# Community Benefit Report

# Hoag Memorial Hospital Presbyterian

# 2014

**OSHPD Facility ID #106301205**

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**Hoag Memorial Hospital Presbyterian**
**www.hoag.org**

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# Hoag Memorial Hospital Presbyterian
# Community Benefit Plan Update 2014

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## Executive Summary

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

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

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

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

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

Finally, Hoag provides uncompensated care (charity) to patients who are unable to pay for the full cost of their care. These expenditures amounted to over $26 million in Fiscal Year 2014 (October 1, 2013 through June 30, 2014.) 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 FY2014 (9-month fiscal year) amounted to over $34 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 2014.

## Introduction

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

Hoag's nonprofit regional health care delivery network consists of two acute-care hospitals, six 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 4,800 employees and more than 2,000 volunteers. Hoag's network of more than 1,500 physicians represents 52 different specialties.

Hoag Hospital Newport Beach, which has served Orange County since 1952, and Hoag Hospital Irvine, which opened in 2010, are designated Magnet hospitals by the American Nurses Credentialing Center (ANCC) and are fully accredited by DNV. In 2013, Hoag entered into an 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.

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 sub-specialists 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 Cancer, Gastroenterology and GI Surgery, Geriatrics, , Gynecology, Nephrology, Neurology and Neurosurgery, Orthopedics, Pulmonology and Urology. National Research Corporation has endorsed Hoag as Orange County's most preferred hospital for the past 18 consecutive years, and for an unprecedented 19 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 19 members with representatives from the Hoag community and medical staff. The hospitals' Chief Executive Officer is also seated on the board as a voting member.

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

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

For more information, visit www.hoag.org.

**Mission, Vision, and Core Values**

## Hoag's Mission

Our mission as a 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 2014 FPL for a family of four was $23,850. The current Charity Care and Self-Pay Discount Policy is provided in Appendix A. In FY2014 the hospital served 7,544 Charity Care cases. Appendix B provides a summary of the quantifiable Community Benefit provided by Hoag in FY2014 (October 1, 2013 through June 30, 2014). Appendix C provides a detailed breakdown of the Community Benefit expenditures by program.

## Community Benefit Committee

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

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

The CBC ensures that Community Benefit activities are:

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

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

## Service Objectives

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

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

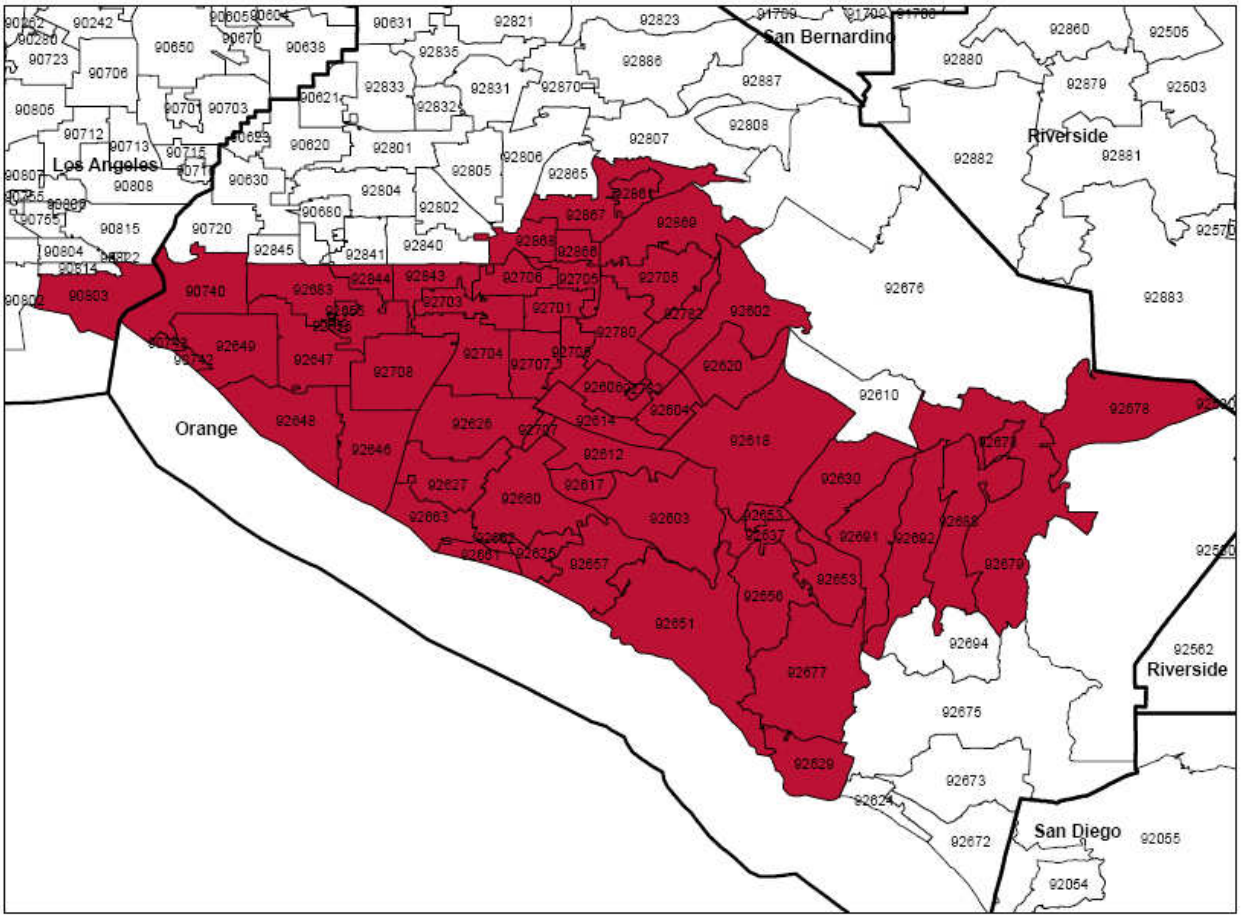
## Community Health Needs Assessment

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

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

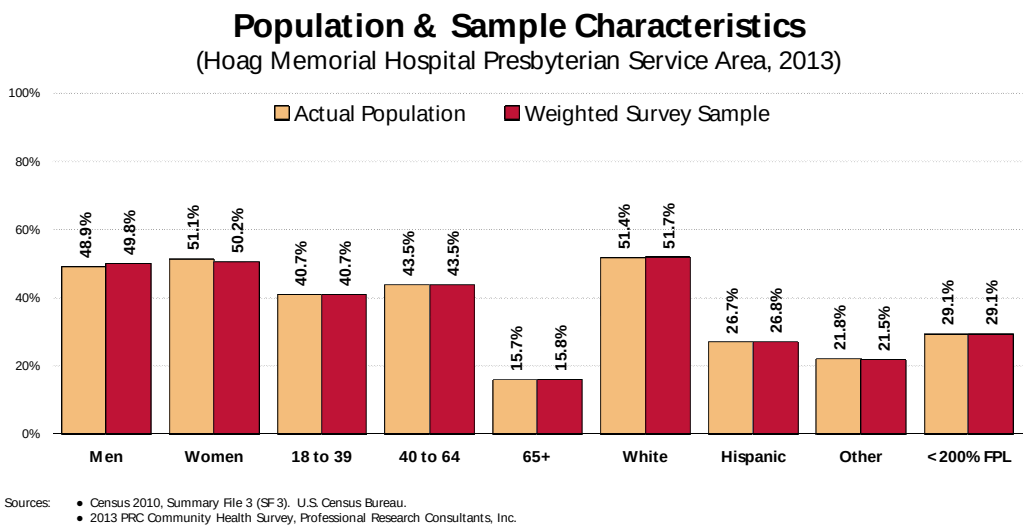
### CHNA Community Definition

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




### Demographics of the Community

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




Sources:
- Census 2010, Summary File 3 (SF 3). U.S. Census Bureau.
- 2013 PRC Community Health Survey, Professional Research Consultants, Inc.

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

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

**CHNA Methodology**

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

**Community Health Survey**

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

**Public Health, Vital Statistics & Other Data**

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

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

**Community Stakeholder Input**

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

**Significant Health Needs of the Community**

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

| Areas of Opportunity Identified Through This Assessment | |
|---|---|
| **Access to Health Services** | • Lack of Health Insurance Coverage<br>o Insurance Instability<br>o Supplemental Coverage (Seniors)<br>• *Access to Healthcare ranked as the #5 top concern among focus group participants; they emphasized:*<br>o Barriers to Accessing Care (Including Language and Transportation)<br>o Uninsured/Under-Insured Population<br>o Low-Income Population |
| **Dementias, Including Alzheimer's Disease** | • Alzheimer's Disease Deaths |
| **Educational & Community-Based Programs** | • Attendance at Health Promotion Events<br>• *Health Education & Prevention ranked as the #4 top concern among focus group participants; they emphasized:*<br>o Preventive Care Programs<br>o Funding |
| **Immunization & Infectious Diseases** | • Pneumonia/Influenza Deaths<br>• Pertussis Incidence<br>• Tuberculosis Incidence |
| **Mental Health & Mental Disorders** | • *Mental Health ranked as the #1 top concern among focus group participants; they emphasized:*<br>o Limited resources<br>o Stigma<br>o Lack of integration (physical/mental) |
| **Nutrition, Physical Activity & Weight** | • Children's Computer Time<br>• *Obesity & Nutrition ranked as the #3 top concern among focus group participants; they emphasized:*<br>o Childhood Obesity<br>o Need for Nutrition Education |
| **Substance Abuse** | • Cirrhosis/Liver Disease Deaths<br>• Adults Seeking Professional Help<br>• *Substance Abuse ranked as the #2 top concern among focus group participants; they emphasized:*<br>o Lack of Treatment Centers<br>o Binge Drinking<br>o Prescription Drug Abuse |
| **Tobacco Use** | • Smoking Cessation Attempts |

**Prioritization of Health Needs**

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

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

**Priority Health Issues**

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

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

   **Strategies to Address Need**

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

2. **HEALTH EDUCATION & PREVENTION**

   **Strategies to Address Need**

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

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

   **Strategies to Address Need**

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

4. **HEALTH PROFESSIONAL EDUCATION PROGRAMS**

   **Strategies to Address Need**

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

## Department of Community Health Programs

The department of Community Health provides direct Community Benefit service programs and coordinates Community Benefit reporting at Hoag Hospital. This section of the report provides information for each of the Community Health programs and achievements in FY2014: October 1, 2013-June 30, 2014.

**Mental Health Center**

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

During FY 2014, the program employed seven full-time bilingual Master's prepared social workers. These social workers provided mental health services to 789 clients in the form of psychotherapy, resource brokering, and/or case management. In addition, the program offered psychotherapeutic and psycho educational groups to 429 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 39 years of age and the average age of the minor population was 14 years of age. Seventy-three percent of the clients reported having an annual household income below $20,000 and a total of 85% of the clients reported annual incomes of less than $30,000. The program has proven to be highly efficient and effective. The program utilized a clinical assessment tool (DASS) to measure levels of depression, anxiety, and stress in clients. According to pre and post test scores, clients who participated in either individual or group psychotherapy saw a statistically significant decline in depression, anxiety, and stress scores. The program also implemented a self esteem tool (Rosenberg) on a pre and post test basis. Across the board for individual and group psychotherapy, there was statistically significant improvement in self esteem.

In FY 2014, the program provided a supervised clinical internship program for 10 MSW (Master of Social Work) students from the University of Southern California, from California State University at Fullerton and California State University at Long Beach, and from University of California, Los Angles. The program provided consultation, support, and education to paraprofessionals at partner agencies such as Girls Incorporated and the Newport Mesa Unified School District. This support included telephone consultation, workshops, and in-service education. In addition to support for the staff of partner agencies, the Mental Health Center offered several different psychotherapeutic and psycho educational groups and workshops for the partner agency clients. These efforts allowed our partner agencies to offer mental health services at no cost to their clientele and all services are provided in-kind to the not-for-profit agencies. Some examples include: a diabetes support group, depression support groups, self esteem groups, and stress management workshops. Group sessions were also offered for parents, families, and adult couples struggling with relationship issues.

During FY 2014, 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.

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**Health Ministries**

Hoag Health Ministries celebrates its twenty-seventh year of serving Orange County faith communities through our Faith Community Nursing (FCN) Program. Currently the program has 52 volunteer FCN's who dedicate their time and service to those in need at 30 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 2014, Health Ministries

- Comprised of 9 denominations amongst the 30 Faith Based Partnerships
- Donated 7,640 Volunteer RN hours at the local, national and international level
- Touched the lives of more than 37,000 congregants
- Administered 5,828 flu vaccine doses to faith members and the community
- Provided 490 flu vaccine doses to various community clinics
- Provided 8 Automated External Defibrillators (AED's) to church partners
- Trained 209 persons in life-saving CPR & Automated External Defibrillator usage
- Screened Blood Pressure readings for 971 individuals, teaching healthy lifestyle options and Stroke recognition skills
- Organized blood donations, receiving 213 units of life-giving blood
- 355 children received disease-preventing hand washing training
- Distributed 1740 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.

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

## Community Programs

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

**Case Management:**
Case management services establish pathways for health care access and specialized attention to people with unique health care navigation needs. Case management provides health care liaison services between Hoag, the Share our Selves (SOS) Clinic, and other community agencies which serve the low income, uninsured and under-insured population within the Hoag service area. Individuals are assessed for funding eligibility by financial counselors and linked to an appropriate care program. Through collaborations involving a multi-disciplinary team of health care providers, 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

- 4,309 Hoag services were provided to SOS patients.
- 70 hospital days were utilized by patients needing medical, surgical or chemical dependency care.
- 55 newly diagnosed persons received free diabetes education through the Mary & Dick Allen Diabetes Center at Hoag, including 32 pregnant women who received specialized gestational diabetes education through the Sweet Success Program.
- In partnership with local senior centers, a personal alert (Lifeline) system was provided for 5 homebound older adult residents.

**Community Collaborations:**

Faith Leaders Conference - Hoag's Department of Community Health co-sponsored the 'Orange County Faith Leaders Conference: Care at Life's End' in collaboration with the Coalition for Compassionate Care of California, Orange County Aging Services Collaborative and the Archstone Foundation. The program, led by the Hoag CARES (Palliative Care) department explored End of Life issues from a mental, physical and spiritual perspective. The conference was attended by 143 community clergy, health care professionals and caregivers.

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 2013 Spirituality Conference – 'Navigating the Journey of Caregiving'. Topics included examining end of life caregiving issues by four distinct faith traditions, coping mechanisms and compassion strategies for caregivers, developing a Spiritual self-care plan, and seeking a balance, humanity and humility for the patient and the caregiver. The conference was attended by 175 community clergy, health care professionals and caregivers.

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

**Project Wipeout**

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

Project Wipeout:

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

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

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

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

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

## Other Hoag Community Benefit Activities

Hoag's commitment to Community Benefit is best exemplified by the dedication of an entire department to the coordination and provision of Community Benefit programs. The hospital's Community Benefit activities are not limited to the department of Community Health. Other hospital departments provided a wide range of Community Benefit activities during FY2014, including health professions education, clinical research, support groups and many more. This section of the report features a discussion of some examples of the Community Benefit activities that were provided by other hospital departments in the current reporting period.

### The Mary & Dick Allen Diabetes Center

The American Diabetes Association and the National Diabetes Statistics Report from the CDC (2014) estimates that nearly 29.1 million Americans (9. 3% of population) live with diabetes and more than 86 million Americans are at increased risk for diabetes. Total estimated cost of diabetes in the United States in 2013 was $245 billion. There are 8.1 million people undiagnosed. With $176 billion in direct medical expenditures and $69 billion in reduced national productivity (American Diabetes Association, 2014). While diabetes alone is ranked as the sixth leading cause of death in the U.S., it also indirectly contributes to deaths by other causes, including cardiovascular disease, stroke and kidney disease (National Vital Statistics Report, CDC, 2014). Diabetes is also closely linked to other serious medical outcomes, including kidney failure, blindness, and leg and foot amputations. Since its opening in June, 2009, the Mary & Dick Allen Diabetes Center has made a positive difference in the lives of many men, women and children with diabetes in the community. There have been many successes, particularly in providing greater access to care for children, supporting healthy pregnancies and providing culturally sensitive education for adults with, and at risk for, diabetes. Below are a few program highlights from FY 2014:

***New Program Director Appointed***

Dr. Nadeau is an accomplished physician who brings extensive experience regarding diabetes, obesity, and nutrition to Hoag Medical Group and the Mary & Dick Allen Diabetes Center. Dr. Nadeau received his medical degree from Tufts University School of Medicine and also earned a master's degree in nutrition from Tufts University School of Nutrition. Dr. Nadeau is the recipient of the National Research Service Award. His publications include both peer-reviewed journal articles and book chapters and he has recently co-authored a book on nutrition entitled The Color Code: A Revolutionary Eating Plan for Optimum Health in collaboration with James Joseph, PhD, of Tufts University and Anne Underwood of Newsweek magazine. Prior to joining Hoag Medical Group, Dr. Nadeau served as an Assistant Professor of Medicine at Tufts Medical School and Medical Director of Diabetes, Endocrinology and Nutrition at Exeter Hospital in New Hampshire and Eastern Maine Medical Center.

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

Diabetes Self-Management Training/Education (DSMT/E) and Medical Nutrition Therapy (MNT) remain the core functions of the Center. The Center saw an overall increase in group patient visits. While individual visits remain important, the evidence indicates that group visits produce better outcomes so the Center is working to increase the proportion of group visits. There were 4140 patient contacts during the financial year ending 2014. New Service Line: We have incorporated all outpatient nutrition services.

***CHOC Children's Services at the Allen Diabetes Center***
CHOC (Children's Hospital of Orange County) at the Allen Diabetes Center provide bilingual clinical services, education, and support for children diagnosed with diabetes. This program also provides outreach and educational screening for children considered at risk for developing diabetes. In FY 2014 approximately 15 % of CHOC medical visits and diabetes education visits were unfunded. There were 1836 patient visits, 1640 MD visits at the CHOC clinic. 213 participants were provided free diabetes related education by PADRE. 15 unfunded patients were seen. In addition 3691 Spanish speaking participants benefited from free Prevention of Obesity Education Research activities.

***Diabetes Nursing Conference***
86 attendees including nurses, pharmacists and other clinicians attended the 2014 Diabetes Conference: Many, over 56 were non-Hoag employees. The Diabetes Conference titled, "Diabetes: What's New, What's Next: 2014" was held at The Mary and Dick Allen Diabetes Center. The conference was rated highly by most participants. Topics included "Diabetes and Women:" "Pumps, Pills and Potions" "Vibrant Health, Vibrant Color"": "Diabetes and Kidney Disease" and "Emerging Adults with type 1 Diabetes." The conference was received by many positive comments regarding healthy food choices for participants in regards to both meals and snacks.

***Herbert Family Program for Young Adults with Type 1 Diabetes***
Key findings from a survey of young adults' ages 18 to 30s with type 1 diabetes mellitus who are transitioning from pediatric endocrinology care to adult care reveal that they have special needs that are often neglected. As an example, they require psycho-social support, assistance with identifying resources, and the ability to link to each other and to the Center via the online communication channels they are already using, including social media. This program saw a 160% growth ending FY 2014 with 111 Facebook members and 35 active members attending monthly events, a 32 % growth. Transition clinic will be in place by June 30, 2015.

***Ueberroth Family Program for Women with Diabetes (Sweet Success)***
Under the oversight of Allyson Brooks, M.D., executive medical director, Hoag Women's Health Institute, and with the active participation of perinatology, as well as nurse practitioners and diabetes educators, the program continues to provide perinatology services to a growing number of women with pre-conception and gestational diabetes. The program includes life-long follow up of women who develop gestational diabetes to help prevent development of type 2 diabetes, or to maintain good control of it. During FY 2014, we had 1131 patient contacts. Gestational diabetes patient care is more effective in groups. As a consequence, the Center is working to increase the proportion of group visits when appropriate for the patients. However, mother-baby follow-up visits are individual by nature so the opportunity for increasing group visits is somewhat limited. In FY 2014, the Center cared for 50 unfunded gestational diabetes patients through their pregnancies. Macrosomia rate dropped from 8.2% to 6.6%, significantly lower than the national average of 11%. 42 unfunded patients Post-Partum OGTT was 30% with 32 of those test had diabetes. Plans are in place for long term follow of patients with GDM up with lab studies.

***Other programs and activities***
Cultural differences, educational challenges and socio-economic status are barriers to care that result in the under-serving of patients and families impacted by diabetes. Culturally sensitive programs are being developed. Free cooking demonstrations held monthly at the center were attended by 528 people a 28 % growth. Patient satisfaction is at 90.2%
**Contact: Kris Iyer, M.D at 949-764-6388 or Kris.Iyer@hoag.org**

## OB Education

Hoag's philosophy is that with the birth of every child, there is also the birth of a new family. Through a variety of educational classes and support services, Hoag's OB Education supports families throughout the exciting journey of pregnancy and parenthood. The comprehensive selection of prenatal classes include: Prepared Childbirth, Breastfeeding, Baby Care Basics, and Baby Saver. OB Education also provides programs and education for specific demographics, including mothers over the age of 35, mothers of multiples, and those experiencing cesarean birth. Other programs offered at no cost to the community include the car seat safety, couples 4th Trimester class, community parenting classes, and hospital orientation and tours. Support group programs such as Post-Partum Adjustment, Perinatal Loss and Pregnancy after Loss are also available for free to the community. These support groups are highly attended, facilitated by a Licensed Clinical Social Worker (LCSW); provide ongoing support, education, and an opportunity to discuss the new challenges of parenthood. Support persons and babies are welcome. Hoag's Babyline is an information hotline for parents that operates five days a week and is answered by an OB Education registered nurse with special expertise and knowledge about pregnancy (before, during, and after), as well as baby care and breastfeeding. The Babyline staff is a key resource for new and expectant parents. The Babyline is available to the community Monday through Friday from 9am – 5:45pm. This hotline receives over 9,000 calls per year.
**Contact: Gabi Shaughnessy at 949-764-5940 Gabi.Shaughnessy@hoag.org**

## Hoag Community Health Associates

The principal strategy of the Department of Community Health is to not "reinvent the wheel" with respect to providing necessary community health programs and services. We work closely with a broad array of community based not-for-profit organizations, and provide grant funding to some organizations whose services are consistent with our priorities. 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 FY2014.

**Share Our Selves**

Share Our Selves (SOS) was established in 1970 by a group of volunteers responding to the unmet needs of Orange County residents living in poverty. Initial services included food, clothing, and emergency financial aid for housing, transportation, and children's basic needs. Historically, the population served by SOS represents diverse ethnicities and age groups, with over 90% living at or below 100% of the Federal Poverty Level. 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.

In the last 44 years, SOS has grown with the county as community needs have presented themselves, always keeping the focus on servant leadership. Below is a snapshot of SOS's increased programming and comprehensive approach:

1970: Founded, Social Services Program
1984: Established SOS Free Medical Clinic
1987: Expanded health services to include Free Dental Clinic
1993: On-Site Dispensary opened
2005: Comprehensive CARE Center integrated Mental Health services
2010: SOS-El Sol Wellness Center opened in Santa Ana
2012: SOS and PEACE Center Health Clinic opened in Lake Forest
2012: Achieved Federally Qualified Health Center to include Health Care for the Homeless Provider Designation
2014: SOS Children & Family Health Center (Fall 2014)

Today, SOS provides comprehensive health and social services to low-income, medically indigent and homeless Orange County residents, annually assisting more than 120,000 unduplicated individuals. SOS is the only community health center in the county providing a full continuum of healthcare and social services to its patients. The SOS network of Community Health Centers provides a comprehensive service delivery model throughout the lifecycle, inclusive of the following:

- Comprehensive Primary, Specialty & Subspecialty Healthcare
- Integrated Behavioral Health
- On-Site Clinical Pharmaceutical Services & Full Service Dispensary
- Full-Mouth Restorative & Preventative Dental Care
- Healthcare for the Homeless
- Multi-Disciplinary Team Care Coordination

- Clinical & Social Case Management
- Health Education (individual and group)
- Discharge Clinic
- Eligibility & Enrollment Services

An adjunct to the network of community clinics and services is the SOS Comprehensive Service Center providing resources and linkages to address the social stressors most often associated with the poverty levels of the SOS patient population. Services include:

- Food Pantry
- Emergency Financial Aid
- Public Health Nurse
- Medi-Cal Case Worker
- Homeless Outreach Case Manager
- Public Law Center
- Wells Fargo Bank Budgeting & Financial Management Classes
- US Mail Services
- Seasonal Programs

During October 1, 2013 to September 30, 2014, SOS provided a medical home to 8,468 unduplicated patients accounting for a total of 27,592 provider encounters.

Hoag and SOS continue to share over 40% of SOS patients, 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. During the reporting period, approximately 1,600 patients identified their SOS encounter an emergency department diversion from Hoag. Over 450 patients were discharged from Hoag to SOS many suffering from chronic disease requiring complex health and case management. Hoag affiliated Specialists and Hoag ancillary support services, monthly provide over 240 specialty care referrals, to the uninsured patients of SOS. SOS and Hoag participate in a strong Continuum of Care that seamlessly transitions patients between the inpatient, outpatient, and specialty care services. This Continuum is achieved by intricate patient/family care coordination and health information exchange technology.

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

**Contact: José Mayorga, MD at (949) 270-2111 or jmayorga@shareourselves.org**

**Alzheimer's Family Services Center**

At Alzheimer's Family Services Center (AFSC), we believe that memory-impaired individuals from all ethnic and socioeconomic backgrounds deserve the right to superior care that will enable them to age with dignity at home. Since 1980, this belief has guided our mission to improve quality of life for families challenged by Alzheimer's disease or another dementia through services tailored to meet individual needs. While the search for a cure to Alzheimer's disease is still underway, we meet the needs of Orange County's most medically vulnerable older adults by providing access to compassionate health care, a supportive environment, and therapeutic adult day health care services that are tailored to the needs of each individual we serve.

To accomplish our vision of being nationally recognized for innovation and excellence in serving families challenged by Alzheimer's disease or another dementia we have established six core values that guide all aspects of what we do: excellence, innovation, quality care, respect, integrity and client-centeredness. As evidence of our commitment to high-quality, person-centered memory care, the Alzheimer's Foundation of America's (AFA) granted our agency "Excellence in Care" distinction in September of 2014, for meeting AFA's rigorous national standards for dementia care settings. These standards include safety and security features, staff training, activities, interpersonal communication, and meeting clients' physiological, functional and social needs. Assisted living and skilled nursing facilities, adult day programs, and continuum of care residential communities can apply for the evaluation. At present, AFSC is the only adult day services provider, and one of just five other facilities in California, to hold this prestigious designation.

We are also proud of our recent certification as a "Service Enterprise" by the Points of Light, the largest organization in the world dedicated to volunteer service. To qualify for the certification, OneOC conducted a site survey where AFSC had to show that it fundamentally leverages the skills and talents of its volunteers across all levels of the organization, to successfully deliver on its social mission. Another significant accolade that AFSC has received this year also includes the CalOptima "Circle of Care" award which recognizes health care professionals, community groups and individuals who demonstrate excellence in the delivery of accessible and high-quality health care services to CalOptima members. The award honors those who go above and beyond in serving their profession, patients or clients. AFSC was selected to receive this prestigious award in the area of Behavioral/ Mental Health Provider.

As an agency, our goals are to (1) introduce families to the multiplicity of services they need to provide care for a loved one affected by dementia in the home environment, from the time of diagnosis to the advanced stages of the disease, (2) promote the cognitive, physical, and emotional well-being of seniors with dementia through specialized, affordable adult day health care services, and (3) increase community awareness of dementia care options available to families caring for a loved one with dementia through targeted outreach efforts. Our services are grounded in the latest research and clinical guidelines, and include:

*Dementia-Specific Adult Day Health Care (ADHC)* – Individuals from the earliest to most advanced stages of dementia, receive compassionate, individualized care daily at AFSC's homelike, secure, dementia-specific facility. Participants benefit from medical, rehabilitative, psychosocial, and nutritional ADHC services based on an individualized plan of care within the context of a stimulating recreational program. Core components of our model of adult day health care include: (1) an enhanced level of supervision by maintaining a staff-to-participant ratio of 1:5, (2) one-on-one assistance with activities of daily living, including toileting (e.g., incontinence care), as well as access to physical, occupational, and speech therapy (3) ongoing reassurance to alleviate anxiety (e.g., concerns about where the caregiver is, going home), (4) step-by-step support to engage in "failure free" activities that promote self-esteem, (5) monitoring to prevent dehydration from pacing, (6) nursing support in managing medications to reduce health care complications that may manifest

in problematic behavioral expressions (e.g., aggression), (7) ongoing case management and communication with family caregivers to help navigate challenges in care at home and in transitions between health care settings. Customized care is further available via two innovative tracks of programming: (1) the "New Connections Club" for active early-stage individuals with the desire, insight, physical capacities, and remaining cognitive abilities to engage in a physically and mentally challenging set of research-based therapeutic activities including cognitive skill classes, and (2) the "Friendship Club" for persons as they progress from the early into the moderate and severe stages of dementia. All care is provided under the supervision of a medical director and coordinated with each participant's primary care physician. Our compassionate staff is not only trained in dementia care through professional education modules approved by the national Alzheimer's Foundation of America, but is also rich in cultural and linguistic diversity so that we are able to provide services in nine languages. Participants receive up to eight hours of care, five days a week, meals catered to their specific dietary needs, as well as door-to-door transportation to and from our program (available countywide).

*Early-Stage Program* – AFSC launched an early-stage pilot program in collaboration with the Orange County Vital Brain Aging Program at the Hoag Neurosciences Institute. The program is a six-week seminar and interactive participation series, taught once a week from 9am-12pm, designed for individuals with early memory loss and their family caregivers. The goal of the program is to equip recently diagnosed individuals and their families with the evidence based education, resources, and skills they need to successfully access early-stage treatments, interventions, and community-based services that will help improve their quality of life across the multiple stages of dementia. The program integrates current research on cognitive fitness and psycho-educational therapy for families affected by dementia.

*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 program. These professionals become "partners in caring" and can be called upon as needed to troubleshoot issues in care, such as transitions from hospital to home or challenges in care coordination (e.g., physician communication). Caregivers also receive relevant education about what to expect and how to prepare for each stage of dementia, training in skills needed to manage dementia-related behavior, information about cognitive strategies for reframing negative emotional responses, and guidance for practicing healthy behaviors and managing stress. We also provide care management support to every caller at no cost. Our care managers link families to the resources they need to develop and implement a plan of care for their memory-impaired loved ones.

*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.

*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. AFSC offers this service in multiple formats (i.e., session-by-session or in sets of sessions) on a sliding pay scale.

*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. In FY 13-14, AFSC was able to:

- Provide dementia-specific adult day health care to 238 unduplicated participants Provide 929 hours of care management and pre-enrollment support to 451 callers.
- Provide 1,666 hours of care management to 714 caregivers of enrolled participants
- Provide 48 caregiver support groups, reaching 39 unduplicated caregivers.
- Provided at least 32 short-term counseling sessions for 11 unduplicated caregivers
- Provided 36 caregiver education sessions, reaching 968 family caregivers.
- Reach over 5,970 community members through our extensive 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.

**Contact: Joanna Richardson-Jones, CEO at (714) 593-1840, JRichardsjones@AFSCenter.org or Guita Sharifi, CFO/Administrator at (714) 593-1841 or GSharifi@AFSCenter.org**

**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**

## Dr. Riba's Health Club

The primary goal of Dr. Riba's Health Club (DrRHC) is the prevention and treatment of nutrition-related health problems in children and their families. DrRHC utilizes a multidisciplinary team by providing direct patient care and individual treatment programs that are tailored to each child's needs. Offering a variety of programs and services at multiple sites, DrRHC reaches over 4,000 families annually. The funding received from Hoag's Community Benefit program was used to see patients at our modular at the Santa Ana Family YMCA and HOPE Clinic (for patients over five), our Fit Club™ after school and summer programs at the YMCA, uncompensated patient labs, and evaluation of program outcomes. Our Health Club program provides individualized patient care plans delivered by the Pediatrician/Medical Director, two Registered Dietitians, a Case Manager, and fitness instructors. This program treats the most severe cases in Orange County by educating families on the psychology of feeding, teaching families how to improve nutrition, promoting physical activity, and assessing and treating medical and psychological comorbidities. Our latest clinic evaluation report was conducted in June 2014 and showed that 79.5% of patients significantly improved their BMI percentile from the 2013-2014 year. DrRHC is continuing to positively impact the lives of these in-need children and families by providing these resources and seeing more patients at our sites throughout Orange County. This funding also helped implement the Fit Club™ after school and summer programs. The goal of the Fit Club™ program is to prevent and treat childhood obesity and prevent the onset of type 2 diabetes through health and nutrition education, cooking demonstrations, and physical activity. This program was implemented throughout the 2013-2014 school year and eight weeks during the summer at the Santa Ana Family YMCA. Some program highlights from the past year include:

- Our 2013-2014 after school program showed great success, with 93.3% of the overweight/obese children significantly improving their BMI percentile. Significant improvements were also found in fitness across the board including situps, pushups, and sit-and-reach.
- Our 2013 summer program was also very successful with 73.3% of children improving BMI percentile and 100% of children improving fitness levels.

Other program updates: Earlier this year, DrRHC began developing an advisory board and creating our own 501c3 nonprofit with the new name, Serving Kids Hope. We have already held several board meetings and began developing marketing and financial sustainability strategies. This is an exciting next step in improving our infrastructure and raising the viability of our organization within Orange County.

**Contact: Patricia Riba, MD at (949) 485-0690 or drriba@drribahc.org**

**Orange County Department of Education (OCDE) Medical Officer**

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

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

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

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

**Oak View Mobile Health Program**

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 2013-2014, OVRP's Healthy Community Initiative facilitated the following programs and services:

- A bi-monthly Mobile Health & Dental Clinic serves approximately 500 clients annually, 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 700 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 was established during the last quarter of 2012 in response to community surveys indicating a lack of easily accessible physical activities for local adults. Classes are offered weekly to over 30 regular participants in the multi-purpose room of the Oak View Elementary School. 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.
- Our Neighborhood Clean-Up draws 50-100 Oak View resident volunteers each month. 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.

- Oak View Elementary hosts a School Pantry that provides 200 families with healthy food options for residents, a partnership with Second Harvest Food Bank, Oak View Elementary and OVRP.
- A community Health Needs Assessment, sponsored by Hoag Hospital, was conducted in the summer of 2014. A research intern from Oak View analyzed volumes of secondary data, conducted 2 focus groups and 100 interviews to determine recommendations for health programming in Oak View.

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

**Senior Transportation**

The Community Benefit Program collaborates with seven community senior centers for transportation services for their program participants. These organizations offer a broad range of services including congregate meals, health screenings, and educational, social and physical activities for their participants. In providing transportation services for seniors, we assist them in their efforts to sustain good mental and physical health, and to maintain their independence. The seniors use the transportation services to attend doctor appointments, shop and do errands, and participate in group social activities. The seven organizations served are: Alzheimer's Family Services Center; Costa Mesa Senior Center; Huntington Beach Council on Aging; Irvine Adult Day Center; Newport Beach's Oasis Senior Center; Age Well Senior Services, and Laguna Beach Seniors. Total Hoag expenditures on transportation for FY 2014 was $338,225 for approximately 106,829 senior passenger trips

# Appendices

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

**Appendix B** **Hoag Hospital Quantifiable Community Benefit for FY2014**

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

# Appendix A

hoag

## POLICY

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

**PURPOSE:**

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

**SCOPE:** Revenue Cycle

**AUTHORIZED PERSONNEL:** Charity Care Specialist

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

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| | | information provided by the patient, PARO provides the best estimate and approach for extending presumptive charity care to these patients. Hoag recognizes that a portion of their patient population may not engage in the traditional charity care application process and PARO provides an equitable and just method for extending benefits to this population. PARO may also be engaged during the revenue cycle process to confirm patient information or as a method to direct patients to other advantageous sources of charity based assistance. Additionally, PARO may be used to validate financial and demographic information provided by the patient during the Payment Assistance eligibility process and complete the application where such information may be missing. | |
| | 1.5 | Emergency physicians means a physician and surgeon licensed pursuant to Chapter 2, Section 2000 of the Business and Professions Code who is credentialed by a hospital and either employed or contracted by the hospital to provide medical services in the emergency department of the hospital, except that an "emergency physician" shall not include a physician specialist who is called into the emergency department of a hospital or who is on staff or has privileges at the hospital outside of the emergency department. Emergency room physicians who provide emergency medical services to patients at Hoag are required by California law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350% of the FPL. Hoag's emergency room physicians will utilize Hoag's Charity Care and Discount Policy approval results to support their compliance with AB 1503. | |
| **2.0** | **Charity And Discount Care Guidelines:** | | Charity Care Specialist |
| | 2.1 | Hoag provides financial assistance to patients who do not have insurance coverage and have family income levels of up to four times the FPL Guidelines. Hoag also gives consideration to eligible patients with insurance if they incur high medical costs as defined by California law, and also have family incomes up to 400% of the FPL. | |
| | 2.2 | Business services staff will, as necessary, meet with all patients that have expressed a need for financial assistance to help them determine eligibility for program options. Qualifying patients may be referred to other potential payers such as MSI or Medi-Cal. Patients who may be eligible for such a potential payer programs must make a reasonable, good faith effort to apply for and comply with the rules and requirements of such programs. Failure to do so may result in Hoag's denial of the programs described in this Policy. Those not eligible for such State or other programs may be reviewed for financial assistance under Hoag's programs. Adjustments are made based upon the patient's eligibility level in the programs. | |
| | 2.3 | Any patient seeking financial assistance (or the patient's legal representative) shall provide and disclose all information concerning health benefits coverage, financial status, and any other information that is necessary to make a determination regarding the patient's status relative to Hoag's charity care policy, discounted payment policy, or eligibility for government-sponsored programs. Failure to provide true, correct and complete information for this purpose may render a patient ineligible under this Policy. Confidentiality of information and the dignity of the individual will be maintained for all that apply for charitable services. | |
| | 2.4 | Charity and discounted care guidelines will be reviewed and adjusted annually according to the FPL Guidelines established by the Department of Health and Human Services (see FPL Table below). | |
| | 2.5 | Hoag will define the standards and scope of practices to be used by its outside (non-hospital) collection agencies, and will maintain written agreements from such agencies that they will adhere to such standards and scope of practices. | |
| | 2.6 | Hoag or outside agencies operating on behalf of the hospital shall not, in dealing with patients eligible for discounted or charity care use wage garnishments or foreclosure of liens on primary residences as a means of collecting unpaid hospital bills, except as provided by Health and Safety Code sections 127425(f)(2)(A) and (B). This requirement does not preclude Hoag from pursuing reimbursement from third party liability settlement or tortfeasors or other legally responsible parties. | |
| | 2.7 | Patients who have an application pending for either government-sponsored coverage or for Hoag's own charity care and financial assistance, will not knowingly be referred to a collection agency prior to 180 days from the date of discharge or date of service. | |
| | 2.8 | At the time of billing, Hoag will provide to all low-income uninsured patients the same information concerning services and charges provided to all other patients who receive care at the hospital. | |
| | 2.9 | Patients who have been denied charity care or other discounts may appeal the denial, | |

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| | in writing, within 10 days of receiving the denial. The appeal should include supporting documentation and evidence as to why the appeal is being made and should be sent to the address below:<br>Hoag Memorial Hospital Presbyterian<br>One Hoag Drive, P.O. Box 6100<br>Newport Beach, CA 92658-6100<br>Attention: Executive Director Business Services<br>The patient's appeal will be considered and a response with the decision will be mailed to the patient within 10 days of receiving the appeal. All decisions of the Executive Director will be considered final and additional appeals will not be permitted. | |
| **3.0** | **Charity Care And Discounted Care (Partial Charity) Eligibility Requirements:**<br>3.1 The following factors will be considered when determining the amount of discount/write-off provided.<br>3.1.1 All patients are eligible to apply for financial assistance under the Charity Care and Discount Policy and will be eligible for the reduced rates provided therein if determined eligible for such reduced rates (see Tables below).<br>3.2 Evidence of eligibility will be requested and must be provided. Patients should be screened for charity or discounted (partial charity) care prior to admission or at time of admission. | Charity Care Specialist |
| | 3.3 Additional considerations will be made such as:<br>3.3.1 family size,<br>3.3.2 family income,<br>3.3.3 amount of hospital and other health care bills during the past year, and<br>3.3.4 Assets as permitted under state law.<br>3.4 All payment resources must first be explored and applied including but not limited to third party payers, Medicare, Medi-Cal, Cal-Optima, MSI, and Victims of Crime.<br>3.4.1 If a patient is eligible for Medi-Cal, any charges for Days of Service Not Covered by the patient's coverage may be written off to charity without a completed financial statement.<br>3.4.2 Patients unable to pay the total billing for specialty services not covered by their insurance may be considered for charity or discounted care (partial charity) for a portion of the cost if eligible as described above.<br>3.4.3 Patients unwilling to disclose any financial information during eligibility screening or Medicare/Medi-Cal screening will not be processed under the Charity Care and Discount Policy.<br>3.4.4 The Executive Director of Revenue Cycle may make discretionary decisions for partial charity or 100% approval write-offs of the liability amounts including extenuating circumstances specific to a patient or family need. | |
| **4.0** | **Charity Care Discount Table:** | Charity Care Specialist |

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

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

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

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

5.2 Cosmetic and excluded procedures are from the discount.

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

**6.0 Self- Pay Discount:** — Charity Care Specialist

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

**Reference:**

**Multidisciplinary Review:**

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

# Appendix B

## Hoag Hospital Quantifiable Community Benefit Summary Trend FY 2014

**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*

| | | FY2014 | | FY2013 |
|---|---|---|---|---|
| Medical Services Indigent (MSI) | $ | 5,705,215 | $ | 13,893,000 |
| Charity Care | $ | 4,748,919 | $ | 7,390,268 |
| MediCal/Cal Optima Cost of Unreimbursed Care | $ | 15,848,241 | $ | 16,304,000 |
| Medicare Cost of Unreimbursed Care | $ | 56,626,973 | $ | 70,825,000 |
| **Total Cost of Unreimbursed Direct Medical Care Svcs** | **$** | **82,929,348** | **$** | **108,412,268** |

**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 | $ | 4,219,773 | $ | 5,510,325 |
| Subsidized Clinical Specialty Services | $ | 73,686 | $ | 134,265 |
| Cash and In-Kind Contributions | $ | 527,234 | $ | 926,955 |
| Women's Health Care | $ | 120,000 | | N/A |
| Community Building Activities | $ | - | $ | 7,414 |
| Community Benefit operations | $ | 637,597 | $ | 842,054 |
| **Total Benefits for Vulnerable Populations** | **$** | **5,578,290** | **$** | **7,421,013** |

**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 | $ | 827,687 | $ | 1,051,629 |
| Health Profession Education | $ | 368,950 | $ | 382,530 |
| Subsidized Clinical Specialty Services | $ | 339,122 | $ | 1,072,975 |
| Cash and In-Kind Contributions | $ | 884,190 | $ | 1,100,783 |
| Women's Health Care | $ | 521,136 | | N/A |
| Community Building Activities | $ | 92,077 | $ | 45,327 |
| **Total Benefits for the Broader Community** | **$** | **3,033,162** | **$** | **3,653,244** |

| | | | | |
|---|---|---|---|---|
| ***Total Community Benefit and Economic Value*** | **$** | **91,540,800** | **$** | **119,486,525** |
| ***Total Community Benefit and Economic Value (excluding Medicare Cost of Unreimbursed Care)*** | **$** | **34,913,827** | **$** | **48,661,525** |

***Notes:***

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

*2. The 2014 Fiscal Year included 9 months: October 1, 2013 through June 30, 2014*

## Benefits for Vulnerable Populations

| | Net CB Expenditure |
|---|---|
| ***Community Health Improvement Services*** | |
| Alzheimer's Family Services Center | $ 1,332,167 |
| Case Management- Community Health | $ 11,658 |
| Mental Health Center-Community Health | $ 520,070 |
| Lifeline | $ 1,540 |
| Newport Community Counseling Center | $ 10,000 |
| Newport Mesa Unified School District (HOPE Clinic) | $ 250,000 |
| Oak View Community Center Mobile Clinic | $ 50,377 |
| Senior Transportation (5 agencies) | $ 338,225 |
| SOS Medical and Dental Clinic | $ 1,705,736 |
| ***Total Community Health Services*** | ***$ 4,219,773*** |
| ***Subsidized Clinical Specialty Services*** | |
| ECU Call Panel | $ 73,686 |
| ***Total Subsidized Clinical Specialty Services*** | ***$ 73,686*** |
| ***Cash and In-Kind Contributions*** | |
| Access California Services | $ 45,000 |
| Age Well Senior Services | $ 45,000 |
| Casa Teresa | $ 2,000 |
| City of HB-Community Services and Senior Programs | $ 55,500 |
| Costa Mesa Senior Center | $ 8,721 |
| Council on Aging Orange County | $ 10,000 |
| Dr. Riba's Health Club (One OC) | $ 75,000 |
| High Hopes for El Sol Academy (One OC) | $ 3,000 |
| Latino Health Access | $ 25,000 |
| March of Dimes | $ 10,000 |
| MOMS Orange County | $ 1,000 |
| Newport Mesa Schools Foundation | $ 5,000 |
| Pediatric Adolescent Diabetes Research Education Foundation | $ 80,538 |
| Providence Speech and Hearing Center | $ 115,000 |
| Save Our Youth (SOY) | $ 20,000 |
| Someone Cares Soup Kitchen | $ 26,475 |
| ***Total Cash and In-Kind Contributions*** | ***$ 527,234*** |
| ***Women's Health Care*** | |
| Casa Teresa | $ 28,000 |
| Girl's Inc | $ 10,000 |
| Human Options | $ 62,000 |
| MOM Orange County | $ 20,000 |
| ***Total Women's Health Care*** | ***$ 120,000*** |
| ***Community Benefit Operations*** | |
| Community Health Department Operations | $ 274,980 |
| Dedicated Staff | $ 359,163 |
| PARO Decision Support (Predictive Modeling for Healthcare) | $ 3,454 |
| ***Total Community Benefit Operations*** | ***$ 637,597*** |

**Total Benefits for Vulnerable Populations $ 5,578,290**

## Benefits for the Broader Community

**Net CB Expenditure**

***Community Health Improvement Services***

| | | |
|---|---|---|
| Community Education and Outreach (various Hoag departments) | $ | 368,215 |
| First Aid Stations at Community Events | $ | 636 |
| Flu Immunization Clinic Expenses | $ | 215,841 |
| Freedom from Smoking Program | $ | 4,657 |
| Health Ministries Program | $ | 84,442 |
| Parkinson's Community Outreach Coordinator | $ | 51,393 |
| Pastoral Care Bereavement Groups | $ | 52,498 |
| Project Wipeout | $ | 50,005 |
| ***Total Community Health Services*** | ***$*** | ***827,687*** |

***Health Professions Education***

| | | |
|---|---|---|
| Cancer Center Social Work Internship | $ | 3,172 |
| Clinical Care Extender Program | $ | 161,078 |
| Hospital Case Management Internships | $ | 122,170 |
| Laboratory Internships | $ | 680 |
| Pharmacy Student Clinical Rotations | $ | 16,500 |
| Physical Therapy Internships | $ | 53,350 |
| Sweet Success Express Program (SSEP) | $ | 12,000 |
| ***Total Health Professions Education*** | ***$*** | ***368,950*** |

***Subsidized Clinical Specialty Services***

| | | |
|---|---|---|
| CHOC Pediatric Diabetes Services at the Allen Diabetes Center | $ | 150,000 |
| ETOH/Psych/Ancillary Patient Transfer Program | $ | 189,122 |
| ***Total Subsidized Clinical Specialty Services*** | ***$*** | ***339,122*** |

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

| | | |
|---|---|---|
| 211 Orange County | $ | 50,000 |
| Alzheimer's Association | $ | 10,000 |
| AIDS Services Foundation | $ | 5,000 |
| American Diabetes Association | $ | 15,000 |
| Arthritis Foundation | $ | 12,000 |
| CA-HI-NV Exchange Club of OC | $ | 775 |
| CHOC Foundation | $ | 200,000 |
| Epilepsy Support Network | $ | 20,000 |
| Healing Hearts: Camp Erin | $ | 15,000 |
| In-Kind Office Lease for Non-Profits | $ | 319,962 |
| Infectious Disease Association of California | $ | 10,000 |
| Irvine Children's Fund | $ | 20,000 |
| Irvine Public Schools Foundation | $ | 58,500 |
| Jewish Federation & Family Services | $ | 253 |
| Kiwanis Costa Mesa | $ | 2,700 |
| Newport Beach Police Explorer Program | $ | 15,000 |
| Orange County Human Relations | $ | 55,000 |
| USC- Keck School of Medicine | $ | 50,000 |
| Youth Employment Services | $ | 25,000 |
| ***Total Cash and In-Kind Contributions*** | ***$*** | ***884,190*** |

***Women's Health Care***

| | | |
|---|---|---|
| Planned Parenthood | $ | 100,000 |
| OB Education | $ | 21,136 |
| UCI - Women's Health Program | $ | 400,000 |
| ***Total Women's Health Care*** | ***$*** | ***521,136*** |

***Community Building Activities***

| | | |
|---|---|---|
| Community Disaster Readiness | $ | 82,077 |
| Health Funders Partnership of OC | $ | 10,000 |
| ***Total Community Building Activities*** | ***$*** | ***92,077*** |

| | |
|---|---|
| | **$** |
| **Total Benefits for the Broader Community** | **3,033,162** |

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