MemorialCare™
Orange Coast Medical Center

Annual Report and Plan for Community Benefit
MemorialCare Orange Coast Medical Center
Fiscal Year 2025 (July 1, 2024 - June 30, 2025)
HCAI Hospital ID: 106300225

Submitted to:
Department of Health Care Access and Information
Accounting and Reporting Systems Section
Sacramento, California

Contents

About Orange Coast Medical Center

MemorialCare

MemorialCare is a nonprofit integrated health system that includes four leading hospitals – Orange Coast Medical Center, Saddleback Medical Center, Long Beach Medical Center, and Miller Children's & Women's Hospital; award-winning medical groups – MemorialCare Medical Group and MemorialCare Independent Physicians; Select Health Plan; and multiple outpatient health centers, urgent care centers, imaging centers, breast centers, ambulatory surgical centers, physical therapy centers and dialysis centers throughout Orange and Los Angeles Counties.

Orange Coast Medical Center

Orange Coast Medical Center (OCMC) was incorporated in December 1995 and became a member of MemorialCare in January 1996. The hospital is a full service, nonprofit hospital with 221 licensed beds. It is home to the MemorialCare Cancer Institute, MemorialCare Breast Center, MemorialCare Imaging Center, MemorialCare Heart & Vascular Institute, MemorialCare Surgical Weight Loss Center, MemorialCare Joint Replacement Center, Neuroscience Institute, Childbirth Center, Digestive Care Center, and Spine Health Center.

Awards and Designations

OCMC is the recipient of the following awards and accolades:

- *U.S. News & World Report* ranked OCMC among the top 14 hospitals in the Los Angeles Metro area and among the top 28 hospitals in California.
- *U.S. News & World Report* Best Regional Hospital for Community Access
- *U.S. News & World Report* also recognized OCMC as "High-Performing" in 3 Adult Specialties and 14 Procedures or Conditions:
    - Abdominal Aortic Aneurysm Repair
    - Colon Cancer Surgery
    - Diabetes
    - Geriatrics
    - Heart Attack
    - Heart Arrhythmia
    - Heart Bypass Surgery
    - Heart Failure
    - Hip Fracture
    - Kidney Failure
    - Knee Replacement
    - Leukemia, Lymphoma & Myeloma
    - Maternity Care
    - Neurology & Neurosurgery
    - Pneumonia
    - Pacemaker Implantation
    - Pulmonology & Lung Surgery
- Healthgrades Five-Star Rating for Clinical Excellence:
    - Coronary Artery Bypass Graft Surgery
    - Treatment of Heart Attack

    - Sepsis
    - Total Knee Replacement
- Healthgrades Specialty Excellence Awards
    - Coronary Intervention
    - Critical Care
    - Orthopedics
- OCMC was recognized as a Blue Shield Blue Distinction Center for Spine Surgery and Knee and Hip Replacement and a Blue Distinction+ Center for Maternity.
- OCMC employees recognized the hospital as a Top Place to Work for the 14th Consecutive Year.
- *OC Register* Best of Orange County Hospitals
- Magnet designated hospital.
- Energy to Care (E2C) Award by the American Society for Health Care Engineering (ASHE) for outstanding achievements in energy management and sustainability.
- Cardiac Program Earned a Three-Star Rating from Society of Thoracic Surgeons.
- Aetna Named OCMC as an Institute of Quality for Orthopedic Care.
- Received California Maternal Quality Care Collaborative (CMQCC) Super Star Award.
- National Silver-Level Beacon Award for Critical Care Excellence by the American Association of Critical-Care Nurses.
- Best Hospital by Women's choice Award for commitment to providing the highest level of care for women, as voted by women.
- Surgical Weight Loss Accreditation by the American College of Surgeons Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).
- Commission on Cancer (CoC) accreditation through American College of Surgeons.
- National Accreditation Program for Breast Centers (NAPBC).

Mission and Values

Mission

To improve the health and well-being of individuals, families and our communities.

Vision

Exceptional People. Extraordinary Care. Every Time.

Values

The iABCs of MemorialCare

The iABCs are a statement of our values—Integrity, Accountability, Best Practices, Compassion and Synergy. They remind us of our commitment to the highest standard of patient care and the active communication of clinical outcomes.

- **Integrity**
  Always holding ourselves to the highest ethical standards and values. Doing the right thing, even when no one is watching.
- **Accountability**
  Being responsible for meeting the commitments we have made, including ethical and professional integrity, meeting budget and strategic targets, and compliance with legal and regulatory requirements.
- **Best Practices**
  Requires us to make choices to maximize excellence, and to learn from internal and external resources about documented ways to increase effectiveness and/or efficiency.
- **Compassion**
  Serving others through empathy, kindness, caring and respect.
- **Synergy**
  A combining of our efforts so that together we are more than the sum of our parts.

Governance

The MemorialCare Orange County Board of Directors guides the direction of community benefit, with assistance from the Community Benefit Oversight Committee (CBOC).

FY25 Board of Directors

Barry S. Arbuckle, PhD
Sharon Cheever
Resa Evans, (MHS Board Chair)
Thomas Feldmar, Chair

Catherine Han, MD
Julio Ibarra, MD, Vice Chair
Lalita Komanapalli, MD
Rhonda Longmore-Grund
Frank Marino, MD
Michael Dean Moneta, MD
Tam Nguyen, MD, Secretary
Tom Rogers
Dale Vital
David A. Wolf

Community Benefit Oversight Committee

The CBOC (Community Benefit Oversight Committee) is an advisory committee for the hospital's community benefit programs and reports to the Board of Directors. The CBOC reviews and validates legal and regulatory compliance specific to community benefit mandates, assures community benefit programs and services are effectively meeting identified community health needs, with emphasis on populations with unmet health needs, and increases transparency and awareness of community benefit activities. The CBOC were consulted on the development of the community benefit plan.

The members of the OCMC CBOC include:

- Sue Allie, Community Member
- Jennifer Ayala, MSN, RNC-OB, Orange Coast Medical Center
- Cheryl Brothers, Community Member
- Tony Coppolino, Community Member
- John Fay, MemorialCare Health System
- Beth Hambelton, MemorialCare Health System
- Erin Hotra-Shinn, Orange Coast Medical Center
- Mark Johnson, EdD, Tustin Unified School District
- Kristen Pugh, MemorialCare Health System
- Xuan "Sue" Tram, RN, Orange Coast Medical Center
- Jenni Worsham, City of Fountain Valley
- Jennifer Zouras, Community Member

Caring for our Community

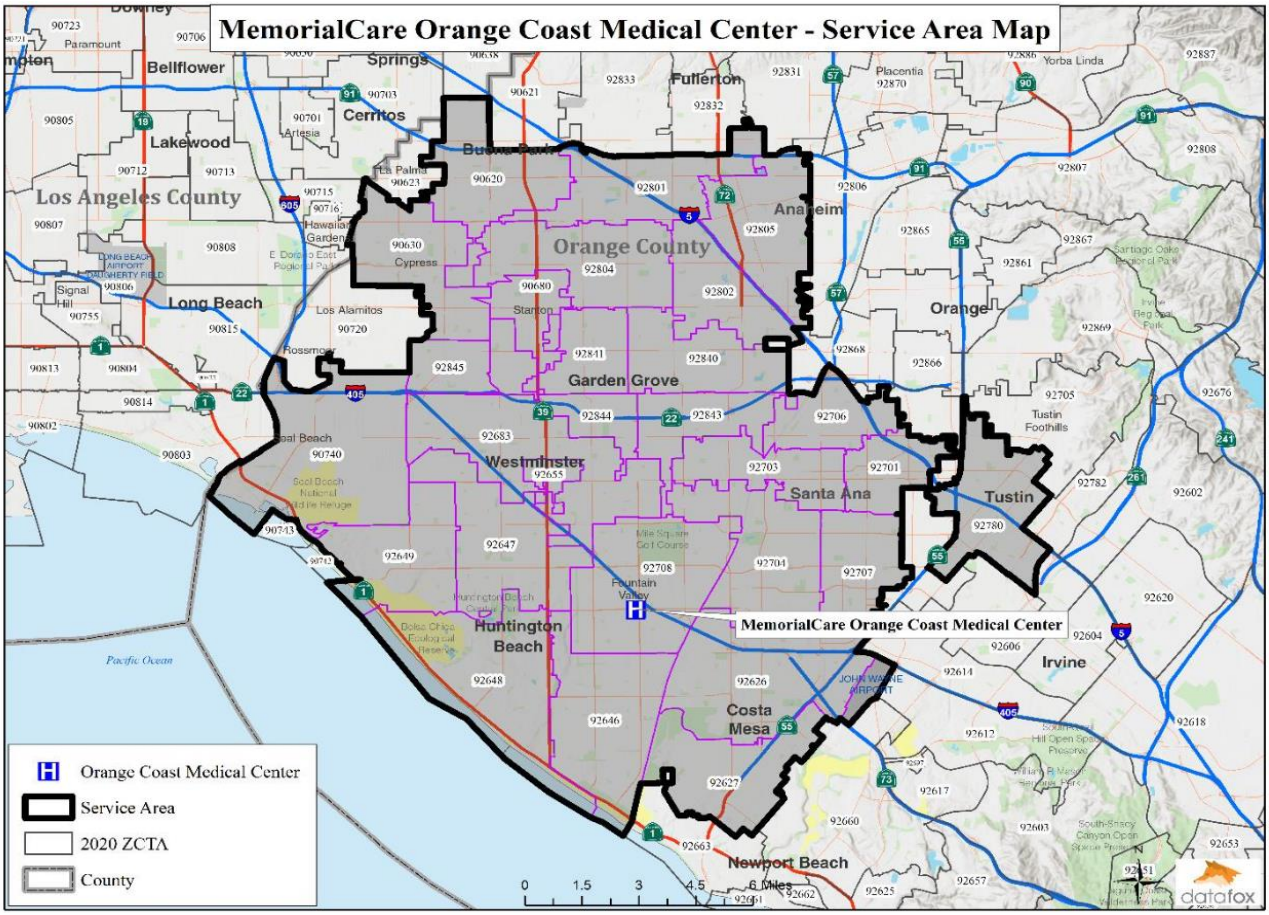
This report demonstrates tangible ways in which OCMC fulfills its mission to improve the health and wellbeing of our community and provide extraordinary care. OCMC provides financial assistance to those in the community who cannot afford services, or whose health insurance does not cover all services rendered. In addition, OCMC invests in the community to increase access to health care services and improve health.

Service Area

OCMC is located at 9920 Talbert Avenue, Fountain Valley, California 92708. The service area is in Orange County and includes 28 ZIP Codes, representing 13 cities or communities. Inpatient admissions were calculated over three years 2021-2023 (calendar years) and 81% of total inpatient ZIP Codes were used to determine the service area.

Orange Coast Medical Center Service Area

Cities	ZIP Codes
Anaheim	92801, 92802, 92804, 92805
Buena Park	90620
Costa Mesa	92626, 92627
Cypress	90630
Fountain Valley	92708
Garden Grove	92840, 92841, 92843, 92844, 92845
Huntington Beach	92646, 92647, 92648, 92649
Midway City	92655
Santa Ana	92701, 92703, 92704, 92706, 92707
Seal Beach	90740
Stanton	90680
Tustin	92780
Westminster	92683



Community Snapshot

OCMC conducted its most recent Community Health Needs Assessment (CHNA) in FY25. The population of the OCMC service area is 1,400,831[1]. Children and youth make up 21.6% of service area population, 63.9% are adults, and 14.5% are seniors, ages 65 and older[2]. In the service area, the largest portion of the population identify as Hispanic or Latino (45.4%) Non-Latino White or Caucasian residents comprise 27.2% of the population. At 22.2% of the population, non-Latino Asian residents are the third largest racial and ethnic group in the service area. The remaining races and ethnicities comprise 5.2% of the service area population[3]. In the services area, 52% of residents speak English only in the home. Spanish is spoken in 39.2% of homes and an Asian or Pacific Islander language is spoken in 5.2% of service area homes. 3.2% of residents in the area speak an Indo-European language[4].

[1] U.S. Census Bureau, American Community Survey, 2013-2017 & 2018-2022, DP05. http://data.census.gov
[2] U.S. Census Bureau, American Community Survey, 2018-2022, DP05. http://data.census.gov/
[3] Ibid.
[44] U.S. Census Bureau, American Community Survey, 2018-2022, DP02. http://data.census.gov/

In the OCMC service area, 21% of adults have not graduated high school, and 37.5% of the population has graduated college, lower than the rate for the county (50.3%) and the state (43.9%)[5]. Among service area residents, 90.7% of the population have health insurance[6].

Vulnerable Populations

- In the service area, 25.1% of the population, ages five and older, speaks English "less than very well" and are considered linguistically isolated.[7]
- Among area residents, 11.2% are at or below 100% of the federal poverty level (FPL) and 28.8% are at 200% of FPL or below (low-income).[8]
- In the service area, 14.8% of children live in poverty, 12.6% of seniors and 27.4% of female head of households with children live in poverty[9].
- In 2024, the point-in-time count of homeless people in Orange County was 7,322 individuals.[10] In Orange County, 9.4% of children under age 18 were experiencing homelessness[11].
- Among the service area civilian population, 3.5% are veterans.[12]
- Among Orange County adults, 2.8% identify as gay, lesbian, or homosexual. 4.5% identify as bisexual[13]. About 1.3% of teens identify as transgender non-conforming and 16.9% of teens said that other people at school would describe them as gender non-conforming.[14]
- Among adults in the service area, 9.9% of the non-institutionalized civilian population identified as having a physical, mental or emotional disability.[15]
- The California Healthy Places Index (HPI) is a measure of socioeconomic need that is correlated with poor health outcomes. For community benefit purposes, California defines vulnerable populations living in areas with inadequate access to clean air and safe drinking water, as defined by an environmental HPI score of 50% or lower. The OCMC service area ZIP Codes have an HPI score for clean environment of 37.8%.[16]

[5] Ibid.
[6] U.S. Census Bureau, American Community Survey, 2018-2022, DP03. http://data.census.gov/
[7] U.S. Census Bureau, American Community Survey, 2018-2022, DP02. https://data.census.gov/
[8] U.S. Census Bureau, American Community Survey, 2018-2022, S1701. http://data.census.gov/
[9] U.S. Census Bureau, American Community Survey, 2018-2022, S1701 & *S1702. http://data.census.gov/
[10] Orange County HMIS, 2024 Point-In-Time Homeless Count Summary, May 16, 2024. https://unitedtoendhomelessness.org/wp-content/uploads/2024/05/2024-Point-In-Time-Count-Summary-FINAL.pdf
[11] Ibid.
[12] U.S. Census Bureau, American Community Survey, 2018-2022, DP02. http://data.census.gov
[13] California Health Interview Survey, 2018-2022 or ±2019-2023, pooled. http://ask.chis.ucla.edu/
[14] California Health Interview Survey, 2019-2022 or ±2019-2023 combined. http://ask.chis.ucla.edu/
[15] U.S. Census Bureau, American Community Survey, 2018-2022, DP02. http://data.census.gov
[16] Public Health Alliance of Southern California, the California Healthy Places Index (HPI) Map, accessed October 26, 2024. https://healthyplacesindex.org

Community Health Needs Assessment

The CHNA is a primary tool used by the hospital to determine its community benefit plan, which outlines how it will give back to the community in the form of health care and other community services to address unmet community health needs. The CHNA adheres to California Senate Bill 697 and the Patient Protection and Affordable Care Act through IRS section 501(r)(3) and is conducted every three years by the hospital. The assessment incorporated components of primary data collection and secondary data analysis that focused on the health and social needs of the service area. The report includes benchmark comparison data that measure the data findings as compared to Healthy People 2030 objectives. Healthy People 2030 is a national initiative to improve the public's health by providing measurable objectives that are applicable at national, state, and local levels.

OCMC conducted targeted interviews to gather information and opinions from people who represent the broad interests of the community served by the hospital. Twenty-eight (28) interviews were completed from October 2024 to February 2025. Leaders and/or representatives of medically underserved, low-income, minority populations, as well as local health or other departments or agencies that have current data or other information relevant to the health needs of the community, were represented in the sample. Input was obtained from the Orange County Health Care Agency.

OCMC also conducted a survey to gather data and opinions from community residents and people who represent the community served by the hospital, including underserved residents. The survey was made available to community-based partner organizations for distribution to their clients. From January 13, 2025 to February 14, 2025, there were 23 usable surveys received.

Significant Community Health Needs

Significant health needs were identified through a review of the secondary health data and validation through stakeholder interviews and community surveys. The identified significant health needs included:

- Access to health care
- Chronic diseases
- Economic insecurity
- Food insecurity
- Housing and homelessness
- Mental health
- Overweight and obesity

- Preventive practices
- Senior health
- Substance use

Prioritization of Health Needs

The identified significant health needs were prioritized with input from the community. The interview respondents ranked mental health, access to health care, housing and homelessness, economic insecurity, and food insecurity as the top five priority needs in the service area. Among community respondent surveys, access to health care, economic insecurity, overweight and obesity, preventive practices, and senior health had the highest scores as priority needs in the community.

The complete CHNA report and the prioritized health needs can be accessed at www.memorialcare.org/about-us/community-benefit . To provide feedback on the CHNA and Implementation Strategy, please contact communitybenefit@memorialcare.org .

Addressing Priority Health Needs

In FY25, OCMC engaged in activities and programs that addressed the priority health needs identified in the FY23-FY25 Implementation Strategy. OCMC has committed to community benefit efforts that address access to care, behavioral health, chronic diseases, overweight and obesity, and preventive practices with a focus on older adults, the social drivers of health, and health equity. Selected activities and programs highlighting the hospital's commitment to community health are detailed below.

FY23-FY25 Priority Health Need: Access to Care and Preventive Practices

Access to care is a key driver of health that provides preventive measures and disease management, reducing the likelihood of hospitalizations and emergency room admissions. Preventive health care includes screenings, check-ups, and counseling to prevent illness, disease, or other health problems. Individuals who receive services in a timely manner have a greater opportunity to prevent or detect disease during earlier, treatable stages.

Response to Need

Financial Assistance

The Patient Financial Assistance Program was available to everyone in the community. This included people without health insurance, as well as patients with insurance who were unable to pay the portion of their bill that insurance did not cover. Patient Financial Services assisted community members with the financial assistance programs.

Health Education, Resources and Community Outreach

OCMC provided support and services for community residents that removed barriers to care and increased access to care and preventive measures. General health and wellness education, social media postings, blogs, podcasts, and informational articles were presented on topics that included: ER vs. urgent care, open enrollment, Medicare, advanced directives, telehealth and virtual care, flu, staying healthy, women's health, men's health, spine health, healthy habits, nutrition and exercise, maternal health, flu prevention, vascular surgery, substance use, and safety education. Over 307,210 community encounters were provided.

Parents-to-be were provided with education, advice, strategies, and tools through prenatal, childbirth and parenting classes. Topics included healthy pregnancy education, safety tips from pediatricians, baby care basics, childbirth, maternal support, midwives, childcare and breastfeeding support. Information was provided in English and Vietnamese and reached 24,400 community members. A breastfeeding clinic provided 221 encounters, breastfeeding support

groups reached 256 individuals, breastfeeding education reached 2,382 individuals, and 36 individuals participated in postpartum support. Infant CPR and Safety reached 223 community members.

MemorialCare provided anytime, anywhere education for expectant mothers through YoMingo®, a maternity education app, available in 18 languages. YoMingo® provides evidence-based information on prenatal care, labor and birth, postpartum, breastfeeding, and newborn care, including numerous educational videos. The app also provides information on available classes, a kick counter, contraction timer, personal journal, feeding log, and immunization log. In FY25, 1,192 individuals accessed the app.

The *CareConnection* quarterly newsletter was made available to community residents to provide health education messages and notify the community of free classes, support groups, and screenings offered at the hospital and in the community. Newsletters were mailed to households, and the information was also posted on https://www.memorialcare.org/blog .

Social Drivers of Health

OCMC screened patients for Social Drivers of Health (SDOH), determining if community members needed referrals and resources. In FY25, 10,417 patients were screened. To support community members in need of assistance with SDOH, MemorialCare supported the website FindHelp.org, a free web-based platform that connected individuals with location-based community programs offering free or reduced-cost services including food, housing, health care, and transportation.

Support Services

The hospital offered services to increase access to care and support preventive health care.

- Transportation was provided to 733 individuals who could not easily access medical care and appointments.
- Provided durable medical equipment, infusion services, home health support, and medication prescriptions to individuals who could not afford the cost of these services.
- Provided clothing and transportation to people experiencing homelessness.
- Social Work support line assisted 463 community members, which included a variety of supportive services and/or referrals.

Vietnamese Community Outreach

OCMC supported a Vietnamese Community Outreach Coordinator who organized and directed free community education and health screenings in the Vietnamese community. The coordinator also assisted with securing medical transportation for the elderly in the Vietnamese community.

Outreach included:

- Hosted a Vietnamese language website to better serve Vietnamese speaking community members.
- Presented an education series on heart problems, hepatitis, vaccines, sciatic pain, diabetes, hematology, hospice, dermatology, and hospice. The series reached 517 Vietnamese community members.
- Offered skin cancer lecture and free skin care screenings to 54 Vietnamese community members.
- Provided 230 free health care screenings at the Vietnamese Physicians Association of Southern California's Free Health Fair.
- Offered Vietnamese postpartum virtual support groups.
- Provided 80 clinical breast exams in partnership with Vital Access Care Foundation.
- Presented health education and prevention messages to the Vietnamese community through social media and newsletters. OCMC offered targeted health outreach to the Vietnamese community on local radio and cable TV. Information was presented weekly on a variety of topics. Radio listeners called in with questions. Health focused Radio and TV talk shows reached over seven million listeners.

FY23-FY25 Priority Health Need: Behavioral Health (includes Mental Health and Substance Use)

Positive mental health is associated with improved health outcomes. The need to access mental and behavioral health services was noted as a high priority among community members.

Response to Need

Behavioral Health Education and Awareness

Outreach, education classes and support groups increased awareness of mental health issues and connected area residents with available resources. Education included presentations on mental health awareness, prolonged grief, survivorship and beyond, substance use, and mindfulness and wellbeing.

Behavioral Health Integration Program

MemorialCare recognizes that physical and mental health should be coordinated in primary care settings. As a result, the Behavioral Health Integration (BHI) program includes all MemorialCare Medical Group Primary Care sites of care throughout our service area. Primary care practitioners screen for mental health conditions and coordinate care options for patients with behavioral health needs. The program includes:

- An embedded clinical social worker at each location.
- Referral to the services needed.

- Telehealth visits to patients enrolled in the program.
- Online patient self-management tools.

Casa Teresa

The OCMC community benefit grant program supported Casa Teresa to assist pregnant women facing addiction and experiencing homelessness to receive shelter and other basic needs, case management, pre and/or postnatal care, classes and supportive services, and visits with mental health professionals, including counseling and support for trauma and substance use disorders. Over the grant period, Casa Terea cared for 68 women plus 22 babies and 6 children.

- Additionally, in addressing the social drivers of health, Casa Teresa provided:
    - 9,869 bed nights for moms, children, and babies.
    - 5,562 meals.
    - 1,080 rides and 210 bus passes.
    - 2,132 case management meetings to help residents navigate social services, legal issues, and financial planning, laying the groundwork for economic stability.

FY23-FY25 Priority Health Need: Chronic Diseases

Chronic diseases are long-term medical conditions that tend to progressively worsen. Chronic diseases, such as cancer, heart disease, diabetes and lung disease, are major causes of disability and death. Chronic diseases are also the major causes of premature adult deaths.

Response to Need

Cancer Support Services

OCMC provided health and wellness education as well as support services related to cancer that were made available to the public. OCMC provided 20,648 community encounters to access cancer education and treatment information on lung cancer screenings, colon and breast cancer awareness, and care during chemotherapy and radiation.

- The Cancer Resource Center provided one-on-one counseling and phone counseling free of charge to 149 individuals and provided information and resources to 729 individuals.
- Support groups, free and open to the public, were provided for bereavement, cancer care, and women's cancer care.
- Colorectal cancer prevention, education, and early detection event reached 330 community members.
- Cancer awareness and survivorship lectures and resources reached 125 individuals.
- 95 community members were educated on lung cancer detection and awareness as well as radon exposure prevention.

- Prostate cancer awareness month was hosted in partnership with the Huntington Beach Fire Department and reached 75 individuals.
- The Look Good Feel Better program taught 62 women beauty techniques to help them manage their appearance as they underwent cancer treatment.
- The Warm Wishes program provided 671 community members, who were diagnosed with cancer. with referrals, resources, blankets, hats, and wigs. Port pillows were provided to 125 people, 8 individuals received breast prosthetics, and 463 individuals undergoing cancer treatment received free wigs from the hospital's wig bank.

Health Education, Resources and Community Outreach

Health and wellness education was made available to the public on topics that included: cardiovascular health, cancer, chronic disease management, surgical weight loss, obesity, safety, diabetes, medication management, nutrition, managing multimorbidity, and healthy habits reached over 1.6 million community members.

Support groups for bereavement, cancer and Parkinson's disease were provided with resources, education and support to individuals, families, and their caregivers.

Cardiac health awareness education provided 670,938 encounters on topics including heart risk assessment, heart health, atrial fibrillation treatment, calcium scoring, interventional cardiology, stroke prevention and treatment, and advanced cardiac care.

Parkinson's Disease Support

OCMC provided health education classes, support groups and special events that focused on Parkinson's disease. Offerings included support groups provided for individuals with movement disorders and early disease onset. In addition, Parkinson's classes included wellness recovery, exercise classes, caregiver support, and LOUD Crowd (speech preservation) classes, which resulted in 3,762 encounters. Lectures on topics such as early detection, essential tremors, vestibular issues, caregivers, and exercise options provided 39,626 encounters.

Senior Outreach Coordinator

OCMC supported a Senior Outreach Coordinator who collaborated with local agencies and organizations to assist older adults in securing needed services. This included coordinating a free medical transportation program for seniors, nutrition support resources, free health screenings, health education and disease prevention classes, socialization and enrichment events, and directly assisting seniors and their families, as needed.

OCMC supported senior-focused events:

- An education series geared toward seniors provided classes on stroke education, cholesterol, cell phone usage, healthy living, mindfulness and wellbeing, nutrition, heart matters, and what's in your medicine cabinet reached 313 seniors.
- Educational materials on Open Enrollment, Medicare, and Advanced Directives reached 174,824 community members.
- An *e*-newsletter was sent to senior residents to notify them of free health classes, events, and lifestyle information.
- Provided 60 vascular screenings at the Lakeview Senior Center.
- Provided funding for senior enrichment activities and the senior fitness center for the City of Fountain Valley.
- Provided AEDs, mini first-aid kits and other equipment for patrol cars to assist older adults in the community.
- Provided funding to support City of Huntington Beach social services for vulnerable seniors and disabled adults.

Vital Access Care Foundation (VACF) dba the Vietnamese American Cancer Foundation

The OCMC community benefit grant program provided funding for VACF's Continuum of Cancer Care program, which provided culturally, linguistically and equitable cancer support services to 104 Vietnamese cancer patients. VACF addressed gaps in cancer education, early detection, patient navigation, mental health, and survivorship support as well as proactively addressed social drivers of health, so participants reduced avoidable stressors and enabled them to prioritize their health and recovery. Support included a weekly food pantry, nutrition classes, referrals to financial aid, housing, legal assistance, peer support groups and counseling services, as well as case management.

FY23-FY25 Priority Health Need: Overweight and Obesity

Overweight and obesity affect a wide range of health issues and are major risk factors for diabetes, cardiovascular disease, and other chronic diseases. Physical activity plays a key role in levels of overweight and obesity, and in the development and management of chronic diseases. Healthy eating and nutrition programs also promote healthy body weight.

Response to Need

Breastfeeding

Breastfeeding in infancy is known to help reduce overweight and obesity later in life. OCMC provided breastfeeding classes, breastfeeding counseling, and a breastfeeding clinic available to the public at no cost.

Health Education, Resources and Community Outreach

OCMC provided support and services for community residents that increased access to care and preventive measures. Health and wellness education, social media postings, blogs, podcasts, and informational articles were presented on topics that included: nutrition, exercise, surgical weight loss, and obesity. These programs provided 21,226 community encounters.

Meals on Wheels Orange County

The OCMC community benefit grant program provided funding for Meals on Wheels Orange County (MOWOC). The program provided home-delivered nutritious meals to homebound older adults at risk of food insecurity, malnutrition, and isolation. Services included three meals a day delivered five days a week, along with nutrition education, case management services, and home safety checks. In FY25, 967 homebound seniors received 349,274 meals and 7,092 older adults were served 155,928 meals at the Lunch Café. To reflect the ethnicity and dietary needs of the population, MOWOC provided Asian-inspired meals, vegetarian meals, lactose-free meals, and Hispanic-inspired meals.

Radiant Health Centers

The OCMC community benefit grant program provided funding for Radiant's HIV Case Management services for people with HIV or at risk of HIV. Radiant Health Centers serve clients in Orange County. Case managers helped 1,216 Radiant patients navigate medical and social services, receive mental health support (available in English and Spanish), access a food pantry and transportation, and receive assistance with housing and financial needs.

Other Community Benefit Services

OCMC provided community benefit services in addition to those programs that focused on addressing priority health needs.

Health Professions Education

Continuing Medical Education (CME)

Twenty-two CME lectures were offered throughout the year and were available to physicians and health care professionals in the community. There were 1,100 encounters by health professionals for these lectures.

Nursing Education

OCMC provided precepting for 19 nursing students. Additionally, four nursing students participated in a Community Health Preceptorship, and nine nursing students worked on their leadership clinical hours.

Other Health Professions

OCMC provided clinical precepting for 32 health professionals. Students were precepted and performed their clinical hours and/or internship rotations for:

- Cardiopulmonary
- Cardiovascular technician
- Imaging
- Lactation Consultation
- Pharmacy
- Social work
- Surgical technician
- Ultrasound

Cash and In-Kind Donations

Cash Donations

OCMC supported community organizations through cash donations that addressed identified community health needs, health equity and the social drivers of health.

In-Kind Donations

- OCMC provided in-kind donations of shoes, clothing, blankets, and hygiene kits for people experiencing homelessness.
- OCMC donated over 25,000 N95 masks to those in need during the LA Fires in early 2025.

- OCMC employees represented the hospital on community boards and collaboratives that focused on increased access to health and social services, and improved safety, addressing vulnerable populations, as well as Vietnamese and senior health issues.

Community Benefit Grant Program

In FY25, OCMC provided community benefit grant funds to support community-based organizations that addressed identified health needs and served vulnerable populations within the hospital service area. Grants were provided to:

- Casa Teresa
    - Pregnant women facing addiction and experiencing homelessness received shelter and other basic needs, case management, prenatal care, classes and supportive services, including visits with mental health professionals. Casa Teresa cared for 68 women, 22 babies, and 6 children. At the shelter they provided 9,869 bed nights for moms, children and babies. They provided 5,562 meals and 1,080 rides and 210 bus passes.
- Meals on Wheels Orange County
    - Through MOWOC, 967 homebound seniors received 349,274 meals and 7,092 older adults were served 155,928 meals at the Lunch Café. These services addressed the three biggest threats to older adults' health and wellbeing: malnourishment, isolation, and loss of independence.
- Radiant Health Center AIDS Services Foundation
    - Provided case management service to 1,216 individuals with HIV or at risk of HIV. Clients received medical and social services, mental health support, access to a food pantry, transportation, housing assistance and financial support.
- Vital Access Care Foundation
    - Assisted 104 Vietnamese cancer patients receive culturally, linguistically and equitable cancer support services, case management and patient navigation services. Provided 1,990 transportation trips to appointments. Also provided a weekly food pantry, nutrition classes, referrals to financial aid, housing, legal assistance, peer support groups and counseling services.

Community Benefit Operations

In FY25, community benefit operations included administrative support and community benefit consultants. Support was provided for the completion of the FY24 Community Benefit Report and Plan, FY25 Community Health Needs Assessment and FY26-FY28 Implementation Strategy.

Community Building Activities

Coalition Building

OCMC staff participated in community coalitions to improve economic stability.

Economic Development

The hospital supported economic development groups that focused on issues that impacted community health improvement and safety.

Health Improvement Advocacy

Hospital staff supported local advocacy for health and safety.

Financial Summary of Community Benefit

OCMC's financial summary of community benefit for FY25 (July 1, 2024 to June 30, 2025) is summarized in the table below. The Hospital's community benefit costs comply with Internal Revenue Service instructions for Form 990 Schedule H. Costs are based on OCMC's overall cost-to-charge ratio. Appendix 1 lists the community benefit programs by category.

Financial Assistance and Means-Tested Government Programs	**Vulnerable Populations**	**Broader Community**	***Total***
Traditional Charity Care	$2,084,950		$2,084,950
Medi-Cal Shortfall	$22,168,180		$22,168,180
Other Means-Tested Government Programs (Indigent Care)	$0		$0
Sum Financial Assistance and Means-Tested Government Programs	$24,253,130		$24,253,130
Other Benefits			
Community Health Improvement Services	$975,206	$0	$975,206
Community Benefit Operations	$0	$56,716	$56,716
Health Professions Education	$0	$1,489,205	$1,489,205
Subsidized Health Services	$0	$0	$0
Research	$0	$0	$0
Cash and In-Kind Contributions	$278,598	$0	$278,598
Other Community Benefit	$0	$8,725	$8,725
Total Other Benefits	$1,253,804	$1,554,646	$2,808,450
Community Benefit Spending			
Total Community Benefit*	$25,506,934	$1,554,646	$27,061,580
Medicare (non-IRS)	$20,476,420		$20,476,420
Total Community Benefit with Medicare	$45,983,354	$1,554,646	$47,538,000

Community Benefit Plan FY26

The Community Benefit Plan describes the actions the hospital intends to take, including programs and resources it plans to commit, to address the priority significant health needs identified in the FY26-FY28 Implementation Strategy.

Significant Health Needs the Hospital Intends to Address

OCMC will address the following significant health needs with a focus on older adults, the social drivers of health, and health equity.

- Access to care
- Behavioral health (mental health and substance use)
- Chronic diseases
- Overweight and obesity
- Preventive practices

FY26-FY28 Priority Health Need: Access to Health Care

Goal: Increase access to health care for the medically underserved.

Strategies

1. Provide financial assistance through free and discounted care for health care services, consistent with the hospital's financial assistance policy.
2. Provide transportation support to increase access to health care services.
3. Provide low-income residents with low-cost or no-cost pharmacy assistance.
4. Offer health education, community outreach, and support services that reduce barriers to care and increase access to health care.
5. Support a Vietnamese Community Outreach Coordinator to direct free community education, flu vaccine clinics, and health screenings in the Vietnamese community.
6. Host a Vietnamese language website to serve Vietnamese speaking community members.
7. Provide social work management, supplies and prescriptions.
8. Provide grant funding and in-kind support to increase access to health care.
9. Work in collaboration with community agencies to address the health care needs of older adults.
10. Work in collaboration with community agencies to address the impact that the social drivers of health and health equity have on health care access.

FY26-FY28 Priority Health Need: Behavioral Health (Mental Health and Substance Use)

Goal: Increase access to mental health and substance use services in the community.

Strategies

1. Increase community awareness of prevention efforts and availability of resources to address mental health and substance use and misuse concerns.
2. Offer community health education, lectures, presentations and workshops focused on mental health and substance use topics.
3. Participate in health and wellness fairs that include information on behavioral health resources.
4. Support multisector collaborative efforts to increase access to behavioral health services.
5. Provide grant funding and in-kind support to increase behavioral health awareness and access to behavioral health services.
6. Provide mental health support for at-risk seniors.
7. Work in collaboration with community agencies to address the impact that the social drivers of health and health equity have on accessing behavioral health services.

FY26-FY28 Priority Health Need: Chronic Diseases

Goal: Reduce the impact of chronic diseases on health and increase the focus on chronic disease prevention and treatment education.

Strategies

1. Offer health education workshops and presentations on chronic disease prevention, treatment, and management.
2. Host health and wellness fairs, including screenings.
3. Provide cancer support services, which include health and wellness education as well as support services related to cancer including nutritional counseling.
4. Senior outreach liaison to work with local agencies and organizations to assist older adults in securing needed services, as well as health screenings and disease prevention classes.
5. Provide support groups to assist those with chronic diseases and their families.
6. Provide public health education in the media and community health awareness events to encourage healthy behaviors and prevent chronic diseases.
7. Provide grant funding and in-kind support for chronic disease prevention and treatment.
8. Work in collaboration with community agencies to address chronic disease prevention and treatment among older adults.
9. Work in collaboration with community agencies to address the impact that the social drivers of health and health equity have on chronic diseases.

FY26-FY28 Priority Health Need: Overweight and Obesity

Goal: Reduce the impact of overweight and obesity on health and increase the focus on healthy eating and physical activity.

Strategies

1. Offer health education workshops and presentations focused on weight management, breastfeeding, healthy eating, and physical activity topics.
2. Host health and wellness fairs that include screenings for BMI, blood pressure, and blood glucose.
3. Provide support for educational outreach to children and their families on nutrition, healthy food choices, and physical activity.
4. Provide grant funding and in-kind support to promote healthy eating and physical activity.
5. Provide support for services to improve senior nutrition.
6. Work in collaboration with community agencies to address healthy eating and physical activity among older adults.
7. Work in collaboration with community agencies to address the impact that the social drivers of health and health equity have on chronic diseases.

FY26-FY28 Priority Health Need: Preventive Practices

Goal: Improve community health through preventive health practices.

Strategies

1. Provide free health screenings.
2. Provide education and resources focused on healthy living and disease prevention.
3. Provide public health education in the media and community health awareness events to encourage healthy behaviors and promote preventive health care.
4. Provide grant funding and in-kind support to expand preventive health services.
5. Work in collaboration with community agencies to provide preventive care services to older adults.
6. Work in collaboration with community agencies to address the impact that the social drivers of health and health equity have on access to preventive care.

Evaluation of Effectiveness

Through the CHNA process, community stakeholders provided input on the health needs impacting the community, prioritization of the needs, and resources to address the needs. Appendix 2 identifies the community groups and local officials that were consulted.

OCMC will monitor and evaluate the programs and activities outlined above. The hospital has implemented a system for the collection and documentation of tracking measures, such as the number of people reached or served, and collaborative efforts to address the health needs. An evaluation of the impact of OCMC's actions to address these significant health needs will be reported in the next scheduled CHNA.

Needs the Hospital Will Not Address

OCMC cannot address all the health needs present in the community, but it will concentrate on those priority health needs that it can most effectively address given its areas of focus and expertise. Taking existing hospital and community resources into consideration, OCMC is choosing to address all the significant health needs identified in the CHNA, which include the social drivers of health and senior health.

Contact Information

Orange Coast Medical Center
9920 Talbert Avenue
Fountain Valley, CA 92708

Web Address
https://www.memorialcare.org/locations/orange-coast-medical-center

Community Benefit Contact
John Fay, MSG
Government & Community Relations Manager
MemorialCare Health System
jfay@memorialcare.org

Appendix 1: Categorization of Community Benefit Programs

Medical Care Services
Charity care/financial assistance
Medi-Cal shortfall
Medicare shortfall (non-IRS)
Other Benefits for Vulnerable Populations
Advanced care planning
Baby Care Basics, childbirth classes
Bereavement support group
Breast health
Breastfeeding classes, support groups and consultation
Cancer screening, support groups, education, outreach, and resources
Cash and in-kind donations to organizations serving vulnerable populations and improving community health
Community benefit grant program to organizations serving vulnerable populations to address priority health needs, health equity and the social drivers of health
Community outreach on access to care, health insurance and financial assistance
Community outreach, health education, and screenings on chronic diseases, preventive care, and healthy living
CPR and first aid
Maternal and infant health, and postpartum support group
Nutrition and healthy eating information and resources
Parkinson's disease support groups, education and exercise classes
Safety and injury prevention
Senior health education and outreach
Social drivers of health screening and referrals
Social work referrals and counseling
Transportation support
Vietnamese community health education and outreach
Other Benefits for the Broader Community
Community benefit operations
Health Research, Education and Training Programs
Clinical precepting for nursing students
Clinical precepting for other health professionals: cardiopulmonary, cardiovascular technician, imaging, lactation consultation, pharmacy, social work, surgical technician, and ultrasound
Continuing Medical Education
Nonquantifiable Benefits
Coalition Building

Economic Development
Health Advocacy

Appendix 2: Community Stakeholders

Name	Title	Organization
Elizabeth Andrade, MBA	Executive Director	211 Orange County
Ameera Basmadji	Fund Development Director	Access California Services
Pooja Bhalla, DNP, RN	Chief Executive Officer	Illumination Foundation
Sandra Crandall	Board of Trustees President	Fountain Valley School District
Allison Cuff	Community Liaison	Jamboree Housing Corporation
Ben Dieterle, MPA	Community Services Supervisor	City of Fountain Valley
Krista Driver, PsyD	Chief Executive Officer	Mariposa Women & Family Center
Justin Fleming, MPA, CTO, EMT-P	Division Chief	Huntington Beach Fire Department
Mary Ann Foo, MPH	Executive Director	Orange County Asian and Pacific Islander Community Alliance (OCAPICA)
Nancy Galeana	Program Director of Community Care	Waymakers Huntington Beach Youth Shelter
Art Groeneveld	Chief Executive Officer	Boys & Girls Clubs of Huntington Valley
Claudia Keller, MPA	Chief Executive Officer	Second Harvest Food Bank of Orange County
Alejandro Lupercio, LNHA, MBA	Vice President of Social Services	Meals on Wheels Orange County
Andrea McCartney	Village of Hope Manager	Orange County Rescue Mission
Patty Barnett Mouton, MSGc	Vice President, Outreach & Advocacy	Alzheimer's Orange County
Becky Nguyen, MPA, MPH	Executive Director	Vital Access Care Foundation
Hang Nguyen	Executive Director	Center for Community Advancement (BPSOS-CCA)
Darla Olson	Chief Development Officer	Meals on Wheels Orange County
Steve Pitman, JD	President of Board of Directors	National Alliance of Mental Illness (NAMI) Orange County
Hiram Rodriguez	Associate Director Food Bank	Community Action Partnership of OC
Michaell Silva Rose, DrPH, LCSW	Chief Health Equity Officer	CalOptima
Laura Rubio, Ed.D	Director of Student Services	Tustin Unified School District
Dr. Almaas Shaikh, MD, MPH, FACS	Deputy Health Officer	Orange County Health Care Agency
Raquel Williams, LCSW	Executive Director	Thrive Together OC
Lisa Wood	Chief Executive Officer	Casa Teresa
Philip Yaeger	Chief Executive Officer	Radiant Health Centers
Cindy Young, MPH, RD	Director of Strategic Partnerships	BreastfeedLA: Breastfeeding Task Force of Greater Los Angeles
Michelle Yerke, MSG	Social Services Supervisor	City of Huntington Beach