MemorialCare Orange Coast Medical Center

Implementation Strategy

FY2026-FY2028

MemorialCare™
Orange Coast Medical Center

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Introduction

MemorialCare is a nonprofit integrated health system that includes leading hospitals – Orange Coast Medical Center, Long Beach Medical Center, Miller Children's & Women's Hospital, 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 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.

In 2025, OCMC 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 OCMC 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 9, 2025. The CHNA and Implementation Strategy are available at www.memorialcare.org/about-us/community-benefit.

Public comment on the CHNA and Implementation Strategy is encouraged as community input is used to inform and influence this work. Written comments can be submitted to communitybenefit@memorialcare.org.

Definition of the Community Served

OCMC is located at 9920 Talbert Avenue, Fountain Valley, California 92708. The service area is located in Orange County and includes 28 ZIP Codes, representing 13 cities or communities. 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.

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

Significant Health Needs

OCMC'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
- Chronic diseases
- Economic insecurity
- Food insecurity
- Housing and homelessness
- Mental health

- Overweight and obesity
- Preventive care
- Senior health
- Substance use

Prioritized Health Needs the Hospital Will Address

This Implementation Strategy details how OCMC 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.

OCMC 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 17, 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 OCMC 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, OCMC will address the following significant health needs with a focus on older adults, the social drivers of health, and health equity:

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

Strategies to Address Prioritized Health Needs

For each health need the hospital plans to address, the Implementation Strategy describes the following: 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. 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.

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
- Local media (cable TV and radio)
- MemorialCare Medical Group
- Orange County Health Care Agency

- Schools and school districts
- Senior services
- Transportation services
- Vietnamese community agencies

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.

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
- MemorialCare Medical Group
- Orange County Health Care Agency, Behavioral Health Services
- Schools and school districts
- Senior centers

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.

Anticipated Impact

- Increase the identification and treatment of chronic diseases.
- Increase public awareness of chronic disease prevention.
- Increase 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

- Alzheimer’s Association Orange County Chapter
- American Cancer Society
- American Diabetes Association
- American Heart Association
- American Lung Association
- Community-based organizations
- Community clinics
- Local city government

- Orange County Aging Services Collaborative
- Orange County Health Care Agency
- Orange County Office on Aging
- Parkinson's Orange County
- Schools and school districts
- Senior Centers

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.

Anticipated Impact
- Increase public awareness of healthy eating and physical activity.
- Improve healthy eating behaviors and increase physical activity.
- Improve senior nutrition programs.
- Increase awareness of the impact that social determinants of health and health equity have on chronic disease.

Planned Collaborative Partners
- American Diabetes Association
- American Heart Association
- Local city government
- Orange County Health Care Agency
- Schools and school districts
- Second Harvest Food Bank Orange County
- 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 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 practices.

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
- Local city government
- Orange County Health Care Agency
- Orange County Office on Aging
- Schools and school districts
- Senior Centers
- Youth-focused organizations

Evaluation of Impact

OCMC 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/served, and collaborative efforts to address health needs. In addition, through our grants program, we track and report program outcomes. An evaluation of the impact of OCMC's actions to address these significant health needs will be reported in the next scheduled CHNA.

Health Needs the Hospital Will Not Address

Since OCMC 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, OCMC will address the significant health needs identified in the CHNA, which include the social drivers of health and senior health.