Community Benefit Report

Hoag Memorial Hospital Presbyterian

2013

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Hoag Memorial Hospital Presbyterian
Community Benefit Plan Update 2013

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Executive Summary

The Community Health department at Hoag Memorial Hospital Presbyterian was established in 1995. Since its beginning the program has focused on two principal strategies:

- Provide necessary healthcare-related services which are unduplicated in the community.
- Provide financial support to existing community based not-for-profit organizations which already provide effective healthcare and related social services to meet community health needs.

The Department of Community Health, led by its Director, Gwyn Parry, MD, is responsible for the coordination of Hoag's Community Benefit reporting, and provides free programs to assist the underserved in the community. These include Mental Health Services, Community Case Management and Health Ministries Coordination. In addition to these services, many other Hoag departments provide community health services including education and support groups which are free to the community. Hoag also has substantial relationships with local colleges and universities to invest in the education of various health professions.

Community Benefit grants support Hoag Health Associates- organizations that provide a broad range of services, including the following:

- Free medical and dental care
- Adult day care and education for persons who suffer from Alzheimer's disease or mild dementia, with support and education for their caregivers and families
- Transportation services for local senior centers

Finally, Hoag provides uncompensated care (charity) to patients who are unable to pay for the full cost of their care. These expenditures amounted to over $37 million in Fiscal Year 2013 (October 1, 2012 through September 30, 2013.) Hoag's charity care and self pay discount policy states that self-pay and uninsured patients who are unable to pay for the full cost of their care may qualify for charity or discounts on a sliding scale for incomes up to 400% of the federal poverty level.

Total quantifiable Community Benefit expenditures (excluding Medicare Cost of Unreimbursed Care) for FY2013 amounted to over $49 million.

This report provides detailed descriptions of Hoag's Community Benefit programs and services, and includes quantifiable data for expenditures by these programs during Fiscal Year 2013.

Introduction

The Hoag Memorial Hospital Presbyterian Community Benefit Program was formalized in 1995 and has grown significantly since that time. We have served over eighty not-for-profit community organizations in a variety of health and social service categories. We continue to emphasize the development of sustained collaborative relationships and the provision of unduplicated services to disadvantaged residents in our community as core elements of the program.

Hoag's nonprofit regional healthcare delivery network consists of two acute-care hospitals, five urgent care centers and seven health centers, and has delivered a level of personalized care that is unsurpassed among Orange County's healthcare providers. Renowned for its excellence, specialized health care services and exceptional physicians and staff, Hoag is admired as one of California's leading hospitals. It is one of the county's largest employers with approximately 5,000 employees and more than 2,000 volunteers. Hoag's network of more than 1,500 physicians represents 52 different specialties.

Hoag Hospital Newport Beach, which has served Orange County since 1952, and Hoag Hospital Irvine, which opened in 2010, are designated Magnet hospitals by the American Nurses Credentialing Center (ANCC) and are fully accredited by DNV. In 2013, Hoag entered into an affiliation with St. Joseph Health to further expand health care services in the Orange County Community. Hoag offers a variety of health care services to treat virtually any routine or complex medical condition. Through its medical staff, state-of-the-art equipment and modern facilities, Hoag provides a full spectrum of health care services including five institutes that provide specialized services in the following areas: cancer, heart and vascular, neurosciences, women's health, and orthopedics through Hoag's affiliate, Hoag Orthopedic Institute.

To further Hoag's commitment to provide comprehensive care to the communities we serve, Hoag Medical Group was established in 2012 with the core values of excellence, innovation, and compassion. The physician group comprises specialties and sub-specialties in internal medicine, family medicine, pediatrics, geriatrics, sports medicine, vascular medicine, genetics, diabetes, HIV and addiction medicine.

Hoag has been named one of the Best Regional Hospitals in the *U.S. News & World Report Metro Edition*. The organization was ranked nationally for Orthopedics and placed high-ranking in Cancer, Geriatrics, Nephrology, Pulmonary, Gastroenterology, Gynecology, Neurology & Neurosurgery, and Urology. National Research Corporation has endorsed Hoag as Orange County's most preferred hospital for the past 18 consecutive years, and for an unprecedented 18 years, residents of Orange County have chosen Hoag as the county's best hospital in a newspaper survey by the *Orange County Register*.

History

Hoag opened in 1952 as a community partnership between the Association of Presbyterian Members and the George Hoag Family Foundation, a private charitable foundation.

The George Hoag Family Foundation and the Association of Presbyterian Members represent the two founding organizations of the hospital and continue to provide leadership as corporate members of the Hoag Corporation. These members annually elect the Board of Directors, which consists of 18 members with representatives from the Hoag community and medical staff. The hospitals' Chief Executive Officer is also seated on the board as a voting member.

An annual meeting at the end of the fiscal year provides the corporate members the opportunity for the election/re-election of directors for the ensuing year.

Since its founding the hospital has welded a strong commitment to the community that it serves, including the provision of services for those who constitute a more vulnerable, at-risk population. Such care, for both inpatients and outpatients, is often only partially compensated. With excellence of management and the diligent stewardship of funds, Hoag has been able to sustain its financial strength. As a result, Hoag has been able to maintain a continuing commitment to quality of care while developing and expanding community programs and partnerships. Most of the funds expended upon Hoag's Community Benefit Program are from operating income.

For more information, visit www.hoag.org.

Mission, Vision, and Core Values

Hoag's Mission

Our mission as a non-profit, faith-based hospital is to provide the highest quality health care services to the communities we serve.

Vision Statement

Hoag is a trusted and nationally recognized healthcare leader

Core Values

Excellence
Respect
Integrity
Patient Centeredness
Community Benefit

Hoag has identified six core strategies as a means to achieve our Vision and maintain our Mission and Values:

Quality and Service

Implement the Quality Management System to drive excellence throughout the organization.

People

Develop a performance-based and integrated culture of patients, physicians and staff.

Physicians Partnership

Create and maintain commitment to the Hoag community from exceptional doctors, through sustainable and satisfying leadership opportunities and mutually beneficial economic relationships.

Strategic Growth

Implement the continuum of care strategy to provide improved access, integration and experience and experiment with new business models to create sustainability for the future.

Financial Stewardship

Achieve enterprise wide growth and financial stability while directly reducing the cost of care.

Community Benefit and Philanthropy

Improve the health of vulnerable populations in Orange County.

Community Benefit Philosophy

We are encouraged by the better angels of our nature and the disposition of our hearts to think favorably of our fellows, regardless of their circumstances, and to do them good: improving and sustaining their health and the quality of their lives and thus benefiting all.

The Department of Community Health provides direct services and collaborates with other not-for-profit community-based organizations to promote the health of our communities. The department coordinates Hoag's Community Benefit activities, driven by the health needs of our surrounding communities, which are regularly reviewed in an ongoing manner.

Hoag's Community Benefit Program is guided by five Core Principles:

1. *Emphasis on Disproportionate Unmet Health-Related Needs (DUHN)* - We concentrate on residents who have a high prevalence of severity for a particular health concern; and on residents with multiple health problems and limited access to timely high quality health care.
2. *Emphasis on Primary Prevention* – We focus on program activities that address the underlying causes of persistent health problems as part of a comprehensive strategy to improve health status and quality of life in local communities.
3. *Build a Seamless Continuum of Care* – We work to develop and sustain operational linkages between clinical services and community health improvement activities to manage chronic illnesses among uninsured and publicly insured populations.
4. *Build Community Capacity* – We target our charitable resources to mobilize and strengthen existing effective community health services.
5. *Emphasis on Collaborative Governance* – We emphasize *Networking* to exchange information; *Coordination* of synergistic activities; *Cooperation* in sharing resources; and *Collaboration* to enhance the combined capacity of our community health partners.

The department provides services which are unduplicated in the community. These currently include mental health services, case management, and the coordination of faith-based community nursing. In order to promote effective access to health care and related services, the department works in collaboration with a number of not-for-profit community based organizations to provide insurance coverage as well as free services to underserved and vulnerable residents, many of whom are undocumented.

Charity care is an integral component of the benefit that Hoag provides to the community. The current hospital Charity Care and Self Pay Discount Policy provide assistance on a sliding scale for uninsured and self-pay patients with family incomes up to 400% of the Federal Poverty Level. The Federal Poverty Level (FDL) is defined as a minimum amount of income that a family needs for food, clothing, transportation, shelter and other necessities. According to the FDL Guidelines established by the department of Health and Human Services, the 2012 FDL for a family of four was $23,050. The current Charity Care and Self-Pay Discount Policy is provided in Appendix A. In FY2013 the hospital served 11,713 Charity Care cases. Appendix B provides a summary of the quantifiable Community Benefit provided by Hoag in FY2013 (October 1, 2012 through September 30, 2013). Appendix C provides a detailed breakdown of the Community Benefit expenditures by program.

Community Benefit Committee

The role of the Community Benefit Committee (CBC) is to establish, implement and monitor the policies and procedures that will provide the appropriate oversight and governance structure for the activities related to the Community Benefit Program at Hoag Hospital.

The CBC functions as a Committee of the Hoag Memorial Hospital Presbyterian Board of Directors. CBC has the primary responsibility of ensuring that Hoag fulfills its moral and legal obligations to the community in serving the underserved and underprivileged through direct and indirect support of philanthropic health-related programs. The committee ensures that Hoag is in full compliance with federal and state regulations governing non-profit hospital organizations pertaining to community benefit and health-related activities.

The CBC ensures that Community Benefit activities are:

- Developed through engagement with community groups and local governmental officials in the identification and prioritization of community needs and to include mechanisms to evaluate the plan's effectiveness.
- Aligned with the mission, vision and strategic objectives/initiatives of the Hospital,
- Consistent with the Hospital's values and founding principles, and
- Developed with the input from Board, Administration and the Medical Staff leadership as appropriate.

The CBC is comprised of Hospital Board members and other members of the community and is supported by the senior management staff of the Community Health department.

Service Objectives

The service objectives of the Community Benefit program remain as initially defined:

- **Access:** To ensure adequate access to medical treatment through the availability of inpatient, outpatient and emergency medical services.
- **Services for Vulnerable Populations:** To provide health care services to uninsured, underinsured and indigent populations.
- **Education/Prevention:** To address the community health needs identified by the community health needs assessment through screening, prevention and education programs and services.
- **Research:** To provide new treatments and technologies to the local community through participation in primary clinical research.
- **Collaboration:** To establish and participate in collaborations which address community health priorities.
- **Coordination:** To provide case management services which coordinate medical and social services for vulnerable community residents.

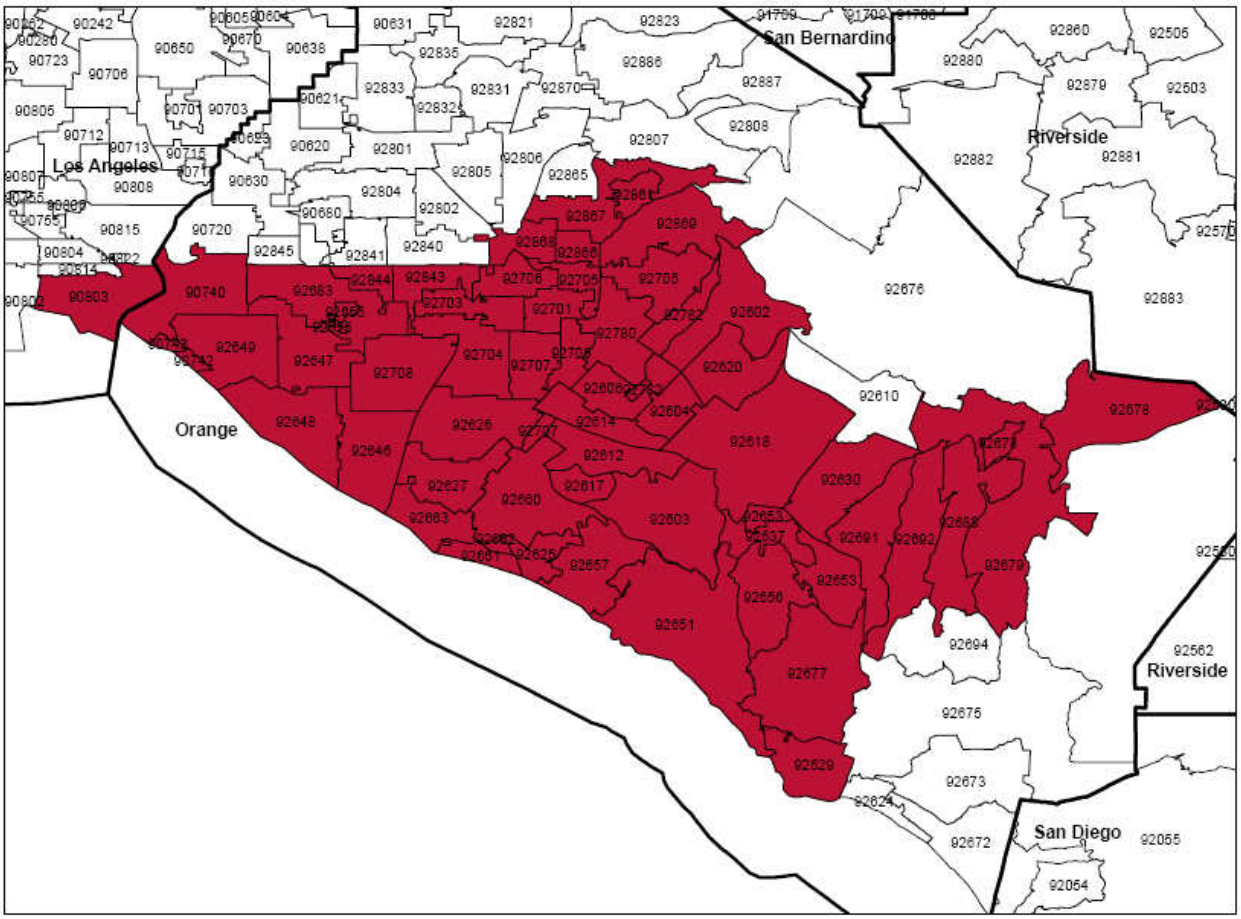
Community Health Needs Assessment

In the Spring of 2013, Hoag embarked on a comprehensive Community Health Needs Assessment (CHNA) process to identify and address the key health issues of our community. This assessment was conducted by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments in communities across the United States since 1994.

To access the 2013 CHNA report in its entirety, please visit:
www.hoag.org/Why-HOAG/Pages/Community-Benefit/Reports

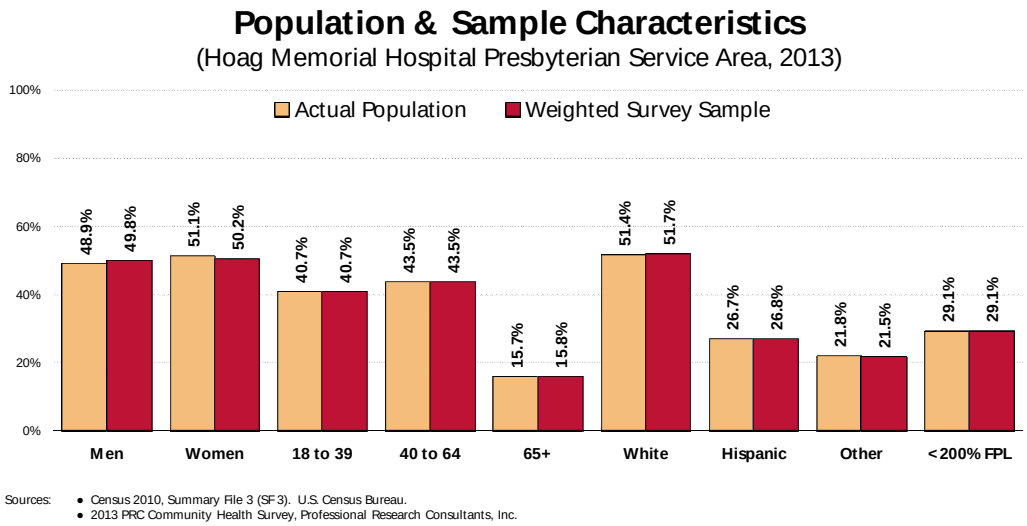
CHNA Community Definition

Hoag's community, as defined for the purpose of the Community Health Needs Assessment, included each of the 56 residential ZIP Codes comprising the hospital's service area. This community definition, illustrated in the following map, was determined because a majority of Hoag's patients originate from this area.



Demographics of the Community

The population of the hospital's service area is estimated at 1,874,329 people. The age distribution of our population is similar to that of that nation as a whole, but our area is racially and ethnically much more diverse, with non-Hispanic White residents comprising only a narrow majority of residents.



The Community Health Needs Assessment (CHNA) is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the service area of Hoag. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness. A CHNA provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This CHNA will serve as a tool toward reaching three basic goals:

- **To improve residents' health status, increase their life spans, and elevate their overall quality of life.** A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- **To reduce the health disparities among residents.** By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors which have historically had a negative impact on residents' health.
- **To increase accessibility to preventive services for all community residents.** More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

CHNA Methodology

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for trending and comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through two Key Informant Focus Groups.

Community Health Survey

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Hoag and PRC. A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency and random selection capabilities. The sample design used for this effort consisted of a random sample of 751 individuals age 18 and older in Hoag's Service Area. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC). The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the service area were obtained from the following sources

- California Department of Public Health
- Centers for Disease Control & Prevention
- National Center for Health Statistics
- State of California Department of Justice
- US Census Bureau
- US Department of Health and Human Services
- US Department of Justice, Federal Bureau of Investigation

Community Stakeholder Input

As part of this Community Health Needs Assessment, two focus groups were held on June 13, 2013. Participants included: physicians, a public health representative, other health professionals, social service providers, business leaders and other community leaders. Hoag recruited the participants for the focus groups. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall. Final participation included representatives of 20 local organizations. Through this process, input was gathered from a representative of public health, as well as several individuals whose organizations work with low-income, minority (including Hispanic, Asian Americans, and undocumented residents), refugees from Africa and the Middle East, and other medically underserved populations (specifically, children and college-age adolescents, elderly, disabled, the uninsured/underinsured, and MediCal recipients).

Significant Health Needs of the Community

The following "areas of opportunity" represent the significant health needs of the community, based on the information gathered through the 2013 Community Health Needs Assessment and the guidelines set forth in *Healthy People 2020*. From these data, opportunities for health improvement exist in the area with regard to the following health issues

Areas of Opportunity Identified Through This Assessment	

Access to Health Services	• Lack of Health Insurance Coverage
	  o Insurance Instability
	  o Supplemental Coverage (Seniors)
	• *Access to Healthcare ranked as the #5 top concern among focus group participants; they emphasized*:
	  o Barriers to Accessing Care (Including Language and Transportation)
	  o Uninsured/Under-Insured Population
	  o Low-Income Population

Dementias, Including Alzheimer's Disease	• Alzheimer's Disease Deaths

Educational & Community-Based Programs	• Attendance at Health Promotion Events
	• *Health Education & Prevention ranked as the #4 top concern among focus group participants; they emphasized*:
	  o Preventive Care Programs
	  o Funding

Immunization & Infectious Diseases	• Pneumonia/Influenza Deaths • Pertussis Incidence • Tuberculosis Incidence

Mental Health & Mental Disorders	• *Mental Health ranked as the #1 top concern among focus group participants; they emphasized*:
	  o Limited resources
	  o Stigma
	  o Lack of integration (physical/mental)

Nutrition, Physical Activity & Weight	• Children's Computer Time
	• *Obesity & Nutrition ranked as the #3 top concern among focus group participants; they emphasized*:
	  o Childhood Obesity
	  o Need for Nutrition Education

Substance Abuse	• Cirrhosis/Liver Disease Deaths
	• Adults Seeking Professional Help
	• *Substance Abuse ranked as the #2 top concern among focus group participants; they emphasized*:
	  o Lack of Treatment Centers
	  o Binge Drinking
	  o Prescription Drug Abuse

Tobacco Use	• Smoking Cessation Attempts

Prioritization of Health Needs

After reviewing the CHNA report, the Community Health Department staff and the Community Benefit Committee members met to evaluate and prioritize the top health needs of the community. Data for the community were examined, and attendees were asked to evaluate each significant health issue along the following criteria:

- **Magnitude.** The number of persons affected, as well as differences from state/national data or Healthy People 2020 objectives.
- **Impact/Seriousness.** The degree to which issue affects/exacerbates other health issues, as well as the degree to which it leads to death, disability or loss of quality of life.
- **Feasibility.** The ability to reasonably impact the issue, given available resources.
- **Consequences of Inaction.** The risk of exacerbating the problem by not addressing at the earliest opportunity.

Priority Health Issues

This process yielded the following priorities for Hoag to address in improving the health of the community. These priorities, and plans to address these, will be integrated into Hoag's Implementation Strategy for the coming years.

1. **ACCESS TO CARE FOR VULNERABLE POPULATIONS**

   Strategies to Address Need

   - Provide funding and/or in kind support to Primary Care Clinics that serve pediatrics through seniors
   - Provide funding and/or in kind support to Mental Health Services including Hoag Mental Health Center
   - Provide funding and/or in kind support to Women's Health Specialty Services

2. **HEALTH EDUCATION & PREVENTION**

   Strategies to Address Need

   - Provide Flu Immunization Clinics through Health Ministries Program
   - Provide Smoking Cessation Classes
   - Provide OB Community Education and Support Groups
   - Provide Cancer Community Education and Support Groups
   - Provide Diabetes Community Education

3. **NUTRITION/PHYSICAL ACTIVITY/WEIGHT MANAGEMENT**

   Strategies to Address Need

   - Provide funding and/or in kind support to obesity prevention programs
   - Provide funding and/or in kind support to nutrition education
   - Provide funding and/or in kind support to school based nutrition programs

4. **HEALTH PROFESSIONAL EDUCATION PROGRAMS**

   Strategies to Address Need

   - Provide internship opportunities through various Hoag Departments:
     - Cancer Center
     - Case Management
     - Medical Records
     - Pharmacy
     - Clinical Care Extenders
     - Physical Therapy

Department of Community Health Programs

The department of Community Health provides direct Community Benefit service programs and coordinates Community Benefit reporting at Hoag Hospital. This section of the report provides information for each of the Community Health programs and achievements in FY2013: October 1, 2012- September 30, 2013.

Mental Health Center

The Mental Health Center was created to provide bilingual bicultural services to people who otherwise could not obtain mental health services. The majority of the program's clients are low-income, uninsured and highly vulnerable. These clients have limited health insurance with no mental health/behavioral health benefits or they have benefits but can no longer afford the co-payments and/or deductibles.

During FY 2013, the program employed seven full-time bilingual Master's prepared social workers. These social workers provided mental health services to 696 clients in the form of psychotherapy, resource brokering, and/or case management. In addition, the program offered psychotherapeutic and psycho educational groups to 817 participants. All services were offered on a voluntary basis. Services were offered on a low-cost sliding scale. The sliding scale starts at zero (free services) and increases according to the individual's self reported annual income level. The vast majority of people were seen at no charge or the nominal five-dollars per session rate. A review of client demographics found that the majority of the clients seen through the Mental Health Center were female, Hispanic, and indicated a language other than English as their primary language. The majority of the clients fell in the 40-49 year old age range. Seventy-five percent of the clients reported having an annual household income below $20,000 and a total of 87% of the clients reported annual incomes of less than $30,000.

The program has proven to be highly efficient and effective. The program utilized a clinical assessment tool (DASS) to measure levels of depression, anxiety, and stress in clients. According to pre and post test scores, clients who participated in either individual or group psychotherapy saw a statistically significant decline in depression, anxiety, and stress scores. The program also implemented a self esteem tool (Rosenberg) on a pre and post test basis. Across the board for individual and group psychotherapy, there was statistically significant improvement in self esteem.

In FY 2013, the program provided a supervised clinical internship program for 9 MSW (Master of Social Work) students from the University of Southern California, from California State University at Fullerton and California State University at Long Beach. The program provided consultation, support, and education to paraprofessionals at partner agencies such as Girls Incorporated and the Newport Mesa Unified School District. This support included telephone consultation, workshops, and in-service education. In addition to support for the staff of partner agencies, the Mental Health Center offered several different psychotherapeutic and psycho educational groups and workshops for the partner agency clients. These efforts allowed our partner agencies to offer mental health services at no cost to their clientele and all services are provided in-kind to the not-for-profit agencies. Some examples include: a diabetes support group, depression support groups, self esteem groups, and stress management workshops. Group sessions were also offered for parents, families, and adult couples struggling with relationship issues.

During FY 2013, the program continued its support to the Mary and Dick Allen Diabetes Center at Hoag Hospital. The Mental Health Center was responsible for all the mental health services being provided to the patients of this center.
Contact: Michaell Rose, LCSW at (949)764-6278 or Michaell.Rose@hoag.org

Health Ministries
Hoag Health Ministries celebrates its twenty-sixth year of serving Orange County faith communities through our Faith Community Nursing (FCN) Program. Currently the program has 50 volunteer FCN's who dedicate their time and service to those in need at 27 congregations throughout Orange County. All denominations are welcome to participate in this spiritually centered wellness program, which seeks to incorporate a balance of the mind, body and spirit. Each FCN works independently within their congregation in creating educational preventive health programs specific to the needs, beliefs and practices unique to their faith traditions.

During FY 2013, Health Ministries

- Comprised of 8 denominations amongst the 27 Faith Based Partnerships
- Donated 3,448 Volunteer Registered Nurse hours
- Touched the lives of more than 32,000 congregants
- Administered 6,540 flu vaccine doses to faith members and the community
- Provided 820 flu vaccine doses to the SOS Clinic
- Trained 142 persons in life-saving CPR & Automated External Defibrillator usage
- Provided 3 Automated External Defibrillators (AED's) to church partners
- Organized blood donations, receiving 250 units of life-giving blood
- Screened Blood Pressure readings for 742 individuals
- Offered disease-preventing hand washing training

Faith Community Nurses – Parish Nurses provide a variety of services to their communities:

- Integrate Faith and Health – Listens intentionally and offers guidance that promotes wellness, incorporating the individual's spiritual beliefs
- Personal Health Counselor, Health Advocate and Health Educator – Discusses health concerns, provides information and clarification, organizes classes on specific health issues, assists with health care assessments and guides options
- Community Resources Liaison – Identifies available health care and social service resources, often for the Older Adult population
- Develops Support Groups - Based on the needs of a congregation
- Trains Volunteers – Coordinates volunteer services to support the Health Ministries program goals

Health Ministries collaborates with a variety of Hoag and community organizations including the Alzheimer's Family Services Center, City of Irvine, Irvine Senior Centers and a host of other partners who share their information and services with the Faith Community Nurses. It is through these collaborations that the volunteer nurses can provide resources to guide their congregations along the journey towards a mental, physical and spiritual health balance.

Contact: Susan Johnson, RN, MPH at (949)764-6594 or Susan.Johnson2@hoag.org

Community Programs

Community Programs consists of case management services and other community engagement activities supported by the Department of Community Health. Through collaborative endeavors with other agencies and organizations in Orange County, access to health education, safety, mental, physical and/or spiritual health care needs of the community is being achieved.

Case Management:

Case management services establish pathways for health care access and specialized attention to people with unique health care navigation needs. Case management provides health care liaison services between Hoag, the Share our Selves (SOS) Clinic, and other community agencies which serve the low income, uninsured and under-insured population within the Hoag service area. Individuals are assessed for funding eligibility by financial counselors and linked to an appropriate care program. Through collaborations involving a multi-disciplinary team of health care providers, individual and effective care plans are developed for each patient including patient support, education and access to needed medical services. By optimizing health and wellness through a seamless continuum of care, hospitalization rates have been reduced.

During FY 2013

- 5,215 Hoag Hospital services were provided to SOS patients.
- 69 hospital days were utilized by patients needing medical, surgical or newborn specialty care.
- 104 newly diagnosed persons received free diabetes education through the Mary & Dick Allen Diabetes Center at Hoag, including 38 pregnant women who received specialized gestational diabetes education through the Sweet Success Program.
- In partnership with local senior centers, a personal alert (Lifeline) system was provided for 5 homebound older adult residents.

Community Collaborations:

Maccabi Games - Hoag provided staffing and medical supplies for 2,000 Jewish teen athletes, convening from around the globe in Irvine for the Merage Jewish Community Center Maccabi Games and ArtFest. Hoag Registered Nurses and local physicians staffed the dozen sports venues throughout Irvine and Tustin, involving more than 700 hours served.

Spirituality Conference- In collaboration with Hoag Neurosciences Institute and the Alzheimer's Family Services Center, Hoag Community Benefit sponsored the 2013 Spirituality Conference - Keeping the Care in Caregiving. The conference was attended by 150 community clergy, health care professionals and caregivers.

Contact: Susan Johnson, RN, MPH at (949)764-6954 or Susan.Johnson2@hoag.org

Project Wipeout

The mission of Project Wipeout is to educate and raise awareness on injury prevention at the beach, particularly neck and spinal cord injuries, by distributing beach safety information locally and nationwide.

Project Wipeout:

- Emphasizes education on drowning and neck and spinal cord injury prevention
- Focuses on those most at risk children and young people between the ages of 16 and 30
- Participates in community events and provides free beach safety educational presentations and materials to schools and community organizations
- Collaborates with members of Lifeguard and Fire Departments, teachers, parents and committed volunteers to broaden public access to our beach safety message.

Project Wipeout's intent is to provide basic information on the types of injuries that occur, how they happen, and what to do to protect against them. This information is disseminated via presentations, videos, and printed materials at schools, community events, lifeguard training, and seminars. More than 30,000 copies of Project Wipeout brochures, coloring books and activity books are distributed annually through community events and at elementary, junior high and high schools.

Print materials are also used at presentations given by local lifeguards, which feature Project Wipeout's video (mandatory viewing for trainees in Orange County's junior guard programs). It is also being used throughout the U.S. and by lifeguard departments as far away as England and Australia, and it is seen by thousands of elementary, junior high and high school children every year.

Hoag now offers our educational materials in English and Spanish. We also have developed a new rip current poster in English and Spanish showing the danger of rip currents and escape routes to safety. All of our materials are downloadable from our website www.hoag.org/projectwipeout

Contact: Linda Reuter, RN at (949) 764-5001 or Linda.Reuter@hoag.org

Other Hoag Community Benefit Activities

Hoag's commitment to Community Benefit is best exemplified by the dedication of an entire department to the coordination and provision of Community Benefit programs. The hospital's Community Benefit activities are not limited to the department of Community Health. Other hospital departments provided a wide range of Community Benefit activities during FY2013, including health professions education, clinical research, support groups and many more. This section of the report features a discussion of some examples of the Community Benefit activities that were provided by other hospital departments in the current reporting period.

The Mary & Dick Allen Diabetes Center

The American Diabetes Association estimates that nearly 26 million Americans live with diabetes and more than 79 million Americans are at increased risk for diabetes. Total estimated cost of diabetes in the United States in 2012 was $245 billion, including $176 billion in direct medical expenditures and $69 billion in reduced national productivity (American Diabetes Association, 2012). While diabetes alone is ranked as the sixth leading cause of death in the U.S., it also indirectly contributes to deaths by other causes, including cardiovascular disease, stroke and kidney disease (National Vital Statistics Report, CDC, 2006). Diabetes is also closely linked to other serious medical outcomes, including kidney failure, blindness, and leg and foot amputations. Since its opening in June, 2009, the Mary & Dick Allen Diabetes Center has made a positive difference in the lives of many men, women and children with diabetes in the community. There have been many successes, particularly in providing greater access to care for children, supporting healthy pregnancies and providing culturally sensitive education for adults with, and at risk for, diabetes. Below are a few program highlights from FY 2013:

New Program Director Appointed
Dr. Daniel A. Nadeau is an accomplished Endocrinologist who brings extensive experience in the areas of diabetes, obesity and nutrition to the Mary and Dick Allen Diabetes Center and Hoag Medical Group. Board Certified in Endocrinology, Diabetes and Metabolism he recently co-authored a book on nutrition entitled: "The Color Code: A Revolutionary Eating Plan for optimum health."

Diabetes Self-Management Training/Education (DSMT/E)
Diabetes Self-Management Training/Education (DSMT/E) and Medical Nutrition Therapy (MNT) remain the core functions of the Center. The Center saw an overall increase in group patient visits. While individual visits remain important, the evidence indicates that group visits produce better outcomes so the Center is working to increase the proportion of group visits. There were 1431 patients with visits during the financial year ending 2013.

Sweet Success Express
The Allen Diabetes Center hosted a collaborative conference with Sweet Success Express on advanced management of diabetes. Over 85 RNs, NPs, MDs, LCSWs, and RDs attended this 2-day conference. Evaluations regarding topics, speakers and conference in its entirety were very positive.

CHOC Children's Services at the Allen Diabetes Center
CHOC (Children's Hospital of Orange County) at the Allen Diabetes Center provide bilingual clinical services, education, and support for children diagnosed with diabetes. This program also provides outreach and educational screening for children considered at risk for developing diabetes.

In FY 2013 approximately 14 % of CHOC medical visits and diabetes education visits were unfunded. There were 1958 patient visits, 1733 MD visits at the CHOC clinic. 252 participants were provided free diabetes related education by PADRE. In addition 3899 Spanish speaking participants benefited from free Prevention of Obesity Education Research activities.

Diabetes Nursing Conference

Nearly 125 attendees including nurses, pharmacists and other clinicians attended the 2013 (a 20% plus increase) Diabetes Nursing Conference, "Diabetes: What's New, What's Next" held at Hoag. The conference was rated as "excellent "by the majority of the attendees and topics included "Diabetes and Pregnancy: Healthy Moms and Healthy Babies" "The Latest and Greatest Technology in Managing Diabetes": "Why Don't I Get Desert Anymore": "Diabetes Eye Care" and "Research Update in Diabetes."

Herbert Family Program for Young Adults with Type 1 Diabetes

Key findings from a survey of young adults [ages 18 to 30s] with type 1 diabetes mellitus who are transitioning from pediatric endocrinology care to adult care reveal that they have special needs that are often neglected. As an example, they require psycho-social support, assistance with identifying resources, and the ability to link to each other and to the Center via the online communication channels they are already using, including social media. This program saw a 160% growth ending FY2013 with 76 Facebook member and 20-30 active members attending monthly events.

Ueberroth Family Program for Women with Diabetes (Sweet Success)

Under the oversight of Allyson Brooks, M.D., executive medical director, Hoag Women's Health Institute, and with the active participation of perinatology, as well as nurse practitioners and diabetes educators, the program continues to provide perinatology services to a growing number of women with pre-conception and gestational diabetes. The program includes life-long follow up of women who develop gestational diabetes to help prevent development of type 2 diabetes, or to maintain good control of it. 799 women were seen in FY 2013, an increase from 700 FY 2012. Gestational diabetes patient care is more effective in groups. As a consequence, the Center is working to increase the proportion of group visits when appropriate for the patients. However, mother-baby follow-up visits are individual by nature so the opportunity for increasing group visits is somewhat limited. In FY 2013, the Center cared for 50 unfunded gestational diabetes patients through their pregnancies. Macrosomia rate dropped from 8.2% to 6.6%, significantly lower than the national average of 11%.

Other programs and activities

Cultural differences, educational challenges and socio-economic status are barriers to care that result in the under-serving of patients and families impacted by diabetes. Culturally sensitive programs are being developed. Free cooking demonstrations held monthly at the center were attended by 411 people. Patient satisfaction is at 89.7%

Contact: Kris Iyer, M.D at 949-764-6388 or Kris.Iyer@hoag.org

OB Education

Hoag's philosophy is that with the birth of every child, there is also the birth of a new family. Through a variety of educational classes and support services, Hoag's OB Education supports families throughout the exciting journey of pregnancy and parenthood. The comprehensive selection of prenatal classes include: Prepared Childbirth, Breastfeeding, Baby Care Basics, and Baby Saver. OB Education also provides programs and education for specific demographics, including mothers over the age of 35, mothers of multiples, and those experiencing cesarean birth. Other programs offered at no cost to the community include the car seat safety, community parenting classes, and hospital orientation and tours. Support group programs such as Post-Partum Adjustment, Perinatal Loss and Pregnancy after Loss are also available for free to the community. These support groups are highly attended, facilitated by a Licensed Clinical Social Worker (LCSW); provide ongoing support, education, and an opportunity to discuss the new challenges of parenthood. Support persons and babies are welcome. Hoag's Babyline is an information hotline for parents that operates five days a week and is answered by an OB Education registered nurse with special expertise and knowledge about pregnancy (before, during, and after), as well as baby care and breastfeeding. The Babyline staff is a key resource for new and expectant parents. The Babyline is available to the community Monday through Friday from 9am – 5:45pm. This hotline receives over 9,000 calls per year.

Contact: Gabi Shaughnessy at 949-764-5940 Gabi.Shaughnessy@hoag.org

Hoag Community Health Associates

The principal strategy of the Department of Community Health is to not "reinvent the wheel" with respect to providing necessary community health programs and services. We work closely with a broad array of community based not-for-profit organizations, and provide grant funding to some organizations whose services are consistent with our priorities. Further, we sometimes act as a fiscal intermediary for third party foundation funds. This collaboration enables us to participate in the follow-up process, by providing guidance and monitoring for grantees. This section of the report provides descriptions of some of our most important community health associates and their achievements in FY2013.

Share Our Selves

Share Our Selves (SOS), established in 1970 provides comprehensive health and social services to low-income, medically indigent and homeless Orange County (OC) residents, annually assisting more than 120,000 individuals. Hoag's Department of Community Health and SOS have nurtured a unique partnership since 1984, when the mission of SOS expanded to include free medical care with Dr. Donald Drake, former Chief of Staff at Hoag Hospital, acting as the Medical Director. Today, SOS is the largest community health center in the county to combine wrap-around social services with health care. Governed by a Board of Directors composed of community members, who serve out of a deep respect for and belief in SOS' mission, "We are servants who provide care and assistance to those in need and act as advocates for systemic change."

In June 2012, SOS received designation as a Federally Qualified Health Center (FQHC) which included designation as a Healthcare for the Homeless Provider. Aside from SOS' FQHC service area, SOS provides comprehensive quality healthcare for all Orange County residents at three clinical sites located in Costa Mesa, Santa Ana and Lake Forest.

- SOS Community Health Center, Costa Mesa is a comprehensive primary care facility, offering medical, dental and mental health services. The medical clinic features six treatment rooms, with an additional three triage stations, lab, and a dispensary. The CHC is also home to the SOS-Hoag Discharge Clinic, Integrated Behavior Health, and Clinical Case Management programs. In addition to health services, the CHC campus houses the SOS Comprehensive Service Center (CSC), providing wrap-around and enabling social services to the SOS clinic patients and the larger Orange County community.
- SOS-El Sol Wellness Center, Santa Ana is located in the heart of Santa Ana on the campus of El Sol Science and Arts Academy. The Wellness Center is a school-based primary care clinic providing healthcare services to the students and families of El Sol, as well as the greater Santa Ana community. SOS was awarded a four-year HRSA grant, one of twelve nationally, to test a model of care for an integrated oral health service delivery in a school-based clinic and create a replicable model of care.
- SOS and PEACE Center Health Clinic opened in August 2012, as a collaborative effort between SOS and Saddleback Church located in Lake Forest. Currently this clinic operates 20-clinical hours per week as a satellite location providing primary health care.
- SOS Pediatric Health Center located in Newport Beach is scheduled to open in July 2014 with healthcare services focusing on obstetrics and pediatrics.

SOS patients represent diverse ethnicities and age groups, with over 90% living at or below 100 percent of the FPL, including seniors on fixed incomes or have disabilities limiting employment options. Accordingly, all services are delivered on a sliding fee schedule based on the FPL table published annually. During October 1, 2012 to September 30, 2013, SOS provided a medical home to 6,654 unduplicated patients accounting for a total of 23, 152 encounters.

Over 40 percent of SOS patients are shared with Hoag, either starting at Hoag and receiving follow up care at SOS or, starting at SOS and referred to Hoag for advanced diagnostics, treatment, surgery, emergency services, or hospital admission. More than 25% of these patients were ER diversions and many of these patients have a chronic disease that needs the complex case management offered by SOS. As well, SOS and Hoag utilize ER Connect, a web-based system and are part of a Health Information Exchange platform allowing for linkage of Hoag discharged patients to SOS as their medical home. Each month SOS refers over 150 uninsured patients to volunteer specialty providers within the Hoag network for care covering the full spectrum of medical specialists.

The extensive and overlapping funding Hoag provides has allowed for SOS to provide exceptional care with a collaborative spirit that is a model in efficient, effective and respectful healthcare. Karen L. McGlinn, SOS Executive Director, praises this extensive hospital-health center connection, stating "this relationship creates a community where healthcare for all becomes the focus of service and sets the standard for others to follow suit."

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Alzheimer's Family Services Center

Orange County's population is aging at a much faster rate than the rest of the state and the nation which means that the close to 80,000 Baby Boomers in Orange County who are currently affected by Alzheimer's disease or another dementia will double across the next 20 years. Demographically, the number of Orange County Latinos and Asians living with the disease will triple in this timeframe, while the number of affected African-American seniors in the county will double. Absent a cure, our community faces the enormous challenge of meeting the complex health and long-term care needs of the impending "Generation Alzheimer's".

Since its founding in 1980, Alzheimer's Family Services Center (AFSC) has held close to the belief that memory-impaired seniors from all ethnic and socioeconomic backgrounds have the right to age with dignity in their own homes for as long as possible. Across the last 34 years, this belief has guided our mission to improve quality of life for families challenged by Alzheimer's disease or another dementia through services tailored to meet individual needs. We understand that caring for a loved one with dementia is a family affair, as 80% of the care that memory-impaired individuals receive at home is delivered by family caregivers (Institute of Medicine, *Retooling for an aging America*, 2008) who often sacrifice their own health and financial wellbeing to take on the responsibilities of eldercare. For this reason, AFSC has developed a continuum of research-based core services that address the needs of both memory-impaired individuals and their family caregivers. At our "one-stop-center" families have access variety of services. Licensed by the California Department of Public Health, AFSC was one of the first Alzheimer's Day Care Resource Centers in California and today maintains the strict guidelines required of centers with this distinction. AFSC's expert staff is equipped to provide compassionate care for persons from the earliest to most advanced stages of dementia. Grounded in the latest research and clinical guidelines, AFSC's services include:

Dementia-Specific Adult Day Health Care (ADHC) – Memory impaired seniors, from the earliest to most advanced stages of dementia, receive compassionate, individualized care daily at AFSC's homelike, dementia-specific facility. Participants benefit from medical, rehabilitative, psychosocial, and nutritional ADHC services based on an individualized plan of care within the context of a stimulating recreational program. AFSC maintains a 1:5 staff-to-participant ratio, far exceeding the minimum ADHC regulatory requirement of 1:8 and the average 1:7 at other centers. Staff members successfully draw out each participant's remaining strengths through a variety of mind stimulating activities, ranging from memory and language exercises to art and pet therapy. Customized care is further available via two innovative tracks of programming:

New Connections Club – Given the efforts of local forward-thinking organizations such as the Hoag Neurosciences Institute, a growing number of seniors in Orange County are being identified at the earlier stages of memory loss. As an affiliate of the Hoag Neurosciences Institute, AFSC is proud to be collaborating on the Orange County Vital Aging Program, which identifies prevalence of mild cognitive impairment (early memory loss) in seniors screened through the project. Although research has repeatedly proven the benefits of early interventions in delaying the progression of dementia, seniors who receive a diagnosis of early memory loss are frequently "turned off" by the general programming at other adult day health care centers. In response to the need for early-stage programs in Orange County, AFSC launched its New Connections Club in 1999,a specialized track of adult day health care services designed for individuals with early memory loss who have the desire, insight, physical capacities, and remaining cognitive abilities to engage in a physically and mentally challenging set of research-based therapeutic activities. Activities include cognitive skills classes (e.g., memory and language exercises), reminiscence, challenging games (e.g., chess, bridge), supportive discussions, and excursions (e.g., a picnic lunch, one-mile walk at the beach). Participants also engage in a newly implemented cognitive exercise class that measures a baseline for cognitive strength and weakness in each participant and tracks performance across several indicators to determine the effectiveness of the program. Participants not only benefit from rich and stimulating programming, but also have the opportunity to socialize with others facing similar challenges. By receiving support from their peers, our New Connections Club participants are able to combat the isolation and depression often experienced by those with memory loss. All care is provided under the supervision of a medical director and coordinated with each participant's primary care physician.

Friendship Club – As individuals' progress from the early into the moderate and severe stages of dementia they are able to transition into a more intensive track of adult day health care programming called the Friendship Club. These participants have more complex medical needs; require more intensive supervision, and greater assistance with activities of daily living (e.g., prompting during meals, assistance with toileting). Our compassionate dementia care professionals successfully draw out each participant's remaining strengths through a variety of activities. Like in New Connections Club, participants benefit from individualized medical, rehabilitative, psychosocial, and nutritional adult day health care services based on a comprehensive plan of care. The Friendship Club is offered Monday through Friday, 7:30 a.m. – 5:30 p.m., with participants receiving breakfast, lunch, and a snack as part of the daily fee. AFSC's mobility manager facilitates transportation to and from the center at no additional charge.

Intensive Care Management – Home care for individuals with severe dementia is exhausting, and may cause mental (e.g., depression, anxiety) or physical health problems, and even increase the risk of premature death, for family caregivers. At AFSC, caregivers of enrolled adult day health care participants, as well as nearly 500 callers annually, receive intensive support to manage the medical, psychosocial, and behavioral complications of dementia from a compassionate team of social workers.

Far exceeding the minimum social work requirement of 3.5 FTE for an adult day health care of our size, AFSC has the capacity to provide every caller with the type of support needed to develop a plan and implement the next step in care. Callers benefit from information and referral, ad hoc telephone and in-person counseling, and relationship-building home visits designed to address high-risk situations (e.g., living alone). Our care managers facilitate access to adult day health care, when appropriate, as well as other AFSC services, including short-term counseling, caregiver support groups, and educational workshops, plus the many community-based services available for caregivers in Orange County. When enrollment in adult day health care occurs, the caregiver is assigned a care manager and nurse who can be called upon as needed. These professionals support the caregiver in developing solutions for everyday challenges, including physician communication.

Support Groups – Caregivers community-wide have access to two free support groups, each offered twice monthly by AFSC in collaboration with the Alzheimer's Association of Orange County. Support groups represent an important vehicle for caregivers to gain knowledge, skills and support from their peers as well as professional leaders. Further, support groups serve as a testing ground for caregivers to "run ideas by" others, particularly when trying to manage a difficult behavior like wandering.

Short-Term Counseling Services – Short-term counseling provides an "extra boost" when a caregiver needs focused support to develop and implement solutions for problems in care. Individual, family, and couples counseling is available to help address problems such as family conflicts over care, negative emotions, and depression. We offer this service in multiple formats (i.e., session-by-session or in sets of sessions).

Community Outreach – Dementia outreach services are designed to educate individuals by providing accurate information about dementia diagnosis, treatment, and available care-related services for at-risk seniors, caregivers, and health care professionals. Outreach efforts range from classes for seniors to participation in health fairs and community events that reach caregivers and at-risk seniors countywide.

All services are provided by an expert staff of 40 professionals rich in cultural, linguistic, and professional diversity. In FY 12-13, AFSC was able to reach unduplicated individuals, as follows:

- 196 unduplicated elders received dementia-specific adult day health care.
- 392 caregivers received intensive care management from a care manager or one of our social work professionals.
- 14 caregivers received clinical counseling from our master's level social workers.
- 75 caregivers attended one or more of our 52 support group sessions led by an Alzheimer's Family Services Center dementia care expert.
- 550 caregivers and at-risk seniors gained knowledge and skills via 21 educational sessions.
- 1,600 community members learned about dementia and available services via 191 community outreach activities.

AFSC's high-quality programs provided highly positive evaluation feedback in FY 12-13:

- 75% of caregivers we serve reported that their loved on functions better mentally since attending our center.
- 87% of caregivers we serve reported that our services help them keep their loved one at home.
- 98% of caregivers we serve reported that their loved one benefits from socializing with other participants.

Deeply embedded within the Orange County community, AFSC has also developed a network of partnerships to advance its mission. Notably, AFSC is affiliated with the Hoag Neurosciences Institute and engaged in joint efforts to improve early identification of memory loss as well as hospital and post-discharge care of patients with dementia. Through its community-wide efforts, AFSC is transforming dementia care from a "nothing can be done" to a proactive approach—one family at a time. Hoag owns the AFSC facility and provides it at no charge, including maintenance services as specified in the lease, to the agency. Additionally, the hospital provides annual operating and transportation grants, and in-kind services such as consultation in nursing and compliance-related issues to the center.

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Newport Mesa Unified School District

Hoag collaborates with the Newport Mesa Unified School District by providing a grant to support staffing at the HOPE Clinic, a school based health center. The HOPE Clinic is a program of Health Services and participates in the Child Health and Disability Prevention Program and the Vaccines for Children Program. Children and families who receive services at the clinic are not charged. Health promotion and well child exams are the cornerstone of the program. The primary focus is to promote wellness and prevent illness through periodic well child exams and routine immunizations. Services are at no cost to families and provided by a bilingual Spanish-speaking staff. Other services include TB screening and testing for students, staff and school volunteers. The clinic also does developmental screening, vision and hearing screenings, dental screening and fluoride application for students. The clinic makes referrals and connects students and their families to resources in our community. The clinic staff are district employees and are familiar with district services and school requirements. One of the clinic's strengths is that the staff knows school requirements and are able to assist families in meeting those requirements for school participation.

The HOPE Clinic is unique in that it is a school based health center located in a community school setting. It is housed on a campus with an elementary school, district run preschool, a Head Start Program, an adult education center run by the district, two after school programs including the Boys and Girls Club and Save Our Youth (SOY) an after school program to prevent gang involvement, and the community theatre. The HOPE Clinic is staffed with Nurse Practitioners, a supervising physician, an Office Assistant and Health Assistant. Dr. Riba's Health Club continued to offer a specialty program addressing childhood obesity, nutrition, and fitness for children and families but their service has been reduced to one day per week. The Children's Health Initiative of Orange County provided an insurance application assistant one day per week. The Reach out and Read Program continued to provide books for our younger patients but they were unable to continue sending a reader for the children.

In May of 2013, the HOPE Clinic was chosen as one of five school based health centers in the state of California to participate in the Hallways to Health grant. This grant is part of a national initiative being led by the National Assembly on School-Based Health Care (NASBHC) and Kaiser Permanente's Thriving Schools campaign. The HOPE Clinic will work collaboratively with community and district partners to facilitate improvement in health behavior among students, their families, and school staff in the areas of obesity prevention, social and emotional wellness, and school employee wellness at Rea Elementary School.

During the 2012-2013 school year, the clinic had over 3186 patient encounters. A total of 894 physical exams were performed. The clinic administered 1331 vaccines and 101 TB tests to children in our district. In addition, 1059 TB tests and 276 immunizations for district employees and volunteers in the district were administered. The clinic performed a total of 447 developmental assessments for children 0 – 5 years utilizing the PEDS and ASQ questionnaires. Parents and/ or guardians were given anticipatory guidance for 1284 children seen in the clinic. Nine hundred and ninety (990) referrals were made for services including dental, vision, hearing, mental health and social services. In addition, referrals were made to Newport Mesa Unified School District for special education assessment and as needed to the Regional Center of Orange County. Over two hundred and fifty seven (257) children were referred for insurance application assistance. The clinic continued to be very involved in the Pertussis (Tdap) campaign to fulfill the new school requirement. Over four hundred individuals received Flu vaccine at the community immunization clinic held on November 17, 2012.

Contact: Natalie Gerdes at 949-515-6725 or ngerdes@nmusd.us

Dr. Riba's Health Club

The primary goal of Dr. Riba's Health Club (DrRHC) is the prevention and treatment of nutrition-related health problems in children and their families. DrRHC utilizes a multidisciplinary team by providing direct patient care and individual treatment programs that are tailored to each child's needs. Offering a variety of programs and services at multiple sites, DrRHC reaches nearly 3,000 families annually. The funding received from Hoag's Community Benefit program was used to see patients at our modular at the Santa Ana Family YMCA and HOPE Clinic (for patients over five), our Fit Club™ after school and summer programs at the YMCA and SOY, uncompensated patient labs, and evaluation of program outcomes. Our Health Club program provides individualized patient care plans delivered by the Pediatrician/Medical Director, a Registered Dietitian, a Case Manager, and a fitness instructor. This program treats the most severe cases in Orange County by educating families on the psychology of feeding, teaching families how to improve nutrition, promoting physical activity, and assessing and treating medical and psychological comorbidities. Our latest evaluation report was conducted in June 2013 and showed that 84.5% of patients significantly improved their BMI percentile.

DrRHC is continuing to positively impact the lives on these in-need children and families by providing these resources and seeing more patients at our sites throughout Orange County. This funding also helped implement the Fit Club™ after school and summer programs. The goal of the Fit Club™ program is to prevent and treat childhood obesity and prevent the onset of type 2 diabetes through health and nutrition education, cooking demonstrations, and physical activity. This program was implemented throughout the 2012-2013 school year and six weeks during the summer at the Santa Ana Family YMCA.

Some program highlights from the past year include:

- Our 2012-2013 after school program showed great success, with 61% of the overweight/obese children significantly improving their BMI percentile. Significant improvements were also found in fitness across the board including situps, pushups, and sit-and-reach.
- Our 2012 summer program was also very successful with 62% of children improving BMI percentile.

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Orange County Department of Education (OCDE) Medical Officer

Hoag's partnership with the Orange County Department of Education's Center for Healthy Kids & Schools is critical to building the health and protecting the future well-being of our County's students. A healthy community supports each child's best chance to fully engage in productive learning in support of their future college and career readiness. Dr. Marc Lerner and the Center's educators, nutritionists, counselors and health professionals deliver consultation on youth-related medical and health issues for the education community.

OC school fitness data demonstrates significant disparities in the levels of childhood obesity across our County. The Center's Move More, Eat Healthy campaign was established last year. The Center team continue to engage teachers, students and community partners through the maintenance of a growing network of classrooms that receive evidence-based tools for the promotion of healthy eating and to increase moderate to vigorous physical activity (now in 300 local schools). In addition to work on this campaign, the OCDE medical officer (MO) has served as co-chair on a project to identify data sources and gaps in the area of childhood obesity, in support of the multi-institutional preventative and treatment efforts for our County's youth. In the last year, additional examples of Center's comprehensive approach to health and wellness programming include:

1. The medical officer and OCDE Center leadership continue to address the behavioral health needs of our County's youth. Projects in the past year included presentations on safe schools and school violence, post-traumatic stress in young children and the link between youth violence and mental health disorders. and expanded trainings for the deployment of evidence-based ' Positive Behavioral Interventions and Supports' which promotes a positive school climate mental health and is shown to impact mental health and bullying prevention.
2. The Medical Officer continues to work (with community partners) on a range of projects in support of student health. Examples include:
    a. Participation on the Waste Not OC Coalition. The MO has joined members of the business, food recovery and public health representatives to respond to the needs of the 153,490 Orange County children who live in food insecure households.
    b. Service on the OC Children's Care Coordination Group which focuses on neonatal ICU graduates with complicated post-discharge care and learning needs. The MO presented to a State-wide care coordination on the pediatrician's role in care coordination for children with special health care needs.
    c. Work on the OC Children's Vision Collaborative: The MO joined preschool health advocates in the development of an innovative effort to find the 6-8% of children ages three to five who are in need of urgent vision eye correction and the two percent with eye medical or surgical problems that need a referral. This work can prevent blindness and support the vision needed for school success.
    d. Participation on the Orange County Health Care Agency's (HCA's) Kids in Disasters (KIDs) workgroup. The MO is a member of the KIDS Pediatrics Behavioral Health Emergencies subcommittee, along with the OCDE Crisis Response Network manager, managers from OC County Behavioral Health and from UC Irvine.
3. The OCDE MO is now a member of the national executive committee of the Council on School Health of the American Academy of Pediatrics and serves on the policy sub-committee.

Contact: Marc Lerner, MD at 714- 327-8186 or mlerner@ocde.us

Oak View Mobile Health Program

The mission of the Oak View Renewal Partnership (OVRP) is to narrow the cultural, social, educational, health, and economic gap between the Oak View community and the remainder of Huntington Beach and Orange County; and to serve as a model for community development.

OVRP was founded in 2005 to focus on the renewal and empowerment of the impoverished Oak View neighborhood in Huntington Beach, California, a one square mile area with a population of approximately 10,000 individuals. While the city of Huntington Beach is a predominantly affluent area with poverty rates hovering near 6%, the rate in our Oak View neighborhood is five-times higher at 32%. The adversity faced by neighborhood residents is further underscored by Oak View's rank of 13 among neighborhoods throughout the *nation*, based on the Rockefeller Institute's "urban hardship index." As a place-based organization, OVRP believes that neighborhood revitalization happens from the ground up – created for, within, and by the community itself. With the larger goal of sustainable change in mind, OVRP continues to seek out and implement programs that can be supported by local, homegrown leadership, and that address systemic issues facing the neighborhood. Unlike more traditional non-profits that focus on a core service or issue, OVRP has adopted a more client-focused and responsive partnership-based service model. In our role cultivating relationships between community partners and residents, we facilitate and incubate projects in their infancy until they become self-sustaining.

In 2012-2013 through OVRP's holistic efforts, over 600 neighborhood youth had access to a positive after-school outlet through the Youth Soccer League; 12 Community Cleanups were hosted, empowering over 500 Oak View residents to demonstrate pride in their neighborhood; 80 residents received job readiness support and 30 residents found successful job placements through our pilot Workforce Development Center; 30 residents regularly participate in the Zumba class; and, over 480 medical and dental services were provided through our Oak View Mobile Health Program.

The Oak View Mobile Health Program began in March 2010 through the catalytic support from Hoag's Community Benefit Program. OVRP facilitated a strategic partnership with Healthy Smiles for Kids, Orange County Rescue Mission's Hurtt Family Clinic and Ocean View High School. This partnership established a resource offering comprehensive health services, operating on Ocean View High School's campus. Though Healthy Smiles and Hurtt Family Clinic have served the county for many years, prior to the Oak View program, they had never integrated their mobile services to target the same community previously.

The program originally began with one clinic day each month, but after the volume of services reached capacity, a second clinic day each month was added. From October 2012 – September 2013 the mobile health program provided approximately 480 dental and medical services to the residents of Oak View and surrounding Huntington Beach communities. The Oak View Mobile Health Program represents a successful model of cross-sectoral partnerships, collectively improving community wellness. As a result of Hoag's generous support and the synergy of these multi-faceted wellness programs, we have created a healthier Oak View community.

Contact: Iosefa Joey Alofaituli at 714-596-7063 or iosefa.ovrp@gmail.com

Senior Transportation

The Community Benefit Program collaborates with seven community senior centers for transportation services for their program participants. These organizations offer a broad range of services including congregate meals, health screenings, and educational, social and physical activities for their participants. In providing transportation services for seniors, we assist them in their efforts to sustain good mental and physical health, and to maintain their independence. The seniors use the transportation services to attend doctor appointments, shop and do errands, and participate in group social activities. The seven organizations served are: Alzheimer's Family Services Center; Costa Mesa Senior Center; Huntington Beach Council on Aging; Irvine Adult Day Center; Newport Beach's Oasis Senior Center; Age Well Senior Services, and Laguna Beach Seniors. Total Hoag expenditures on transportation for FY 2013 was $454,425 for approximately 112,255 senior passenger trips

Appendices

Appendix A **Hoag Hospital Charity Care and Self Pay Discount Policy**

Appendix B **Hoag Hospital Quantifiable Community Benefit for FY2013**

Appendix C **Hoag Hospital Community Benefit Expenditures by Program**

Appendix A

POLICY

CATEGORY: REVENUE CYCLE	Effective Date: See footer
Owner: Executive Director Revenue Cycle	
TITLE: Charity Care and Discount Policy	

PURPOSE:

- A significant component of the mission of Hoag Memorial Hospital Presbyterian (Hoag) is to provide care for patients in times of need. Hoag is committed to assisting patients in need with demonstrated financial hardship and eligible low-incomes through a well-communicated and appropriately implemented discounted payment and charity care program. All patients will be treated fairly, with dignity, compassion, and respect.
- Financial assistance policies must balance a patient's need for financial assistance with the hospital's broader fiscal stewardship.
- Outside debt collection agencies and the hospital's internal collection practices will reflect the mission and vision of the hospital and will be consistent with Health and Safety Code Section 127425.
- Financial assistance provided by Hoag is not a substitute for personal responsibility. It is the responsibility of the patient to actively participate in the financial assistance screening process and where applicable, contribute to the cost of their care based upon their individual ability to pay, consistent with Health and Safety Code Section 127405. Failure to participate in the screening process (e.g. failure to complete applications and/or provide the required supportive documents and materials) may result in an application denial.

SCOPE: Revenue Cycle

AUTHORIZED PERSONNEL: Charity Care Specialist

Description	Responsible Person
1.0 Definitions of Charity Care Services and Discounted Payment Services: 1.1 Charity Care will be provided for the following: 1.1.1 Patients may request that they be screened for possible financial assistance. If such screening establishes that family income is at or below 200% of the Federal Poverty Level (FPL), the patient is eligible for a 100% write-off of their liability for services. 1.2 Charity Care <u>Excludes</u>: 1.2.1 Elective services are generally not eligible for consideration under the Charity Care program. 1.2.1.1 Certain specialty services are excluded under this Policy. Following are a few excluded examples: CDU, cosmetic and gastric bypass services. 1.3 Discounted Care or partial charity care will be provided for the following: 1.3.1 Patients may request that they be screened for possible financial assistance. If such screening establishes that family income is at or below 400% of the FPL, the patient is eligible for reduced rates as described based on the sliding income scale as shown in Section 5.0. 1.4 Presumptive Charity: Payment Assistance Rank Ordering (PARO) Score: PARO is a patient account scoring mechanism, which uses patient demographic data to estimate the financial status of patients by accessing specific publicly available databases. PARO provides estimates of a patient's likely socio-economic status, as well as, the patient's household income and size. The PARO rule set shall be applied	Charity Care Specialist
to those unresponsive consumers who may have likely qualified if they applied at the time of service. These rules are calibrated to reflect the charity care policy of Hoag and replicate the traditional policy for extending charity care. In the absence of additional	

		information provided by the patient, PARO provides the best estimate and approach for extending presumptive charity care to these patients. Hoag recognizes that a portion of their patient population may not engage in the traditional charity care application process and PARO provides an equitable and just method for extending benefits to this population. PARO may also be engaged during the revenue cycle process to confirm patient information or as a method to direct patients to other advantageous sources of charity based assistance. Additionally, PARO may be used to validate financial and demographic information provided by the patient during the Payment Assistance eligibility process and complete the application where such information may be missing.	
	1.5	Emergency physicians means a physician and surgeon licensed pursuant to Chapter 2, Section 2000 of the Business and Professions Code who is credentialed by a hospital and either employed or contracted by the hospital to provide medical services in the emergency department of the hospital, except that an "emergency physician" shall not include a physician specialist who is called into the emergency department of a hospital or who is on staff or has privileges at the hospital outside of the emergency department. Emergency room physicians who provide emergency medical services to patients at Hoag are required by California law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350% of the FPL. Hoag's emergency room physicians will utilize Hoag's Charity Care and Discount Policy approval results to support their compliance with AB 1503.	
2.0	**Charity And Discount Care Guidelines:**		Charity Care Specialist
	2.1	Hoag provides financial assistance to patients who do not have insurance coverage and have family income levels of up to four times the FPL Guidelines. Hoag also gives consideration to eligible patients with insurance if they incur high medical costs as defined by California law, and also have family incomes up to 400% of the FPL.	
	2.2	Business services staff will, as necessary, meet with all patients that have expressed a need for financial assistance to help them determine eligibility for program options. Qualifying patients may be referred to other potential payers such as MSI or Medi-Cal. Patients who may be eligible for such a potential payer programs must make a reasonable, good faith effort to apply for and comply with the rules and requirements of such programs. Failure to do so may result in Hoag's denial of the programs described in this Policy. Those not eligible for such State or other programs may be reviewed for financial assistance under Hoag's programs. Adjustments are made based upon the patient's eligibility level in the programs.	
	2.3	Any patient seeking financial assistance (or the patient's legal representative) shall provide and disclose all information concerning health benefits coverage, financial status, and any other information that is necessary to make a determination regarding the patient's status relative to Hoag's charity care policy, discounted payment policy, or eligibility for government-sponsored programs. Failure to provide true, correct and complete information for this purpose may render a patient ineligible under this Policy. Confidentiality of information and the dignity of the individual will be maintained for all that apply for charitable services.	
	2.4	Charity and discounted care guidelines will be reviewed and adjusted annually according to the FPL Guidelines established by the Department of Health and Human Services (see FPL Table below).	
	2.5	Hoag will define the standards and scope of practices to be used by its outside (non-hospital) collection agencies, and will maintain written agreements from such agencies that they will adhere to such standards and scope of practices.	
	2.6	Hoag or outside agencies operating on behalf of the hospital shall not, in dealing with patients eligible for discounted or charity care use wage garnishments or foreclosure of liens on primary residences as a means of collecting unpaid hospital bills, except as provided by Health and Safety Code sections 127425(f)(2)(A) and (B). This requirement does not preclude Hoag from pursuing reimbursement from third party liability settlement or tortfeasors or other legally responsible parties.	
	2.7	Patients who have an application pending for either government-sponsored coverage or for Hoag's own charity care and financial assistance, will not knowingly be referred to a collection agency prior to 180 days from the date of discharge or date of service.	
	2.8	At the time of billing, Hoag will provide to all low-income uninsured patients the same	

	information concerning services and charges provided to all other patients who receive care at the hospital. 2.9 Patients who have been denied charity care or other discounts may appeal the denial, in writing, within 10 days of receiving the denial. The appeal should include supporting documentation and evidence as to why the appeal is being made and should be sent to the address below: Hoag Memorial Hospital Presbyterian One Hoag Drive, P.O. Box 6100 Newport Beach, CA 92658-6100 Attention: Executive Director Business Services The patient's appeal will be considered and a response with the decision will be mailed to the patient within 10 days of receiving the appeal. All decisions of the Executive Director will be considered final and additional appeals will not be permitted.	
3.0	**Charity Care And Discounted Care (Partial Charity) Eligibility Requirements:** 3.1 The following factors will be considered when determining the amount of discount/write-off provided. 3.1.1 All patients are eligible to apply for financial assistance under the Charity Care and Discount Policy and will be eligible for the reduced rates provided therein if determined eligible for such reduced rates (see Tables below). 3.2 Evidence of eligibility will be requested and must be provided. Patients should be screened for charity or discounted (partial charity) care prior to admission or at time of admission.	Charity Care Specialist
	3.3 Additional considerations will be made such as: 3.3.1 family size, 3.3.2 family income, 3.3.3 amount of hospital and other health care bills during the past year, and 3.3.4 Assets as permitted under state law. 3.4 All payment resources must first be explored and applied including but not limited to third party payers, Medicare, Medi-Cal, Cal-Optima, MSI, and Victims of Crime. 3.4.1 If a patient is eligible for Medi-Cal, any charges for Days of Service Not Covered by the patient's coverage may be written off to charity without a completed financial statement. 3.4.2 Patients unable to pay the total billing for specialty services not covered by their insurance may be considered for charity or discounted care (partial charity) for a portion of the cost if eligible as described above. 3.4.3 Patients unwilling to disclose any financial information during eligibility screening or Medicare/Medi-Cal screening will not be processed under the Charity Care and Discount Policy. 3.4.4 The Executive Director of Revenue Cycle may make discretionary decisions for partial charity or 100% approval write-offs of the liability amounts including extenuating circumstances specific to a patient or family need.	

4.0 Charity Care Discount Table: — Charity Care Specialist

The 2012 Poverty Guidelines for the 48 Contiguous States and the District of Columbia			
People in family	**Poverty guideline**	**200% of Poverty guideline**	**400% of Poverty guideline**
1	$11,170	$22,340	$44,680
2	$15,130	$30,260	$60,520
3	$19,090	$38,180	$76,360
4	$23,050	$46,100	$92,200
5	$27,010	$54,020	$108,040
6	$30,970	$61,940	$123,880
7	$34,930	$69,860	$139,720
8	$38,890	$77,780	$155,560
For families with more than 8 people, add $3,960 to the Poverty Guidline for each additional person			

Sliding Scale Table					
From FPL%	To FPL%	**Discount**		**Liability**	
		Inpatient % of Balance	Outpatient % of Balance	Inpatient % of Balance	Outpatient % of Balance
0%	200%	100%	100%	0%	0%
201%	400%	60%	60%	40%	40%
401%	+	0%	0%	100%	100%

5.0 Self-Pay Discount Eligibility Requirements: — Charity Care Specialist

5.1 Patients who do not qualify for charity care under Hoag's Hospital Charity program and who do not have insurance or those persons with insurance but are requesting a self-pay discount may be considered as "self-pay" and eligible for a discount.

5.2 Cosmetic and excluded procedures are from the discount.

5.3 Payment is due in full at or before services are rendered, unless other arrangements where previously agreed amongst the parties.

6.0 Self- Pay Discount: — Charity Care Specialist

6.1 Thirty-five percent off total billed charges for a discount or predefined service flat rate pricing.

Reference:
Multidisciplinary Review:
Review and/or input for this policy was given by the following:

Appendix B

Hoag Hospital Quantifiable Community Benefit Summary Trend FY 2013

A. Unreimbursed Cost of Direct Medical Care Services – Charity Care

Definition: The direct cost of medical care provided by Hoag; consists of unreimbursed costs (calculated utilizing cost-to-charge ratios) of providing services to the county indigent population, charity care, and care provided to patients identified and referred by the SOS Medical and Dental Clinic

		FY2013		FY2012
Medical Services Indigent (MSI)	$	13,893,000	$	11,889,000
Charity Care-Hospital	$	5,331,138	$	5,132,585
Charity Care-SOS Clinic	$	2,059,130	$	2,556,327
MediCal/Cal Optima Cost of Unreimbursed Care	$	16,304,000	$	14,570,000
Medicare Cost of Unreimbursed Care	$	70,825,000	$	71,122,000
Total Cost of Unreimbursed Direct Medical Care Svcs	**$**	**108,412,268**	**$**	**105,269,912**

B. Benefits for Vulnerable Populations

Definition: Services and support provided to at-risk seniors and children, the indigent, uninsured/underinsured and homeless to facilitate access to preventive and immediate medical care services.

Community Health Services	$	5,510,325	$	4,643,853
Subsidized Clinical Specialty Services	$	134,265	$	227,208
Cash and In-Kind Contributions	$	926,955	$	570,217
Community Building Activities	$	7,414	$	22,573
Community Benefit operations	$	842,054	$	786,250
Total Benefits for Vulnerable Populations	**$**	**7,421,013**	**$**	**6,250,101**

C. Benefits for the Broader Community

Definition: Health education, prevention and screening programs, information and referral services, and supportive services available to community residents.

Community Health Services	$	1,051,629	$	958,595
Health Profession Education	$	382,530	$	261,750
Subsidized Clinical Specialty Services	$	1,072,975	$	750,818
Cash and In-Kind Contributions	$	1,100,783	$	1,070,212
Community Building Activities	$	45,327	$	85,308
Foundation Expenditures for Community Benefit		N/A	$	2,173,798
Total Benefits for the Broader Community	**$**	**3,653,244**	**$**	**5,300,481**
Total Community Benefit and Economic Value	**$**	**119,486,525**	**$**	**116,820,494**
Total Community Benefit and Economic Value (excluding Medicare Cost of Unreimbursed Care)	**$**	**48,661,525**	**$**	**45,698,494**

Notes:

1. Cost of care figures (section A) are estimated, based upon annualized results of 9 months of operations.

2. The 2013 Fiscal Year included 12 months: October 1, 2012 through September 30, 2013

Appendix C

Benefits for Vulnerable Populations

Net CB Expenditure

Community Health Improvement Services

Alzheimer's Family Services Center	$	1,788,705
Case Management- Community Health	$	16,471
Mental Health Center-Community Health	$	747,451
Community Mobile Meals Programs	$	3,142
Lifeline	$	1,936
Newport Community Counseling Center	$	10,000
Newport Mesa Unified School District (HOPE Clinic)	$	250,000
Oak View Community Center Mobile Clinic	$	64,875
Senior Transportation (5 agencies)	$	454,425
SOS Medical and Dental Clinic	$	2,173,320
Total Community Health Services	***$***	***5,510,325***

Subsidized Clinical Specialty Services

ECU Call Panel	$	134,265
Total Subsidized Clinical Specialty Services	***$***	***134,265***

Cash and In-Kind Contributions

Academy of International Dance- Reading Program	$	10,000
Access California Services	$	45,000
Age Well Senior Services	$	75,000
Casa Teresa	$	5,000
Children's Health Initiative of Orange County (One OC)	$	24,000
City of HB-Services for Frail and Homebound Seniors	$	55,000
Clinic in the Park (OneOC)	$	15,000
Costa Mesa Senior Center	$	30,562
Council on Aging Orange County	$	10,000
Dr. Riba's Health Club (One OC)	$	25,000
Girls Inc	$	12,000
Human Options	$	10,000
Irvine Adult Day Health Services	$	10,000
Irvine Children's Health Program (i-CHP) City of Irvine	$	25,000
Juvenile Diabetes Research Foundation	$	35,000
Latino Health Access	$	25,000
March of Dimes	$	5,000
Mardan Foundation of Educational Therapy	$	5,000
MOMS Orange County	$	26,000
Newport Mesa Schools Foundation	$	5,000
Orange Coast Interfaith Shelter	$	10,000
Orange County Department of Education- Medical Officer	$	200,000
Pediatric Adolescent Diabetes Research Education Foundation	$	92,918
Providence Speech and Hearing Center	$	115,000
Save Our Youth (SOY)	$	25,000
Someone Cares Soup Kitchen	$	31,475
Total Cash and In-Kind Contributions	***$***	***926,955***

Community Building Activities

Project SEARCH	$	7,414
Total Community Building Activities	***$***	***7,414***

Community Benefit Operations

Community Health Needs Assessment	$	69,832
Community Health Department Operations	$	240,544
Dedicated Staff	$	521,495
PARO Decision Support (Predictive Modeling for Healthcare)	$	10,183
Total Community Benefit Operations	***$***	***842,054***

Total Benefits for Vulnerable Populations $ 7,421,013

Benefits for the Broader Community

Net CB Expenditure

Community Health Improvement Services

Community Education and Outreach (various Hoag departments)	$	367,676
First Aid Stations at Community Events	$	300
Flu Immunization Clinic Expenses	$	364,121
Freedom from Smoking Program	$	5,000
Health Ministries Program	$	125,013
OB Education	$	25,608
Parkinson's Community Outreach Coordinator	$	77,866
Pastoral Care Bereavement Groups	$	24,744
Project Wipeout	$	61,301
Total Community Health Services	***$***	***1,051,629***

Health Professions Education

California Associations of Hospitals & Health Systems	$	10,000
Cancer Center Social Work Internship	$	8,548
Clinical Care Extender Program	$	158,776
Hospital Case Management Internships	$	81,470
Laboratory Internships	$	9,500
Medical Records Internship	$	3,840
Pharmacy Student Clinical Rotations	$	16,500
Physical Therapy Internships	$	71,896
Sweet Success Express Program (SSEP)	$	22,000
Total Health Professions Education	***$***	***382,530***

Subsidized Clinical Specialty Services

CHOC Pediatric Diabetes Services at the Allen Diabetes Center	$	960,000
ETOH/Psych/Ancillary Patient Transfer Program	$	112,975
Total Subsidized Clinical Specialty Services	***$***	***1,072,975***

Cash and In-Kind Contributions

211 Orange County	$	50,000
Alzheimer's Association	$	10,000
American Heart Association	$	10,000
American Lung Association	$	15,000

CA-HI-NV Exchange Club of OC	$	5,000
CHOC Foundation	$	225,000
City of Newport Beach- Bike Safety Improvement Program	$	10,000
Crohn's & Colitis	$	15,000
Donations to Community Organization	$	55,571
Family Service Team (OneOC)	$	10,000
Friends of Oasis	$	20,000
In-Kind Office Lease for Non-Profits	$	398,685
Invest in Children Fund (One OC)	$	5,000
Irvine Children's Fund	$	20,000
Irvine Public Schools Foundation	$	41,158
Jewish Federation & Family Services	$	4,000
Kiwanis Costa Mesa	$	2,500
Maccabi Games 2013	$	25,368
Merage Jewish Community Center OC	$	10,000
Mothers Against Drunk Driving	$	10,000
Newport Beach Police Explorer Program	$	5,000
Newport Beach Sunrise Rotary Foundation-Families of Wounded Warriors	$	10,000
Orange County Human Relations Council	$	35,000
Orange County United Way	$	69,952
Ovarian Cancer Orange County Alliance (OCOCA)	$	1,000
Pulse Point Foundation	$	2,000
Susan Komen Race for the Cure	$	10,000
UCI Foundation	$	10,000
Youth Employment Services	$	15,549
Total Cash and In-Kind Contributions	***$***	***1,100,783***

Community Building Activities

Community Disaster Readiness	$	35,103
Health Funders Partnership of OC	$	10,224
Total Community Building Activities	***$***	***45,327***

Total Benefits for the Broader Community $ 3,653,244