children’s Hospital in 2008, had never participated in the procedure before. CHLA’s director of Fetal Cardiology, he had diagnosed critical aortic stenosis numerous times, but always had to refer the patients elsewhere for treatment. The hospital simply didn’t have the people to execute it.

“But when Dr. Ing joined us, and we knew we had Dr. Chmait, we realized that now was the moment,” says Pruetz. “We had the people with the expertise and the skills to make this not only doable, but likely successful.”

Even recently, Pruetz had seen several patients who were considered for the procedure. The first three dropped out. The fourth was Barraza, a Sylmar, Calif., resident having her first child with Joseph Molina; the two were to be married a month after the surgery. After making the diagnosis, Pruetz sent Barraza to Ing and Chmait.

“I didn’t get it at first,” she says. So Ing played her a video of the procedure, and Chmait showed her a slide show of the heart. The risk of moving forward was explained: If she went into labor during the surgery, the baby wouldn’t survive.

There was virtually equal risk in not doing it. With critical aortic stenosis, the aortic valve is so pinched, blood can’t pump adequately out to the body and gets trapped in the left ventricle. Untreated, the ventricle would become so damaged that Barraza’s baby would be born with hypoplastic (meaning underdeveloped) left heart syndrome, or HLHS, with only the right ventricle capable of pumping blood. Aortic valvuloplasty opens the valve and allows the baby the opportunity to have a normal, two-ventricle circulation.

(continued on next page)
But there was no guarantee of reward, or even favorable odds of it. Even when the procedure succeeds in stretching the valve, both Ing and Pruetz note that the desired outcome of two functioning ventricles is seen in less than half of cases. Ing says, “What we haven’t figured out is: Will the heart grow the way we want it to grow?”

Rehearsal time
As director of the Los Angeles Fetal Therapy program, a component of the Institute for Maternal-Fetal Health, Chmait does about 130 fetal surgeries a year. He was confident the experience of the IMFH team would see Barraza through.

“It’s true that this particular intervention was new to Children’s Hospital Los Angeles,” he says, “but the people who were going to do the procedure had done it before.” Chmait’s experience had come at St. Joseph’s Women’s Hospital in Tampa, Fla., assisting Ruben Quintero, MD, considered a pioneer in fetal surgery.

Molina, the baby’s father, saw the advantages of going first. “I felt more confident they would go the extra mile to make sure that everything went right, and better than expected,” he says. “You don’t want your grand opening to go bad.”

Ing, too, said as much: “If you mess up the first time, it’s going to take a long time to get to the next case.”

To guard against that, Ing called on a best practice he had employed in the past. He sunk a grape into a Jell-O mold, which then obscured the small fruit from view. Could Chmait next plunge a needle into the Jell-O and find the grape using only Pruetz’s ultrasound guidance?

“It’s not an exact model, but it replicates an idea that you have a tiny little shape you have to enter without seeing it,” Ing says. “Prove to me you can get the needle there based on this image.”

“I was literally imaging the grape,” Pruetz says. “I’m telling Dr. Chmait, ‘This is where you are, you’re at the grape.’”

Chmait found the mark.

But the dry runs served a larger purpose than target practice. They also gave Chmait and Ing the chance to sync the placement of their hands. During the procedure, the two men would be working one on top of the other, Chmait first passing the needle toward the aortic valve, Ing then inserting the wire. Ing wanted to balance his hand on the flat, stable part of Chmait’s hand—the soft patch between the thumb and forefinger—as he advanced the wire.
“Just like any basketball team, you put players together, they have to learn to work with each other,” Ing says. “It’s just trying to figure out each other’s preferences, knowing what the steps would be.”

Start to finish
For 45 minutes, Chmait manipulated Barraza’s abdomen as if he were kneading dough, but to no avail. The baby wouldn’t budge. So he got resourceful. He drew back the needle from the tube that enclosed it and then used the blunted instrument to turn the fetus over. “I actually used the side of it to get the baby to flip in the right direction,” he says.

The procedure could now begin, and the benefits of all the rehearsing became apparent. Steered by Pruetz’s images, Chmait routed his needle to the baby’s left ventricle. Ing inserted the wire, got the balloon into position and inflated it, tearing open the leaflets of the aortic valve. The needle, wire and balloon were promptly removed. Chmait and Ing were in and out in 15 minutes without complication.

“There was a valve that was tight, and we opened it. It’s pumping blood forward, unlike before the procedure. So we were technically successful, 100 percent. There’s no question.”

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Defining success
In the aftermath, one question prevailed: Did it work? That won’t likely be answerable for some time. All three doctors make a point of separating technical and clinical success.

“The there was a valve that was tight, and we opened it,” Chmait says. “It’s pumping blood forward, unlike before the procedure. So we were technically successful, 100 percent. There’s no question.”

– Ramen Chmait, MD

Ultrasound images guided Chmait and Ing through the mother’s womb and into the fetal heart.
But the problems with the baby’s heart didn’t end with the aortic valve. The mitral valve—which leads into the left ventricle, while the aortic valve leads out of it—was also diseased. That had been a concern of Pruetz’s throughout.

“It’s thick and immobile and just not opening up well,” he says. But no action could be taken because no intervention exists for the mitral valve. Pruetz suspects it may be “the Achilles’ heel of this lesion.”

Ing contends that even if it turns out the procedure was unable to avert hypoplastic left heart syndrome, that wouldn’t automatically negate the work the doctors did. “There are questions about whether we can bring these patients to two ventricles,” he says. “Some do get there, but even if they don’t, are they still better off? Is their survival better? We need time to figure that out.”

No one, though, would dispute the success of the collaboration, across expertise, across institutions, across the professional histories of the three physicians. “We all fought for this baby,” Chmait says, “different people with very different backgrounds. We all had to come together.”

Looking forward, Pruetz says Children’s Hospital is now positioned as a leader in fetal cardiology. “Building this type of intervention program gives us the ability to push the field forward.

“The truth is, this is a relatively new science, so we don’t really know the long-term ramifications of doing this procedure. It’s to be continued, right?”

He didn’t say whether he meant the hospital or the baby. Either way, it was true for both.

Jay Pruetz, MD (left), with Joseph Molina, Sandra Barraza, and their son, Joseph Nathaniel Molina
Noche de Niños 2014

The much-anticipated Children’s Hospital Los Angeles Gala: Noche de Niños—a biennial event benefiting the tens of thousands of young patients served by Children’s Hospital Los Angeles each year—is happening Saturday, Oct. 11, 2014. More than 1,000 of our closest friends and most dedicated supporters will gather to celebrate our hospital and this year’s Courage to Care honorees: Costco Wholesale, Academy Award-winning actress Natalie Portman, and philanthropists and longtime hospital supporters Sally and Bill Hurt.

The extravaganza, held at the Event Deck at L.A. LIVE in downtown Los Angeles, has become a highlight of the event season. Hosted in a luxurious setting with an enchanting atmosphere, premier entertainment and sumptuous cuisine from world-famous chefs, the evening is a tribute worthy of one of the best children’s hospitals in the nation.

The evening will be hosted by hospital supporter and television personality Maria Menounos. It will also feature performances by Grammy Award-winning performer Seal and legendary Brazilian band leader and Grammy Award-winner Sergio Mendes and his band, Brasil 2014.

For information about the event, visit CHLA.org/GALA or contact the Children’s Hospital Los Angeles Special Events team at 323-361-5972 or specialevents@chla.usc.edu.

On the evening of Dec. 27, 2013, Joseph Nathaniel Molina was born at CHA Hollywood Presbyterian Medical Center. He was welcomed, briefly, by his mother and father before being hastened off to Children’s Hospital Los Angeles, where a team of pediatric cardiologists was waiting to check on the condition of the imperiled left side of his heart. They would quickly determine that his left ventricle was too weak to support blood flow, requiring surgery to establish the right ventricle as the lone heart pump. It was only the beginning—the first in a series of three procedures—but it was enough that it was a beginning.

Visit WeTreatKidsBetter.org/ImagineVideos to watch the Imagine television special segment on this amazing procedure.
It was a warm September evening, just before 7:30 p.m., when 16-year-old Grant Virgin set out from his Palm Desert home to make the familiar walk to a friend’s house.

He never made it. Shortly after he left his home, passing motorists discovered the high school junior lying in the road, alone. Grant had been struck by a car—the victim of a hit-and-run driver.

He was near death.

Grant was airlifted to a Los Angeles-area hospital for emergency surgery. His injuries were devastating. The impact had traumatized his brain and plunged him into a deep coma. His aorta, the main artery in the body, was crushed—an injury few people survive. He had broken bones from head to toe and lacerations to his spleen and liver.

“We didn’t know if he would survive the helicopter ride,” says his mother, JJ Virgin. “Then they told us he would never wake up.”

Still, his family refused to give up hope. And after three weeks in a coma, Grant woke up. Soon after, he spoke his first words. Against all odds, he had survived. But his toughest battle was still ahead.

Grant not only had to relearn fundamental skills like walking and talking, but in the wake of his traumatic brain injury, doctors weren’t sure how much of his cognitive function would return.

His parents began searching for the rehabilitation program that would give him the best possible chance to regain the life he’d once had. Nine weeks after the accident, they brought him to Children’s Hospital Los Angeles.

A team effort

The Acute Rehabilitation Program at Children’s Hospital provides coordinated, interdisciplinary care for children and adolescents with the most complex and serious illnesses and injuries, including brain injuries, seizure disorders, spinal conditions, fractures, cancers and rheumatologic conditions.

Each aspect of care prepares young patients to return to life outside the hospital, with individualized treatment plans combining medical, nursing and psychosocial care, along with occupational, physical, speech and respiratory therapies.

“We call it interdisciplinary because we all work together for a common goal: the best possible rehabilitation for the patient,” says Kevan Craig, DO, head of the Division of Rehabilitation Medicine at Children’s Hospital. “It’s a complete team effort.”

Among the many strengths of the hospital’s Acute Rehabilitation Unit is its ability to care for medically complex patients, including patients like Grant recovering from traumatic injuries and cancer patients undergoing chemotherapy.

“Not many rehab units in the country can care for kids as sick as the ones we care for,” explains Phan Dang, RN, manager of the Acute Rehabilitation Unit. “That’s the beauty of our unit. We’re able to bring kids here much sooner so they can begin the intense rehabilitation they need.”

Because of the unit’s extensive capabilities, the number of patients it serves has nearly tripled over the past decade. To accommodate that increased demand, Children’s Hospital is building a new, larger center, to be called the Margie and Robert E. Petersen Foundation Rehabilitation Center honoring Bobby and Richie Petersen, on the sixth floor of the Mary Duque Building.
The Margie and Robert E. Petersen Foundation Rehabilitation Center, set to open in October, will house 22 beds—16 of them in private rooms—with more spacious and comfortable accommodations for patients and families. The new space will also feature larger, more modern therapy areas and new, state-of-the-art equipment.

Learning to live again
When Grant arrived at the Acute Rehabilitation Unit, he was in a wheelchair, and his vocabulary consisted mostly of “let’s go” and “no.” Most concerning, he had little short-term memory or cognitive understanding.

“He was awake enough to know that he wasn’t at home, but he didn’t know why,” his mother says. “He didn’t understand who he was, where he was, what had happened to him. It was a really tough time.”

Therapy on the unit is intense for every patient—three hours a day, six days a week, for an average of four to six weeks. Grant’s stay was expected to be several months. Day by painstaking day, the rehabilitation team went to work helping

Getting Better, Giving Back
It’s been more than a decade, but Chris Graves and his family and friends have never forgotten the care Chris received in the Acute Rehabilitation Unit at Children’s Hospital Los Angeles.

At the time, Chris was 13, a previously healthy, athletic kid who had suddenly been stricken with dermatomyositis, a rare autoimmune disorder that left him unable to walk, talk or even swallow.

After nearly three months in the unit, Chris went home on Thanksgiving. As Christmas approached, a close family friend, David Venghaus, suggested bringing toys and good cheer to the kids and families who could not make it home for the holidays.

Therapy on the unit is intense for every patient—three hours a day, six days a week, for an average of four to six weeks. Grant’s stay was expected to be several months. Day by painstaking day, the rehabilitation team went to work helping

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“The team found more innovative ways to help him than I could ever imagine. They’re just absolutely dedicated to their work.”
— John Virgin

Grant’s therapy sessions ran three hours a day, six days a week.

him regain his memory, his cognition and his ability to do countless essential tasks: from walking and talking to tying his shoes and brushing his teeth.

“The team found more innovative ways to help him than I could ever imagine,” says Grant’s father, John Virgin. “They’re just absolutely dedicated to their work.”

That work was made especially challenging because Grant was prone to sudden, violent outbursts, common in patients recovering from a severe traumatic brain injury. But at 6 feet tall and 200 pounds, Grant could be dangerous.

To keep the teen and everyone around him safe, the staff employed seamless communication and teamwork, and expert medical care. In addition, a security guard was stationed outside his room, and Grant’s hospital bed had a tent cover that could be zipped up to protect him and the staff during an outburst.

His parents took turns being at his side during his entire hospital stay. The rehab team also worked with them to support their wishes to supplement Grant’s care with a range of alternative therapies, including high doses of fish oil. John is a tennis coach and JJ is a celebrity nutrition and fitness expert and author, as well as former co-host of “Freaky Eaters” on the TLC television network.

“Rehab is family-centered care,” Craig says. “We engage the families as much as the patient. They’re part of the health care team and are absolutely central to their child’s recovery.”

**Going home**

At the end of January 2013, after just two months at Children’s Hospital, Grant went home.

He was now walking and had regained 50 percent of his speech abilities. His cognitive skills, while not completely recovered, had greatly improved. He could eat, dress, shower, and throw and catch a ball. His violent outbursts had subsided and were under control.

The day he left, he hugged his nurses and therapists.

“He was a different kid than when he came,” Dang says. “That’s what is so rewarding about working on this unit. Every day you have a chance to make a dramatic difference in a young person’s life.”

Grant has continued his intense rehabilitative therapy at home in Palm Desert, and he continues to make major strides. Now 17, he’s taking classes at home with a teacher and heads to school daily to see his friends. His speech is about 85 percent restored. He works out and even does 220-yard sprints on the soccer field.

“We’ve got a happy, healthy, strong, good-looking kid who needs a haircut!” says his dad with a laugh.

Over the holidays, Grant and his family returned to the Acute Rehabilitation Unit to say thank you—and deliver toys and gifts to the patients.

“I wanted to do something to help others,” Grant explains, “and to just show the kids that it takes time, but you will get better.”
CHLA’s rehab unit has seen its patient count nearly triple over the past decade.

The demand has led to the building of a new, larger facility, the Margie and Robert E. Petersen Foundation Rehabilitation Center honoring Bobby and Richie Petersen, scheduled to open in October.

The Children’s Hospital Rehabilitation Unit was the first dedicated pediatric rehabilitation facility in Southern California.

The new Margie and Robert E. Petersen Foundation Rehabilitation Center will feature: 16 private rooms, three semi-private rooms and two isolation rooms (for immune-compromised children), a Child Life playroom and a state-of-the-art rehabilitation gym showcasing the center’s safari theme.
It’s a child’s dream to be invincible—to be able to regrow injured body parts after a make-believe battle. But what if this superhuman power was real? Scientists in the Developmental Biology and Regenerative Medicine Research program at The Saban Research Institute of Children’s Hospital Los Angeles are working to make it possible.

As the rates of diabetes, chronic kidney disease and short bowel syndrome increase in the U.S., more pediatric patients with damaged organs must turn to life-altering procedures such as transplants and dialysis. These invasive treatments offer a temporary solution, but patients often face complications due to the need for lifelong medications and the gradual deterioration of their “replacement parts.”

“We rely heavily on transplants and pharmaceuticals to treat serious diseases, despite significant limitations in these approaches. The ideal treatment would be the regeneration and repair of damaged areas by our own body,” says Roger De Filippo, MD, physician and principal investigator in Pediatric Urology at The Saban Research Institute and associate professor of Urology at the Keck School of Medicine of the University of Southern California (USC).

“A cut on our arm gradually heals as the skin is replaced by new cells. Who’s to say that this can’t be done in our more vital organs?”

With hopes of making this treatment option a reality, De Filippo and Laura Perin, PhD, director of research in Pediatric Urology at the Institute and assistant professor of Urology at the Keck School of Medicine of USC, are studying cell-based strategies for treating organ damage. They are currently testing a specific type of stem cell, derived from amniotic fluid, in the repair of tissues damaged by kidney, pancreas and lung diseases. Amniotic fluid stem cells, housed in an embryo’s surrounding liquid, release specialized molecules to spark tissue repair and regeneration. And they are easy to collect.

Amniotic fluid is safely obtained during amniocentesis, a common diagnostic procedure used during pregnancy. Stem cells are isolated from the fluid and can be used in laboratory models with chronic kidney, pancreas and lung diseases. In recent tests,
De Filippo and Perin have demonstrated that amniotic fluid stem cells are able to stimulate tissue repair in living, breathing organisms.

“Our early findings show that amniotic fluid stem cells are able to induce regenerative mechanisms of repair in the diseased organ. They also increased the life span of the treated animals,” says Perin. “The success of these specific stem cells in living models allows us to establish a precedent for regenerative medicine in the treatment of chronically ill patients.”

“By using human cells to regenerate the tissue in damaged areas,” concludes De Filippo, “we can hopefully restore structure and function in the safest way.”

This goal is shared by Tracy Grikscheit, MD, who is using tissue-engineering techniques to develop treatments for short bowel syndrome (SBS).

Can stem cells taken from amniotic fluid help repair diseased organs?

As its name suggests, SBS occurs when the majority of the small intestine is missing or fails to function correctly, leading to profound dehydration and malnutrition. “Ridges and folds along the length of the small intestine provide the expansive surface area for nutrient absorption into the body,” says Grikscheit, a pediatric surgeon at Children’s Hospital, principal investigator at The Saban Research Institute and assistant professor of Surgery at the Keck School of Medicine of USC. “This crucial length can be lost after intestinal failure due to infection, trauma, surgery, cancer or prematurity.”

Current treatments for SBS include total parenteral nutrition (TPN), a type of intravenous feeding, and transplants to replace the missing tissue. Unfortunately, prolonged use of TPN is associated with liver failure and sepsis, and organ transplants have only a 67 percent survival rate after five years.

“Long term, these options are still not good enough. When we think about treating children, we need a solution that will last a lifetime,” says Grikscheit. “To improve patient outcomes, my lab is working to engineer human intestinal tissue in hopes that SBS patients will one day be able to grow their own missing intestine. This would bypass the need for supplementary nutrition, invasive surgeries and lifelong medications.”

Grikscheit’s latest work expands upon previous proof-of-concept studies to test the viability of tissue-engineered small intestines for humans. In a study recently published in the Journal of Pediatric Surgery, Grikscheit collected the small intestine’s functional units from donated surgical tissue. The units were placed on supporting scaffolds and allowed to incubate and grow. After one month, the regrown intestine was examined with astonishing results.

“The tissue-engineered intestine is definitely growing from human cells,” says Grikscheit. “The sample contained a specific protein marker found only on cells of human origin.” Each of the four differentiated types of epithelial cells found in the human small intestine were also found in the engineered small intestine.

“This accomplishment brings us one step closer to offering the most personalized therapy to our patients,” notes Grikscheit. “Our next steps will be to understand which patients have cells that grow well so that we know who will respond best to this therapy. And we always want to make this treatment safer, more efficient and more reliable—key factors we intend to work out before an approved clinical trial.”

From chronic kidney disease to various forms of intestinal failure, tissue engineering may one day give patients the ability to regrow their damaged organs and successfully fight back against disease. The technology may take several years to become available for patient use, but the recent work by De Filippo, Perin and Grikscheit gives hope that regenerative superpowers are on the horizon.
Rudy Mayorga, age 21

Rudy Mayorga is an artist and computer whiz who dreams of going back to school and building a career in graphic design or computer animation.

“I have a lot of goals,” says Rudy, 21. “I’ve always loved drawing and computers, and I’d love to work for Disney or Pixar and create my own animated characters.”

First, though, he has to finish his leukemia treatment.
The Los Angeles resident has been battling acute lymphoblastic leukemia since he was 16. It’s been a rough road, and Rudy has relapsed twice. And last year, while undergoing treatment, he learned he had another foe to fight: iron overload.

Iron overload is a serious condition that occurs when too much iron builds up in the body—often as a result of frequent blood transfusions, which contain iron. Although the body needs iron, it has no mechanism for eliminating excess amounts of it.

Severe iron overload can be fatal. In Rudy’s case, it was causing liver failure, exacerbating his type 2 diabetes and even impacting his heart.

Fortunately, his doctor, Leo Mascarenhas, MD, section head of Oncology at the Children’s Center for Cancer and Blood Diseases at Children’s Hospital Los Angeles, recognized Rudy’s symptoms and immediately called Thomas Coates, MD, the Center’s section head of Hematology and an international expert in iron overload.

While Mascarenhas focuses on treating cancer patients, Coates specializes in treating patients with inherited blood
Scientists believe chemotherapy is the culprit. Normally, when red blood cells die, the bone marrow recycles the iron from those dead cells to make new ones. But because chemotherapy decreases the bone marrow’s ability to make new blood, excess iron from old blood cells is never used—and can accumulate in tissues and organs. The issue could have far-reaching implications for many children with cancer.

“A lot of pediatric cancers are cured, but many patients also have an increased risk of new cancers in adulthood,” Coates says. “There’s a lot of circumstantial evidence in the literature that even mild cases of excess iron can contribute to that risk of second malignancy, but at most places, patients aren’t being screened.”

The good news is that iron overload can be easily treated with “iron chelation” therapy—medicines that remove excess iron from the body. In addition, diagnosing and monitoring iron levels can now be done safely and non-invasively with magnetic resonance imaging (MRI).

In fact, Children’s Hospital is one of only a handful of centers worldwide and the first in the United States to pioneer the use of MRI to measure iron levels. That achievement, too, came out of a collaboration, begun in 2000 between John Wood, MD, PhD, director of Cardiovascular MRI at The Saban Research Institute of Children’s Hospital Los Angeles, and Coates to address the problem of cardiac iron overload and heart failure in patients with genetic anemias like thalassemia major.

Wood has continued to advance his research into MRI and iron overload and has helped introduce the technology to

Far-reaching implications
That collaboration is key because iron overload is often missed in cancer patients, even though many of them undergo blood transfusions during treatment.

“The common wisdom has been that it takes 10 years of transfusions to develop iron overload in the heart,” explains Coates, director of the Sickle Cell Disease program at Children’s Hospital. “But we’re now discovering that cancer patients develop iron overload much faster than thalassemia patients do, and with much less transfusion.”

disorders such as sickle cell disease and thalassemia, where patients often receive frequent blood transfusions and are at high risk for iron overload. Children’s Hospital has one of the largest programs in North America for treating thalassemia and the largest in California for treating sickle cell disease.

“We worked together to diagnose Rudy and quickly get him started on treatment for iron overload,” says Mascarenhas, director of the hospital’s Solid Tumor Program and the Pediatric Cancer Research Foundation Clinical Trials Program. “That’s one of the advantages of Children’s Hospital: We work as a team. We can collaborate easily and tap into each other’s expertise to care for patients with complex conditions.”
other centers in the U.S. and internationally. In addition, Coates and Mascarenhas are considering creating a pilot study to look at iron overload in cancer patients. Researchers in the HOPE Health Outcomes and Cancer Control Research Program at Children’s Hospital have also been looking at the issue as part of long-term survivorship studies.

**Another chance**

Since beginning iron chelation treatment, Rudy has seen his iron levels steadily decline. His diabetes is under control again, and his liver iron levels have dropped 64 percent so far.

Even better, he’s in remission from his leukemia and almost finished with chemotherapy. He’s looking forward to returning to school and getting a part-time job. Meanwhile, he’s busy building websites, fixing his friends’ computers, drawing pictures and writing calligraphy for the nurses at Children’s Hospital.

“When I first got sick, I prayed to God for another chance and I got it,” Rudy says. “Now there are so many things I want to do.”

A talented artist, Rudy writes calligraphy for his CHLA nurses.

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**Alan S. Wayne, MD, Joins Children’s Hospital**

Internationally renowned hematologist-oncologist Alan S. Wayne, MD, joined Children’s Hospital Los Angeles on July 1, 2013, as the new director of the Children’s Center for Cancer and Blood Diseases and division head of Hematology, Oncology and Blood and Marrow Transplantation.

Wayne comes to the hospital from the National Cancer Institute at the National Institutes of Health (NIH), where he spent 14 years as clinical director of Pediatric Oncology.

At the NIH, he directed a leading-edge research program in the discovery of new treatments for blood cancers, developing and leading multiple clinical trials. Those pioneering efforts have achieved complete remissions for children with chemotherapy-resistant leukemia.

“This is a major recruitment for Children’s Hospital and represents a significant step forward in distinguishing ourselves as the undisputed clinical leader in the treatment of pediatric cancer and blood diseases, and the research hub that identifies the cures for these debilitating conditions,” says Richard D. Cordova, FACHE, president and chief executive officer of Children’s Hospital Los Angeles.

Wayne assumed the Stuart E. Siegel Endowed Chair in Pediatric Oncology at Children’s Hospital. In addition, he now serves as professor of Pediatrics at the Keck School of Medicine of the University of Southern California (USC) and associate director for Pediatric Oncology at the USC Norris Comprehensive Cancer Center.

“It is a great honor and privilege to join the hospital and the university and to follow the impressive legacy of Dr. Siegel, who in his decades of service led the development of the Children’s Center for Cancer and Blood Diseases into an internationally recognized institution,” says Wayne.
Kevin Haigh admits to being a father-in-progress. “I don’t know what I’m doing, actually,” he says.

But he’s trying, having spent the past 18 months attending L.A. Fathers, a support program for young Los Angeles-area fathers run by the Children’s Hospital Los Angeles Division of Adolescent and Young Adult Medicine. And he’s made strides, judging by his small smile as he relates how his girlfriend’s 3-year-old daughter greets him when he comes home.

“She goes, ‘Hey, Kevin!’ and I go, ‘Hey, Violet,’ and I tap her on the head. Then she asks me for food. I can’t really make anything, so there’s Lunchables in the fridge.” Here’s where he shows his maturing parenting skills. “I know that’s bad—a little fattening.”

The perils of processed food may not be one of the lessons Haigh picked up at L.A. Fathers, but his general attention to fatherly responsibility can certainly be traced back there. He is an exemplary case, having advanced from participating in the program to being employed by it, but he’s not an unusual one. Hundreds of young men who want to do right by their children, whether they’re fathers by birth or by circumstance, as in Haigh’s case, have joined L.A. Fathers since its introduction in summer 2012.

Funded by a grant from the U.S. Office of Family Assistance (OFA), L.A. Fathers is an outgrowth of the Division of Adolescent and Young Adult Medicine’s Project NATEEN, which provides services for teen moms. The program loads a trio of workshops on parenting, healthy relationships and job development into weekly two-hour sessions. It’s that last item—job development—that generally hooks recruits. “Basically, there are a lot of guys out there who need work, and that’s our angle—helping them get jobs,” says Frank Blaney, program coordinator.
There was a time when Blaney himself would have been a candidate for the program. He grew up poor, the son of a single mother; his dad left when he was 5. At age 24, with nothing but a high school diploma to lean on, he became a father. “I think that background influenced my decision to get into this type of work,” he says.

Now 51, Blaney holds a master’s degree in negotiation, conflict resolution and peace building and facilitates the healthy relationships component of the program. Each session establishes a new dialogue. He gives the example of a recent class that focused on self-care. “We asked them, ‘What do you guys do when you get stressed?’” A tai chi enthusiast and teacher, he demonstrated an option perhaps they had never considered: deep breaths.

Blaney came to L.A. Fathers in April 2012, a precarious time for the program as it struggled to attract interest. The first workshops drew barely half a dozen attendees; the tally for the year reached only 30, far short of the annual goal of 250 participants spelled out in the funding proposal. OFA officials weren’t impressed. “They were expecting that 250,” Blaney says. When they didn’t get it, they flew in to find out why. “They weren’t real happy. We were all trying hard, but they were like, ‘What’s going on?’”

The on-site visit prompted a change in strategy. Program leaders abandoned their reliance on referrals from community and governmental organizations. Instead, they got personal. Blaney and two other case managers rode around on scooters to parks and housing projects, and even at opening day at Dodger Stadium, approaching young men who looked the part—namely, they were with a kid or were pushing a stroller. “We’d ask, ‘Hey, are any of you guys dads?’” Blaney says. “It’s not necessarily the safest way, but we got some guys signed up, and we just kept with it.”

The new ground game, complemented by a marketing campaign that placed posters promoting the program in the city’s trains and buses, found the mark. Recruiting numbers surged in the spring. Five sign-ups in February and 18 in March shot up to 62 in April and 74 in May. Enrollment totaled 310 by year’s end, safely clearing the target. The Wednesday workshop grew so large that a Tuesday class was created to accommodate the overflow. “We’re getting our guys,” Blaney says.

Haigh, 23, was convinced to enroll by two friends already in the program, who told him he needed tips on parenting his girlfriend’s daughter. But he already had an interest in social services, having taken two sociology classes at Los Angeles City College. Plus, he had his own personal history driving him. His father left when Haigh was little, chasing a drug and alcohol addiction. Haigh says he was determined to “deviate from his course. I knew I had to make a change.” He now works for the program, reaching out to potential participants on the Metro train to and from his home.

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The L.A. Fathers program has become so popular that a second day of workshops was added to meet demand.

He still takes part in the workshops, speaking up whenever he thinks the other fathers are hesitant. “One of the facilitators might say: ‘How would you talk to your child, in what kind of tone? Would you get down on your knees to their eye level so they don’t feel scared?’ If dads aren’t comfortable saying it, I’m thinking that they might be thinking it. I usually put in my 2 cents.”

The program is aimed at young men ages 15 to 25, but as a recipient of federal funding it can’t turn anyone away, which leaves its doors open to some nontraditional fathers—such as mothers. The only genuine requirement is nerve, which is what got Emely Zavala in.

As a high school graduate past the age of 18, Zavala, a 22-year-old single parent of an autistic child, didn’t qualify for programs designed for young mothers, including the one run by Project NATEEN. She saw the L.A. Fathers poster on the Metro and called up. The voice mail response said to leave a message if, among other options, “you’re acting the role of a father.” She was—and so she did.

“I’m a risk-taker,” says Zavala. “I’ve always put myself in awkward situations.”

This one was no different initially, as she was met with some immediate curiosity from the men in the program. “One of them asked me why I was there. He said, ‘Aren’t there other programs for you?’ I said, ‘Maybe there are, but I like it here. I feel comfortable talking to you guys.’”

Zavala is now in the midst of her second session, with no intention of leaving. “I’ve given up in so many other therapies, but this is the first group that I’ve not given up on. I feel like I need to go, like I’m free. Even if the day has been super-negative, it becomes positive as soon as you walk through that door.”

The novelty of her presence wore off months ago. “They’ve accepted me. I’m like one of the guys.”

Not entirely. Though the program isn’t obliged to make any modifications for her, one accommodation was provided—a slight edit to her diploma for completing the workshop. “They all say, ‘for being a committed father’ at the end. Mine says, ‘for being a committed mother.’”
Zavala’s story notwithstanding, this is a program intended for young men and the distinct pressures, codes and expectations that fall on them. An emphasis on treating women well, nonviolence and what defines a man prevails. “We get into what it really means to be a man,” Blaney says.

He recently asked his class to consider just that: “What are we supposed to be?” Haigh says. “I said three things—intelligent, responsible and …” He pauses, trying to complete his answer, before finally giving in. “I don’t remember the third one.”

He raises another slender grin, revealing a front tooth he says is fake, the result of being on the wrong end of a scuffl e while attempting to retrieve his stolen bike. The bike was a replacement for one taken from him only a month earlier, during an assault that sent him to the hospital for a week.

Today, just a year since the two incidents, Haigh is on the honor roll at Los Angeles City College, carrying a 3.7 GPA and hoping to transfer to UCLA once he gets his associate degree. “That’s my biggest aspiration right there,” he says.

Later, he’ll expose a year-old tattoo across the back of his right arm that doubles as a kind of self-assessment: “Damaged,” it reads. Perhaps down his opposite arm a more optimistic status update is due: “Under construction.”

Good News Santa Monica!

Children’s Hospital Los Angeles recently opened the doors of a new, 3,000-square-foot outpatient care center in Santa Monica. Located in the St. John’s Medical Plaza, Children’s Hospital Los Angeles – Santa Monica offers top medical expertise from Board-certified and Board-eligible members of the award-winning staff at Children’s Hospital Los Angeles in endocrinology, gastroenterology and nutrition, hematology-oncology, medical genetics, neurology, orthopaedics, plastic and maxillofacial surgery, and urology.

This is the fourth ambulatory care facility the hospital has opened since 2010, with the Santa Monica facility joining outpatient centers in Arcadia, Valencia and the South Bay. For more information about the hospital’s latest outpatient center, visit CHLA.org/SantaMonica.

Visit WeTreatKidsBetter.org/ImagineVideos to watch the Imagine television special segment on the L.A. Fathers program.
At 72 gallons and counting, Jim O’Connor’s cumulative donation of blood and platelets to Children’s Hospital Los Angeles has finally surpassed his age, which is saying something considering O’Connor just turned 71. By a good margin, he is the leading blood donor in the hospital’s history.

O’Connor, a high school math teacher, first gave blood at Children’s Hospital in 1989. Today you can find him at the blood bank donating blood or platelets every month.

“If somebody’s life can be saved, and it just takes you getting poked with a needle, it’s not a big deal,” O’Connor says. “It’s a no-brainer.”

Meet Jim O’Connor, the top blood donor in the history of Children’s Hospital Los Angeles.

O’Connor sits back to make one of his nearly 600 donations.
BLOOD TYPE: O-NEGATIVE
A UNIVERSAL DONOR

ROUND-TRIP: ROUGHLY 2,000 HOURS

TOTAL NUMBER OF JIM’S DONATIONS: 590

COST OF BLOOD IF PURCHASED FROM A COMMUNITY BLOOD BANK: $330 PER PINT

1 PINT OF BLOOD = 3 LIVES SAVED (ACCORDING TO THE RED CROSS)

DID YOU KNOW?
ONLY ABOUT 7 PERCENT OF THE U.S. POPULATION IS O-NEGATIVE.

WHAT ARE PLATELETS?
CELLS IN THE BLOOD THAT HELP TO FORM A CLOT AND KEEP YOU FROM BLEEDING

O’CONNOR ALSO VOLUNTEERS AT THE HOSPITAL TWO OR THREE DAYS A WEEK, USUALLY TENDING TO BABIES.

2,000 UNITS OF BLOOD COMPONENTS ARE NEEDED EACH MONTH FOR PATIENTS AT CHILDREN’S HOSPITAL LOS ANGELES.
Members of the South Bay Auxiliary, 1928

In 1914, World War I broke out in Europe, Babe Ruth made his Major League Baseball debut, construction began on the Lincoln Memorial, and the first-ever Mother’s Day was celebrated.

At Children’s Hospital Los Angeles, it was also an historic year. The hospital opened a new, 100-bed inpatient facility. And in Hermosa Beach, a small group of philanthropic-minded women quietly joined together to form the hospital’s first auxiliary.

The founding of that group, known today as the South Bay Auxiliary, marked the birth of what would become the most successful volunteer fundraising force of any pediatric hospital in the country: the Associates and Affiliates (A&As).

This year, the A&As are celebrating their 100th anniversary—and there’s a lot to celebrate. Their membership exceeds 3,000 women and men in 38 groups, which extend north to the Antelope Valley, east to Whittier, south to Palos Verdes and west to the ocean.

Over the past half-century alone, they’ve collectively raised more than $136 million for Children’s Hospital—helping from research to capital campaigns, the Associates and Affiliates have devoted a century of support to Children’s Hospital Los Angeles.
to build two major hospital buildings and funding multimillion-dollar campaigns for genetic research, minimally invasive surgery, developmental biology, resident education, multiple hospital departments and much more.

Their activities not only raise vital funds, but also raise awareness about the hospital in communities throughout Southern California.

“The Associates and Affiliates have been and continue to be absolutely essential to the growth and development of Children’s Hospital Los Angeles,” says Cathy Siegel Weiss, co-chair of the hospital’s Board of Trustees. “We’re extremely grateful for their support and their tireless dedication to the hospital’s mission.”

Blankets, buildings and research

Kate Page Crutcher, the hospital’s first president, served from 1907 to 1946. During her tenure, she organized seven auxiliaries to support Children’s Hospital, which then operated entirely on donations.

The volunteers, all women, initially focused on the basics: donating blankets and sheets, sewing hospital gowns and pajamas, and raising funds for medical supplies—and even an industrial-strength potato peeler for preparing patient meals. Fundraisers included teas, bridge parties and rummage sales. At one event, an auxiliary raffled off a kid goat that was brought in from Catalina.

In 1947, the ranks of volunteers rose exponentially when Mary Duque joined the hospital’s Board and was appointed the groups’ chair. Mrs. Duque, who would become the hospital’s preeminent fundraiser for the next 40 years, immediately set about expanding the guilds, eventually creating 32 new groups.

(continued on next page)

“[Mary Duque] understood that members needed to feel a strong sense of personal involvement and individual responsibility. To this day, that sense of connection continues.”

— Bonnie McClure, volunteer chair of the A&As
In recent years, the A&As played a vital role in funding construction of the Marion and John E. Anderson Pavilion and have been enduring champions of research—funding groundbreaking programs in developmental biology, gene and stem cell therapy, neuroscience, surgery, autism and more.

Although each group raises money individually, the 26 Associate groups pool their funds to support a common cause—currently, the $6 million Associates Rehabilitation Center Caregiver Wing and the Associates Sarcoma Program Chair at Children’s Hospital Los Angeles.

Each Affiliate group, meanwhile, raises money for a separate project, with some supporting research and others dedicated to a hospital department or program.
Meet the First A&A Group: South Bay Auxiliary

Along Aviation Boulevard in Redondo Beach, just minutes from the Hermosa Beach Pier, sits an unassuming storefront with a rich history: the South Bay Children’s Hospital Los Angeles Thrift Shop.

The store serves as the major fundraiser for the South Bay Auxiliary, which is celebrating its 100th anniversary this year.

A Common Bond

If there’s one word to describe the A&As, it’s dedicated.

“It’s rewarding to work with other volunteers who are so committed to supporting Children’s Hospital,” says Pat Harrison, president of the South Bay Auxiliary. “We have members in their 90s who are still volunteering. It’s inspiring.”

That theme of dedication runs through all 38 groups, each with its own signature fundraising vehicles—from charity balls, luncheons and galas to holiday card sales, golf tournaments, horse shows, poker tournaments, thrift stores, gift shops and more.

True to Mrs. Duque’s long-ago vision, new groups have continued to form—a total of eight in the past decade. Although the A&As began as an all-female force, some groups now have co-ed memberships, and a Men’s Guild was created in 2004. While each group maintains its own unique identity, all A&A members share a common bond.

“We all love Children’s Hospital,” McClure says. “The members know that every dime they raise is being used to help make a sick child better. You won’t find a more dedicated and loyal group.”

A complete list of the Associates and Affiliates can be found on page 57.
Children’s Miracle Network Hospitals® celebrated its 30th anniversary in 2013. Bringing together corporate partners to raise funds for 170 children’s hospitals across the United States and Canada since 1983, the organization has raised more than $4.7 billion, meeting the hospitals’ areas of greatest need.

Children’s Hospital Los Angeles is supported by local Children’s Miracle Network Hospitals partners who work tirelessly throughout the year raising funds, one dollar at a time. This fiscal year, donations to CHLA by Children’s Miracle Network Hospitals partners totaled nearly $6 million. We extend our heartfelt gratitude to our local partners, whose commitment to pediatric health care enables us to make great advances in the compassionate services provided at Children’s Hospital Los Angeles. We recognize these generous contributors in the Fiscal Year 2013 Honor Roll of Friends.

Costco Wholesale reached a milestone in fundraising this year, donating more than $1.9 million to Children’s Hospital Los Angeles. Over the past 30 years, Costco Wholesale has given more than $28 million to Children’s Hospital Los Angeles through its Children’s Miracle Network Hospitals campaign and the Los Angeles Regional Charity Classic.
In 1901, a small group of caring individuals recognized that the sick and injured children in their community were in need of special pediatric care, and so began Children’s Hospital Los Angeles. More than a century later, the compassion of those founding members continues to blossom, as support for Children’s Hospital is carried from one generation to the next. The hospital’s international recognition as one of the world’s finest pediatric academic medical centers is a testament to the years of dedicated efforts from faculty, staff and volunteers, as well as our generous philanthropic partners.

As an academic medical center, we provide more than just the finest clinical care; we also remain at the forefront of research and training. A global leader in improving treatment options, developing cures and elevating the next generation of pediatric professionals, we have seen our commitment to caring—and the impact of our donors’ support—grow and extend far beyond Los Angeles.

We are honored to recognize individuals, organizations, corporations and foundations for their generosity during fiscal year 2013. This Honor Roll includes donors who contributed $1,000 or more in cash gifts, pledges or pledge payments. We also are proud to recognize those who have contributed gifts of $150 to $999 on the Red Wagon Society Honor Roll of Donors, viewable at CHLA.org/HonorRoll.

In addition, we express heartfelt thanks to those who, forgoing individual recognition, directed their generosity through one of our Associate and Affiliate or allied groups.

In spite of our best efforts, errors and omissions may occur. Please inform us of any inaccuracies by contacting Michele Phillips, associate director of Donor Relations, at 323-361-1788 or mPhillips@chla.usc.edu.
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Marion and John E. Anderson

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41
$10,000 TO $49,999

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mdovale@chla.usc.edu

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tgreen@chla.usc.edu

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Associate Senior Vice President, Development
tjohann@chla.usc.edu

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Associate Senior Vice President, Development
rbianco@chla.usc.edu

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mdovale@chla.usc.edu

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