

# **Community Benefit Report**

## **Hoag Memorial Hospital Presbyterian**

### **2015**

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# Hoag Memorial Hospital Presbyterian Community Benefit Plan 2015

## Table of Contents

<b>Executive Summary</b>	<b>1</b>
<b>Introduction</b>	<b>2</b>
History	3
Mission, Vision, and Core Values	4
Community Benefit Philosophy	5
Community Health Committee	6
<b>Community Health Needs Assessment</b>	<b>7</b>
Priority Health Issues	14
<b>Department of Community Health Programs</b>	<b>16</b>
Mental Health Center	16
Health Ministries	17
Community Programs	18
Project Wipeout	19
<b>Other Hoag Community Benefit Activities</b>	<b>20</b>
The Mary & Dick Allen Diabetes Center	20
OB Education	22
<b>Hoag Community Health Associates</b>	<b>23</b>
Share Our Selves Free Clinic	23
Alzheimer's Family Services Center	24
Human Options	26
Newport Mesa Unified School District-HOPE Clinic	27
Oak View Mobile Health Program	28
Providence Speech and Hearing Center	29
Senior Transportation	30
<b>Appendices</b>	<b>31</b>
Appendix A Hoag Hospital Charity and Discount Policy	
Appendix B Hoag Hospital Quantifiable Community Benefit for FY2015	
Appendix C Hoag Hospital Community Benefit Expenditures by Program	

## **Executive Summary**

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

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

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

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

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

Finally, Hoag provides uncompensated care (charity) to patients who are unable to pay for the full cost of their care. These expenditures amounted to over \$28 million in Fiscal Year 2015 (July 1, 2014 through June 30, 2015.) 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 FY2015 amounted to over \$40 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 2015.

## Introduction

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 eight urgent care centers and six 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. 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 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, endocrinology, genetics, rheumatology, diabetes, allergy & immunology, HIV and addiction medicine.

Hoag has been named one of the Best Regional Hospitals in the *U.S. News & World Report Metro Edition*. The organization ranked high-performing in Gastroenterology and GI Surgery, Geriatrics, and Gynecology. National Research Corporation has endorsed Hoag as Orange County's most preferred hospital for the past 20 consecutive years, and for an unprecedented 20 years, residents of Orange County have chosen Hoag as one of the county's best hospitals in a newspaper survey by *The Orange County Register*.

## **History**

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

The George Hoag Family Foundation and the Association of Presbyterian Members represent the two founding organizations of the hospital and continue to provide leadership as corporate members of the Hoag Corporation. These members annually elect the Board of Directors, which consists of 17 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).

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

### **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.

## **Community Benefit Philosophy**

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

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

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

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

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

Charity care is an integral component of the benefit that Hoag provides to the community. The current hospital Charity Care and Self Pay Discount Policy provide assistance on a sliding scale for uninsured and self-pay patients with family incomes up to 400% of the Federal Poverty Level. The Federal Poverty Level (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 2015 FPL for a family of four was \$24,250. The current Charity Care and Self-Pay Discount Policy is provided in Appendix A. In FY2015 the hospital served 11,540 Charity Care cases. Appendix B provides a summary of the quantifiable Community Benefit provided by Hoag in FY2015 (July 1, 2014 through June 30, 2015). Appendix C provides a detailed breakdown of the Community Benefit expenditures by program.

## Community Health Committee

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.

## Community Health Needs Assessment

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.

## Methodology

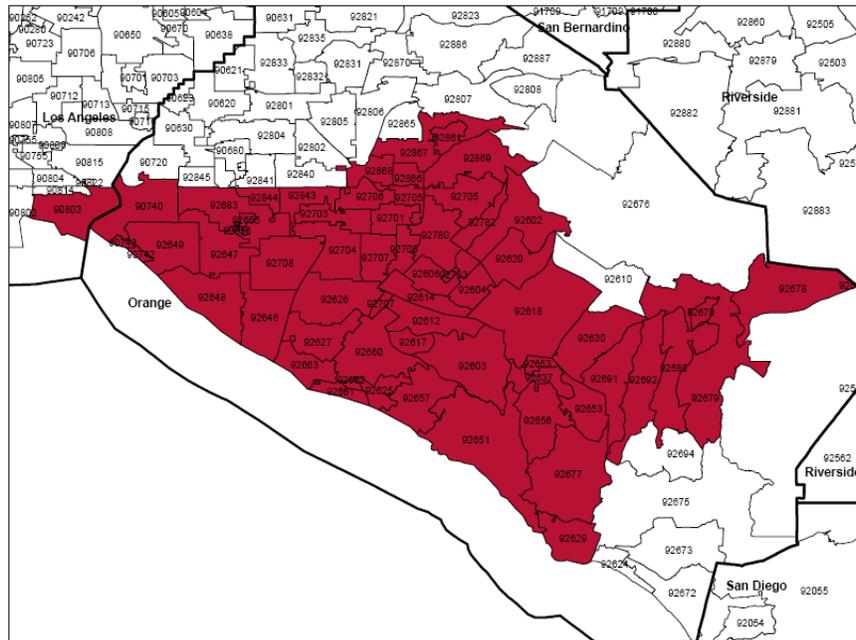
This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for trending and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

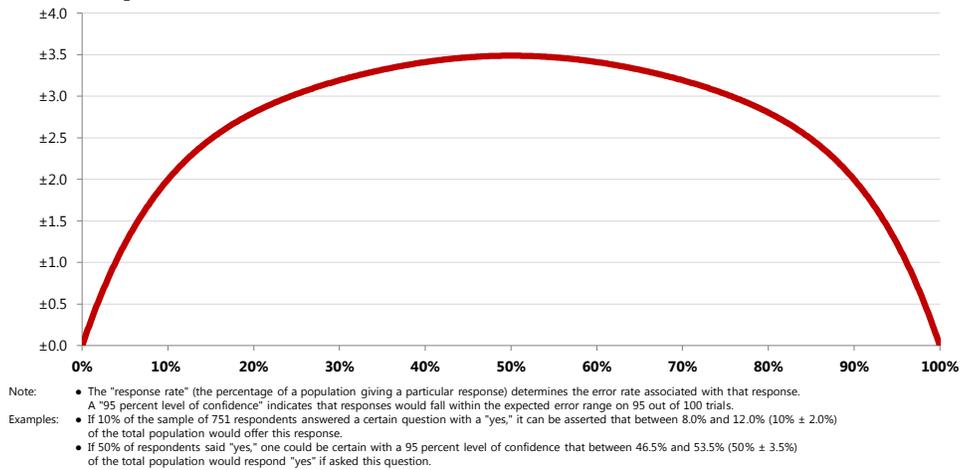
A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — 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.

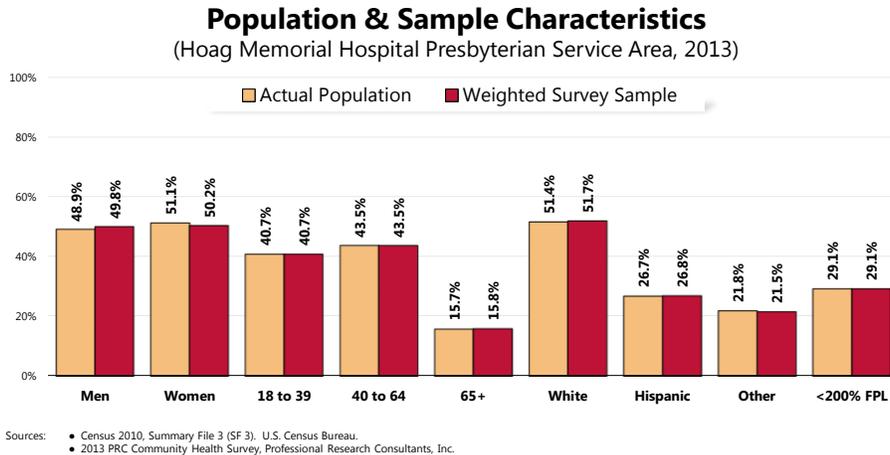
## Expected Error Ranges for a Sample of 751 Respondents at the 95 Percent Level of Confidence



### 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

Through this process, 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).

Areas of Opportunity Identified Through This Assessment	
<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. 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**

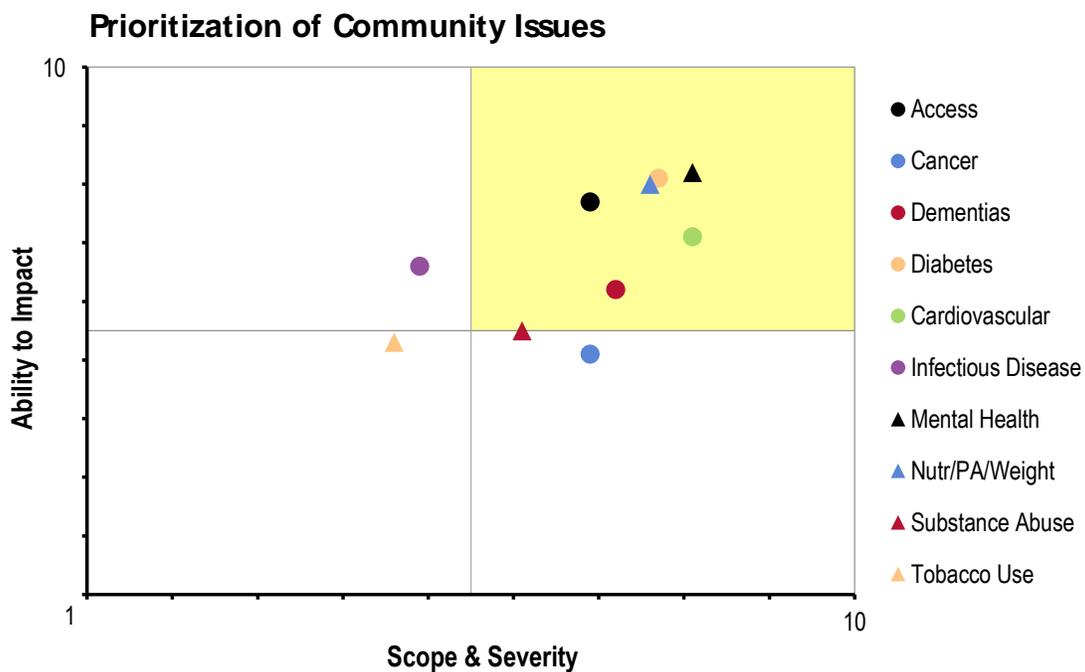
**Cancer**

**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.

## 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 FY2015: July 1, 2014- June 30, 2015.

### Mental Health Center

The Mental Health Center was created to provide bilingual bicultural services to people who otherwise could not obtain mental health services. The majority of the program's clients are low-income, uninsured and highly vulnerable 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 2015, the program employed seven full-time bilingual Master's prepared social workers, 6 of the staff are licensed. These social workers provided mental health services to 746 clients in the form of psychotherapy, resource brokering, and/or case management. In addition, the program offered psychotherapeutic and psycho educational groups to 897 participants. All services were offered on a voluntary basis. Services were offered on a low-cost sliding scale. The sliding scale starts at zero (free services) and increases according to the individual's self-reported annual income level. The vast majority of people were seen at no charge or 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. 44% 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 2015, the Mental Health Center provided a supervised clinical internship training program for 14 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 572.5 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. During FY 2015, the program continued its support to the Mary and Dick Allen Diabetes Center at Hoag Hospital. The Mental Health Center was responsible for all the mental health services being provided to the patients of this center. A LCSW served a total of 138 clients by means of 62 mental health consults and 12 stress management classes.

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## **Health Ministries**

Hoag Health Ministries celebrates its twenty-eighth year of serving Orange County faith communities through the Faith Community Nursing (FCN) Program. The program has grown to 64 volunteer FCN's who dedicate their time and service to those in need at 33 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 individual and population health based preventive health programs specific to the needs, beliefs and practices unique to their faith traditions.

During FY 2015, Health Ministries

- Comprised of 9 denominations amongst the 33 Faith Based Partnerships
- Donated 8,000 Volunteer RN hours at the local, national and international level
- Touched the lives of more than 45,000 congregants
- Administered 7,373 flu vaccine doses to faith members and the community
- Served 503 congregants with spiritually based aging and dementia care lectures
- Provided 2 Automated External Defibrillators (AED's) to partners, total 32 placed
- Trained 212 persons in life-saving CPR & Automated External Defibrillator usage
- Screened Blood Pressure readings for 1058 individuals, teaching healthy lifestyle options and Stroke recognition skills
- Organized blood donations, receiving 407 units of life-giving blood
- 194 children received disease-preventing hand washing training
- Distributed 1871 Project Wipeout Beach Safety booklets

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

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## **Community Programs**

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

### **Case Management:**

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

During FY 2014

- 6,052 unduplicated SOS patients received Hoag services.
- 268 hospital days were utilized by patients needing medical, surgical or obstetric care.
- 68 newly diagnosed persons received free diabetes education through the Mary & Dick Allen Diabetes Center at Hoag, including 45 pregnant women who received specialized gestational diabetes education through the Sweet Success Program.
- In partnership with local senior centers, a personal alert (Lifeline) system was provided for 4 homebound older adult residents.

### **Community Collaborations:**

Spirituality Conference – In collaboration with St. Joseph Health/St. Jude Medical Center - Caregiver Resource Center and the Alzheimer’s Family Services Center, Hoag Community Benefit sponsored the 2015 Spirituality Conference – ‘Growing in Life’s Transitions’. The conference explored the role of spirituality in healing and coping for caregivers, family members, clergy and health professionals who are involved with the care of others. Faith-based approaches to successful aging, mindfulness, the role of hospice care in life’s transitions, and the ethical dilemmas challenging the 21<sup>st</sup> century citizen on end-of-life choices were all examined. The conference was attended by 175 community clergy, health care professionals and caregivers.

Cinco de Mayo Heart Health Fair –Hoag Community Health collaborated with Hoag’s Heart & Vascular Institute, Edwards Lifesciences and the SOS Clinic in providing telemedicine heart screening services to 1,000 low-income community members. Follow-up services for the 480 individuals identified with pre/hypertension, valve or other heart problems were scheduled with the SOS Clinic if they did not have a medical home. Additionally, each participant received a \$10 Farmer’s Market gift certificate, promoting access to healthy foods.

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## **Project Wipeout**

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

Project Wipeout:

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

Project Wipeout's intent is to provide basic information on the types of injuries that occur, how they happen, and what to do to protect against them. This information is disseminated via presentations, videos, and printed materials at schools, community events, lifeguard training, and seminars. More than 30,000 copies of Project Wipeout brochures, coloring books and activity books are distributed annually through community events and at elementary, junior high and high schools. Print materials are also used at presentations given by local lifeguards, which feature Project Wipeout's video (mandatory viewing for trainees in Orange County's junior guard programs). It is also being used throughout the U.S. and by lifeguard departments as far away as England and Australia, and it is seen by thousands of elementary, junior high and high school children every year.

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

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## **Other Hoag Community Benefit Activities**

Hoag's commitment to Community Benefit is best exemplified by the dedication of an entire department to the coordination and provision of Community Benefit programs. The hospital's Community Benefit activities are not limited to the department of Community Health. Other hospital departments provided a wide range of Community Benefit activities during FY2015, including health professions education, clinical research, support groups and many more. This section of the report features a discussion of some examples of the Community Benefit activities that were provided by other hospital departments in the current reporting period.

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

According to the 2014 National Diabetes Statistics Report from the CDC, nearly 29.1 million Americans live with diabetes and more than 86 million Americans are pre-diabetic. 1 of 4 do not know they have diabetes and 9 of 10 do not know they have prediabetes. The total economic burden in 2012 was \$332 billion for costs related to diagnosed diabetes, undiagnosed diabetes, prediabetes, and gestational diabetes (American Diabetes Association, 2015). Diabetes was the seventh leading cause of death in the US. Many complications and comorbidities include cardiovascular disease, stroke, kidney disease, blindness, and loss of lower limbs. The risk of death for adults with diabetes is 50% higher than for adults without diabetes (CDC, 2014). Nonetheless, diabetes can be managed through expert medical care and embracing healthier lifestyles, which are the driving forces of the Mary & Dick Allen Diabetes Center (referred to as "the Center").

Since its opening in 2009, the Center has offered comprehensive services that include health education by our nurses and dietitians, medication management by our pharmacist, and medical consultation and evaluation by our endocrinologist. The Center has also participated in various outreach events including lectures at the Costa Mesa Senior Center, diabetes risk assessments at local health fairs, and cooking demonstrations. **Below are a few program highlights from FY 2015:**

#### ***Program Director named Top Doctor in Orange County***

Daniel A. Nadeau, MD, who joined Hoag as the program director of the Allen Diabetes Center in 2013, is the first recipient of the Dr. Kris V. Iyer Endowed Chair in Diabetes Care funded by donor support. Dr. Nadeau brought his extensive experience with research, insulin and nutrition. This year, Dr. Nadeau was named to the exclusive list of 2015 Castle Connolly Orange County Top Doctors based on peer physician research, as seen in Orange Coast Magazine. In addition to providing state of the art care, he is also overseeing two Type 2 diabetes clinical research studies in which both studies are currently open for enrollment.

#### ***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, nurses, dietitians, and certified diabetes educators. A total of 624 initial DSMT assessments and 511 MNT visits were completed in which 68 were unfunded patients.

#### ***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 FY2015, there were 2096 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. 4787 participants joined the PODER classes, and 223 participants were involved in the PADRE classes.

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

The Annual Diabetes Conference titled “Diabetes: What’s new? What’s next?” is scheduled for November 13<sup>th</sup>. Certified Diabetes Educators, Pharmacists, Registered Nurses and Registered Dietitians are invited and encouraged to attend for an educational day on clinical management. This one-day conference provides information on diabetes management and topics will include emerging adults and type 1 diabetes, nutrition, diabetes and cognitive impairment, cholesterol management, and the most recent technology and pharmacology updates.

### ***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. In the upcoming year, a licensed clinical social worker will be joining the team at the Allen Diabetes Center to provide the psychological and emotional support that are of great need to further emphasize the importance of comprehensive care in regards to diabetes management.

### ***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 a collaborative effort with the Hoag Women’s Health Institute and the Department of Perinatology, the program continues to provide perinatology services to a growing number of women with pre-conception and gestational diabetes. During FY 2015, we had 2073 patient encounters in which 46 unfunded patients were seen. Macrosomia rate dropped from 8.2% to 6.6%, significantly lower than the national average of 10%. Plans are in place to encourage physicians to order the oral glucose tolerance test for patients with gestational diabetes, improve the referral processes, and to ensure continuity of care from the in-patient setting to the Allen Diabetes Center.

### ***Outreach Events***

This past year, approximately 450 people participated in the Sweet Life cooking classes. During these classes, a professional chef and our nutritionist and certified diabetes educator provide insight on recipes and nutrition. The recipes used in the Sweet Life classes are designed by nutritionists and tailored to the dietary needs of individuals with diabetes. Our educators have also participated in various health fairs and senior centers by providing health education materials, presenting lectures, and conducting risk assessments to continue to positively impact the overall health outcomes in our community.

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## **OB Education**

Hoag's philosophy is that with the birth of every child, there is also the birth of a new family. Through a variety of educational classes and support services, Hoag's OB Education supports families throughout the exciting journey of pregnancy and parenthood. The comprehensive selection of prenatal classes include: Prepared Childbirth, Breastfeeding, Baby Care Basics, and Baby Saver. OB Education also provides programs and education for specific demographics, including mothers over the age of 35, mothers of multiples, and those experiencing cesarean birth. Other programs offered at no cost to the community include the car seat safety, couples 4<sup>th</sup> Trimester class, and hospital orientation and tours. Support group programs such as Post-Partum Adjustment, Perinatal Loss and Pregnancy after Loss are also available for free to the community. These support groups are highly attended, facilitated by a Licensed Clinical Social Worker (LCSW); provide ongoing support, education, and an opportunity to discuss the new challenges of parenthood. Support persons and babies are welcome. Hoag's Babyline is an information hotline for parents that operates five days a week and is answered by an OB Education registered nurse with special expertise and knowledge about pregnancy (before, during, and after), as well as baby care and breastfeeding. The Babyline staff is a key resource for new and expectant parents. The Babyline is available to the community Monday through Friday from 9am – 5:45pm. This hotline receives over 9,000 calls per year.

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## **Hoag Community Health Associates**

The principal strategy of the Department of Community Health is to not “reinvent the wheel” with respect to providing necessary community health programs and services. We work closely with a broad array of community based not-for-profit organizations, and provide grant funding to some organizations whose services are consistent with our priorities. This collaboration enables us to participate in the follow-up process, by providing guidance and monitoring for grantees. This section of the report provides descriptions of some of our most important community health associates and their achievements in FY2015.

### **Share Our Selves**

Share Our Selves (SOS) has served Orange County since founding in 1970 and remains principled on providing social and health services to the most at-risk in our community. SOS’s history is intimately tied to Hoag Memorial Hospital Presbyterian and its Community Benefit Programs, a partnership which has greatly benefited Orange County. In 1984, SOS opened the SOS Free Clinic with Dr. Donald Drake, Hoag’s Chief of Staff at the time, as the first acting Medical Director.

The target population of SOS and Hoag are shared. Historically, the population served by SOS represents the uninsured, underinsured, and homeless of diverse ethnicities and age groups; with over 90% living at or below 100% of the Federal Poverty Level. Organizationally, SOS assists more than 120,000 unduplicated individuals annually. Below is an overview of SOS programs and health center network:

- 1970: Founded, Social Services Program
- 1984: Established SOS Free Medical Clinic
- 1987: Expanded to include Free Dental Clinic
- 1993: Full-Service, On-Site Dispensary opened
- 2005: Integrated Behavioral Health Program
- 2010: SOS-El Sol Wellness Center, Santa Ana
- 2012: SOS and PEACE Center Health Clinic, Lake Forest
- 2012: Achieved Federally Qualified Health Center to include Health Care for the Homeless Provider Designation
- 2014: SOS Children & Family Health Center, Newport Beach
- 2015: National accreditation as Patient Centered Medical Home
- 2015: SOS Health Center at the Samuelli Academy, Santa Ana (12/2015)
- 2016: SOS & Dr. Robert and Dorothy Beauchamp Family Dental center (1/2016)

Across our network of clinics, SOS’s service delivery model is the Patient Centered Medical Home; for which SOS is nationally recognition by the National Committee for Quality Assurance (<http://www.ncqa.org/>). This model of care provides comprehensive health throughout the lifecycle inclusive of comprehensive primary and specialty healthcare, full-mouth restorative and preventative dental care, integrated behavioral health services, and clinical pharmaceutical services program. Outpatient care is complemented by hospitalist inpatient follow-up, treatment adherence education, clinical case management, disease management, counseling, and education. SOS is a Federally Qualified Health Center (FQHC), 1 of 1,600 nationally, with special designation as a Healthcare for the Homeless provider, 1 of 256 nationally. FQHC’s are community-based agencies that provide comprehensive primary and preventive care to persons of all ages, regardless of their ability to pay or health insurance status, in a Medically Underserved Area. Unlike other FQHC’s, SOS continues to provide access to care to all Orange County residents, providing access beyond its federal service area. Over thirty years ago, SOS founded its clinic programs on the principle and provision of social services to address the social determinants of health. Only recently has there been national recognition by the healthcare industry to consider social determinants of health, concurrently with health conditions.

Today, SOS is the only community health center network in the county providing a full continuum of healthcare and social services to its patients. The SOS Comprehensive Service Center provides patients access to extensive social support services addressing these social determinants of health. On-site services are inclusive of:

- Food Pantry
- OC Health Care Agency
- Public Health Nurse
- Homeless Outreach Case Manager
- CalFresh Enrollment
- Emergency Financial Aid
- Medi-Cal Case Worker
- Public Law Center
- US Mail Services
- California LifeLine

Acknowledging growth of services and our expanded reach within the community it is in large part due to the support of collaborative partners. With the extensive funding and in-kind support provided by Hoag, SOS is afforded the ability to provide exceptional care within a collaborative spirit that is principle on efficient, effective and respectful healthcare. Hoag and SOS continue to share in the care of the targeted population, either starting at Hoag and receiving follow up care at SOS or starting at SOS and referred to Hoag for advanced diagnostics, treatment, surgery, emergency services, or hospital admission. Through a shared Health Information Exchange, this hospital-clinic model allows the Hoag and SOS Nurse Case Manager's to develop a discharge plan coordinating care inclusive of primary, specialty, and enabling social services; reducing patient re-admission through comprehensive care coordination.

During the Fiscal Year of July 1, 2014 through June 30, 2015, SOS provided a medical home to 11,966 unduplicated patients accounting for a total of 35,961 provider encounters; a 35% growth over prior FY. The continuum of care between SOS and Hoag allows for a seamless transition of uninsured patients accessing Hoag affiliated Specialists and Hoag ancillary support services, evidenced by over 3,000 charity care encounters completed by Hoag during the fiscal year.

This close partnership between SOS and Hoag demonstrates a sustainable and replicable model of care for others to follow and truly expands access to all levels of health care for the community. Further, it increases efficiencies, reduces the use of the Emergency Department (reducing costs and opening access for true emergencies), protects public health, and improves opportunities for county residents without insurance to receive primary care and control their chronic diseases.

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### **Alzheimer's Family Services Center**

Alzheimer's Family Services Center (AFSC) plays 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. Our innovative services and dementia care expertise enable us to meet the medical and psychosocial needs of our community's most vulnerable seniors – those facing a host of chronic health conditions in addition to dementia at all levels of severity.

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. The impact of the Alzheimer's epidemic is a growing challenge and public health concern given the rising incidence of the disease in our community, the devastating emotional and financial losses to families, the massive economic burden on our already taxed healthcare system, and the substantial costs to local businesses as a result of declining worker productivity for employed caregivers. We are not only poised to meet the growing healthcare needs of the impending "Generation Alzheimer's", but are committed to supporting 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 six-week seminar and interactive participation and education series focused on early treatment, interventions, and improving quality of life for individuals and families dealing with early memory challenges.

*New Connections Club* – AFSC’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* – AFSC’s adult day health care program for individuals as they transition into the moderate-to-severe stages of dementia.

*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.

*Intensive Care Management Support* – We assign a social worker and a nurse 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, And 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 two free support groups, each offered twice monthly by AFSC in collaboration with the Alzheimer’s Association of Orange County. Support groups represent an important vehicle for caregivers to gain knowledge, skills and support from their peers as well as professional leaders. Further, support groups serve as a testing ground for caregivers to “run ideas by” others, particularly when trying to manage a difficult behavior like wandering. Research has indicated that support group participation is successful at disseminating information and increasing caregiver informal social networks.

*Caregiver Depression Screenings* – AFSC 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 38 professionals rich in cultural, linguistic, and professional diversity. Generous grant support from the Hoag’s Community Benefit Program helped us serve 13,114 individuals through the provision of affordable, high-quality, culturally- appropriate services in fiscal year 2014-15. With Hoag’s gift, we were able to achieve the following last year:

- 225 unduplicated elders received dementia-specific adult day health care, based on an individual plan of care provided by our compassionate multidisciplinary clinical team.
- 432 callers received 801 hours of care management and pre-enrollment support.
- 675 caregivers received 1,575 hours of intensive care management from one of our social work professionals.
- 10 dementia caregivers received clinical counseling from our master's level social workers.
- 52 family caregivers attended one or more of our 43 support group sessions led by a dementia care expert.
- 11,720 plus community members learned about dementia and available services via 103 community outreach activities.

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.

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### **Human Options**

Human Options is a nonprofit agency in Irvine, CA with the mission to provide safe haven and life changing programs to help abused women, their children and families rebuild their lives – and works with the community to break the cycle of domestic violence. Last year Human Options served over 1,400 clients with direct services, the 24-hour emergency hotline fielded over 4,000 hotline calls, and the community education program served over 6,800 community members.

Human Options' programs change and save lives and further the organization's mission by providing intervention and prevention services in order to break the intergenerational cycle of domestic violence in families and in the community.

Programs include:

- *Residential Shelter program* - provides clients with shelter, basic needs, counseling, and case management. This program includes the 24-hour emergency hotline, emergency shelter, and two transitional housing facilities.
- *Community Based programs* – provides services in the community where graduates of our residential programs, as well families affected by domestic violence who do not wish to enter a residential program can receive individual and family counseling, support groups, psycho-educational programs, parenting education, legal advocacy, and a specialized elder abuse prevention program. Services are provided at the Center for Children and Families in Costa Mesa, with satellite offices in five Family Resource Centers across Orange County.
- *Community Education program* - provides educational programming to schools, community groups, healthcare professionals, employers, law enforcement agencies, faith based groups, human resource professionals, and social service agencies aimed at reducing and preventing the occurrence of domestic violence and changing societal attitudes and beliefs that perpetuate the cycle of violence.

Partnering with Hoag allows Human Options to enrich services at the Center for Children and Families (CCF) through a bilingual counselor. CCF's main objective is to help battered victims, their children, and surrounding communities to enhance the physical safety and health of families, to provide tools to reduce risk of abuse, and to break the cycle of domestic violence through education, counseling, and legal assistance. Our reputation and expertise as a culturally competent provider have enabled us to reach families in the shadows of poverty that typically do not access services due to crisis-prone orientations and fear of legal repercussions.

The goals of the program are to help victims of domestic violence break out of the cycle of violence by educating them about the dynamics of domestic violence, safety planning, and the wide-ranging effects of violence on themselves and their children; to improve the overall well-being of adults and children by reducing trauma and anxiety symptoms; and to enhance adults' and children's ability to engage in healthy communication and healthy coping. Specific outcome measurements include:

After treatment:

- 80% of clients will report increased safety, coping skills, and domestic violence knowledge as measured by scores on Human Options' self-administered Pre and Post-test
- 80% of clients will exhibit reduced levels of anxiety as measured by a lower GAD7 score
- 80% of clients will exhibit reduced levels of depression as measured by a lower PHQ9 score
- 90% of participants in the Personal Empowerment Program groups (PEP) will exhibit increased knowledge of how to stay safe, effects of domestic violence on children and legal rights as measured by scores on Human Options' self-administered Pre and Posttest

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### **Newport Mesa Unified School District**

Hoag collaborates with the Newport-Mesa Unified School District by providing a grant to the HOPE Clinic, a school based health center. The HOPE Clinic is located in Costa Mesa and housed on a campus with Rea Elementary school, a district run preschool, an adult education center, several after school programs, and a Head Start Program as well as a community theatre.

The HOPE clinic is unique in that it facilitates children's access to school programs and serves to keep children healthy and in school. Health promotion and well child exams are the cornerstone of the program. The primary focus is to promote wellness and prevent illness through periodic well child exams and recommended immunizations. Services are at no cost to families and provided by a bilingual Spanish-speaking staff.

The HOPE Clinic is a nurse practitioner and school nurse run practice supervised by a volunteer community pediatrician. Clinic providers are school district employees who are familiar with district and community programs. Staff serve as liaisons to services within the district and the broader community. At the HOPE Clinic, children are linked to a variety of programs including Dr. Riba's Health Club which offers a specialty program addressing childhood obesity. Assistance with health insurance is available on site or by referral. At each visit, parents are encouraged to read to their children and books are distributed through the Reach Out and Read Program, an initiative supporting literacy. Other services at HOPE Clinic include TB screening and testing for students, staff and school volunteers and influenza immunizations for the entire community.

The HOPE Clinic continues to participate in a national initiative led by Kaiser Permanente and the National School Based Health Alliance to improve health behavior among students, their families, and school staff at Rea Elementary.

During the 2013-2014 school year, major accomplishments included:

- 3775 patient encounters.
- 785 children's comprehensive physical exams.
- 1411 child immunizations provided.
- 991 Tuberculosis skin tests.
- Referral and case management services including dental, vision, hearing, mental health and social services.
- Over 282 children received insurance at the clinic and more were referred for assistance.
- Over 300 individuals received flu vaccine at the Community Flu Vaccine clinic hosted at Rea Elementary School.
- Rejuvenating the student supported garden at Rea Elementary School.
- Implementing a targeted Staff Wellness Program at Rea Elementary School to help lessen stress and improve the educational experience for both students and staff.

**Contact: Merry Grasska, MPH, RN, FNP-C (949) 515-6730 or [mgrasska@nmusd.us](mailto:mgrasska@nmusd.us)**

## **Oak View Mobile Health Program**

Oak View Renewal Partnership's (OVRP) mission is to narrow the cultural, social, educational, health, and economic gap between the Oak View community and the remainder of Huntington Beach and Orange County; and to serve as a model for community development. Our vision is an empowered and healthy community. OVRP prides itself on being a strong, grassroots organization whose place-based initiative helps identify and address the roots of poverty within one community. Central to our work is the philosophy that sustainable change along the path to community renewal cannot be achieved through service provision alone. Sustainable change must be accompanied by the empowerment, buy-in, and leadership from the community we serve. By empowering the people who live in the neighborhood, our programs are more sustainable and bring the most substantial impact, and as a result the community becomes more vibrant and sustainable.

OVRP serves all residents in the Oak View neighborhood. The Oak View neighborhood, home to approximately 10,000 individuals, faces significant challenges including generational poverty, high unemployment, low home ownership, and poor graduation rates. One hundred percent of the individuals that will be served by this proposal are low- to moderate-income, as defined by having income levels below 80% of the area median income. 97% of students qualify for free or reduced-price lunch. While the city of Huntington Beach is predominantly affluent with poverty rates hovering near 6%, the rate is five times that in the Oak View neighborhood where 32% of residents live below the federal poverty level; furthermore, 70% of those 25 or older lack a high school diploma or GED. Nearly 40% of residents live in households of seven or more, and approximately 90% of the adult population has limited English-speaking abilities.

In 2014-2015, OVRP's Healthy Community Initiative facilitated the following programs and services:

- A community Health Needs Assessment, sponsored by Hoag Hospital, was conducted in 2014. A research intern from the Oak View neighborhood analyzed volumes of secondary data, conducted 2 focus groups and 100 interviews to determine recommendations for health programming in Oak View. Findings of the assessment validated existing programming, but also identified additional needs: adult dental care, health screenings, additional nutritional education and active living opportunities for 0-5yrs population. Study
- Mobile Health & Dental Clinic served approximately 250 clients, bringing previously inaccessible services right into the heart of the neighborhood through partnerships with the Hurtt Family Clinic, Healthy Smiles, Ocean View High School and other community-based organizations.
- A Youth Soccer League serves 40 boys and girls teams for youth ages 5 to 15 and provides a positive outlet for over 500 children from Oak View and surrounding neighborhoods. Partnerships with the Ocean View School District, Ocean View High School, and local Boys and Girls Clubs have provided facilities for the teams to practice and play games. Primarily driven by community leadership, the league keeps local youth off the streets while promoting healthy living and physical activity.
- A Zumba Class program was developed and enhanced in response to community surveys indicating a lack of easily accessible physical activities for local adults. Classes are offered weekly at the Family Resource Center, and over 1200 residents participated this past year. Many in the class meet 30 minutes beforehand to discuss nutrition or host a nutrition expert. The success of this class has led to the start of two additional classes in the neighborhood park, supported and run by local resident leaders. There are now Zumba options provided throughout the neighborhood every day of the week.
- Our Neighborhood Clean-Up, which takes place monthly, included over 500 Oak View volunteers last year. In addition to cleaning the streets, we attempt to build security and community pride through community arts and mural projects where people can gather to meet each other and work collaboratively building neighborhood unity through accomplishment.

- In partnership with Oak View Elementary and Second Harvest Food Bank, we host a School Pantry that provided 1362 residents last year with access to fresh produce on a monthly basis. Residents are now volunteering to help the operations of the program.
- Ongoing evaluation improvements are being made to better understand the impact of the programs and the organization on the community. We are currently collaborating with the USC Center for Social Innovation and The Olin Group to enhance our programmatic logic models/outcomes measures system, and further develop our community-wide evaluation index.

**Contact: Iosefa Joey Alofaituli at 714-596-7063 or [iosefa.ovrp@gmail.com](mailto:iosefa.ovrp@gmail.com)**

### **Providence Speech and hearing Center**

Providence Speech and Hearing Center (Providence) was founded in 1965 to provide Audiology and Hearing Care and Speech-Language Pathology to all those in need--regardless of their ability to pay. What began in a single room at a local hospital has grown to become one of the largest clinics of its kind in the country. Providence strives to achieve its mission of *Enriching Life Through the Gifts of Speech and Hearing* by continually providing the highest quality services in the identification, diagnosis, treatment and prevention of speech, language and hearing disorders for persons of all ages, races and socio-economic backgrounds. Providence is the ONLY safety net clinic of its type in Orange County and the only agency of its kind willing to accept Medi-Cal and other patients with government sponsored insurance. Approximately 61% of our work is dedicated to low-income patients all of whom are uninsured or under-insured.

Providence received grant funding in support of its Low Income Subsidy Program. This program works to respond to and resolve the speech, language and hearing barriers that exist for low-income children, adults and seniors. Our Low Income Subsidy Program offers comprehensive auditory, speech and language services to ALL low-income people in need – regardless of their ability to pay. Providence provides “Center of Excellence” quality of service of the highest caliber and results in each patient experiencing a dramatic improvement in their quality of life.

Providence achieved the following results during the grant period:

- Served 6,869 unduplicated low-income patients with 64,087 appointments
- Provided 48,742 speech/language sessions or appointments to low-income pediatric patients
- Distributed 1,217 free or reduced cost hearing aids to low-income patients
- 96% of adults fitted with hearing aids expressed improvement in their hearing and 98% of caregivers whose children were fit with hearing aids expressed a noticeable improvement in their child's hearing
- 99.1% of patients felt Providence met their needs

When someone invests in the mission of Providence, they are investing in the lifetime of our patients. Meet Michael Ramsey. As a sophomore in high school, Michael was in a terrible accident in November 2011 that resulted in major head trauma. The doctors had to remove a portion of his skull to control the internal bleeding and swelling. After several weeks of surgeries and rehabilitation, doctors were ready to reattach that section of his skull. Unfortunately, that caused a hemorrhage in his speech center resulting in aphasia. Michael couldn't speak, spell or read. Michael came to Providence in March 2012. Weekly therapy helped him regain the cognitive functions that were impacted by the injury to his brain -- attention, memory, organization of thoughts, and reasoning. By the time Michael began his junior year of high school in September 2012, he had successfully graduated from speech therapy and was back in his AP classes. He is now in his second year of college and is studying to be a neurosurgeon.

Providence provides critical follow up to the mandatory newborn hearing screening program done in all hospitals. Meet Jessica who was born without external ears (bilateral microtia). She came to us as an infant so that we could perform an Auditory Brainstem Response (ABR) test to assess the functionality of her auditory nerves. Luckily, the test proved that all of the internal components of her hearing were perfectly intact. Soon after, she was fit with bone-anchored hearing aids (BAHAs) to help her process sound. Now, 15 months later, Jessica is thriving. She is very playful and loves to interact with her family and playmates.

Sometimes Providence needs to step in to help a senior citizen regain their independence. A few years ago, Natalija had a stroke, and the related medical bills put her in financial distress. At the same time, her hearing was starting to decline, but hearing aids were out of reach, so she got by as best she could without them. But Natalija, who works as a court translator and interpreter, must be able to hear to provide specific and accurate dictation. Without hearing aids, that was becoming very difficult. Then she heard about Providence. Shortly after applying for a scholarship to help with the cost of hearing aids, she was thrilled to learn that she had been approved. “You cannot imagine how much you have helped me,” said Natalija. “Now I can keep working and be self-sufficient. In my job, I never want to put someone in jeopardy because I can’t hear them. We are fragile, and you have helped my life tremendously. Thank you!”

We are so proud of Michael, Jessica and Natalija for the great progress they have made, which was made possible through your support. We are truly grateful to you for helping us serve these patients and ALL patients in need!

### **Senior Transportation**

The Community Benefit Program collaborates with seven community senior centers for transportation services for their program participants. These organizations offer a broad range of services including congregate meals, health screenings, and educational, social and physical activities for their participants. In providing transportation services for seniors, we assist them in their efforts to sustain good mental and physical health, and to maintain their independence. The seniors use the transportation services to attend doctor appointments, shop and do errands, and participate in group social activities. The seven organizations served are: Alzheimer’s Family Services Center; Costa Mesa Senior Center; Huntington Beach Council on Aging; Irvine Adult Day Center; Newport Beach’s Oasis Senior Center; Age Well Senior Services, and Laguna Beach Seniors. Total Hoag expenditures on transportation for FY 2015 was \$538,885 for approximately 145,553 senior passenger trips.

## Appendices

- Appendix A**      **Hoag Hospital Charity Care and Self Pay Discount Policy**
- Appendix B**      **Hoag Hospital Quantifiable Community Benefit for FY2015**
- Appendix C**      **Hoag Hospital Community Benefit Expenditures by Program**

APPENDIX A



# 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	

**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

## 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 apply and be considered.</li> <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>	<p>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:</p> <table border="1" style="width: 100%;"> <thead> <tr> <th style="text-align: center;">Stage</th> <th style="text-align: center;">Description</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1</td> <td>Full payment is requested.</td> </tr> <tr> <td style="text-align: center;">2</td> <td>A reasonable payment plan based on the estimate is offered. A deposit payment is requested, if appropriate.</td> </tr> <tr> <td style="text-align: center;">3</td> <td>Eligibility for Government-Funded Programs is explored in programs including , but not limited to:                      Medicare                      Medi-Cal (CA)                      Covered California                      other state or county funded health coverage programs</td> </tr> <tr> <td style="text-align: center;">4</td> <td>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.   <b>Important:</b> If at any time, patient requests information or an application for Hoag Financial Assistance, it is promptly provided to the patient.</td> </tr> </tbody> </table>	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: Medicare Medi-Cal (CA) Covered California other state or county funded health coverage programs	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.  <b>Important:</b> If at any time, patient requests information or an application for Hoag Financial Assistance, it is promptly provided to the patient.
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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 upmost 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</p>

	<p>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 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>
<p><b>Patient Billing</b></p>	<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. The notice shall also:</p> <ul 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> </ul> <p>Disputes:</p> <p>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>
<p><b>Proof of Income</b></p>	<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 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</p>

income should be immediately requested.

## 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:

If the income % of FPL is:	And the patient is:	Then:					
<b>200% or less,</b>	Uninsured <i>or</i> insured	The entire (100%) patient liability portion of the bill for services will be written off.					
<b>201% - 400%,</b>	Uninsured,	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: <table border="1" style="margin: 5px auto; width: 80%;"> <thead> <tr> <th style="background-color: #e1f5fe;">If the income % of FPL is:</th> <th style="background-color: #e1f5fe;">Then the % of Medicare LIKE Rate Payable is:</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">201 – 400%</td> <td style="text-align: center;">50%</td> </tr> </tbody> </table>	If the income % of FPL is:	Then the % of Medicare LIKE Rate Payable is:	201 – 400%	50%	
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Insured,	The patient's obligation will be reduced by insurance payments: <table border="1" style="margin: 5px auto; width: 80%;"> <thead> <tr> <th style="background-color: #e1f5fe;">If:</th> <th style="background-color: #e1f5fe;">Then:</th> </tr> </thead> <tbody> <tr> <td style="background-color: #e1f5fe;">The amount paid by insurance exceeds what Medicare would have paid,</td> <td style="background-color: #e1f5fe;">The entire (100%) patient liability portion of the bill will be written off.</td> </tr> <tr> <td style="background-color: #e1f5fe;">The Medicare Payment <b>LIKE</b> Rate is greater than the HMO/PPO Payment Rate for services rendered,</td> <td style="background-color: #e1f5fe;">The patient's payment obligation will be based on the HMO/PPO Payment Rate.</td> </tr> </tbody> </table>	If:	Then:	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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<b>201% - 400%,</b>	Insured, <i>yet</i> services are not covered by the payer,	The following will apply: <table border="1" style="margin: 5px auto; width: 80%;"> <thead> <tr> <th style="background-color: #e1f5fe;">If...</th> <th style="background-color: #e1f5fe;">Then ...</th> </tr> </thead> <tbody> <tr> <td style="background-color: #e1f5fe;">The patient ordinarily would be responsible for the full billed charges,</td> <td style="background-color: #e1f5fe;">The total patient payment obligation will be the HMO/PPO Payment Rate.</td> </tr> </tbody> </table>	If...	Then ...	The patient ordinarily would be responsible for the full billed charges,	The total patient payment obligation will be the HMO/PPO Payment Rate.	
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### 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

<p><b>Other Special Circumstances</b></p>	<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>
<p><b>Presumptive Charity</b></p>	<p>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.</p>
<p><b>Approval Levels</b></p>	<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</p>

	Newport Beach, CA 92663
<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)

## 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.
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	Share ourselves program (SOS) and La Amistad have been pre-determined to

Term	Definition
(PARO, SOS and La Amistad programs)	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.

## 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).

### Reference:

References	These publications are relevant to this document:	
	Document Type	Title
	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)

## Appendix B

### Hoag Hospital Quantifiable Community Benefit Summary Trend FY 2015

#### 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*

	FY2015	FY2014
*County Indigent Programs	\$ 365,355	\$ 5,705,215
Charity Care	\$ 6,671,000	\$ 4,748,919
MediCal/Cal Optima Cost of Unreimbursed Care	\$ 21,628,875	\$ 15,848,241
Medicare Cost of Unreimbursed Care	\$ 69,434,051	\$ 56,626,973
<b>Total Cost of Unreimbursed Direct Medical Care Svcs</b>	<b>\$ 98,099,281</b>	<b>\$ 82,929,348</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	\$ 5,089,050	\$ 4,219,773
Subsidized Clinical Specialty Services	\$ 65,037	\$ 73,686
Cash and In-Kind Contributions	\$ 1,256,131	\$ 527,234
Women's Health Care	\$ 355,000	\$ 120,000
Community Benefit Operations	\$ 1,151,243	\$ 637,597
<b>Total Benefits for Vulnerable Populations</b>	<b>\$ 7,916,461</b>	<b>\$ 5,578,290</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	\$ 855,209	\$ 827,687
Health Profession Education	\$ 303,127	\$ 368,950
Subsidized Clinical Specialty Services	\$ 660,925	\$ 339,122
Cash and In-Kind Contributions	\$ 1,489,528	\$ 884,190
Women's Health Care	\$ 397,677	\$ 521,136
Community Building Activities	\$ 37,700	\$ 92,077
<b>Total Benefits for the Broader Community</b>	<b>\$ 3,744,166</b>	<b>\$ 3,033,162</b>

<b>Total Community Benefit and Economic Value</b>	<b>\$ 109,759,908</b>	<b>\$ 91,540,800</b>
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<b>Total Community Benefit and Economic Value (excluding Medicare Cost of Unreimbursed Care)</b>	<b>\$ 40,325,857</b>	<b>\$ 34,913,827</b>
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#### Notes:

1. Cost of care figures (section A) are estimated, based upon annualized results of 9 months of operations.
2. The 2015 Fiscal Year included 12 months: July 1, 2014 through June 30, 2015
3. 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***

Alzheimer's Family Services Center	\$ 1,440,158
Case Management- Community Health	\$ 17,144
Mental Health Center-Community Health	\$ 796,874
Lifeline	\$ 1,680
Newport Mesa Unified School District (HOPE Clinic)	\$ 275,000
Oak View Mobile Health Program	\$ 92,849
Senior Transportation (5 agencies)	\$ 538,885
SOS Medical and Dental Clinic	\$ 1,926,460
<b>Total Community Health Services</b>	<b>\$ 5,089,050</b>

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

ECU Call Panel	\$ 65,037
<b>Total Subsidized Clinical Specialty Services</b>	<b>\$ 65,037</b>

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

Academy of International Dance- Healthy Lifestyle Program	\$ 15,000
Access California Services	\$ 45,000
Acess OC	\$ 40,000
Age Well Senior Services	\$ 83,165
Boys and Girls Club of Santa Ana	\$ 25,000
Children's Health Initiative of OC (One OC)	\$ 25,000
City of HB-Community Services and Senior Programs	\$ 55,500
Clinic in the Park (One OC)	\$ 25,000
Community Senior Serve	\$ 10,000
Council on Aging Orange County	\$ 10,000
Dr. Riba's Health Club (One OC)	\$ 100,000
Facilities Improvement for local non-profits by REFCO	\$ 134,300
Families Forward	\$ 20,000
Food Donations to local non profits	\$ 4,760
High Hopes for El Sol Academy (One OC)	\$ 5,000
Illumination Foundation	\$ 15,000
Irvine Adult Day Health Services	\$ 46,469
Kid Healthy (One OC)	\$ 25,000
Latino Health Access-Children's Initiative	\$ 10,000
MOMS Orange County	\$ 10,000
Oak View Renewal Partnership	\$ 125,000
OC Fire Chief's Association- Alternate Destination Pilot Program	\$ 50,685
OC Vital Brain Aging Program	\$ 180
Pediatric Adolescent Diabetes Research Education Foundation	\$ 106,072
Providence Speech and Hearing Center	\$ 135,000
Save Our Youth (SOY)	\$ 25,000
Serve the People Community Health Center- Dental Care	\$ 25,000
Someone Cares Soup Kitchen	\$ 10,000
Strength in Support	\$ 25,000
The Cambodian Family	\$ 50,000
<b>Total Cash and In-Kind Contributions</b>	<b>\$ 1,256,131</b>

**Women's Health Care**

Casa Teresa	\$	25,000
Girl's Inc	\$	30,000
Human Options	\$	125,000
Latino Health Access	\$	50,000
Laurel House	\$	15,000
Mariposa Women and Family Center	\$	25,000
MOM Orange County	\$	35,000
Susan G Komen	\$	50,000
<b>Total Women's Health Care</b>	<b>\$</b>	<b>355,000</b>

**Community Benefit Operations**

Community Health Department Operations	\$	466,598
Dedicated Staff	\$	671,052
PARO Decision Support (Predictive Modeling for Healthcare)	\$	13,593
<b>Total Community Benefit Operations</b>	<b>\$</b>	<b>1,151,243</b>

**Total Benefits for Vulnerable Populations    \$            7,916,461**

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

Community Education and Outreach (various Hoag departments)	\$	343,780
First Aid Stations at Community Events	\$	7,127
Flu Immunization Clinic Expenses	\$	80,859
Freedom from Smoking Program	\$	6,000
Health Ministries Program	\$	129,048
Parkinson's Community Outreach Coordinator	\$	79,093
Pastoral Care Bereavement Groups	\$	33,689
Project Wipeout	\$	175,613
<b>Total Community Health Services</b>	<b>\$</b>	<b>855,209</b>

***Health Professions Education***

Clinical Care Extender Program	\$	171,439
Hospital Case Management Internships	\$	99,060
Pharmacy Student Clinical Rotations	\$	16,500
Physical Therapy Internships	\$	16,128
<b>Total Health Professions Education</b>	<b>\$</b>	<b>303,127</b>

***Subsidized Clinical Specialty Services***

CHOC Pediatric Diabetes Services at the Allen Diabetes Center	\$	525,000
ETOH/Psych/Ancillary Patient Transfer Program	\$	135,925
<b>Total Subsidized Clinical Specialty Services</b>	<b>\$</b>	<b>660,925</b>

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

211 Orange County	\$	50,000
AIDS Services Foundation	\$	25,000
America on Track	\$	20,000
American Lung Association	\$	20,000
American Red Cross	\$	10,000
CA-HI-NV Exchange Club of OC	\$	275
CHOC Foundation	\$	200,000
City of Irvine-Mental Health Outreach	\$	45,000
Crohn's & Colitis	\$	25,000
Domestiv Violence Awareness	\$	1,106
Epilepsy Support Network	\$	25,000
Family Service Team (One OC)	\$	10,000
Facilities Improvement for local non-profit organizations by Hoag REFCO	\$	39,100
Goodwill of Orange County	\$	20,000
Healing Hearts: Camp Erin	\$	25,000
Infectious Disease Association of California	\$	15,000
In-Kind Office Lease/Meeting Space for Non-Profits	\$	373,828
Irvine Children's Fund	\$	45,000
Irvine Community Drug Prevention	\$	20,000
Irvine Public Schools Foundation	\$	100,000
Jewish Federation & Family Services	\$	40,000
Juvenile Diabetes Research Foundation	\$	41,000
Laguna Beach Seniors	\$	24,000
National Kidney Foundation of Southern California	\$	25,000
Newport Beach Police Department- Every 15 Minutes Youth Education	\$	4,000

Orange County Department of Education- Medical Officer	\$	120,000
Orange County Human Relations	\$	57,500
Orange County United Way	\$	52,719
Pulse Point Foundation	\$	3,500
Saint Joachim Catholic Church	\$	10,000
The Center Orange County	\$	20,000
Trauma Intervention Program	\$	2,500
Youth Employment Services	\$	20,000
<b>Total Cash and In-Kind Contributions</b>	<b>\$</b>	<b>1,489,528</b>

**Women's Health Care**

Planned Parenthood	\$	100,000
OB Education	\$	32,677
OC Women's Health Project	\$	250,000
Sweet Success Extension Program	\$	15,000
<b>Total Women's Health Care</b>	<b>\$</b>	<b>397,677</b>

**Community Building Activities**

Community Disaster Readiness	\$	27,700
Health Funders Partnership of OC	\$	10,000
<b>Total Community Building Activities</b>	<b>\$</b>	<b>37,700</b>

**Total Benefits for the Broader Community    \$            3,744,166**

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