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# **Hoag Memorial Hospital Presbyterian Community Benefit Report**

## **2017**

**July 1<sup>st</sup>, 2016 – June 30<sup>th</sup>, 2017**

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**OSHPD Facility ID #106301205**

**[www.hoag.org](http://www.hoag.org)**

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**Hoag Memorial Hospital Presbyterian  
Community Benefit Plan 2017**

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## *EXECUTIVE SUMMARY*

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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 and low cost programs to assist the underserved in the community. These include Mental Health Services, Health Ministries Coordination, and a Grants Program. In addition to these services, many other Hoag departments provide community health services including education and support groups which are free to the community.

The Community Benefit program supports 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 \$40 million in Fiscal Year 2017 (July 1, 2016 through June 30, 2017.) 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 FY2017 amounted to over \$53 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 2017.

## CHAPTER I: HISTORY & COMMUNITY BENEFIT STRUCTURE

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### *Introduction*

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The Hoag Memorial Hospital Presbyterian Community Benefit Program was formalized in 1995 and has grown significantly since that time. We have served over 80 nonprofit 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 health care delivery network consists of two acute-care hospitals – Hoag Hospital Newport Beach, which opened in 1952, and Hoag Hospital Irvine, which opened in 2010 – in addition to ten urgent care centers and seven health centers, and has delivered a level of personalized care that is unsurpassed among Orange County's health care 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 is a designated Magnet<sup>®</sup> hospital by the American Nurses Credentialing Center (ANCC) and is fully accredited by DNV. 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, which consists of an orthopedic hospital and two ambulatory surgical centers.

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 specialists and subspecialists in internal medicine, family medicine, pediatrics, geriatrics, acupuncture, neuromusculoskeletal, endocrinology, genetics, rheumatology, diabetes, allergy & immunology and HIV medicine. In 2013, Hoag entered into an alliance with St. Joseph Health to further expand health care services in the Orange County community, known as St. Joseph Hoag Health.

Hoag has been named one of the Best Regional Hospitals in the 2017 - 2018 U.S. News & World Report, and Becker's Hospital Review named Hoag as one of the 2016 "100 Great Hospitals in America" – a designation Hoag has received four times. For an unprecedented 21 years, residents of Orange County have chosen Hoag as one of the county's best hospitals in a local newspaper survey.

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## *History*

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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 15 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](http://www.hoag.org).

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## ***Mission, Vision, and Core Values***

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### **Hoag's Mission**

Our mission as a nonprofit, 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.

#### ***Physician Partnerships***

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.

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## *Community Benefit Philosophy*

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***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 serve them well: 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 (FPL) is defined as a minimum amount of income that a family needs for food, clothing, transportation, shelter and other necessities. According to the FPL Guidelines established by the department of Health and Human Services, the 2016 FPL for a family of four was \$24,600. The current Charity Care and Self-Pay Discount Policy is provided in Appendix A. Appendix B provides a summary of the quantifiable Community Benefit provided by Hoag in FY2017 (July 1, 2016 through June 30,

2017). Appendix C provides a detailed breakdown of the Community Benefit expenditures by program.

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### *Community Health Committee*

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The role of the Community Health Committee ("CHC") 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 Memorial Hospital Presbyterian ("Hospital").

The CHC is a Committee of the Hoag Memorial Hospital Presbyterian Board of Directors (the "Board") and has the primary responsibility of ensuring that Hospital 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. CHC ensures that Hospital is in full compliance with federal and state regulations governing non-profit hospital organizations pertaining to community benefit and health-related activities.

The CHC 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 CHC 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.

## CHAPTER II: COMMUNITY HEALTH NEEDS ASSESSMENT

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### *Overview*

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This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the service area of Hoag Memorial Hospital Presbyterian (HMHP) on behalf of Hoag Memorial Hospital Presbyterian, Newport Beach and Irvine, as well as Hoag Orthopedic Institute, Irvine. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment 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 Community Health Needs Assessment 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.

This assessment was conducted on behalf of Hoag Memorial Hospital Presbyterian by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments such as this in hundreds of communities across the United States since 1994.

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## *Methodology*

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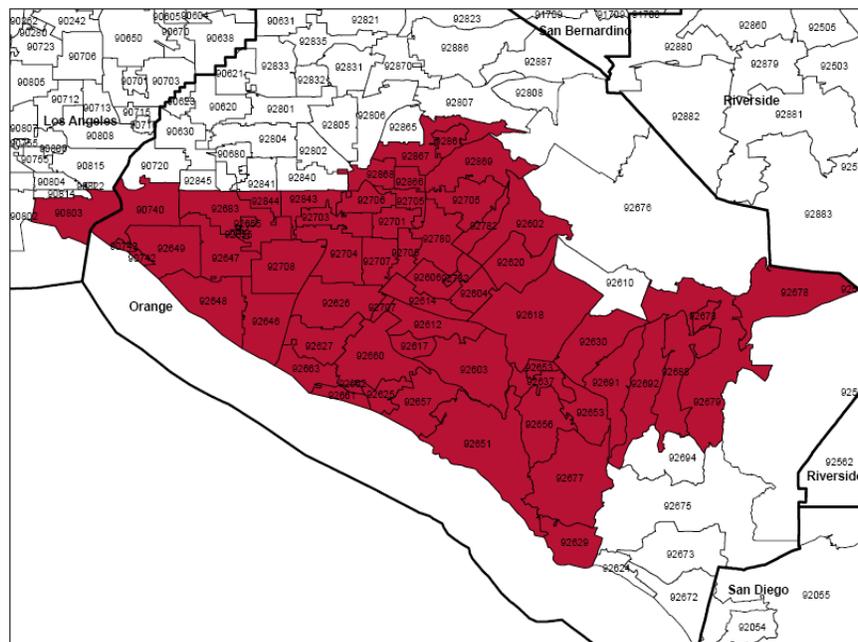
This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for trending and comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through an Online Key Informant Survey. The survey data used in this assessment reflect data collected by PRC on behalf of Hoag Memorial Hospital Presbyterian in 2013.

### *Survey Instrument*

The survey instrument was 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 Memorial Hospital Presbyterian and PRC.

### *Community Defined for This Assessment*

The study area for the survey effort (referred to as the “HMHP Service Area” in this report) is defined as each of the 56 residential ZIP Codes comprising the hospital’s service area. This community definition, determined based on the ZIP Codes of residence of recent patients of Hoag Memorial Hospital Presbyterian, is illustrated in the following map.



## Sample Approach & Design

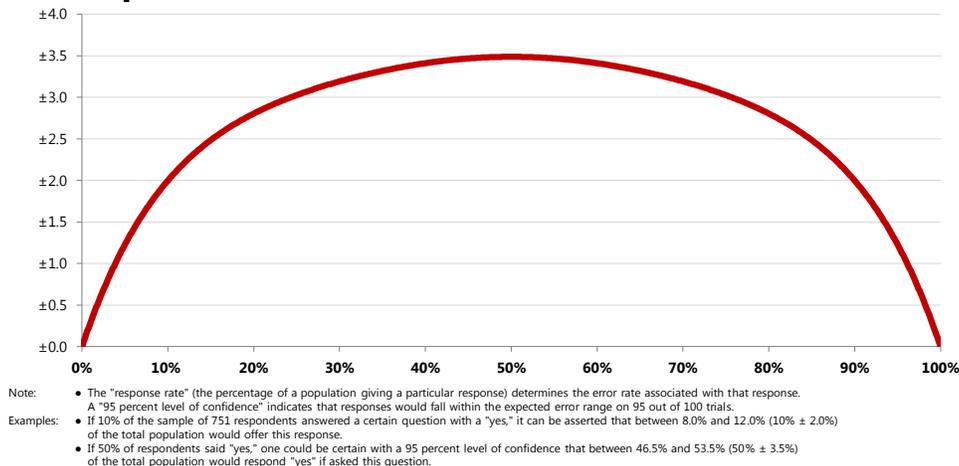
A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — 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 the HMHP Service Area. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

## Sampling Error

For statistical purposes, the maximum rate of error associated with a sample size of 751 respondents is  $\pm 3.5\%$  at the 95 percent level of confidence.

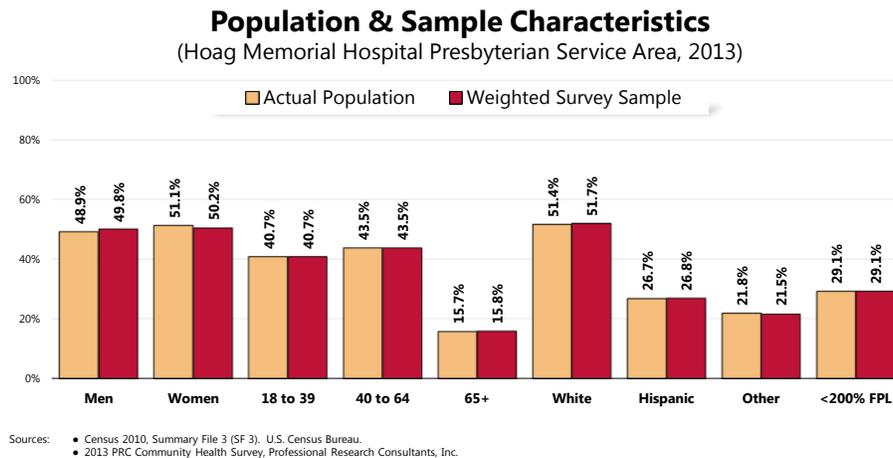
**Expected Error Ranges for a Sample of 751 Respondents at the 95 Percent Level of Confidence**



## Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. And, while this random sampling of the population produces a highly representative sample, it is a common and preferred practice to "weight" the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely gender, age, race, ethnicity, and poverty status) and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual's responses is maintained, one respondent's responses may contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose

demographic characteristics may have been slightly oversampled, may contribute the same weight as 0.9 respondents. The following chart outlines the characteristics of the HMHP Service Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child’s healthcare needs, and these children are not represented demographically in this chart.]



Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (*e.g., the 2013 guidelines place the poverty threshold for a family of four at \$23,550 annual household income or lower*). In sample segmentation: “**very low income**” refers to community members living in a household with defined poverty status; “**low income**” refers to households with incomes just above the poverty level, earning up to twice the poverty threshold; and “**mid/high income**” refers to those households living on incomes which are twice or more the federal poverty level. 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.

### ***Online Key Informant Survey***

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was also implemented as part of this process. A list of recommended participants was provided by Hoag Memorial Hospital Presbyterian; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. 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. Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation.

In all, 151 community stakeholders took part in the Online Key Informant Survey, as outlined below:

Online Key Informant Survey Participation		
Key Informant Type	Number Invited	Number Participating
Physicians	11	6
Public Health Experts	16	7
Other Health Providers	59	22
Social Service Providers	157	82
Business and Community Leaders	60	34

*Input was gathered from several individuals whose organizations work with low-income, minority populations, or other medically underserved populations:*

***Minority populations represented:***

*African-Americans, American Indian/Alaskan Native, Asians, blind/low vision, Cambodians, Caucasians, children, children of prisoners, Chinese, disabled, elderly, ESL, families, Filipinos, foster children, hard-to-reach, Hispanics, homeless, immigrants, Iranians, Japanese, Jewish, Kenyan, Korean, LGBT, low-income, Marshallese, MediCal, Medicare, mentally-ill, middle class, Middle Eastern, multiracial, non-English-speaking, other ethnic demographics, Pacific Islander, Persian, political refugees, pregnant women, Somalian, teen parents, the underserved, the undocumented, uninsured/underinsured, veterans, victims of abuse, Vietnamese, women, young adults*

***Medically underserved populations represented:***

*African-Americans, all populations, those with Alzheimer's/dementia, Asians, blind/low-vision, Cambodians, Caucasians, children, children of prisoners, diabetics, disabled, elderly, eligible public program recipients, families, foster children, high-risk for unprotected sexual activity, Hispanic, homebound, homeless, immigrants, Koreans, LGBT, low education level, low-income, Medicaid, MediCal, Medicare, mentally ill, Middle Eastern, MSI, newly-insured, non-English-speaking, non-seniors (don't Qualify for SSD), pregnant women, severe traumatic histories, substance abusers, teenagers, undocumented, unemployed, uninsured/underinsured, veterans, "working-poor" families, young adults*

Participants include representatives of the following organizations:

211  
AIDS Services Foundation Orange County  
Alzheimer's Association  
Alzheimer's Family Services Center  
American Diabetes Association  
American on Track  
Boys & Girls Club of Santa Ana  
Care Connections Network  
Casa Teresa Inc.  
City of Irvine  
Cordula Cares  
Families Forward  
HCA  
Hoag Memorial Hospital Presbyterian  
Hoag Mental Health Center  
Illumination Foundation  
Irvine Children's Fund  
Irvine Public Schools Foundation  
Kid Healthy  
Laguna Beach Seniors  
Latino Health Access  
Local Law Enforcement  
March of Dimes  
MOMS Orange County  
Newport-Mesa Unified School District  
Orange Coast Unitarian Universalist  
Orange County Health Care Agency, Public Health Svcs  
Providence Speech and Hearing Center  
Seneca Family of Agencies  
SeniorServ

*NOTE: These findings represent qualitative rather than quantitative data. The groups were designed to gather input from participants regarding their opinions and perceptions of the health of the residents in the area. Thus, these findings are based on perceptions, not facts.*

### ***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 (specific citations are included with the graphs throughout this report):

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  
*\*Note that secondary data reflect county-level data (Orange County)*

## ***Benchmark Data***

### *California Risk Factor Data*

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data are reported in the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trend Data* published by the Centers for Disease Control and Prevention and the US Department of Health & Human Services. State-level vital statistics are also provided for comparison of secondary data indicators.

### *Nationwide Risk Factor Data*

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2011 PRC National Health Survey*; the methodological approach for the national study is identical to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

### *Healthy People 2020*



Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. The Healthy People initiative is grounded in the principle that setting national objectives and monitoring progress can motivate action. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:

- Encourage collaborations across sectors.
- Guide individuals toward making informed health decisions.
- Measure the impact of prevention activities.

Healthy People 2020 is the product of an extensive stakeholder feedback process that is unparalleled in government and health. It integrates input from public health and prevention experts, a wide range of federal, state and local government officials, a consortium of more than 2,000 organizations, and perhaps most importantly, the public. More than 8,000 comments were considered in drafting a comprehensive set of Healthy People 2020 objectives.

## **Information Gaps**

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be

recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly a great number of medical conditions that are not specifically addressed.

## *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 this 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 (see also the summary tables presented in the following section).

<b>Areas of Opportunity Identified Through This Assessment</b>	
<b>Access to Health Services</b>	<ul style="list-style-type: none"> <li>• Lack of Health Insurance Coverage               <ul style="list-style-type: none"> <li>○ Insurance Instability</li> <li>○ Supplemental Coverage (Seniors)</li> </ul> </li> </ul>
<b>Cancer</b>	<ul style="list-style-type: none"> <li>• #2 Leading Cause of Death</li> </ul>
<b>Dementias, Including Alzheimer's Disease</b>	<ul style="list-style-type: none"> <li>• Alzheimer’s Disease Deaths</li> <li>• <i>Dementias/Alzheimer’s Disease ranked as the #4 top concern among key informants.</i></li> </ul>
<b>Diabetes Mellitus</b>	<ul style="list-style-type: none"> <li>• <i>Diabetes ranked as the #2 top concern among key informants.</i></li> </ul>
<b>Heart Disease &amp; Stroke</b>	<ul style="list-style-type: none"> <li>• #1 (Heart Disease) and #4 (Stroke) Leading Causes of Death</li> </ul>
<b>Immunization &amp; Infectious Diseases</b>	<ul style="list-style-type: none"> <li>• Pneumonia/Influenza Deaths</li> </ul>
<b>Mental Health &amp; Mental Disorders</b>	<ul style="list-style-type: none"> <li>• <i>Mental Health ranked as the #1 top concern among key informants.</i></li> </ul>
<b>Nutrition, Physical Activity &amp; Weight</b>	<ul style="list-style-type: none"> <li>• Children’s Computer Time</li> <li>• <i>Nutrition, Physical Activity &amp; Weight ranked as the #3 top concern among key informants.</i></li> </ul>
<b>Substance Abuse</b>	<ul style="list-style-type: none"> <li>• Adults Seeking Professional Help</li> <li>• <i>Substance Abuse ranked as the #5 top concern among key informants.</i></li> </ul>
<b>Tobacco Use</b>	<ul style="list-style-type: none"> <li>• Smoking Cessation Attempts</li> </ul>

## Prioritization of Health Needs

On May 27, 2015, a total of 37 community stakeholders met to evaluate, discuss and prioritize health issues for the community, based on findings of the 2015 PRC Community Health Needs Assessment (CHNA). This group included both health providers and representatives of various community organizations. Professional Research Consultants, Inc. (PRC) began the meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see Areas of Opportunity above).

Following the data review, PRC answered any questions and facilitated a group dialogue, allowing participants to advocate for any of the health issues discussed. Participants were then provided an overview of the prioritization exercise that followed.

In order to assign priority to the identified health needs (i.e., Areas of Opportunity), a wireless audience response system was used in which each participant was able to register his/her ratings using a small remote keypad. The participants were asked to evaluate each health issue along two criteria:

**Scope & Severity** — The first rating was to gauge the magnitude of the problem in consideration of the following:

- How many people are affected?
- How does the local community data compare to state or national levels, or Healthy People 2020 targets?
- To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?

Ratings were entered on a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).

**Ability to Impact** — A second rating was designed to measure the perceived likelihood of the hospital having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc.

Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

Individuals' ratings for each criteria were averaged for each tested health issue, and then these composite criteria scores were averaged to produce an overall score.

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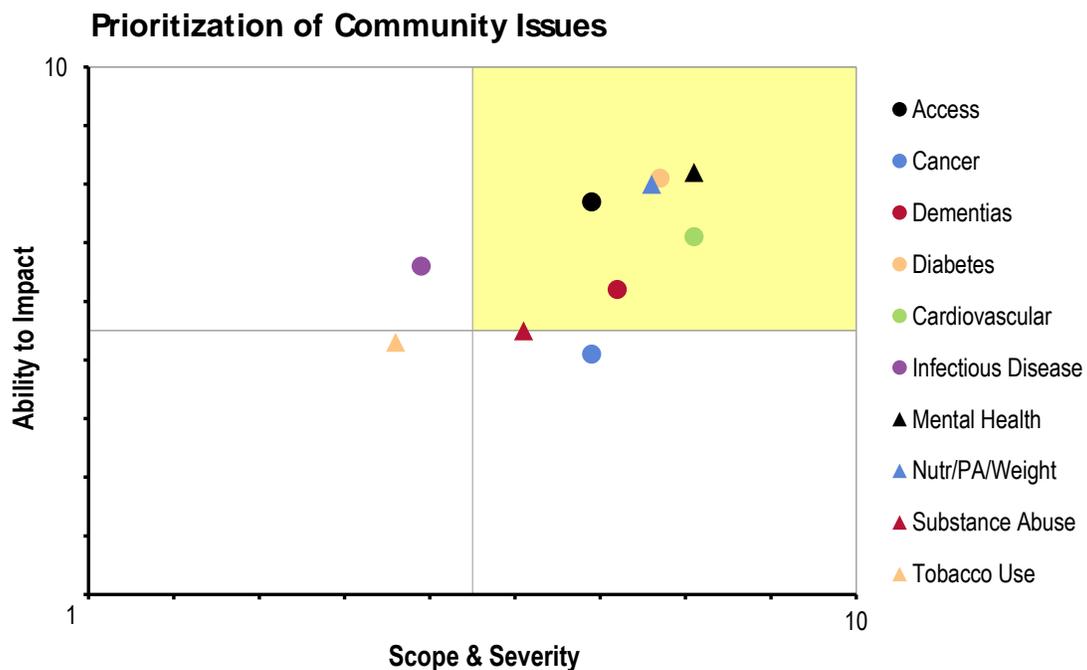
## *Priority Health Issues*

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This process yielded the following prioritized list of community health needs:

- Mental Health**
- Diabetes**
- Nutrition, Physical Activity & Weight**
- Heart Disease & Stroke**
- Access to Healthcare Services**
- Dementias, Including Alzheimer's Disease**
- Cancer**
- Substance Abuse**
- Immunization & Infectious Diseases**
- Tobacco**

Plotting these overall scores in a matrix illustrates the intersection of the Scope & Severity and the Ability to Impact scores. Below, those issues placing in the upper right (shaded) quadrant represent health needs rated as most severe, with the greatest ability to impact.



While the hospitals will likely not implement strategies for all of these health issues, the results of this prioritization exercise will be used to inform the development of the hospitals' Implementation Strategies to address the top health needs of the community in the coming years.

## CHAPTER III: 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 FY2017: July 1, 2016- June 30, 2017.

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### *Mental Health Center*

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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 clients are low-income, uninsured and highly vulnerable and present with a mild to moderate level of distress/symptomatology. These clients have limited health insurance with no mental health/behavioral health benefits or they have benefits but cannot afford the co-payments and/or deductibles.

During FY 2017, the program employed seven full-time bilingual Master's prepared social workers, 5 of the staff are licensed. These social workers provided mental health services to 802 clients in the form of psychotherapy. Resource brokering, and/or case management was provided to 179 individuals. In addition, the program offered psychotherapeutic, psycho educational groups and community presentations which resulted in 2,709 encounters. 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 at a nominal fee per session. 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 average client age for our adult population was 38.9 years of age and the average age of the minor population was 14.8 years of age. 59% percent of the adult clients and 45% of minor clients reported having an annual household income below \$20,000. 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 assessment 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 2017, the Mental Health Center provided a supervised clinical internship training program for 9 MSW (Master of Social Work) students. The center collaborates with the University of Southern California, California State University at Fullerton and California State University at Long Beach. Each intern was provided with weekly one hour long supervision and one and a half hour long group supervision for a total of 351 direct clinical supervision hours provided to the group. The internship program includes providing 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. Lastly, the Mental Health Center's part time Psychiatrist had 313 consultation appointments during the fiscal year.

**Contact: Rocio Valencia Vega, LCSW at 949 764-8547 or [rocio.valenciavega@hoag.org](mailto:rocio.valenciavega@hoag.org)**

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### *Community Benefit Grants Program*

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Hoag's Community Benefit Grants Program serves to reinforce Hoag's mission as a non-profit, faith-based hospital, providing the highest quality health care services to the community. The Community Benefit Grants Program focuses on meeting the unique needs of Orange County residents, with particular emphasis upon the disadvantaged and underserved. Every year, the program provides grants to community organizations who strive to meet the health and social service related needs of the Orange County community.

Eligibility for the program is dependent on the organization and the program funding is sought after. The eligibility criteria consist of:

- Organization must have operations in Orange County, CA
- Must be 501(c)(3) tax exempt organization, local government entity, or education institution
- Services are provided to disadvantaged and/or underserved populations
- Services must align with at least one of the four Priority Areas listed
- Services are provided within the geographic boundaries of Orange County, CA
- Priority will be given to organizations that recognize the need for partnership and collaboration with other organizations that are meeting critical needs

The Priority Focus Areas are determined by the Community Health Needs Assessment, conducted every three years. The needs are identified first through secondary data for the county, and then narrowed to significant health needs using input from persons representing the broad interests of the community, as well as persons with special knowledge or expertise in public health. The significant health needs are then prioritized into the Priority Focus Areas that the hospital will plan on addressing through programming and services. The 2017 Priority Focus Areas for the Community Benefit Grants Program were:

- Access to Care for Vulnerable Populations
- Chronic Disease Management
- Mental Health
- Preventive Health

The grant terms span the fiscal year, from July 1, 2016 – June 30, 2017. Funds must be used specifically for the designated program outlined in the grant application. Organizations that do receive funding are required to submit a 6-month progress report, as well as a final outcomes report.

During FY17, 98 grants were funded, with the following breakdown for the Priority Focus Areas:

Priority Area	Grant Count
Access to Care for Vulnerable Populations	38
Chronic Disease Management	8
Mental Health	17
Preventive Health	35
<b>Grand Total</b>	<b>98</b>

**Contact: Lauren Tabios, MPH at (949) 764-5321 or [Lauren.Tabios@hoag.org](mailto:Lauren.Tabios@hoag.org)**

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### *Health Ministries*

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Hoag Health Ministries has 65 volunteer RNs that serve communities locally, nationally and internationally through the Faith Community Nursing Program. Celebrating the thirtieth year of providing care to faith communities, the FCNs dedicate their time and service to those in need at 41 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 cost-effective individual and population health based preventive health programs specific to the needs, beliefs and practices unique to their faith traditions.

During FY 2017, Health Ministries

- Included 10 denominations amongst the 41 Faith Based Partnerships, located within a 300 square mile area throughout Orange County
- Welcomed 5 new churches into the program
- Donated countless volunteer RN hours at the local, national and international level

- Touched the lives of more than 14,000 congregants:
- 14% served through individual case management
- 42% received group clinical services – Flu vaccines, BP screenings, Blood Drives
- 26% participated in community health education programs
- Other services included home/hospital visits, program planning & volunteer coordination
- Administered 8,312 flu vaccine doses to faith members and the community
- Served 332 congregants with spiritually based aging and dementia care lectures
- Trained 143 persons in life-saving CPR & Automated External Defibrillator usage

#### During FY 2017 Nursing Outreach

- Provided a Foundations of Faith Community Nursing course; trained and commissioned 24 FCNs in the 36 hour course at Hoag and St Mary's in Apple Valley
- Provided the annual Spirituality Conference, 'The Power of Spiritual Support in Health and Healing', attended by 166 health care professionals, religious leaders and caregivers
- Hosted the Westberg on the Road conference for Faith Community Nurses. Hoag was the first national site to host the regional meeting, attended by 72 FCNs.

Faith Community Nurses, the umbrella term for Parish, Congregational and Crescent Nurses, can 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 – Assists with health care assessments and guides options, provides information and clarification on health and medication concerns, organizes classes on specific health topics.
- 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 St. Joseph Hoag Health Hospitals, local cities, Alzheimer's Family Center and a host of other community 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-BC, MPH at (949)764-6594 or [Susan.Johnson2@hoag.org](mailto:Susan.Johnson2@hoag.org)**

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### *Project Wipeout*

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Project Wipeout was created to provide beach and water safety information to the nearby beach communities after seeing an increased incidence of spinal cord injuries in the Hoag Newport

Beach Emergency Department. The program was developed to provide education highlighting prevention of spine injuries. Over time, education efforts have transitioned towards overall injury prevention and beach and water safety for both beach safety service providers and for the general public. Education topics include rip current safety and escape, marine animal behavior and safety, best practices in the water, and sun protection.

Project Wipeout partners and collaborates with members of the beach safety community, which includes the lifeguard and fire department for the county and city agencies throughout Orange County, as well as the California Surf Life Saving Association and other lifesaving agencies. Additionally, Project Wipeout works closely with the Orange County Lifeguard Chiefs Association, as well as the Orange County Drowning Prevention Taskforce, as part of multiple county-wide collaboratives.

In FY17, Project Wipeout hosted the annual Lifeguard Education Symposium, with almost 300 lifeguards and fire personnel from all over Orange County in attendance. The conference continues to grow each year, and serves as an opportunity for lifeguards and other first responder service providers to receive education on current beach and water safety information, that can be integrated into their training and safety responses. Additionally, the conference intends to address health and wellness topics pertinent to beach exposures for personnel working and responding on the beach.

For most of FY17, programming for Project Wipeout has been under evaluation, to better identify and determine what the needs are for the beach community, and how can Project Wipeout address them. A needs assessment of the beach community was conducted, which included input from stakeholder's representative of every lifesaving agency in Orange County and Hoag Hospital. From this needs assessment, Project Wipeout created a governing structure, where representatives from lifesaving agencies throughout Orange County would sit on, as members of an Advisory Committee. This committee would serve as content experts and programming oversight for Project Wipeout, as the program begins planning and development for a school-based curriculum.

During FY17, Project Wipeout's main community outreach took place at large county events, which included Imaginology and Public Safety Day in Newport Beach. Altogether, these events allowed for thousands of interactions between lifeguards, educators, children, and families that included distribution of beach safety materials. Materials include video segments available for class presentations, as well as printed materials such as brochures, coloring books, activity books, and rip current posters. In addition to these large events, Project Wipeout materials are used by local lifeguards at each agency's headquarters, both as education materials for beach visitors and as training for the junior guard programs. Materials are available in both English and Spanish, and have been previously sent out nationally and internationally, as teaching tools for different water safety agencies outside of California, such as within New Zealand and Baja California. All materials are available to download for free from the Hoag Project Wipeout website: [www.hoag.org/projectwipeout](http://www.hoag.org/projectwipeout).

**Contact: Lauren Tabios, MPH at (949) 764-5321 or [Lauren.Tabios@hoag.org](mailto:Lauren.Tabios@hoag.org)**

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## *Melinda Hoag Smith Center for Health Living*

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The city of Costa Mesa has been identified as a resource desert due to an absence of sufficient resources to address key health determinants in the community. In order to help address these health determinants in our community, Hoag has created a synergistic model of service delivery, which not only addresses the lack of resources but also seeks to bridge gaps between services. This service delivery model has helped facilitate collaboration and build capacity in our community partner agencies, by providing non-profit partners with physical space and resources within the Melinda Hoag Smith Center for Healthy Living. Since opening in 2016 our collaborative has grown extensively and now includes the following:

Hoag's Mental Health Center	211
Hoag's Health Ministries	Alzheimer's OC
SOS Children & Family Health Center	Orange County Vital Aging Program
SOS Dr. Robert & Dorothy Beauchamp Child and Family Dental Center	Big Brothers Big Sisters Spin
ASPIRE	Project Self Sufficiency
OC Public Health Nursing	Epilepsy Support Network
Public Law Center	CIELO
National Alliance for the Mentally Ill	Vital Aging
Be the Change Yoga	Moms Orange County
Council on Aging OC	Raise Foundation
Susan G. Komen OC	Human Options
Youth Employment Services	Girls Inc.
	Children's Bureau

The Melinda Hoag Smith Center for Healthy Living has provided space to like-minded community agencies, who seek to improve the quality of lives of those in the community. A key component which makes the collaborative unique and is essentially the glue between the community and the center, is our centralized registration and case management team. The team assures that all client's coming into the center fill out a screener which seeks to identify; socio-economic stressors, potential health risks, mental and emotional health issues, legal issues, access to health care, and other life stressors that can affect ones quality of life.

The case-management team plays a critical role in linking clients to the appropriate services, while also monitoring client's progression through the referral process. This model for service delivery helps bridge gaps between community, clients and agencies, while also leveraging resources and the fostering collaboration between organizations. The Melinda Hoag Smith Center for Healthy Living's co-location of resources has created a cohesive, one-stop, welcoming environment where community members can find a breadth of services and support. This year this collaborative was able to provide the following services to individuals and families.

In FY17, programming for the Melinda Hoag Smith Center for Healthy Living resulted with the following outcomes:

<p>Life skills</p>	<p>194 people were CPR certified</p> <p>This helps with job security and job placement for several nannies, child care workers, and preschool teachers.</p>
<p>Health driven classes focusing on improved health and decrease in obesity</p>	<p>2164 encounters for yoga</p> <p>4012 encounters for Zumba</p>
<p>Education and support to individuals and families affected by mental illness</p>	<p>990 people participated in a NAMI class/support group</p>
<p>Youth support services</p>	<p>653 encounters for Girls Inc. after school homework lab and STEM activities (boys and girls)</p>
<p>Diversion programs targeting at risk youth</p>	<p>170 teenagers participated in OC Bar Foundation’s diversion programing – Short Stop and Stop Short of Addiction</p>
<p>Adult Education</p>	<p>417 encounters for our adult ESL classes</p>
<p>Women’s Health</p>	<p>59 women attended our women’s conference</p>
<p>Legal aid and representation</p>	<p>32 people have received legal consultation or representation from the Public Law Center</p> <p>Free legal representation is key because this is the service that is in highest demand and is least available in the community, focusing on Family Law – divorce, DV, child custody etc.</p>
<p>Nutrition</p>	<p>1480 families have received food at our food distribution</p>

## CHAPTER IV: OTHER HOAG COMMUNITY BENEFIT ACTIVITIES

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### *The Mary & Dick Allen Diabetes Center*

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In 2015, 30.3 million Americans had diabetes in which 24% were undiagnosed, and there was an estimated 1.5 million new cases of diabetes diagnosed among adults (CDC, National Diabetes Statistics Report, 2017). Nonetheless, diabetes and pre-diabetes can be managed through expert medical care and embracing lifestyle modifications, and the Mary & Dick Allen Diabetes Center (referred to as “the Center”) provides education and support for patients, providers, and the community. Since its opening in 2009, the Center has offered comprehensive services that include health education and support from certified diabetes educators, nurses, dietitians, and clinical social worker, medication management by our pharmacist and nurses, and medical consultation and evaluation by our endocrinologist. The Center has also participated in various outreach events including lectures at local senior centers, diabetes risk assessments at health fairs, and cooking demonstrations in the community.

#### **Program highlights from FY 2017:**

Staffing: Addition of Patient Educator RN, CDE: Stephanie Decker, RN, CDE

#### Services:

- 6-8 weeks postpartum oral glucose tolerance test offered at Center free to patients with referral
- In partnership with PADRE Foundation, peer support groups for youth/young adults with T1D and families offered quarterly
- Peer support groups for T2DM offered monthly
- Diabetes Prevention Program offered (Viviendo Saludable, Healthy Lifestyle Program for those with Prediabetes)
- Psychosocial assessments for all new patients with diabetes

#### ***Research Studies***

The Center has pursued various research studies in FY2017 lead by Harsimran Singh, PhD, clinical research scientist and health psychologist. Dr. Singh presented Study #1 as a moderated poster presentation at the annual American Diabetes Association conference on June 10<sup>th</sup>, 2017.

**Study #1:** Delivery Outcomes, Emergency Room Visits, and Psychological Aspects of Gestational Diabetes: Results from a Community Hospital Multi-ethnic Cohort

Certain ethnic groups are disproportionately burdened with gestational diabetes (GDM). Significant gaps exist in our understanding of their clinical and psychological needs. We performed a retrospective cohort study of 647 women with GDM from community hospital.

Sample represented ethnically diverse mix. Multivariable logistic regression models examined ethnic differences in maternal and neonatal outcomes. Semi-structured interviews were conducted with 29 women from the cohort to evaluate experiences of GDM and perceptions of type 2 diabetes risk. Interviews were tape-recorded and transcribed verbatim for qualitative analyses. Significant differences were identified between ethnic groups in mother's age, education, BMI, pre-conception weight, diabetes family history, ER utilization, cesarean delivery and baby birth weight. Hispanic women were more likely to deliver by Cesarean (OR 95% CI 2.45 [1.49, 4.05],  $p < 0.001$ ) and utilize ER during pregnancy (OR 95% CI 2.86 [1.32, 6.21],  $p = 0.008$ ). Association between Hispanic ethnicity and Cesarean delivery persisted in an adjusted model controlling for mother's age, BMI, education level, ED utilization during pregnancy and diabetes family history (aOR 95% CI 2.06 [1.19, 3.55],  $p = 0.010$ ). Adjusting for maternal age and education, marginal effect of Hispanic ethnicity persisted (OR 95% CI 2.07 [0.91, 4.69],  $p = 0.083$ ), for ER utilization. Interview analyses reflected strong psychological impact of GDM diagnoses. Women expressed shock and disappointment over diagnoses, highlighted need for psychological support from healthcare professionals including more sensitive ways to report diagnosis, and indicated difficulties with the recommended lifestyle changes. Risk perceptions for type 2 diabetes were low. Study results emphasize need for improved psychological support for GDM women including implications for clinical care.

***Study #2:*** Feasibility and preliminary efficacy of *Viviendo Saludable*: A community based lifestyle program targeting diabetes prevention and psychological well-being in Hispanic women with pre diabetes.

This study was conducted in collaboration between the Mary & Dick Allen Diabetes Center and the Melinda Hoag Smith Center for Healthy Living. The design included a single arm, prospective, intervention trial involving 34 Hispanic women with pre diabetes. This included a formal consent, and group in-person sessions focusing on culturally sensitive information around physical activity, nutrition, and psychological health. Each of these sessions was followed by a maintenance week where participants were encouraged to practice the information that had been provided. The program and curriculum were developed in Spanish and delivered by four Spanish-speaking instructors including social workers, a registered dietitian certified diabetes educator, and a public health professional. The primary focus of the intervention was to empower participants to take charge of their health (both physical and psychological) and implement necessary changes in their lifestyle to achieve the desired health outcomes. The research team is currently analyzing outcomes data and hopes to present the study outcomes at a national health conference next year.

### ***Diabetes Self-Management Training/Education (DSMT/E)***

Diabetes Self-Management Training/Education (DSMT/E) and Medical Nutrition Therapy (MNT) are the core functions of the Center in which participants learn to live successfully with diabetes through guidance from our dedicated physician, certified diabetes educators, nurses, dietitians, and clinical social worker. In FY2017, there were 1378 total DSMT encounters and 772 MNT visits. 149 patients were provided free care.

### ***Ueberroth Family Program for Women with Diabetes (Sweet Success)***

Expectant mothers with diabetes prior to pregnancy and those diagnosed with gestational diabetes, who are at higher risk of developing Type 2 diabetes after pregnancy, benefit from pre-conception family planning, diabetes education, as well as ante-partum and post-partum glucose management. In FY2017, we had a total 767 unique patients and a total of 2351 encounters. Macrosomia rate was 7%, which is lower than the national average of 10%. The Center offers free oral glucose tolerance testing (OGTT) 6-12 weeks postpartum. In FY2017, 131 patients came to receive their OGTT at the Center.

### ***Annual Diabetes Nursing Conference***

The Annual Diabetes Conference titled “Diabetes: What’s new? What’s next?” was held on October 29<sup>th</sup>, 2016. There were 110 attendees which included Certified Diabetes Educators, Pharmacists, Registered Nurses and Registered Dietitians. This one-day conference provided information on diabetes management and topics that included emerging adults with type 1 diabetes, diabetes medication management, new approaches to hypertension and peripheral artery disease, and culturally sensitive nutritional and clinical management of pregnancy and diabetes.

### ***CHOC Children’s Services at the Allen Diabetes Center***

Children’s Hospital of Orange County (CHOC) Diabetes and Endocrine Center at the Allen Diabetes Center provides pediatric specialty care services for patients with diabetes. This program provides clinical services, health maintenance and treatment, and outreach for children considered at risk for developing diabetes. In FY2017, there were a total of 2321 clinical encounters. Prevention of Obesity and Diabetes through Education Resources (PODER) offers no-cost diabetes and obesity prevention education programs, cooking classes and Zumba exercise classes. PADRE (Pediatric Adolescent Diabetes Research Education Foundation) provides support to Type 1 diabetic patients and to their families through events and educational workshops. 6482 participants joined the PODER classes, and 114 participants were involved in the PADRE classes.

### ***Herbert Family Program for Young Adults with Type 1 Diabetes***

The Herbert Family Program focuses on catering to the unique needs of young adults with Type 1 Diabetes (ages 18-30). The program addresses various aspects including the financial, psychological, social and physical changes that challenge the young adult, their family, and support systems. We hosted First Fridays with a consistent attendance of 10-15 emerging adults in which these are held monthly.

### ***Outreach Events***

This past year, approximately 935 people participated in the Sweet Life cooking classes. During these classes, a professional chef and certified diabetes educator provide insight on recipes and healthy eating to help manage diabetes or pre-diabetes. Our educators have participated in various health fairs and senior centers by providing health education, presented lectures to the community, conducted risk assessments at health fairs, and have been present at various health fairs and outreach events.

**Contact: Eunice Lee, MS, MPH; [Eunice.Lee@hoag.org](mailto:Eunice.Lee@hoag.org); 949-764-8065**

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## *OB Education*

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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 department supports families throughout the exciting journey of pregnancy and parenthood. Board certified lactation consultants who are also experienced registered nurses assess, educate and support new couples and their infants in breastfeeding following delivery in the hospital and in the out-patient breastfeeding clinic. They provide breastfeeding consultations in the hospital 365 days per year and Monday through Friday from 9:00am - 4:00pm in the out-patient clinic. These nurses also teach a comprehensive selection of prenatal classes including: Prepared Childbirth, Breastfeeding (offered in person and also in an eLearning format), Baby Care Basics, Baby Saver (infant first aid and CPR) and Multiple Miracles which is a class for couples expecting twins, triplets, quadruplets and more. This year OB Ed nurses partnered with Hoag's Center for Health Womanology program to create a Pre-Birth Boot Camp for Couples class. This new full day session includes a Breastfeeding, Baby Saver and pelvic floor preparation and recovery class. The pelvic floor care class is taught by a licensed physical therapist that is specially trained in female pelvic floor issues. Several other programs are offered at no cost to the community and include car seat safety, couples 4th Trimester class, hospital orientation and maternity unit tours.

Hoag's Community Benefit program promotes community mental health through support of a weekly Post-Partum Adjustment and Perinatal Loss group and a biweekly Pregnancy after Loss group. These groups are lead and facilitated by a licensed clinical social worker whose professional fees are funded by the Community Benefit program. In 2017, the groups provided services to 494 postpartum women reflecting a 6% increase from 2016 and are offered at no cost to the community. They provide ongoing support, education, and a safe setting to discuss the new challenges of parenthood. Support persons and babies are welcome. In addition to that, the Community Benefit program provides breastfeeding supplies to women that are cared for in OB Education's out-patient breastfeeding clinic.

Hoag's Babyline is an information telephone 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 phone line is available to the community Monday through Friday from 9:00am – 5:00pm and received over 14,000 calls in FY 2017.

Summary of Classes and Services provided by the OB Education Department in FY2017

Class	Attendance
Baby Care	2,174
Baby Saver	2,884
Breastfeeding	1,280
Car Seat Safety	1,348
4th Trimester	202
Maternity Orientation	2,142
Multiple Miracles ( <i>offered quarterly</i> )	29
Prepared Childbirth	2,082
Pre-Birth Boot Camp for Couples ( <i>new class offered 2 times</i> )	24
Breastfeeding Clinic Visits ( <i>outpatient</i> )	1,200
Baby Line telephone calls	14,162
Postpartum Support Groups: Postpartum Adjustment, Perinatal Loss, & Pregnancy after Loss Groups ( <i>funded by community benefit</i> )	494

Contact: Jeannette Cummings at 949-764-5951 or [jeannette.cummings@hoag.org](mailto:jeannette.cummings@hoag.org)

## CHAPTER V: HOAG COMMUNITY HEALTH ASSOCIATES

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### *Share Our Selves Corporation*

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Share Our Selves Corporation (SOS) is a Coordinated Care Agency with a 47-year history of providing safety-net services to low-income individuals and families living in Orange County. SOS's commitment to the integration of health and social services for the most at-risk population in our community is defined as the uninsured, insured through government insurance, and homeless remains the mission of SOS. Generous grant funding from Hoag Community Benefit Program during the Fiscal Year July 1, 2016 through June 30, 2017 provided the ability to personalize care to 3,689 unduplicated uninsured individuals during 7,683 medical encounters at the SOS Community Health Center located in Costa Mesa. Most notable, this is a unique partnership focused on reducing the utilization of the Emergency Department as a means of accessing primary health care, while increasing access to timely, efficient, and quality health care in effort to improve the well-being of our shared community.

A comprehensive overview of all SOS health centers is confirmed by its 2016 Uniform Data System (UDS) which identified a total of 53,421 provider encounters caring for 14,515 unduplicated patients; 1,338 identified themselves as homeless. Of the individuals cared for by SOS, 40% were uninsured with 60% insured by MediCal/Medicare, 81% live at or below 100% of the Federal Poverty Level (FPL) with the remaining 19% living below 200% of FPL, 75% identified as Hispanic/Latino, 25% non-Hispanic/Latino, and a full 60% were best served in a language other than English.

The SOS clinical network is a Federally Qualified Health Center with special designation as a Healthcare for the Homeless provider. SOS centers of care are nationally recognized as a Patient Centered Medical Home by the National Committee for Quality Assurance. Today, the SOS network consists of eight (8) service sites located throughout Orange County with centers of care located: one in Costa Mesa, three in Newport Beach, one in Lake Forest, two school-site centers in Santa Ana, and a mobile unit. Across this network, SOS provides timely, efficient, and quality health care services throughout the lifecycle inclusive of primary medical, dental, and behavioral health. Ancillary health care services and programs include clinical pharmaceutical services, case management, education, and linkage to specialty and subspecialty health care.

Patient care remains complimented by our founding program, SOS Social Services, providing direct access to extensive support services addressing the social determinates of health. Annually, the Social Service Department serves over 100,000 unduplicated low-income and/or homeless county residents through direct services and referrals. Programs under the umbrella of the Social Services Department include but are not limited to, the SOS Food Pantry, SOS Center of Care for the Homeless, Emergency Financial Aid, and Case Management. All social service programs provided by SOS are accessible to all Orange County residents regardless of participation in SOS health care programs.

**For more information regarding Share Our Selves [www.shareourselves.org](http://www.shareourselves.org)**

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## *Alzheimer's Family Services Center*

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Alzheimer's Family Center (AFC) creates happier and healthier days for families affected by the Alzheimer's epidemic in Orange County. We play a key role in Orange County's continuum of long-term care services by providing affordable access to high quality, culturally appropriate dementia care and supportive services that help families maintain their health, financial security, and quality of life. For 37 years, AFC has promoted an elevated standard of care for patients with dementia. Our exclusive capacity to provide specialized services to this vulnerable population has been recognized nationally by the Alzheimer's Foundation of America with an "Excellence in Care" designation. At present, we are one of just six other facilities in California to hold this prestigious designation.

Since 1980, we have served the growing number of families who are affected by the Alzheimer's epidemic in Orange County, a community that is aging at a faster rate than the rest of California and the rest of the nation. Less than 20 years from now, the number of seniors and family caregivers affected by the disease will more than double from 150,000 to nearly 400,000 individuals. Alzheimer's Family Center (AFC) is Orange County's trusted day care resource for dementia patients – and their families.

- As Orange County's first day care program exclusively devoted to treating people with dementia, we have a long and proven track record of helping Alzheimer's patients and their families successfully cope with the many challenges of memory loss.
- In addition to our day care programs for dementia patients, we provide much-needed respite, support and resources for family caregivers.
- We are often able to detect health problems early on — before they become serious medical concerns.
- AFC's medical oversight, enhanced nursing services, fall prevention interventions, and ongoing patient monitoring paves the way for improved patient outcomes.

We are committed to serving both dementia patients and their family caregivers, who are the primary source of care for individuals with dementia. Our services are grounded in the latest research and clinical guidelines for dementia care, and include:

### ***Mind Boosters Series***

A four-week evidence-based educational intervention that equips older adults in the community with the tools needed to maximize and maintain their brain health, learn prevention and risk management strategies for cognitive decline, and gain information about aging and memory loss.

### ***New Connections Club***

AFC's early-stage track of adult day health care programming provides medical, rehabilitative, psychosocial, and nutritional benefits based on an individualized plan of care within the context of a stimulating recreational program.

### ***Friendship Club***

AFC's adult day health care program for individuals as they transition into the moderate-to-severe stages of dementia.

### ***Enhanced Nutrition Services***

Enhanced meals based on dietary assessments and individualized nutritional plans that optimize the nutritional status of AFC's adult day health care patients. These services are designed to overcome challenges such as the need for feeding assistance, the presence of challenging eating behavior disturbances, problems with motor coordination, concentration, and swallowing as memory loss progresses.

### ***Saturday Respite Program***

An adult day program (social model) to offered Saturdays from 9 a.m. to 2 p.m. (closed Sundays) that meets the therapeutic and supervisory needs of frail, older adults, who may otherwise be left at home unsupervised.

### ***Outpatient Behavioral Health Program***

A one-of-a-kind intensive outpatient program serving individuals with mild cognitive impairment and co-occurring psychiatric disorders. The program offers intense psychotherapeutic intervention, psychiatric care, nursing services, socialization and cognitive stimulation.

### ***Intensive Care Management Support***

A social worker and a nurse are assigned to each family caregiver who has a loved one enrolled in our adult day health care. These professionals become "partners in caring" and can be called upon as needed to troubleshoot issues in care.

### ***Individualized Assessments***

All participants enrolling in our adult day care programs receive comprehensive three-day assessments to measure baseline psychosocial and health functioning.

***Information, Referral, & Linkages To Appropriate Community Resources*** Upon calling the center, every caregiver is connected with a case manager who will listen, provide answers, problem-solve, and link the family to appropriate and diverse resources.

### ***Caregiver Support Groups***

Caregivers community-wide have access to a free support group offered twice monthly at AFC, and facilitated by one of our masters-level clinicians.

Support groups represent an important vehicle for caregivers to gain knowledge, skills and support from their peers as well as professional leaders.

### ***Caregiver Depression Screenings***

AFC provides depression screenings and assessment of family caregivers based on clinical need.

### ***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.

### ***Community Outreach***

Community outreach services are designed to improve community health by addressing the lack of accurate information about dementia diagnosis, treatment, and available care-related services among at-risk seniors, families, health care professionals, and the community at-large.

All services are provided by an expert staff of professionals rich in cultural, linguistic, and professional diversity. Generous grant support from the Hoag’s Community Benefit Program helped us provide 22,522 cumulative patient days for 254 unduplicated adult day health care patients across fiscal year 2016-17. In addition, Hoag’s support enabled us to also:

- Provide 2,024 hours of care management by a licensed social worker to 759 unduplicated caregivers of enrolled patients.
- Field 294 inquiries from families community wide seeking to access supportive services (e.g., adult day health care, caregiver support groups) for themselves and their memory impaired loved ones. Approximately 33% of the families who inquired about our services admitted their loved one into our adult day health care program.
- Make 1,354 contacts to address patient medical needs. Our nursing team worked directly with family caregivers and primary care physicians.
- Coordinate 23,120 specialized, one-way transportation rides for our adult day health care patients.
- Host 8 Mind Booster Series alongside 9 community partners to reach 369 unduplicated individuals with high-quality, community-based prevention/early-intervention education about reducing the risk of dementia and tools for healthy brain aging.
- Participate in 45 community-based outreach activities that reached over 9,500 individuals.

Through our continuum of dementia care services, we are equipping Orange County families with the direct care, support, and knowledge they need to delay costly institutionalization of their memory-impaired loved ones.

**Contact: Joanna Richardson-Jones, CEO at (714) 593-1840 or [JRichardsjones@AFCenter.org](mailto:JRichardsjones@AFCenter.org)**

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## ***Costa Mesa Family Resource Center***

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The Costa Mesa Family Resource Center (CM FRC) is a family friendly community based collaborative with the capacity to provide on-site access to comprehensive prevention, intervention, and treatment services. As one of 15 Family Resource Centers throughout Orange County, the Costa Mesa FRC provides social, educational, health, and supportive services for all

families including birth, blended, kinship, adoptive, and foster families. Services are culturally sensitive and offered by staff in the language reflecting the families and communities served. The Costa Mesa FRC serves as a vehicle for engaging local residents and community organizations by actively seeking and promoting leadership of community members through partnership with Community Engagement Advisory Councils (CEAC's). Families walking into the Costa Mesa FRC can access a menu of "Core Services," which have been designed based on best practices. These Core Services include:

- Counseling
- Parenting Education
- Family Support Services
- Domestic Violence Personal Empowerment Program
- Information and Referral Services
- Comprehensive Case Management Services
- Out of School Time Youth Programs
- Family Reunification Family Fun Activities
- Adoption and Promotion Services

The collaboration with Hoag has strengthened the CM FRC in providing additional community resources and network of supports and services. Located in Hoag's Center for Healthy Living, the Costa Mesa FRC is able to provide families with access to a broad range of comprehensive services. Below are some highlights from this last Fiscal Year (2016-2017). The collaborative partners that help the CMFRC to provide these services include: Human Options, Girls Inc., Raise Foundation, and Children's Bureau. Additional collaborations have also included Moms of Orange County and Second Harvest Food Program. This last fiscal year, CMFRC served 4,701 children and families. This includes walk-ins, referrals, accessing services and/or attending events. With the CMFRC completing its 2nd year, there has been significant growth in clients served and linkage to services.

### ***Teen Conference***

This year marked the 2<sup>nd</sup> Annual Teen Dating Conference. The conference was dedicated to promoting awareness about Healthy Relationships while increasing communication between teens and their parents. The event was hosted at one of the local high schools in Costa Mesa. Over 50 participants attended the event, exceeding the projected number.

### ***Food Distributions***

The CM FRC have been a tremendous help to families not only from the Newport and Costa Mesa areas, but through all of Orange County. On average, there are about 120 families served each month. The food distribution is a collaboration between the Raise Foundation, CM FRC, the Center for Healthy Living, and community volunteers who donate their time and support. Food distributions are held the 1<sup>st</sup> Saturday of the month (excluding holidays) from 1-3pm.

### ***Pancakes & Prevention Event***

This event, in partnership with Hoag's Center for Healthy Living was held on a weekend on the premises of the CMFRC and CHL. The day included various screenings for children including: vision, hearing, car/helmet safety, dental, blood pressure and developmental screenings. Families were provided with a pancake breakfast to engage families with one another. As a result of this service, over 90 families were served, while many community members learned more about various services in the community.

### ***Out of School Program***

This last 2016-2017 fiscal year, it was evident that there was a need for after school programming for youth. As a way to meet the needs of the community, the Costa Mesa Family Resource Center in partnerships with Hoag were able to host a spring and summer camp for elementary aged children in the Costa Mesa community. Over 80 children ages 5 to 11 years were served through the course of these camps ranging from existing to new families. The staff were able to provide various programming while maintaining a fun learning environment. This services continues to demonstrate its need and success in the community, and nearly doubling the projected number of partnerships.

**Contact: Arezoo Shahbazi, MSW at 949-764-8100 Ext. 53693 or [ashahbazi@humanoptions.org](mailto:ashahbazi@humanoptions.org)**

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## ***MOMS Orange County***

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MOMS Orange County was founded as a non-profit organization in 1992 to serve the "working poor" who, due to various barriers, are less likely to access preventative health care and are often isolated by lack of education, family support and transportation. Almost 100% of the organization's clients are eligible for MediCal insurance. MOMS provides a unique service model for low-income families and is the only in-home program that serves pregnant women at lower levels of health risk who may not qualify for more intensive County-provided services. MOMS Orange County does not provide direct medical care but works with physicians and public health nurses to ensure clients are accessing appropriate care. The organization provides two core programs -- both at no cost and with voluntary enrollment for the client.

### ***Maternal-Child Health Coordination***

This low-cost, high-impact model of monthly in-home visits begins during pregnancy and continues through the baby's first birthday. Monthly home visits are provided by highly trained paraprofessionals under RN supervision. Each home visitor is bilingual, has a bachelor's degree in a health-related field and shares the client's culture. During pregnancy, mothers receive comprehensive prenatal health screenings including screenings for gestational diabetes, risk of premature birth, and depression, and are educated on prenatal care, nutrition, exercise, stress

management, attending doctor’s appointments and preparing for the baby’s arrival. After birth, the focus is on promoting the baby's healthy growth and development and the mother's well-being by establishing a medical home, tracking immunizations, promoting breastfeeding and nutrition, educating parents on early brain stimulation, screening for achievement of developmental milestones, promoting infant play and exercise, and enhancing parenting skills.

***Health Education***

MOMS’ second core program is a series of health education classes. Also provided at no cost, group classes are offered throughout the County to augment Maternal-Child Health Coordination with additional education, peer support and reduction of isolation. Classes are provided in Spanish, English and Vietnamese, and include:

<p>Prenatal Health Education          Childbirth Preparation          Breastfeeding Education &amp; Support          Gestational Diabetes Prevention</p>	<p>Mommy, Daddy &amp; Me          Mommy &amp; Me (in three age groups through baby’s 18-month)          Workshop for New Fathers</p>
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MOMS' efforts have resulted in verified improvement in birth outcomes, improved infant health and development, and improved maternal health. In fact, a research partnership between MOMS Orange County and the UC Irvine School of Nursing studied the effectiveness of MOMS Orange County home visitation model on birth outcomes and found that every prenatal visit is associated with 62 grams of increase in birth weight, with .38 weeks of increase in gestational age at birth, and a 27% reduction in the odds of spending at least one day in the Neonatal Intensive Care Unit

Using birth data from clients served in 2010, UCI estimated that MOMS Orange County generates \$1.6 million in savings in Orange County, \$2.1 million in California State and \$3.2 million in the U.S. in reducing preterm births. The evidence suggests that MOMS Orange County has the potential to save significant healthcare costs by increasing the rates of positive birth outcomes.

With support and partnership through Hoag’s Community Benefit Program, in Fiscal Year 2016-17, MOMS Orange County was able to provide 16,969 prenatal, postpartum and Mother-Baby home visits and 753 health education classes and support groups to 3,349 mothers, 2,568 babies, and education and support to more than 450 fathers and other caring adults.

MOMS screened 100% of pregnant women for their risks of gestational diabetes, preterm labor and maternal depression and provided additional services (education, classes, support groups, counseling, etc.) and/or referrals for medical and community services, as needed. Through these efforts during FY17:

- 55% of newly enrolled pregnant women were determined to be at moderate-to-high risk for gestational diabetes; of this figure, 89% did not develop gestational diabetes
- 86.5% of babies born had positive birth outcomes (as defined by not having low birth weight, premature birth and/or admission to the NICU)
- 2,609 developmental screenings were provided using the Ages & Stages Questionnaire® and 98% of babies had results within normal range
- Of the 1,214 babies who completed the program during FY17:
  - 96% were on track developmentally
  - 93% were on track with immunizations
  - 98% had a medical home

Hoag is a long-time partner of MOMS Orange County dating to our inception in 1992, when Hoag was among the Orange County hospitals that contributed seed money to help launch MOMS. Over the years, Hoag has lent expertise, leadership and tangible support to accelerate program development and expand services leading to increased access to prenatal care for low-income pregnant women. Hoag has also invested in MOMS’ programming for maternal health, maternal depression, gestational diabetes and childhood obesity prevention. More recently, MOMS Orange County was among the stakeholders that collaborated on the development of the Melinda Hoag Smith Center for Healthy Living. In 2016, MOMS began offering Spanish-language Childbirth Preparation, Mommy & Me and Breastfeeding classes at the new center in Newport Beach.

As a result of these core programs, women in our community who experience poverty gain improved access to prenatal health and education programs which lead to improved birth outcomes and improved maternal health and well-being. Clients in our program gain increased knowledge and self-confidence as parents. Ultimately, these investments in the youngest members of the community – and their parents – serve to prevent and identify health and developmental issues early on, addressing concerns early, strengthen family functioning, and improving the well-being of future generations.

**Contact: Pamela Pimentel, RN at 714-972-2610 or [ppimentel@momsorangecounty.org](mailto:ppimentel@momsorangecounty.org)**

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***Community for Innovation, Entrepreneurship, Leadership & Opportunities (CIELO)***

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CIELO’s mission is to launch successful entrepreneurs by unleashing innovation, creativity, and passion. By surrounding entrepreneurial-minded individuals with a support system of experts

dedicated to helping cultivate their skills and creativity, CIELO empowers hardworking, low-income Orange County residents to pursue economic self-sufficiency through starting a small business or seeking new or better paying jobs. CIELO targets low-income and underserved individuals, helping to reduce opportunity inequality by providing them with the resources or connections they wouldn't otherwise have, but are needed to successfully launch a career or small business.

### ***Educational and Career Pathway Programs***

CIELO's entrepreneurial services became an on-site partner at the Melinda Hoag Smith Center for Healthy Living in FY17. CIELO has worked on establishing training programs and offering one-on-one consulting services to Hoag clients. Additionally, CIELO has partnered with the Public Law Center to provide business legal assistance to participants.

CIELO's core educational program with Hoag consists of a three-week workshop series of business fundamentals and entrepreneurial mindset. Participants learn to combine their skills and experience to create meaningful and economically rewarding opportunities to launch and improve their businesses. The workshop series seeks to address the following objectives:

- Developing an entrepreneurial mindset by fostering habits of self-reliance, maximizing skills and experiences to expand work opportunities
- Creating a value proposition, developing a brand, and training to market a company in varying competitive environments
- Planning and understanding financing to reach economic self-sufficiency

### ***Career Pathway Program***

CIELO's Career Pathway Program consists of providing career and educational 1:1 coaching where CIELO meets the participant at their current career stage. Participants discuss their challenges along their career journey and create a plan for how they can open up career opportunities for themselves. CIELO encourages career participants to also emerge themselves in an entrepreneurial mindset to take control of their life and career. Specific services through this program include: resume development, job searching, skill & strengths development, mock interviewing and networking. CIELO has also partnered with Quidian, a local based start-up from Irvine, which assists in providing CIELO participants with premier workforce and labor market research, career navigation and exploration. Using an emotional intelligence approach, many participants also experience a higher level of confidence on how to conquer the job market.

In FY17 CIELO has served 186 participants through weekly workshops, one-on-one consulting and group collaborations (Co-Labs). Outcomes include four businesses launched and 55 clients in the process of career path and entrepreneurship.

**Contact: John Hobson at [jhobson@cielocommunity.org](mailto:jhobson@cielocommunity.org)**

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## *The Cambodian Family*

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The Cambodian Family (TCF) is a grassroots, community-based organization that was formed in 1980 when Cambodian refugees first settled in America after escaping the horrors of war and genocide in their homeland. Feeling compelled to address the desperate needs of their community, a small group of the more skilled and knowledgeable Cambodian refugees rented a small apartment in Santa Ana, CA and volunteered their time teaching English and providing other critical resettlement. Over the years, our programs and services such as community health, youth development, and civic engagement have been expanded to immigrants and refugees from all over the world. TCF's mission is to provide opportunities for refugee and immigrant families to develop the knowledge, skills, and desires for creating health and well-being in their lives.

TCF's Healthy Changes Program (HCP) has been established in response to the needs of increasing access of underserved, low-income, limited-English-proficient Cambodian residents of Orange County (OC) to culturally and linguistically appropriate preventive health and health care services. The primary target population for HCP is Cambodians, who are among the most disadvantaged of all Southeast Asians in terms of income, education, and health outcomes. Over 51% of Cambodians reported symptoms of major depression and 62% reported PTSD. Also, this population group experiences significant health disparities because of limited language skills, transportation, social isolation, limited Cambodian-speaking health care providers, and limited access to quality care.

HCP uses a 3-level approach to increasing awareness of chronic disease prevention and promoting healthier lifestyle choices and behaviors: (1) improved knowledge/awareness, behaviors, and skills (through health education), (2) improved access to preventive health and health care services (through bilingual case management/care coordination), and (3) healthy lifestyle changes (through Change Club activities). During FY 2017, Healthy Change Program offered services to 114 participants, which significantly exceeded our annual goal of serving 80. Of the participants served, over 95% are low-income; 77% are female, 23% male; 64% are between the ages of 25-64, 33% are over the age of 65; and 100% reported a language other than English as their primary language. Also, over 65% of the participants reported having at least one or multiple health issues, including cardiovascular disease, diabetes, chronic pain, etc.

HCP offered a variety of educational workshops and health-promoting classes and activities throughout the program year. We offered culturally and linguistically-tailored health and nutrition education workshops to improve participants' knowledge of the importance of being physically active, eating healthy foods, and maintaining a healthy weight. In addition, exercise and healthy cooking demonstration classes were offered to help promote participants' healthy behaviors. In partnership with over six community health partners, the program had also offered free health screenings and our bilingual and bicultural health navigators provided case management services to participants who faced barriers in accessing follow-up health care services. Our key program staff have many years of experience and extensive expertise in providing services to our community. Our staff are very well verse in the language and culture of our participants, as they are Cambodian themselves and understand the language and the

barriers our community members go through on a daily base to access health and wellness services.

During FY2017, HCP provided 22 group and individual health education sessions to 42 participants, 4 nutrition education/healthy cooking demonstration classes to 49 participants, 129 different types of health screening to 62 participants at no cost, and several health care accessing services to 11 participants.

The support from Hoag Community Benefits Program has helped to provide the most needed services that help our underserved and limited English proficient participants increase their healthy lifestyle knowledge and behaviors and reduce the risk factors for chronic diseases such as heart disease, stroke, diabetes, hypertension, and depression.

**Contact: Amina Sen-Matthews, MA, Health Program Director @ 714-571-1966 ext. 113 or [aminasm@cambodianfamily.org](mailto:aminasm@cambodianfamily.org)**

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*Appendices*

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**Appendix A Hoag Hospital Charity Care and Self Pay Discount Policy (Page 42)**

**Appendix B Hoag Hospital Quantifiable Community Benefit for FY2017 (Page 53)**

**Appendix C Hoag Hospital Community Benefit Expenditures by Program (Page 54)**

## APPENDIX A

	Policy
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<b>Category:</b> REVENUE CYCLE	<b>Effective Date:</b> See footer
<b>Owner:</b> Executive Director, Revenue Cycle	
<b>Title:</b> Financial Assistance Policy	

**PURPOSE:** This policy outlines Hoag Memorial Hospital Presbyterian’s operational guidelines on the Financial Assistance Program (FAP) in relation to the patient collections process.

**SCOPE:** Revenue Cycle

**AUTHORIZED PERSONNEL:** Charity Care Coordinator, Self-Pay Manager, Self-Pay Supervisor, Collectors, Financial Councilors, PAS Supervisors, Insured and Uninsured Patients

### Description

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### Financial Assistance Policy

<b>Policy</b>	<p>Hoag seeks to address patient’s health care and financial needs while remaining committed to the stewardship of Hoag resources. To ensure that Hoag obtains appropriate reimbursement for services provided, several payment options and programs are available to support the needs of uninsured and underinsured patients. When it is determined that a payment solution cannot be obtained through such payment options and programs, then the patient is provided with information about the Hoag Financial Assistance Program (FAP).</p> <p>Patient collections processes shall remain in compliance with Hoag policies relevant to patient financial assistance:</p> <ul style="list-style-type: none"> <li>■ Any patient who requests financial assistance will be afforded the opportunity to</li> </ul>
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Effective Date: January 1, 2015  
Revised: January 26, 2015



# Policy

<b>Category:</b> REVENUE CYCLE	<b>Effective Date:</b> See footer
<b>Owner:</b> Executive Director, Revenue Cycle	
<b>Title:</b> Financial Assistance Policy	

	<p>apply and be considered.</p> <ul style="list-style-type: none"> <li>■ Access to necessary care shall in no way be affected by whether financial assistance eligibility exists; medically necessary care will always be provided to the extent the Hospital can reasonably do so.</li> <li>■ The need for financial assistance is a sensitive and deeply personal issue for patients. All Hoag employees will maintain confidentiality of requests for assistance, the information obtained in the application process, and the funding or denial of assistance.</li> <li>■ In an effort to ensure patients' post-acute and follow-up health care needs are met, patients who demonstrate lack of financial coverage by third-party insurance are offered information on how the patient may obtain applications for Medicare, Medicaid, Medi-Cal and the Healthy Families Program (CA), coverage offered through the Covered California (CA), or other state or county funded health coverage programs. Hoag will assist patients with applying for government-sponsored programs and follow through to acceptance or denial.</li> </ul>
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## Patient Collections

<b>Collections Process Overview</b>	It is the expectation that the patient's estimated cost or liability will be collected in full prior to or at the time of service. If a patient states they cannot pay in full, payment options and programs are offered during the collections process in a consistent sequential order as outlined below:	
	Stage	Description
	1	Full payment is requested.
	2	A reasonable payment plan based on the estimate is offered. A deposit payment is requested, if appropriate.
	3	Eligibility for Government-Funded Programs is explored in programs including , but not limited to: <ul style="list-style-type: none"> <li>■ Medicare</li> <li>■ Medi-Cal (CA)</li> <li>■ Covered California</li> <li>■ other state or county funded health coverage programs</li> </ul>
4	When a payment solution cannot be found in Stages 1-3, then the patient is provided with information about the Hoag Financial Assistance Program (FAP). Pending applications for coverage through FAP and from a government funded health program will not preclude the patient's eligibility for eligibility for the other program.	



# Policy

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<b>Title:</b>	Financial Assistance Policy		

		<p><b>Important:</b> If at any time, patient requests information or an application for Hoag Financial Assistance, it is promptly provided to the patient.</p>
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## Financial Assistance Program

<b>Overview</b>	<p>Hoag Financial Assistance Program (FAP) ensures that medically necessary health care is provided at discounted or no cost to qualified uninsured and underinsured patients. Any uninsured or underinsured patient who is unable to pay his or her Hospital bill and whose income meets the approved federal poverty level (FPL) qualifications will be considered eligible for Hoag Financial Assistance (FA). Additionally, patients who incur qualified High Medical Costs may be deemed eligible for financial assistance.</p> <p>Hoag Hospitals serve all persons in the communities where we are located. We aspire to provide health services with the utmost dignity and compassion for each patient and family in our care. In a confidential and caring environment patients in need are provided financial assistance to pay their Hoag Hospital bills and, in turn, to ensure access to needed healthcare as an essential element of fulfilling their human dignity and ability to live more healed, more whole, and more able to contribute to the common good.</p>
<b>Completion of FAP Application</b>	<p>Upon a patient's request, a Financial Assistance Program (FAP) application shall be provided. Designated personnel will assist patients in completing the Financial Assistance Application and determining eligibility for financial assistance, charity care, or government-funded programs, if applicable. Financial Assistance notices printed in English and Spanish are also placed in the public admission areas at Hoag hospitals. Interpretation services are available to address any questions or concerns and to assist in the completion of Financial Assistance Applications.</p> <p>A patient, or patient's legal representative, who requests a discounted payment, charity care, or other assistance in meeting his or her financial obligation to the hospital shall make every reasonable effort to provide the hospital with documentation of income and health benefits coverage. If the person requests charity care or a discounted payment and fails to provide information that is reasonable and necessary for the hospital to make a determination, the hospital may consider that failure in making its determination.</p> <p>Upon establishing full or partial eligibility under the financial assistance program the</p>

Effective Date: January 1, 2015  
 Revised: January 26, 2015



# Policy

<b>Category:</b>	<b>REVENUE CYCLE</b>	<b>Effective Date:</b>	<b>See footer</b>
<b>Owner:</b>	Executive Director, Revenue Cycle		
<b>Title:</b>	Financial Assistance Policy		

	<p>coverage will be valid for six (6) months from the date of the eligibility letter. Additionally, other pre-existing patient account outstanding balances at the time of eligibility determination will be included as eligible, excluding exceptions set forth in this policy.</p>
<b>Patient Billing</b>	<p>Patients applying for Hoag Financial Assistance will continue to receive monthly statements as an awareness of the open balance and to encourage patient engagement if needed. Statements mailed to the patient will include a clear and conspicuous notice advising the patient of Hoag Financial Assistance Program and the appropriate contact information.</p> <p>The notice shall also:</p> <ol style="list-style-type: none"> <li>a. advise the patient that he or she may be eligible for programs such as Medicare, Medi-Cal(CA), Covered California or other state or county funded health coverage programs</li> <li>b. how the patient may apply for any of these programs and that the Hospital will provide the patient with an application.(CA)</li> <li>c. that the Hospital will refer the patient to a local consumer assistance center housed at legal services offices.(CA)</li> </ol> <p>Disputes: Efforts to collect healthcare debts by an affiliate, subsidiary or external collection agency of Hoag must adhere to the standards set forth in this policy including the definition and application of a reasonable payment plan.</p> <p>In dealing with patients eligible for Hoag Financial Assistance or a reasonable payment plan, the Hospital shall not use wage garnishments or place liens on homes as a means of collecting unpaid Hospital bills. This requirement does not preclude Hospitals from pursuing reimbursement from third party liability settlements.</p> <p>Accounts without an existing FAP or payment arrangement will transfer to an external collection agency at 150 days from first patient billing cycle.</p> <p>Accounts with a defaulted payment plan with three consecutive missed payments will transfer to an external collection agency upon review and approval of the department supervisor to ensure reasonable attempts to reach the patient/guarantor were made.</p>
<b>Proof of Income</b>	<p>The patient will submit all necessary income documentation, including copies of IRS forms, W-2 Wages &amp; Earnings, disability payment statements, etc. An application for a government program (i.e., prescription drug assistance programs, DHS, SSI, or any</p>



# Policy

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	<p>other signed federal program document), may be used to qualify for financial assistance. Financial information obtained will not be used to determine collection activities.</p> <p>In cases where documentation is unavailable, the patient's income may be verified by having the patient sign the assistance application attesting to the veracity to the income information provide. If the proof of income is questionable, validation of the income should be immediately requested.</p>
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## Income Qualifications – CA Hospitals

Any uninsured or underinsured patient whose family income is less than 400% of the current federal poverty level (FPL) and is unable to pay his or her Hospital bill shall be considered eligible for financial assistance. Full or partial assistance is based on the criteria outlined below:

<b>If the income % of FPL is:</b>	<b>And the patient is:</b>	<b>Then:</b>					
200% or less,	Uninsured <i>or</i> insured	The entire (100%) patient liability portion of the bill for services will be written off.					
201% - 400%,	Uninsured,	<p>The patients' payment obligation will be a percentage of the gross amount the Medicare program would have paid for the service based on the sliding scale below:</p> <table border="1" style="margin-left: 20px;"> <thead> <tr> <th><b>If the income % of FPL is:</b></th> <th><b>Then the % of Medicare LIKE Rate Payable is:</b></th> </tr> </thead> <tbody> <tr> <td>201 – 400%</td> <td>50%</td> </tr> </tbody> </table>	<b>If the income % of FPL is:</b>	<b>Then the % of Medicare LIKE Rate Payable is:</b>	201 – 400%	50%	
	<b>If the income % of FPL is:</b>	<b>Then the % of Medicare LIKE Rate Payable is:</b>					
201 – 400%	50%						
Insured,	<p>The patient's obligation will be reduced by insurance payments:</p> <table border="1" style="margin-left: 20px;"> <thead> <tr> <th><b>If:</b></th> <th><b>Then:</b></th> </tr> </thead> <tbody> <tr> <td>The amount paid by insurance exceeds what Medicare would have paid,</td> <td>The entire (100%) patient liability portion of the bill will be written off.</td> </tr> <tr> <td>The Medicare Payment <b>LIKE</b> Rate is greater than the HMO/PPO Payment Rate for services rendered,</td> <td>The patient's payment obligation will be based on the HMO/PPO Payment Rate.</td> </tr> </tbody> </table>	<b>If:</b>	<b>Then:</b>	The amount paid by insurance exceeds what Medicare would have paid,	The entire (100%) patient liability portion of the bill will be written off.	The Medicare Payment <b>LIKE</b> Rate is greater than the HMO/PPO Payment Rate for services rendered,	The patient's payment obligation will be based on the HMO/PPO Payment Rate.
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201% - 400%,	Insured, <i>yet</i> services are not covered by the payer,	<p>The following will apply:</p> <table border="1" style="margin-left: 20px;"> <thead> <tr> <th><b>If...</b></th> <th><b>Then ...</b></th> </tr> </thead> <tbody> <tr> <td>The patient ordinarily would be responsible for the full billed charges,</td> <td>The total patient payment obligation will be the HMO/PPO Payment Rate.</td> </tr> </tbody> </table>	<b>If...</b>	<b>Then ...</b>	The patient ordinarily would be responsible for the full billed charges,	The total patient payment obligation will be the HMO/PPO Payment Rate.	
<b>If...</b>	<b>Then ...</b>						
The patient ordinarily would be responsible for the full billed charges,	The total patient payment obligation will be the HMO/PPO Payment Rate.						
201% - 400%,	Insured, and services are covered by the payer,	<p>The following will apply:</p> <table border="1" style="margin-left: 20px;"> <thead> <tr> <th><b>If:</b></th> <th><b>Then:</b></th> </tr> </thead> <tbody> <tr> <td>The patient is responsible for only a portion of the billed charges (deductible, copay, etc.),</td> <td>There is no discount.</td> </tr> </tbody> </table>	<b>If:</b>	<b>Then:</b>	The patient is responsible for only a portion of the billed charges (deductible, copay, etc.),	There is no discount.	
<b>If:</b>	<b>Then:</b>						
The patient is responsible for only a portion of the billed charges (deductible, copay, etc.),	There is no discount.						

Effective Date: January 1, 2015  
Revised: January 26, 2015



# Policy

<b>Category:</b> REVENUE CYCLE	<b>Effective Date:</b> See footer
<b>Owner:</b> Executive Director, Revenue Cycle	
<b>Title:</b> Financial Assistance Policy	

## Automatic Classification for Charity Care

Under the following special circumstances, a patient may be deemed eligible for Charity Care without absolute requirement for submission of a financial assistance application:

Circumstance	CALIFORNIA
Eligible for other FPL-qualified programs	(Addressed in Other Special Circumstances section below)
Disabled	n/a
Deceased	Is deceased and without third-party insurance coverage or identifiable estate, no living spouse
Incarcerated	n/a
Homeless	Is determined to be homeless and is not currently enrolled in Medicare, Medicaid or any government sponsored program, without third-party insurance coverage
Seen in ER, unable to bill	Is treated in the Emergency Department but the Hospital is unable to issue a billing statement
Access to Care	Is treated through an Access to Care Program

<b>Other Special Circumstances</b>	<p>Patients who are eligible for FPL-qualified programs such as Medi-Cal, Medicaid , and other government-sponsored low-income assistance programs, are deemed to be indigent. Therefore, such patients are eligible for Charity Care when payment for services is not made by the programs. Patient account balances resulting from non-reimbursed charges are eligible for full charity write-off. Medi-Cal Share of Cost obligations are not eligible for charity write off or the discount program. Specifically included as eligible are charges related to the following:</p> <ul style="list-style-type: none"> <li>■ Denied inpatient stays</li> <li>■ Denied inpatient days of care</li> <li>■ Non-covered services</li> <li>■ Treatment Authorization Request (TAR) denials</li> <li>■ Denials due to restricted coverage</li> </ul>
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# Policy

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<b>Presumptive Charity</b>	Hoag recognizes that a portion of the uninsured or underinsured patient population may not engage in the traditional financial assistance application process. If the required information is not provided by the patient, Hoag utilizes an automated, predictive scoring tool to qualify patients for Charity Care. The PARO™ tool predicts the likelihood of a patient to qualify for Charity Care based on publicly available data sources. PARO provides estimates of the patient's likely socio-economic standing, as well as, the patient's household income and size.
<b>Approval Levels</b>	<p>Financial assistance determination will be made only by approved Hospital personnel according to the local Hospital levels of authority.</p> <p><b>Notification of Determination</b></p> <p>Patients will receive notification of Hospital determination within 30 days of submitting the completed application and supporting documentation.</p> <p><b>Patient Disputes</b></p> <p>FAP qualifications are determined after the application is reviewed for eligibility based on criteria contained in this policy. Financial assistance shall not be provided on a discriminatory or arbitrary basis, however the hospital retains full discretion to establish eligibility criteria based on sufficient evidence and information provided by the patient or guarantor.</p> <p>In the event of a dispute, a patient or guarantor may seek review from management or the executive director of revenue cycle via email at PFS@hoag.org or in writing by providing additional information to support the dispute at:</p> <p style="text-align: center;">Hoag Memorial Hospital Presbyterian Attn: Executive Director of Revenue Cycle 500 Superior, Suite 250 Newport Beach, CA 92663</p>
<b>Proof of insurance</b>	If a hospital bills a patient who has not provided proof of coverage by a third party at the time the care is provided or upon discharge Hoag will provide the patient with a Notice Of Availability Financial Assistance (NAFA)

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# Policy

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<b>Owner:</b>	Executive Director, Revenue Cycle		
<b>Title:</b>	Financial Assistance Policy		

## Definitions

This publication contains the following terms:

Term	Definition
Affordable Care Act (ACA)	A federal mandate that aims to increase the quality and affordability of health insurance.
Charity Care	Medically necessary Hospital services provided at no cost to a patient who lacks or has inadequate insurance and meets defined low-income requirements.
Covered California	California's Health Insurance Marketplace program that provides assistance in shopping for affordable health care and possibly financial assistance. Covered California will also assist in determining qualification for Medi-Cal.
Deposit	When payment arrangements are made, the first installment payment is considered the deposit. The deposit is negotiated, starting at 50% of total estimated patient liability.
Government-Funded Insurance Programs	The following are included in "government-funded insurance programs" (but is not limited to): <ul style="list-style-type: none"> <li>■ Medicare</li> <li>■ Presumptive Eligibility (Medi-Cal)</li> <li>■ Medi-Cal (CA)</li> <li>■ Covered California (CA)</li> <li>■ Out Of State Medicaid</li> </ul>
Health Insurance Marketplace	A component of the Affordable Care Act (ACA) is the Health Insurance Marketplace (formerly known as Exchange). Each state is mandated to have this on-line venue for consumers and small businesses to compare and purchase insurance coverage options and to learn if they are eligible for federal insurance subsidies.
High Medical Costs	California: A patient is considered to have High Medical Costs if he or she has either of the following: <ul style="list-style-type: none"> <li>■ Annual out-of-pocket costs incurred by the individual at the Hospital that exceed 10 percent of the patient's family income in the prior 12 months.</li> <li>■ Annual out-of-pocket expenses that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.</li> </ul>
HMO/PPO Payment Rate	The average amount of payment the Hospital would receive from all contracted HMOs/PPOs for providing services. This rate, represented as a percent of total billed charges, is Hospital-specific and updated periodically.
Out of State Medicaid	Hoag will bill for Out of State Medicaid provided a contract is approved by the state and/or obtained through an outsourced vendor.



# Policy

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Term	Definition
Medi-Cal (CA)	Medi-Cal is California's federally funded health insurance programs that pays for a variety of medical services for children and adults who have limited resources and low-income. Under ACA, Medi-Cal has expanded who may be eligible.
Medically Necessary Services	Services or supplies determined to be proper and needed for the diagnosis, direct care or treatment of the medical condition and meet the standards of good medical practice in the medical community.
Excluded services	If services not deemed a medical necessity, CDU, Cosmetic, gastric bypass for weight loss.
Presumptive Charity (PARO, SOS and La Amistad programs)	Share ourselves program (SOS) and La Amistad have been pre-determined to meet the program guidelines as these individuals were determined to be at or below 200% FPL. SOS and La Amistad complete their own screening and approval. Payment Assistance Rank ordering (PARO) Score: PARO is a patient account scoring mechanism. PARO score is evaluated bi-annually and calibrated to reflect the charity care policy of Hoag for evaluation and eligibility criteria.
Medicare	Medicare is a federally funded health insurance program for qualified people age 65 or older. Certain people younger than 65 also qualify based on disabilities or renal disease. This program helps with the cost of health care, but it does not cover all medical expenses or the cost of long-term care. It is not based on low-income. It is not part of the Health Insurance Marketplace, but there are some coverage changes as a result.
Medicare Payment Rate	The average amount of payment the Hospital would receive from Medicare for providing services. This rate is Hospital-specific and updated periodically.
Payment Arrangements / Installment Plans	A plan negotiated and agreed to by the Hospital and the patient that sets the terms of extended payment for services provided by the Hospital. Any pre-service payment plan is based on an estimate and the financial counselors and/or schedulers coordinate payment plans through the self-pay supervisor as Final terms are set up after final billing.
Reasonable Payment Plan (CA)	If Hoag and the patient/guarantor, cannot agree, the Hospital shall create a reasonable payment plan Monthly payments pursuant to a reasonable payment plan cannot exceed more than 10 percent of a patient's family's monthly income, excluding deductions for essential living expenses.
Essential Living Expenses (CA)	Expenses for any of the following: rent or house payment and maintenance; food and household supplies; utilities and telephone; clothing; medical and dental payments; insurance; school or child care; child or spousal support; transportation and auto expenses, including insurance, gas and repairs, installment payments; laundry and cleaning; and, other extraordinary expenses.

Effective Date: January 1, 2015  
 Revised: January 26, 2015



# Policy

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## Attachment A: Hoag Notice of Availability of Financial Assistance

### Mission

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

### What is the Patient Financial Assistance Program?

Hoag Hospital's Financial Counseling Department offers free financial screenings for people who do not have health insurance and cannot pay their hospital bill, as well as patients who do have insurance, but are unable to pay their portion of the bill that insurance does not cover.

Our Financial Counselors will review your eligibility for Medicare, Healthy Families Program, Medi-Cal, or other coverage offered through the California Health Benefit Exchange, California Children's Services program, other state- or county-funded health coverage, or charity care. If you already have coverage through one of these programs please notify our Financial Counselors immediately. Patients ineligible for government assistance may still qualify for discount or charity programs available through Hoag Hospital.

### How and When to Apply

Please contact our Financial Counselors immediately after discharge or completion of services by calling 949-764-5564 or by e-mail at [FC@hoag.org](mailto:FC@hoag.org). We can assist with your application and provide the applications for Medicare, Healthy Families Program, Medi-Cal, or other coverage offered through the California Health Benefit Exchange, California Children's Services program, other state- or county-funded health coverage. You may also be referred to [www.OCGOV.com](http://www.OCGOV.com) for local assistance.

If you lack, or have inadequate, insurance, and you meet low- and moderate-income requirements, you may qualify for discounted payment or charity care. Please remember that access to necessary health care is not affected by eligibility for financial assistance. Hoag Memorial Hospital is committed to treating all those who come to us for care.

You may also apply directly for the above programs by accessing their website directly:

Medi-Cal: <http://www.dhcs.ca.gov/services/medi-cal/pages/applyformedi-cal.aspx>

Affordable Care Act: [www.HealthCare.gov](http://www.HealthCare.gov) to apply by phone Call 1-800-318-2596

Medicare: [www.ssa.gov/medicare/apply.html](http://www.ssa.gov/medicare/apply.html)

Hoag Charity care program: [www.Hoag.org](http://www.Hoag.org) (Patient & Visitors tab, Billing, Charity Care Application)

### Confidentiality

We understand that the need for financial assistance can be a sensitive and deeply personal issue. We are committed to maintaining the confidentiality of requests, information and funding.

For more information please contact one of our Financial Counselors at 949-764-5564, we are available Monday through Friday from 8:30 AM to 4:30 PM, or by e-mail at [FC@hoag.org](mailto:FC@hoag.org).



# Policy

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<b>Title:</b>	Financial Assistance Policy		

Reference:

<b>References</b>	These publications are relevant to this document:	
	<b>Document Type</b>	<b>Title</b>
	Process	Collection Process for Patient Financial Services
	Policy	Financial Counseling – Government-Funded Insurance (RCS.13)
	DLP	Offering Payment Arrangements
	Policy	Patient Discounts (RCS.26)
Policy	Payment Arrangements (Installment Plans) (RCS.18)	

Review and/or input for this procedure was given by the following:

Revision Designation:

Effective Date: January 1, 2015  
Revised: January 26, 2015

## APPENDIX B

### Hoag Hospital Quantifiable Community Benefit Summary Trend FY 2017\*

#### 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*

	FY2017		FY2016
<sup>1</sup> County Indigent Programs	109,530	\$	47,065
Charity Care	7,122,000	\$	6,082,000
MediCal/Cal Optima Cost of Unreimbursed Care	33,158,750	\$	21,656,359
Medicare Cost of Unreimbursed Care	75,748,518	\$	70,033,961
<b>Total Cost of Unreimbursed Direct Medical Care Svcs</b>	<b>116,138,798</b>	<b>\$</b>	<b>97,819,385</b>

#### 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	\$ 717,747		\$ 801,569
Subsidized Clinical Specialty Services	\$ 37,291		\$ 25,818
Cash and In-Kind Contributions	\$ 7,228,881		\$ 5,125,578
Community Benefit Operations	\$ 1,424,213		\$ 1,286,461
<b>Total Benefits for Vulnerable Populations</b>	<b>\$ 9,408,132</b>		<b>\$ 7,239,426</b>

#### 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	\$ 774,136		\$ 826,709
Health Profession Education	\$ 228,255		\$ 346,968
Subsidized Clinical Specialty Services	\$ 280,659		\$ 181,336
Cash and In-Kind Contributions	\$ 2,301,534		\$ 2,170,011
Community Building Activities	\$ 9,900		\$ 36,590
<b>Total Benefits for the Broader Community</b>	<b>\$ 3,594,484</b>		<b>\$ 3,561,614</b>

<b>Total Community Benefit and Economic Value</b>	<b>129,141,414</b>		<b>\$ 108,620,425</b>
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<b>Total Community Benefit and Economic Value (excluding Medicare Cost of Unreimbursed Care)</b>	<b>53,392,896</b>		<b>\$ 38,586,464</b>
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#### Notes:

\*The 2017 Fiscal Year included 12 months: July 1, 2016 through June 30, 2017

1. The MSI Program ended in 2013, replaced by the Medical Safety Net (MSN) Program.

## APPENDIX C

### **Benefits for Vulnerable Populations**

### **Net CB Expenditure**

#### ***Community Health Improvement Services***

Mental Health Center-Community Health	\$717,747
<b>Total Community Health Services</b>	<b>\$717,747</b>

#### ***Subsidized Clinical Specialty Services***

ECU Call Panel	\$37,291
<b>Total Subsidized Clinical Specialty Services</b>	<b>\$37,291</b>

#### ***Cash and In-Kind Contributions***

Acacia Adult Day Services	\$10,000
Academy of International Dance- Healthy Lifestyle Program	\$10,000
Access California Services	\$50,000
AccessOC of Southern California	\$15,000
Age Well Senior Services	\$50,000
Alzheimer's Family Services Center	\$1,733,084
America on Track	\$25,000
Boys and Girls Club of Santa Ana	\$25,000
Casa Teresa	\$25,000
Community Health Initiative of OC	\$25,000
CHOC Foundation	\$300,000
City of HB-Community Services and Senior Programs	\$55,000
City of HB- Project Self Sufficiency	\$20,000
Coalition of Orange County Community Clinics	\$25,000
Community Action Partnership of OC	\$75,000
Community Health Initiative of OC	\$25,000
Community Senior Serve Inc.	\$15,000
Community Services Program Inc.	\$10,000
Council on Aging Orange County	\$100,000
Families Forward	\$50,000
Girls Inc.	\$93,587
Healthy Smiles for Kids OC	\$50,000
Human Options	\$25,000
Illumination Foundation	\$20,000
Irvine Adult Day Health Services	\$35,000
Jewish Federation and Family Services of Orange County	\$40,000
Kid Healthy (One OC)	\$35,000
Kiwanis Costa Mesa	\$5,000
Laguna Beach Seniors	\$30,000
Latino Health Access	\$50,000
Laurel House	\$15,000
Mariposa Women and Family Center	\$30,000

MOMS Orange County	\$40,000
National Alliance of Mental Health (NAMI)	\$40,000
National Kidney Foundation Inc.	\$20,000
New Vista School	\$25,000
Newport Mesa Spirit Run Scholarship Program	\$5,000
Newport Mesa Unified School District (HOPE Clinic)	\$275,000
Oak View Renewal Partnership	\$100,000
OC Vital Brain Aging Program	\$225
Omid Multicultural Institute for Development	\$45,000
Pediatric Adolescent Diabetes Research Education Foundation	\$98,064
Project Kinship (Charitable Ventures OC)	\$30,000
Providence Speech and Hearing Center- Low Income Program	\$155,000
Public Law Center	\$25,000
Save Our Youth (SOY)	\$50,000
SENECA Family of Agencies	\$25,000
Senior Transportation (6 agencies)	\$600,000
Serve the People Inc.	\$20,000
Serving Kids Hope	\$200,000
Share Our Selves Medical and Dental Clinic	\$1,701,321
Shoes That Fit	\$5,000
Social Model Recovery Systems Inc.	\$10,000
Someone Cares Soup Kitchen	\$67,600
Strength in Support	\$30,000
Susan G Komen	\$75,000
Talk About Curing Autism	\$15,000
The Cambodian Family	\$25,000
The Wooden Floor	\$10,000
Wiseplace	\$20,000
Women's Health Services Committee Grants	\$400,000
Young Lives Redeemed	\$20,000
Young Men's Christian Association (YMCA) of Orange County	\$25,000
<b>Total Cash and In-Kind Contributions</b>	<b>\$7,228,881</b>

**Community Benefit Operations**

Community Health Department Operations	\$722,643
Dedicated Staff	\$674,762
Community Health Needs Assessment	\$16,338
PARO Decision Support (Predictive Modeling for Healthcare)	\$10,470
<b>Total Community Benefit Operations</b>	<b>\$1,424,213</b>

**Total Benefits for Vulnerable Populations**

**\$9,408,132**

**Benefits for the Broader Community****Net CB Expenditure*****Community Health Improvement Services***

Community Education and Outreach (various Hoag departments)	\$443,078
Flu Immunization Clinic Expenses	\$111,457
Freedom from Smoking Program	\$3,000
Health Ministries Program	\$167,287
OB Education Classes	\$21,223
Project Wipeout	\$28,091
<b>Total Community Health Services</b>	<b>\$774,136</b>

***Health Professions Education***

Clinical Care Extender Program	\$170,672
Hospital Case Management Internships	\$31,013
Palliative Care Internship	\$14,800
Pharmacy Student Clinical Rotations	\$4,125
Rehab Therapy Internships	\$7,645
<b>Total Health Professions Education</b>	<b>\$228,255</b>

***Subsidized Clinical Specialty Services***

ETOH/Psych/Ancillary Patient Transfer Program	\$280,659
<b>Total Subsidized Clinical Specialty Services</b>	<b>\$280,659</b>

***Cash and In-Kind Contributions***

AIDS Services Foundation	\$40,000
Alzheimer's Orange County	\$112,500
American Lung Association	\$5,000
American Red Cross	\$25,000
Better Breathers Support Group	\$1,960
Big Brother Big Sisters Of Orange County	\$60,000
CHOC Pediatric Diabetes Services at the Allen Diabetes Center	\$640,000
City of Irvine	\$30,000
Clinic in the Park (One OC)	\$40,000
Crohn's & Colitis	\$20,000
Discovery Science Center of Orange County	\$25,000
Domestic Violence Awareness	\$281
Epilepsy Support Network	\$25,000
Families & Communities Together F.A.C.T- (Charitable Ventures OC)	\$5,000
Family Service Team (One OC)	\$10,000
Gay and Lesbian Community Services Center of OC	\$25,000
Health Funders Partnership of OC (One OC)	\$10,000
Hurtt Family Health Clinic Inc.	\$20,000
Infectious Disease Association of California	\$10,000
In-Kind Office Lease/Meeting Space for Non-Profits	\$654,793
Irvine Children's Fund	\$25,000
Irvine Community Drug Prevention	\$15,000
Irvine Public Schools Foundation	\$100,000
March of Dimes	\$15,000

Marshall B Ketchum University	\$15,000
Newport Beach Police Association- Every 15 Minutes Youth Education	\$7,000
Newport Mesa Schools Foundation	\$10,000
OC Funders Roundtable (Charitable Ventures)	\$5,000
Orange County Advance Care Planning Partners (OC-ACPP/POLST)	\$75,000
Orange County Bar Foundation	\$30,000
Orange County Human Relations	\$80,000
Orange County United Way	\$5,000
Orange County Women's Health Project (Charitable Ventures of OC)	\$25,000
People for Irvine Community Health (DBA 211 OC)	\$50,000
Sweet Success Extension Program (SSEP)	\$15,000
Trauma Intervention Programs Inc.	\$5,000
Youth Employment Services	\$40,000
<b>Total Cash and In-Kind Contributions</b>	<b>\$2,276,534</b>

**Community Building Activities**

Community Disaster Readiness	\$9,900
<b>Total Community Building Activities</b>	<b>\$9,900</b>

**Total Benefits for the Broader Community                    \$3,569,484**

*Prepared By:*

**Gwyn P. Parry, M.D.**  
**Director, Community Health and Community Benefit Program**  
**Telephone: (949) 764-5724 Email: [Gwyn.Parry@hoag.org](mailto:Gwyn.Parry@hoag.org)**

**Minzah Z. Malik, MPH, MBA**  
**Manager, Community Benefit Program**  
**Telephone: (949) 764-6597 Email: [Minzah.Malik@hoag.org](mailto:Minzah.Malik@hoag.org)**

**Lauren Tabios, MPH**  
**Coordinator, Grants & Special Projects**  
**Telephone: (949) 764-5321 Email: [Lauren.Tabios@hoag.org](mailto:Lauren.Tabios@hoag.org)**