

MemorialCare Long Beach Medical Center

# Implementation Strategy

**FY2026-FY2028**



**MemorialCare**<sup>™</sup>  
Long Beach Medical Center

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## Introduction

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

MemorialCare Long Beach Medical Center (LBMC) has been providing compassionate, quality health care for more than 115 years. LBMC is a 453 bed, state-of-the-art regional medical center. As a regional medical center, LBMC provides health care through many specialties and services, including the Certified Comprehensive Stroke Center, Long Beach Adult and Pediatric Sleep Center, MemorialCare Breast Center, MemorialCare Heart & Vascular Institute, MemorialCare Imaging Center, MemorialCare Joint Replacement Center, MemorialCare Rehabilitation Institute, MemorialCare Todd Cancer Institute, Spine Health Center and a Level II Trauma Center.

In 2025, LBMC conducted a Community Health Needs Assessment (CHNA) in compliance with state and federal regulations guiding tax-exempt hospitals, assessing the significant health needs for the hospital’s service area. California Senate Bill 697 and the Patient Protection and Affordable Care Act through IRS section 501(r)(3) regulations direct nonprofit hospitals to conduct a CHNA every three years and develop a three-year Implementation Strategy that responds to identified community health needs.

The CHNA and Implementation Strategy help guide the hospital’s community health improvement programs and community benefit activities, as well as its collaborative efforts with organizations that share a mission to improve health. This Implementation Strategy explains how LBMC plans to address the significant health needs identified by the CHNA.

### Report Adoption, Availability and Comments

This Implementation Strategy was adopted by the Board of Directors on June 10, 2025. The CHNA and Implementation Strategy are available at [www.memorialcare.org/about-us/community-benefit](http://www.memorialcare.org/about-us/community-benefit).

Public comments on the CHNA and Implementation Strategy are encouraged as community input is used to inform and influence this work. Written comments can be submitted to [communitybenefit@memorialcare.org](mailto:communitybenefit@memorialcare.org).

## Definition of the Community Served

LBMC is located at 2801 Atlantic Avenue, Long Beach, California, 90806. The hospital tracks ZIP Codes of origin for all patient admissions and includes all who received care without regard to insurance coverage or eligibility for financial assistance. For the purposes of this report, 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.

The hospital defines its service area to include 31 ZIP Codes, located in 17 communities. The 28 ZIP Codes in Los Angeles County comprise portions of Los Angeles County Service Planning Areas (SPAs) 6, 7 and 8. The hospital service area is detailed below by community and ZIP Code.

**Long Beach Medical Center Primary Service Area**

Cities	ZIP Code	Service Planning Area
Artesia	90701	7
Bellflower	90706	7
Carson	90745, 90746	8
Cerritos	90703	7
Compton	90220, 90221	6
Cypress	90630	N/A – Orange County
Hawaiian Gardens	90716	7
Lakewood	90712, 90713, 90715	7
Long Beach	90802, 90803, 90804, 90805, 90806, 90807, 90808, 90810, 90813, 90814, 90815	8
Los Alamitos	90720	N/A – Orange County
Lynwood	90262	6
Norwalk	90650	7
Paramount	90723	6
Seal Beach	90740	N/A – Orange County
Signal Hill	90755	7
South Gate	90280	7
Wilmington	90744	8

## Significant Health Needs

LBMC's CHNA incorporated demographic and health data collected from a variety of local, county and state sources to present community demographics, social drivers of health, access to health care, birth characteristics, leading causes of death, acute and chronic disease, health behaviors, mental health, substance use and preventive practices. Analysis of secondary data included an examination and reporting of health disparities for some health indicators. The report includes benchmark comparison data that measure the data findings as compared to Healthy People 2030 objectives, where appropriate.

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

- Access to care
- Birth indicators
- Chronic diseases
- Economic insecurity
- Environmental pollution
- Food insecurity
- Housing and homelessness
- Mental health
- Overweight and obesity
- Preventive practices
- Racism and discrimination
- Substance use
- Violence and injury prevention

## **Prioritized Health Needs the Hospital Will Address**

This Implementation Strategy details how LBMC plans to address the significant health needs identified in the 2025 CHNA. The hospital plans to build on previous CHNA efforts and existing initiatives, while also considering new strategies and efforts to improve health.

LBMC examined the identified significant health needs and prioritized them with community stakeholder input. Stakeholders included a broad range of key informants and residents in the service area who spoke about the issues and needs in the communities served by the hospital. Once the CHNA was completed, the hospital convened the Community Benefit Oversight Committee (CBOC) on April 21, 2025, to discuss and prioritize the significant health needs. Prior to the meeting, the committee received the 2025 CHNA and had an opportunity to review the CHNA findings.

The CBOC applied the following criteria to the significant health needs to determine the priority health needs LBMC will address in the Implementation Strategy.

- Existing infrastructure: There are programs, systems, staff, and support resources in place to address the issue.
- Established partners: There are established relationships with community partners 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.

Results of the prioritization process were compiled, and priority health needs identified. As a result of this process, LBMC will address the following significant health needs with a focus on the social drivers of health (e.g. economic insecurity, environmental health, food insecurity, housing and homelessness, transportation, etc.) and health equity:

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

## **Strategies to Address Prioritized Health Needs**

For each health need the hospital plans to address, the Implementation Strategy describes the actions the hospital intends to take, including programs and resources it plans to commit; anticipated impacts of these actions; and planned collaboration between the hospital and other organizations.

### **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. Offer health education, community outreach, and support services that reduce barriers to care and increase access to health care.
4. Provide social work management, supplies, prescriptions, and other supportive care services.
5. Provide grant funding and in-kind support to increase access to health care.
6. Work in collaboration with community agencies to address the impact that the social drivers of health and health equity have on health care access.

#### **Anticipated Impact**

- Increase access to health care and reduce barriers to care.
- Provide financial assistance to qualified patients.
- Support access to health care services by providing transportation assistance.
- Increase awareness of the impact that the social drivers of health and health equity have on access to health care services.

#### **Planned Collaborative Partners**

- Community clinics
- Community-based organizations
- County of Los Angeles Public Health
- City of Long Beach
- City of Long Beach Office of Equity
- Long Beach Department of Health and Human Services
- Long Beach Forward
- Long Beach Multi-Service Center
- MemorialCare Medical Group
- Schools and school districts
- Senior services

- Transportation services

## **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 residents.
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.

### **Anticipated Impact**

- Increase the availability of mental health and substance use services in community settings through collaboration with community partners.
- Improve screening and identification of mental health and substance use needs.
- Improve coordination among providers and community resources and programs.
- Increase awareness of the impact that the social drivers of health and health equity have on behavioral health issues.

### **Planned Collaborative Partners**

- Community clinics
- Community-based organizations
- County of Los Angeles Department of Mental Health
- County of Los Angeles Department of Public Health
- Homeless Service Agencies
- Long Beach Community Crisis Response Team
- Long Beach Department of Health and Human Services
- MemorialCare Family Medicine Clinic
- MemorialCare Medical Group
- Schools and school districts
- Senior centers
- Youth-focused organizations



## **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 diabetes support services and cancer support services, which include health and wellness education as well as support services.
4. Provide support groups to assist those with chronic diseases and their families.
5. Provide public health education in the media and community health awareness events to encourage healthy behaviors and prevent chronic diseases.
6. Provide grant funding and in-kind support for chronic disease prevention and treatment.
7. Work in collaboration with community agencies to address chronic disease prevention and treatment.
8. Work in collaboration with community agencies to address the impact that the social drivers of health and health equity have on chronic diseases.

### **Anticipated Impact**

- Increase the identification and treatment of chronic diseases.
- Increase public awareness of chronic disease prevention.
- Increase individuals' compliance with chronic disease prevention and management recommendations.
- Improve healthy eating and increase physical activity among community members.
- Increase awareness of the impact that the social drivers of health and health equity have on chronic disease.

### **Planned Collaborative Partners**

- American Cancer Society
- American Diabetes Association
- American Heart Association
- American Lung Association
- Community-based organizations
- Community clinics
- County of Los Angeles Department of Public Health
- Local city government
- Long Beach Department of Health and Human Services
- Long Beach Multi-Service Center
- Schools and school districts

- Senior Centers
- Youth-focused organizations

## **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.
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.

### **Anticipated Impact**

- Increase availability and access to preventive care services.
- Increase compliance with preventive care recommendations (screenings, immunizations, injury prevention, and lifestyle and behavior changes).
- Increase awareness of the impact that the social drivers of health and health equity have on access to preventive practices.

### **Planned Collaborative Partners**

- Community clinics
- Community-based organizations
- County of Los Angeles Department of Public Health
- Local city government
- Long Beach Department of Health and Human Services
- Schools and school districts
- Senior Centers
- Youth-focused organizations

## **Evaluation of Impact**

LBMC is committed to monitoring and evaluating key initiatives to assess the programs and activities outlined in this Implementation Strategy. We have 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 priority health needs. In addition, through our grants program, we track and report program outcomes. An evaluation of the impact of LBMC's actions to address these priority health needs will be reported in the next scheduled CHNA.

## **Health Needs the Hospital Will Not Address**

Since LBMC cannot directly address all the health needs present in the community, we will concentrate on those health needs that can most effectively be addressed given our areas of focus and expertise. Taking existing hospital and community resources into consideration, LBMC will not directly address the remaining significant health needs identified in the CHNA, which include birth indicators, overweight and obesity, and violence prevention.