

HOAG MEMORIAL HOSPITAL
PRESBYTERIAN

Implementation Strategy (IS) 2023 - 2025

The logo for Hoag Memorial Hospital Presbyterian, featuring the word "hoag." in a white, lowercase, sans-serif font. The period is replaced by a solid orange circle. The logo is set against a background of horizontal brown slats.

MELINDA HOAG SMITH
CENTER FOR HEALTHY LIVING

A woman in a red and black plaid shirt and dark pants is walking with a small child in a red shirt. They are walking along a path in front of a building with horizontal brown slats. A tall, thin, light blue vertical signpost is visible to the right. There are some green plants in the foreground.

To provide feedback about this
Implementation Strategy or obtain a
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CommunityBenefit@hoag.org

Vision: To create access to quality health care and achieve health equity in the communities we serve.

Implementation Strategy Priorities

As a result of the findings of our 2022 Community Health Needs Assessment (CHNA) and through a prioritization process aligned with our mission, resources, and strategic plan, Hoag will focus on the following areas for its 2023-2025 Community Benefit efforts:

PRIORITY 1: MENTAL HEALTH AND BEHAVIORAL HEALTH

Consistent across all data, behavioral and mental health was identified as a significant concern in the community. Nearly a quarter (23%) of community survey respondents (n=637) indicated that the most pressing health need (out of a list of 23 needs) in their household was emotional wellbeing. Furthermore, when asked about the most pressing health need in their communities, focus group and interview participants overwhelmingly cited behavioral health despite not being prompted with a list. This includes 78% of interviewees (14 interviewees) and eight of the nine focus groups. Additionally, provider survey (n=160) respondents also indicated that the most pressing health.

What's the Issue?

Behavioral health is the scientific study of the emotions, behaviors and biology relating to a person's mental well-being, their ability to function in everyday life and their concept of self. Behavioral health is sometimes called mental health and often includes substance use.

Why is it an issue?

An estimated 26% of Americans ages 18 and older — about 1 in 4 adults — suffers from a diagnosable mental disorder in a given year. Prior to the pandemic, 12.1% of adults living in Orange County report suffering from severe psychological distress. Approximately 19.5% of Orange County adults need help for emotional-mental and/or alcohol drug issues. Of those who needed help, about half were not able to receive any treatment.

Providers who responded to our survey explained that services addressing behavioral health and mental health are disorganized and not holistic in Orange County. While access to and adequacy of behavioral and mental health services need considerable improvement, two populations have emerged as particularly vulnerable groups in Orange County: older adults and youth. Older adults face higher occurrences of social isolation and loneliness, conditions that have been exacerbated by the pandemic. Young people have also experienced significant isolation and trauma in their lives during the pandemic. For some, it has led to an increase of anxiety and depression as well as substance use. In 2021, there were a total of 1,346 deaths from substance use in Orange County. The Orange County Health Care Agency reports that during the COVID-19 pandemic years of 2020 and 2021, drug and alcohol-related deaths increased notably across the county. The number of deaths from drugs and alcohol among all ages increased by 32% from 2019 to 2020, and another

30% from 2020 to 2021. However, the most dramatic changes in mortality were among youth in Orange County. For residents ages 10-17 years, the number of deaths from drugs and alcohol increased by 800% from 2019 to 2020, and another 122% from 2020 to 2021. Although the number of deaths were relatively small compared to other age groups, the fact that this age group would normally have 0 or 1 deaths in pre-pandemic years, compared to 9 deaths (in 2020) and 20 deaths (in 2021), makes this rise in mortality a concerning trend.

Mental Health Indicators, Adults, Ages 18 and Older

	Orange County	California
Adults who likely had serious psychological distress during past year	12.1%	12.6%
Adults who needed help for emotional-mental and/or alcohol-drugs issues in past year	19.5%	21.7%
Adults who sought/needed help but did not receive treatment	46.9%	45.6%

Source: California Health Interview Survey, 2019. <http://ask.chis.ucla.edu>

PRIORITY 2: ACCESS TO HEALTH CARE

One of the greatest barriers to healthcare identified through this needs assessment was access to and delivery of care. Seven (39%) of 18 interviewees noted healthcare access and delivery were the greatest health needs and 19% of provider survey respondents (n=160) indicated healthcare access and delivery were contributing to poor health outcomes in the communities they serve. This was also a pervasive theme throughout focus groups. Barriers associated with healthcare access included 1) costs, 2) availability of services, 3) navigating the healthcare system 4) lack of awareness and education about resources available in the community.

What's the Issue?

Access to comprehensive, quality affordable health care is important for health and quality of life. Components of access to care include insurance coverage, availability of services, timeliness, and workforce. Insurance coverage helps facilitate an individual's entry into the healthcare system. Availability of services affords residents greater access to primary care physicians and a regular healthcare provider which improves screening and prevention services. Timeliness is an important factor to provide care when the need is identified. Workforce refers to having adequate primary and specialty care providers and support staff who can meet the needs of the community. Components of delivery of care include quality, transparency and cultural competence.

In Orange County, residents with low socioeconomic status are more likely than higher-status groups to have access-related issues, such as no health insurance, an inability to afford medications, inadequate transportation to medical appointments, and a lack of recent health screenings. According to the 2020 American Community Survey, people of Latinx, Pacific Islander and other ancestries have the lowest rates of health insurance.

PRIORITY 3: CANCER/CHRONIC DISEASE

Ten percent of respondents in the provider survey listed cancer as a top health concern, which placed it among the top 10 health concerns identified by a community of medical practitioners, community health workers and other service providers. Twenty-five percent of community survey respondents also cited cancer as a top health concern.

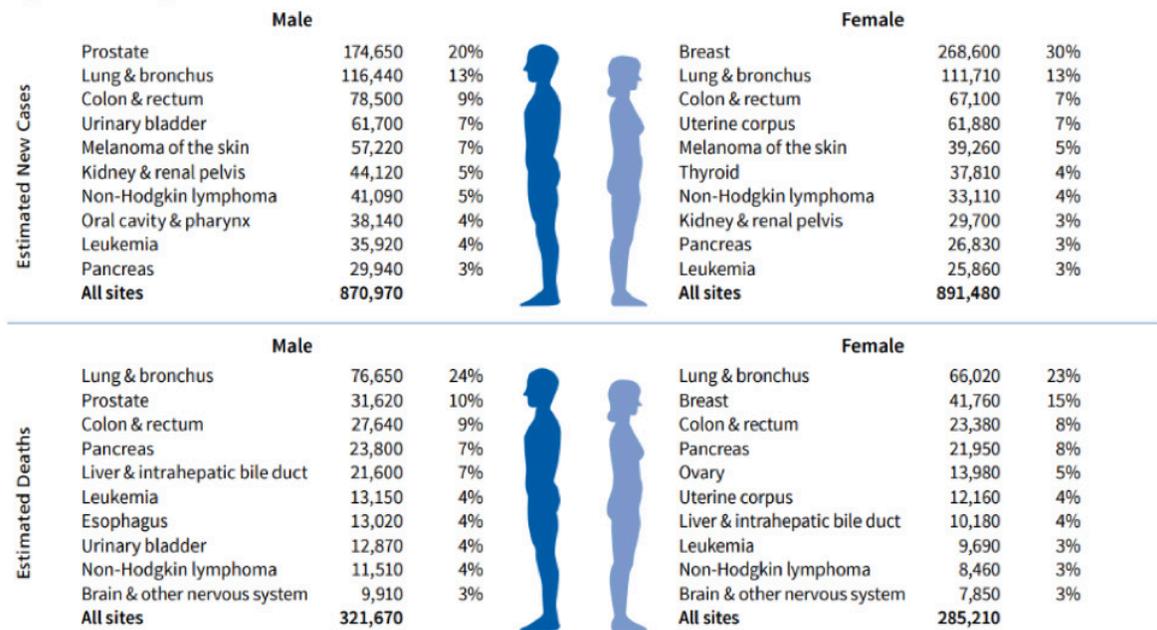
What’s the Issue?

Cancer is the second leading cause of death in Orange County, and rates of childhood cancer diagnoses are higher in Orange County compared to California. Cancer is the costliest illness in the United States and people with cancer often have high out-of-pocket health care costs. It is also often physically and emotionally difficult for those living with it and for their care providers. People who say they have had cancer are more likely to report poor health and symptoms of depression. Despite the fact that cancer is an important health problem, many Americans don’t comply with cancer screening protocols or take preventive measures such as protecting themselves from the sun.

Why is it an issue?

In addition to being the second leading cause of death in Orange County and having high rates of childhood cancer diagnoses, Orange County ranks in the top three highest counties in California for overall cancer prevalence, following Los Angeles County and San Diego County. Significant ethnic disparities in cancer occurrences are seen for White, African ancestry, Latino and Pacific Islander populations. In Orange County, cancer accounts for nearly one in four deaths among men and women.

Figure 3. Leading Sites of New Cancer Cases and Deaths – 2019 Estimates



Estimates are rounded to the nearest 10, and cases exclude basal cell and squamous cell skin cancers and in situ carcinoma except urinary bladder. Estimates do not include Puerto Rico or other US territories. Ranking is based on modeled projections and may differ from the most recent observed data.

©2019, American Cancer Society, Inc., Surveillance Research

Research has found that health disparities related to cancer contribute to higher, avoidable death rates among low-income and ethnic minority populations. The disparities may be exacerbated by delivery issues in cancer screening and follow-up. Although personal behavioral and environmental factors are significant (smoking, exposure to known carcinogens), the most important risk factors for cancer are lack of health insurance and low socioeconomic status.

HOAG'S IMPLEMENTATION STRATEGY

The Implementation Strategy was developed with input from the Community Benefit Committee and the Department of Community Health. For each health need that Hoag plans to address, the Implementation Strategy describes: actions that Hoag intends to take, including programs and resources it plans to commit; anticipated impacts on these actions; and planned collaboration with other organizations.

Mental Health and Behavioral Health

Strategies

1. Provide mental health care services through Hoag's Mental Health Center primarily focused on the low-income population
2. Provide funding and/or in-kind support to community nonprofit organizations that focus on mental health that goes beyond our scope of care. This includes partnerships with local FQHCs and BE WELL OC.
3. Provide workforce development opportunities (internships, internal and external professional development) for the mental health profession.
4. Use existing pathways to expand our continuum of care for mental health.

Expected Outcomes for this health need

- Increase access and remove barriers to mental health care services in community settings.
- Provide bilingual, bi-cultural mental health care services to people who otherwise could not obtain mental health services.
- Bridge gaps, improve referrals and increase coordination among mental health care providers and community resources and programs.
- Leverage Hoag assets to build capacity among community clinics and community organizations to improve access to mental health care.

Access to Health Care

Strategies

1. Provide financial assistance through free and discounted care for health care services, consistent with the hospital's financial assistance policy.
2. Offer information and enrollment assistance for no cost and low-cost insurance programs.

3. Provide funding and/or in-kind support to community clinics.
4. Provide funding and/or in-kind support to community nonprofit organizations that reduce barriers to accessing care.
5. Provide partners with space and resources at the Melinda Hoag Smith Center for Healthy Living.
6. Provide transportation support for seniors to increase access to health care services.
7. Collaborate with Share Our Selves to provide orthopedic care to the under-served (HOI)
8. Provide in-kind clinics to young athletes during fall sports (HOI)

Expected Outcomes for this health need

- Increase access to primary health care and a medical home.
- Bridge gaps, improve referrals and increase coordination among health care providers and community resources and programs.
- Leverage Hoag assets to build capacity among community clinics and community organizations to improve access to health care.

Cancer/ Chronic Disease

Strategies

1. Provide funding and/or in-kind support to community clinics.
2. Provide funding and/or in-kind support to community nonprofit organizations that focus on cancer/chronic disease prevention and management.
3. Provide partners with space and resources at the Melinda Hoag Smith Center for Healthy Living.
4. Offer chronic disease prevention, management, education, care navigation, screenings and support groups.
5. Continue to provide wellness and prevention programs to vulnerable communities.

Expected Outcomes for this health need

- Improve individuals' compliance with chronic disease prevention and management recommendations.
- Increase community awareness of disease prevention strategies.
- Leverage Hoag assets to build capacity among community clinics and community organizations to improve chronic disease management among at-risk populations.
- Provide access to needed health promotion resources for vulnerable populations at-risk for or suffering with chronic diseases.
- Continue health education and health coaching efforts – e.g. public school presentations, community lectures, on-line education.
- Continue physician and healthcare provider education.

Joint Implementation Strategy

The IRS regulations allow for the conduct of joint Community Health Needs Assessments (CHNA) when hospitals define their service area communities the same. In compliance with these regulations, the CHNA was conducted jointly by Hoag Hospital Newport Beach, Hoag Hospital Irvine and Hoag Orthopedic Institute.

Planned Collaboration

To accomplish these strategies Hoag will collaborate with community partners. Sharing resources and enhancing the capacity of partner organizations supports the achievements of our goals.

Potential collaborative partners include, but are not limited to:

- Federally Qualified Health Centers (FQHCs)
- OC Publicly Funded Health Insurance Plan
– Cal Optima
- Be Well OC
- Orange County Health Care Agency
- Community health centers and community clinics
- Community-based organizations
- Faith based organizations
- Family resource centers
- Local municipalities
- Mental health associations
- School districts and schools
- Local food banks
- Senior centers and adult day centers
- Advocacy groups

Evaluation of Impact

Hoag will monitor and evaluate the programs and activities outlined above. Hoag anticipate the actions taken to address significant health needs will improve health knowledge, increase wellness behaviors; increase access to health and mental health care; and support self-sufficiency among vulnerable populations. Hoag is committed to monitoring key initiatives to assess impact and has implemented a system that tracks the implementation of the activities and documents the anticipated impact.

The reporting process includes the collection and documentation of tracking measures, such as the number of people reached/served, increases in knowledge or changes in behavior as a result of planned strategies, and collaborative efforts to address health needs. An evaluation of the impact of the Hoag's' actions to address these significant health needs will be reported in the next scheduled CHNA.

Health Needs Hoag Will Not Prioritize During Calendar Years 2023- 2025

Knowing that there are not sufficient resources to address all the identified community health needs, Hoag chose to concentrate on those health needs that can be addressed effectively given the facilities' areas of focus and expertise. This Implementation Strategy is not exhaustive of everything Hoag does to enhance the health of the community. Hoag will continue to look for opportunities to address community needs where it can appropriately focus on those needs.

The following community health needs identified in the 2022 CHNA will not be prioritized, however an explanation is provided below on various efforts that address these needs:

- **Community and Family Safety** – Other organizations in the community have the expertise and competency to effectively address these needs. Hoag partners with Human Options in providing support groups and workshops at the Melinda Hoag Smith Center for Healthy Living focused on domestic violence prevention and parenting classes.
- **COVID-19/Contagious and Infectious Diseases** – While Hoag is not prioritizing COVID-19 in the implementation plan at this point in the pandemic, Hoag will continue to deliver vaccines, testing, and medical care to address COVID-19 in the community. Hoag will also connect with local clinics and the Orange County Health Care Agency to refer out services to address these unmet needs.
- **Economic Insecurity** – Hoag partners with the Second Harvest Food bank to provide fresh produce and groceries twice a month to those in need. Hoag will partner with Cal Optima health plan to launch the medically tailored meal program for eligible patients upon hospital discharge. In addition, Hoag hosts a diaper distribution in partnership with Community Action Partnership OC to provide diapers to those families in need. Hoag also partners with CIELO, a nonprofit organization that provides educational workshops related to workforce development, business and entrepreneurial skills, and financial and computer literacy. Project Self Sufficiency is another collaborative partner that provides support and resources for single parents enrolled in college. Hoag is also starting a new partnership with United Way’s Spark Point program to advance economic security for low-income and under resourced families.
- **Environment/Climate Change** – Other organizations in the community are addressing this need.
- **Housing and Homelessness** – Hoag partners with Share Our Selves and Families Forward to provide rental and motel assistance to those eligible applicants. Hoag also partners with Serving People In Need (SPIN) to provide guided assistance to permanent housing placement.

Report Adoption and Comments

This Implementation Strategy was adopted by the Board of Directors of Hoag Memorial Hospital Presbyterian on May 9, 2023. The Community Health Needs Assessment (CHNA) and Implementation Strategy (IS) are available on the Hoag website at <https://www.hoag.org/about-hoag/department-of-community-health/reports>. To request a paper copy without charge, provide feedback or comments on the CHNA or IS Report, or any additional inquiries, please email CommunityBenefit@hoag.org.