Hoag Memorial Hospital Presbyterian

IMPLEMENTATION STRATEGY (IS)

2020 - 2022

To provide feedback about this Implementation Strategy or obtain a printed copy free of charge, please email CommunityBenefit@hoag.org

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EXECUTIVE SUMMARY

Since 1952, Hoag has served the local communities and continues its mission to provide the highest quality health care services through the core strategies of quality and service, people, physician partnerships, strategic growth, financial stewardship, community benefit and philanthropy.

Hoag is a nonprofit regional health care delivery network in Orange County, California, consisting of two acute-care hospitals, 13 urgent care centers, nine health centers and a network of more than 1,700 physicians, 100 allied health members, 6,500 employees and 2,000 volunteers. More than 30,000 inpatients and 450,000 outpatients choose Hoag each year.

Hoag's dedication to the community began at its inception, and as the hospital continued to expand its outreach efforts, it became clear that a structured program was necessary. Hoag's formal commitment was initiated in 1995 when the hospital established the department of Community Health- charged with improving the health of the vulnerable population in Orange County.

The Department of Community Health is responsible for the coordination of Hoag's Community Benefit Program and provides services to assist the low-income and underserved in the community.

An Implementation Strategy is required by federal tax law set forth in Internal Revenue Code section 501(r). It is a written plan that describes how the hospital plans to address the significant health needs identified in the Community Health Needs Assessment or identifies the health needs the hospital does not intend to address and explains why the hospital does not intend to address the health need. In 2019, Hoag Hospitals conducted a Community Health Needs Assessment (CHNA) to assess the significant health needs for the hospitals' service area. Information on the CHNA process and a copy of the report can be found at www.hoag.org/about-hoag/community-benefit/reports/. Public comment on the CHNA is encouraged and comments are used to inform this work.

The CHNA and the resulting Implementation Strategy identify and address significant community health needs and help guide the hospitals' community health improvement programs and community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health. This Implementation Strategy explains how Hoag plans to address the significant health needs identified by the CHNA.

Collaborating Organizations

Joint CHNA The IRS regulations allow for the conduct of joint Community Health Needs Assessments (CHNA) when hospitals define their service area communities the same. In compliance with these regulations, this CHNA was conducted jointly by Hoag Hospital Newport Beach, Hoag Hospital Irvine and Hoag Orthopedic Institute. Project Oversight of the Community Health Needs Assessment process was overseen by: Minzah Malik, MPH, MBA Manager, Community Benefit Program and Lauren Tabios, MPH Specialist of Grants & Special Projects.

Implementation Strategy Priorities

As a result of the findings of our 2019 Community Health Needs Assessment (CHNA) and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, Hoag will focus on the following areas for its 2020-2022 Community Benefit efforts:

PRIORITY 1: MENTAL HEALTH

Mental illness is a common cause of disability and may result in individuals at-risk for substance use and violent behavior. In Orange County, the annual prevalence of mental health among adults was 6.7%. Of those with mental health needs, about half reported they had not received treatment in the past year for their mental health symptoms. Additionally, 35% of teens needed help for an emotional or mental health problem, and 15% of 9th and 11th graders reported considering suicide in the past 12 months.

Utilization of mental health treatment varies across ethnic groups, with Latino, African Americans, and Asian/Pacific Islanders with mental health needs significantly less likely to receive any treatment. Latinos report the highest rates of experiencing serious psychological distress at 10.8%. Additionally, spatial disparities in mental health exist with neighborhoods in Huntington Beach, Fountain Valley, Costa Mesa, Irvine, and Laguna Niguel more likely to report psychological distress.

PRIORITY 2: ACCESS TO CARE

Access to health care affects a person's health and well-being. Reliable access to health services can prevent disease and disability, reduce premature death and increase quality of life. Health insurance coverage is considered a key component to accessing health care. In Orange County, 48% of the population has employment-based health insurance; 24% are covered by Medi-Cal and 16% of the population has coverage that includes Medicare. Delayed care may also indicate reduced access to care; 9% of Orange County residents reported delaying or not seeking medical care and 8% reported delaying or not getting their prescription medication in the last 12 months. Additionally, 63% of Orange County residents reported delaying or not seeking care due to cost or lack of insurance.

In addition to delays in care, racial disparities persist across health outcomes and access to care. Pockets of neighborhoods in Anaheim, Santa Ana, and Garden Grove report their health quality as fair or poor. When broken down by race, Latinos and Asian Americans are more likely to rate their healthy quality as fair or poor. And although Orange County has the second largest number of Covered California enrollees, Latinos and other minority ethnic groups are more likely to report having no usual source of care.

PRIORITY 3: ECONOMIC SECURITY

Education, adequate employment and housing are components that provide a level of economic security for individuals and families. Poverty is intrinsically linked with other indicators, such as education opportunity, health and environmental opportunity, and social and economic opportunity. Among area residents, 11% are at or below 100% of the federal poverty level (FPL).

Additionally, people of color are more likely to be in poverty or among the working poor. They experience racial economic gaps and lack access to resources such as healthy food. Poverty was found to be the highest among Latinos and Native Americans with Latinos having the highest share of working poor. The number of Latino working poor continues to increase. Within Orange County, pockets of highly concentrated poverty have grown in prevalence, especially within neighborhoods in Anaheim, Santa Ana, Garden Grove and northern Irvine.

Within the social determinants of health, housing and transportation racial disparities exist. Low income African American and Latino immigrants are most likely dependent on public transportation. People of color are also facing higher housing cost burdens in Orange County, with Latino and African American households most likely to spend a larger share of their income on housing. However, although people of color spend most of their income on housing, they ranked the lowest in homeownership rates at 32% for Latinos and 34% for African Americans. Within homelessness, people of color represent the majority of the population experiencing homelessness in the county. African Americans make up 2% of Orange County's total population, but 13% of the homeless population.

PRIORITY 4: CHRONIC DISEASE

Chronic disease encompasses a wide range of health issues including, arthritis, diabetes, cardiovascular disease, cancer and asthma, among others. Diabetes is a growing concern in the community; 7% of adults in Orange County have been diagnosed with diabetes, and 13% have been diagnosed as pre-diabetic. In Orange County, 12% of the population has been diagnosed with asthma in their lifetime.

Racial inequity exists with chronic disease diagnosis and treatment. Orange County's Latino population face higher rates of obesity and diabetes. Within the Asian subgroups, different ethnicities report higher risks to chronic disease. Filipinos report higher rates of diabetes at 19.5%, and Pacific Islanders are also at a higher risk for diabetes, obesity, and cardiovascular disease. Orange County's African American and Native American populations report the highest incidence of heart disease mortality.

PRIORITY 5: WOMEN'S HEALTH

Women's health embodies the multi-faceted and specialized healthcare needs of women throughout their lives. Women's health follows women through different life stages to ensure continued health and support. Women's health during pregnancy is especially critical, with 87% of pregnant women entered into prenatal care during the first trimester. Additionally, 6% of infants experienced low weight at birth. Following women from pregnancy to giving birth, 96% of mothers use some form of breastfeeding.

Within Orange County, disparities exist in women's health needs. Of the adults needing and receiving behavioral health care services, 59% were women. Domestic violence for women in Orange County occurs for 26.3% of women. This is higher than the state occurrence. Additionally, women's cancer incidence for breast and ovarian cancer in Orange County are higher than at the state level. For maternal health, although the rates for mothers who receive early prenatal care and exclusively breastfeed are higher than the state value, they have been trending downward.

PRIORITY 6: SUBSTANCE USE

Substance use and substance use disorders has been growing in number, with nearly 1 in 6 people in Orange County reporting needing help with mental, emotional, or substance abuse problems. Chronic substance use is often associated with increased risk of chronic diseases, such as heart disease, diabetes, stroke, cancer, and unintended injuries.

Although Orange County has lower drug and alcohol mortality rates compared to the nation and state, Orange County still had higher hospitalization rates due to alcohol or substance use compared to 75% of other California counties. Additionally, Orange County's identified risk factors for substance use differed from the national and state risk factors. In Orange County, males were nearly two times more likely than females to be hospitalized for and or die from a drug and alcohol related incident. However, females were 1.6 times more likely than males to overdose from prescription drugs. Additionally, cities along the coastal and south county regions tended to have higher rates of drug and alcohol related hospitalizations and deaths compared to other parts of the county. Of the overdose deaths reported, 78.6% were accidental, with over half involving prescription drugs and 66.8% related to opioid use.

Among the youth, substance use trends among students in Orange County revealed that older students are more likely to report ease of access to substances, with e-cigarettes perceived to be the easiest of all. Additionally, school districts that fall within the coastal and south county regions rank higher than the county rate of marijuana use, alcohol consumption, and opioid use.

Racial disparities exist in the addiction rate and overdose deaths for Orange County. Hospital visits due to drug and alcohol use can be broken down by 78% Caucasian, followed by 14% Latino. Although Latinos make up a small portion of hospital visits, 37.5% of Latinos are more likely to die of an illegal drug overdose, and 30.1% are likely to die from a prescription drug overdose.

MISSION, VISION, AND VALUES

Mission

To provide the highest quality health care servcies to communiites we serve

Vision Statement

Hoag is a trusted and nationally recognized health care leader

Core Values

Excellence

Respect

Integrity

Patient Centeredness

Community Benefit

INTRODUCTION

Who We Are

Hoag Memorial Hospital Presbyterian (Hoag) is a nonprofit regional health care delivery network that has been operating in Orange County, California since 1952. The regional network consists of two acute-care hospitals, 12 urgent care center, and nine health centers. Each year Hoag serves more than 480,000 patients (for both inpatient and outpatient services).

Hoag offers a variety of health care services including five specialized care institutes for cancer, heart and vascular, neurosciences, women's health, and orthopedics. Orthopedic services are offered through Hoag's affiliate Hoag Orthopedic Institute, which consists of an orthopedic hospital and two ambulatory surgical centers.

Our Commitment to Community

Hoag established the Department of Community Health in 1995 to support its vision of a healthy Orange County and has since provided millions of dollars in support of health care for the county's vulnerable populations.

The Department of Community Health is led by its Director, Michaell Rose DrPH, LCSW. The department is responsible for the coordination of Hoag's Community Benefit Program and provides services to assist the low-income and vulnerable community. The department functions with the same vision of promoting population-based health efforts. Housed within the Melinda Hoag Smith Center for Healthy Living (MHSCHL), the department focuses its efforts on improving health and well-being by providing services to the vulnerable and at-risk surrounding community. The program focuses on two primary strategies (see below):

1. Provide necessary healthcare-related services that are not already available in the community.
2. Provide financial support to existing community based nonprofit organizations which provide healthcare and related social services to address and support community health needs.

The Community Health department provides services and programs to the community through:

- Community Case Management
- Mental Health and Psychotherapy Services
- Health Ministries/Parish Nursing
- Grantmaking

Many other departments within Hoag provide free community health services including education and support groups. Additionally, Community Benefit collaborates with more than 60 community-based nonprofit providers to deliver health related programs and services throughout the county by offering:

- Free and discounted care
- Care for low-income and vulnerable populations

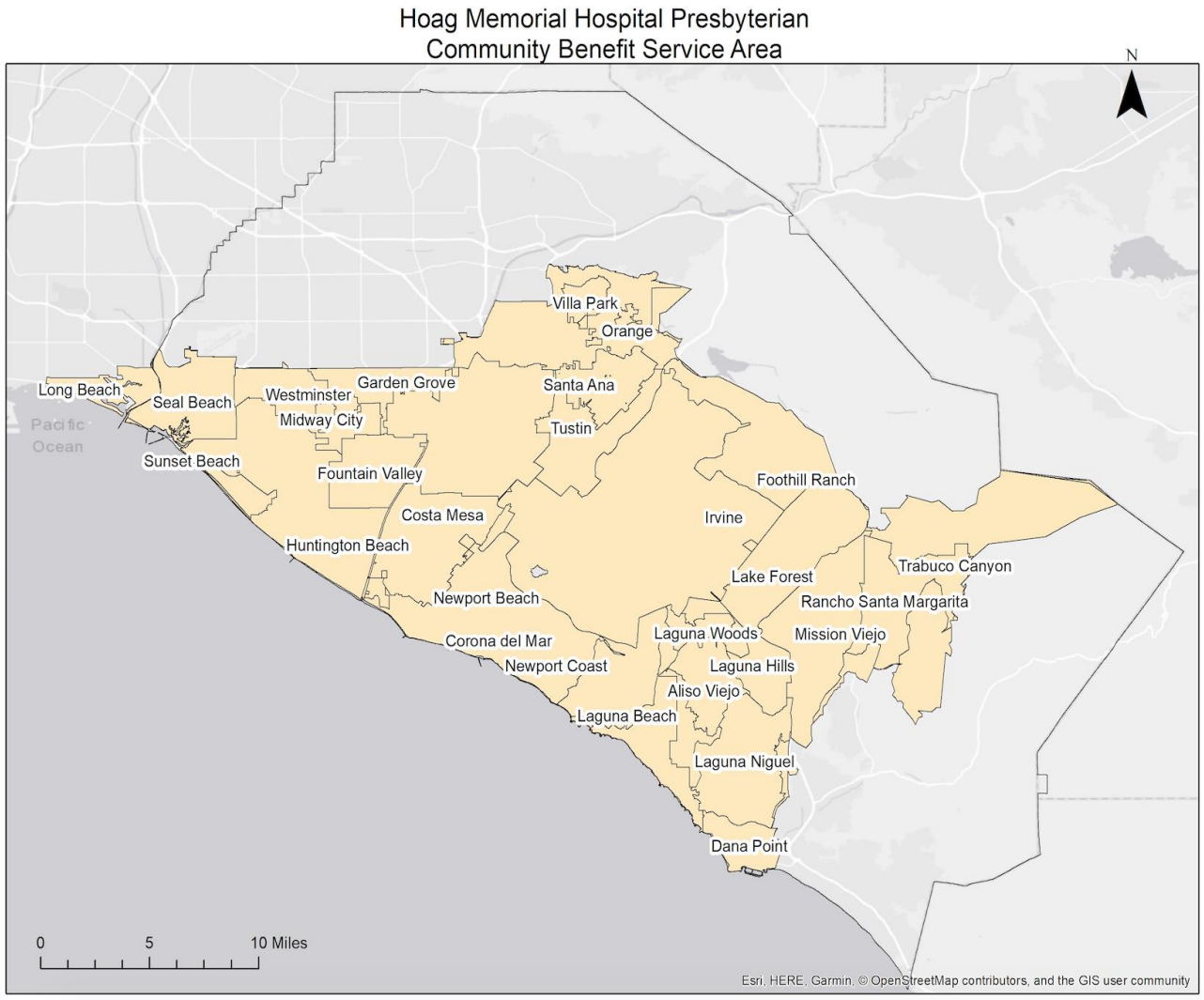
OUR COMMUNITY

Description of Community Served

Hoag's service area includes 53 zip codes (See **Table 1**. below) spanning 27 cities and unincorporated communities in both Orange County and Los Angeles County (one zip code is located in Long Beach).

Table 1. Hoag Service Area	
Zip Code(s)	**City/Unincorporated Area**
92656	Aliso Viejo
92625	Corona Del Mar
92626, 92627	Costa Mesa
92629	Dana Point
92610	Foothill Ranch
92708	Fountain Valley
92843, 92844	Garden Grove
92646, 92647, 92648, 92649	Huntington Beach
92602, 92603, 92604, 92606, 92612, 92614, 92617, 92618, 92620	Irvine
92651	Laguna Beach
92653	Laguna Hills
92677	Laguna Niguel
92637	Laguna Woods
92630	Lake Forest
90803	Long Beach
92655	Midway City
92691, 92692	Mission Viejo
92660, 92661, 92662, 92663	Newport Beach
92657	Newport Coast
92866, 92867, 92868, 92869	Orange
92688	Rancho Santa Margarita
92701, 92703, 92704, 92705, 92706, 92707	Santa Ana
90740	Seal Beach
90742	Sunset Beach
92679	Trabuco Canyon
92780, 92782	Tustin
92861	Villa Park
92683	Westminster

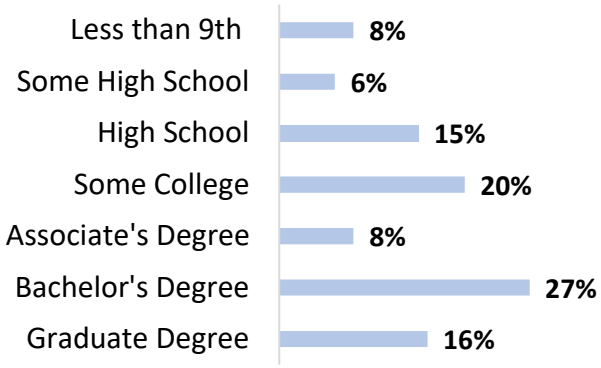
Service Area Map



Demographic Profile within the Service Area

1,991,457
Service Area Population

Educational Attainment for Residents 25+



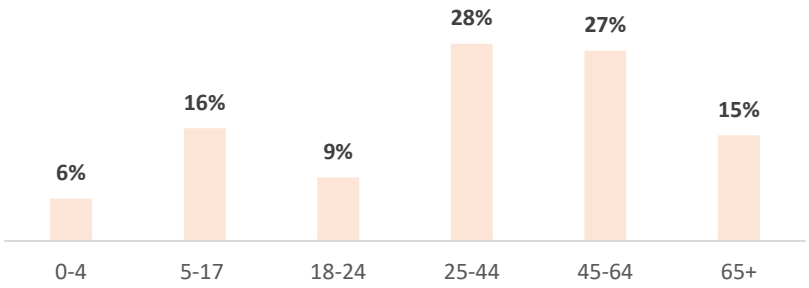
6% of households receive SNAP benefits.

11% of residents live 100% below the Federal Poverty

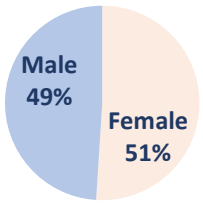
$93,000 Median Household Income

5% of the civilian labor force (16 and older) are unemployed.

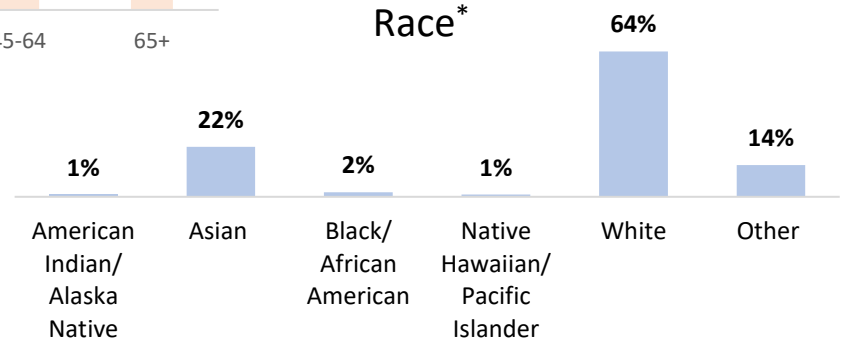
Age



Gender



Race*



31% Identify as Hispanic/Latino

5% of residents (18+) are veterans

*Percentages exceed 100% because respondents could select more than one response option.

COMMUNITY HEALTH NEEDS ASSESSMENT

Significant Community Health Needs Prioritized

This section highlights the emergent themes across the primary data collected. Detailed reports summarizing findings from each type of primary data collection activity (i.e., key stakeholder interviews, focus groups, provider survey, and community member survey) have been developed separately and were used to inform this section.

Across community members and local health experts the top themes that emerged were:

- Mental Health
- Obesity/ Diabetes
- Substance Use
- Heart Disease/ Cardiovasculr Health
- Reproductive/ Sexual Health

Social Determinants to Health:

Acces to Care

Housing Insecurity

Low Socioeconomic Status

Social Determinants to Health. Community members and experts engaged in the CHNA process were asked to describe what they believed to be contributing to the health concerns. The top emergent themes were: (1) difficulty accessing appropriate resources and care, (2) homelessness/housing insecurity, (3) low socioeconomic status, and (4) poor health behaviors (i.e., lack of exercise, poor diet, etc.).

IMPLEMENTATION STRATEGY

Summary of Implementation Strategy Process

The Implementation Strategy was developed with input from the hospital Community Benefit Committee and the Department of Community Health. The following criteria were used to determine which significant health needs Hoag will address in the Implementation Strategy:

- Organizational Capacity: There is capacity to address the issue.
- Existing Infrastructure: There are programs, systems, staff and support resources in place to address the issue.
- Ongoing Investment: Existing resources are committed to the issue. Staff time and financial resources for this issue are counted as part of our community benefit effort.
- Focus Area: Has acknowledged competencies and expertise to address the issue and the issue fits with the organizational mission.

As a result of the review of needs and application of the above criteria, Hoag will address: access to care; economic security; mental health; chronic disease, including obesity and diabetes prevention and management; women's health; and substance use through a commitment of community benefit programs and charitable resources.

Hoag anticipates that implementation strategies may change and therefore, a flexible approach is best suited for the development of its response to the CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by Hoag in the enclosed Implementation Strategy.

Needs Beyond the Hospital's Service Program

By taking existing hospital and community resources into consideration, Hoag is able to address all the priority health areas identified in the 2019 CHNA. This Implementation Strategy is not exhaustive of everything Hoag does to enhance the health of the community. Hoag will continue to look for opportunities to address community needs where it can appropriately focus on those needs.

Addressing the Needs of the Community: 2020- 2022 Key Community Benefit Initiatives and Evaluation Plan

Prioritized Community Health Needs	Needs Selected by the Hospitals	Criteria for Selecting Needs
• Housing Insecurity • Low Socioeconomic Status • Mental Health • Access to Care • Substance Use • Obesity/Diabetes • Reproductive/ Sexual Health • Heart Disease/ Cardiovascular Health • Poor Health Behaviors	• Economic Security: Housing, Low Socioeconomic Status • Mental Health • Access to care • Chronic Disease (Includes Heart Disease, Diabetes, Obesity, and Poor Health Behaviors) • Women's Health (Includes Reproductive/Sexual Health) • Substance Use	• Organizational Capacity • Existing Infrastructure/Partnerships • Ongoing Investment • Focus Area

HOAG'S IMPLEMENTATION STRATEGY

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

Mental Health
Strategies
1) Provide mental health care services through Hoag's Mental Health Center primarily focused on the low-income population 2) Provide funding and/or in-kind support to community nonprofit organizations that focus on mental health that goes beyond our scope of care. 3) Provide workforce development opportunities (internships, internal and external professional development) for the mental health profession. 4) Use existing pathways to expand our continuum of care for mental health.
Expected Outcomes for this health need
• Increase access and remove barriers to mental health care services in community settings. • Provide bilingual, bicultural mental health care services to people who otherwise could not obtain mental health services. • Bridge gaps, improve referrals and increase coordination among mental health care providers and community resources and programs. • Leverage Hoag assets to build capacity among community clinics and community organizations to improve access to mental health care.

Access to Care
Strategies
1) Provide financial assistance through free and discounted care for health care services, consistent with the hospital's financial assistance policy. 2) Offer information and enrollment assistance for no cost and low-cost insurance programs. 3) Provide funding and/or in-kind support to community clinics. 4) Provide funding and/or in-kind support to community nonprofit organizations that reduce barriers to accessing care. 5) Provide partners with space and resources at the Melinda Hoag Smith Center for Healthy Living. 6) Provide transportation support for seniors to increase access to health care services.

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

Economic Security
Strategies
1) Provide funding and/or in-kind support to community nonprofit organizations that focus on economic security measures. 2) Build community capacity by providing collaborative partners with space and resources at the Melinda Hoag Smith Center for Healthy Living 3) Continue and expand programs that alleviate food insecurity
Expected Outcomes for this health need
• Increase access to supportive services for individuals and families to help them maintain stability and self-sufficiency. • Leverage Hoag assets to build capacity among community organizations to improve food, housing, employment and education among at-risk populations.

Prevention of Chronic Disease and Management
Strategies
1) Provide funding and/or in-kind support to community clinics. 2) Provide funding and/or in-kind support to community nonprofit organizations that focus on disease prevention, including obesity prevention and chronic disease management. 3) Provide partners with space and resources at the Melinda Hoag Smith Center for Healthy Living. 4) Offer chronic disease prevention, management, education, care navigation, screenings and support groups. 5) Continue to provide wellness and prevention programs to vulnerable communities.
Expected Outcomes for this health need
• Improve individuals' compliance with chronic disease prevention and management recommendations. • Increase community awareness of disease prevention strategies. • Leverage Hoag assets to build capacity among community clinics and community organizations to improve chronic disease management among at-risk populations. • Provide access to needed health promotion resources for vulnerable populations at-risk for or

suffering with chronic diseases.

- Continue health education and health coaching efforts – e.g. public school presentations, community lectures, on-line education.
- Continue physician and healthcare provider education.

Women's Health
Strategies
1) Provide funding and/or in-kind support to organizations focused on women's health 2) Collaborate with Hoag Women's Health Institute in identifying gaps in care for the low income and vulnerable patient population 3) Offer health education, care navigation, advocacy and resource brokering.
Expected Outcomes for this health need
• Increase access and remove barriers to women's health services in community settings. • Provide bilingual, bicultural women's health services to people who otherwise could not obtain women's health services. • Bridge gaps, improve referrals and increase coordination among women's health providers and community resources and programs. • Leverage Hoag assets to build capacity among community clinics and community organizations to improve access to women's health care.

Substance Use
Strategies
1) Provide funding and/or in-kind support to organizations focused on substance use 2) Collaborate with Hoag's Addiction Treatment Centers to develop opportunities for low-income population. 3) Collaborate with Federally Qualified Health Centers (FQHCs) that address substance use disorders and provide Medication-Assisted Treatment (MAT).
Expected Outcomes for this health need
• Increase access and remove barriers to substance use treatment in community settings. • Provide bilingual, bicultural substance abuse services to people who otherwise could not obtain substance abuse treatment. • Leverage Hoag assets to build capacity among community clinics and community organizations to improve access to substance use services and treatment.

Planned Collaboration

To accomplish these strategies Hoag will collaborate with community partners. Sharing resources and enhancing the capacity of partner organizations supports the achievements of our goals. Potential collaborative partners include, but are not limited to:

- Advocacy Groups
- Community Health Centers and community clinics
- Community-based organizations
- Faith based organizations
- Family Resource Centers
- Federally Qualified Health Centers (FQHCs)
- Local municipalities
- Mental Health Associations
- Orange County Health Care Agency
- School districts and schools
- Local Food Banks
- Senior centers and adult day centers

Evaluation of Impact

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

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

2020- 2022 IMPLEMENTATION STRATEGY APPROVAL

This Implementation Strategy was adopted by the Board of Directors of Hoag Memorial Hospital Presbyterian on November 5-6, 2020

11/06/20

Chair, George H. Wood — Date

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To request a paper copy without charge, provide feedback about the CHNA or IS Report, or any additional inquiries, please email CommunityBenefit@hoag.org.

Appendix 1: Definition of Terms

Community Benefit: An initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives:

a. Improves access to health services;
b. Enhances public health;
c. Advances increased general knowledge; and/or
d. Relieves government burden to improve health.

Community benefit includes services to persons living in poverty, persons who are vulnerable, and the broader community.

To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following:

a. Community health needs assessment developed by the ministry or in partnership with other community organizations;
b. Documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; or
c. The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

Health Equity: Healthy People 2020 defines *health equity* as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."

Social Determinants of Health: Powerful, complex relationships exist between health and biology, genetics, and individual behavior, and between health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies. These factors, which influence an individual's or population's health, are known as *determinants of health*. *Social determinants of health* are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Initiative: An initiative is an umbrella category under which a ministry organizes its key priority efforts. Each effort should be entered as a program in CBISA Online (Lyon Software). Please be sure to report on all your Key Community Benefit initiatives. If a ministry reports at the initiative level, the goal (anticipated impact), outcome measure, strategy and strategy measure are reported at the initiative level. Be sure to list all the programs that are under the initiative. Note: All Community Benefit initiatives must submit financial and programmatic data in CBISA Online.

Program: A program is defined as a program or service provided to benefit the community (in alignment with guidelines) and entered in CBISA Online (Lyon Software). Please be sure to report on all community benefit programs. Note: All community benefit programs, defined as "programs", are required to include financial and programmatic data into CBISA Online.

Outcome measure: An outcome measure is a quantitative statement of the goal and should answer the following question: "How will you know if you're making progress on goal?" It should be quantitative, objective, meaningful, and not yet a "target" level.